

## MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

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

Thursday, November 8, 2007  
9:40 a.m.

## COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair  
ROBERT D. REISCHAUER, Ph.D., Vice Chair  
MITRA BEHROOZI, J.D.  
JOHN M. BERTKO, F.S.A., M.A.A.A.  
KAREN R. BORMAN, M.D.  
RONALD D. CASTELLANOS, M.D.  
FRANCIS J. CROSSON, M.D.  
THOMAS M. DEAN, M.D.  
NANCY-ANN DePARLE, J.D.  
DAVID F. DURENBERGER, J.D.  
JACK M. EBELER, M.P.A.  
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N  
NANCY M. KANE, D.B.A.  
ARNOLD MILSTEIN, M.D., M.P.H.  
WILLIAM J. SCANLON, Ph.D.  
BRUCE STUART, PH.D.  
NICHOLAS J. WOLTER, M.D.

AGENDA	PAGE
Increasing participation in the Medicare savings programs and low-income drug subsidy -- Joan Sokolovsky and Hannah Neprash	3
Part D benefit design: formulary analysis -- Jack Hoadley, Georgetown University -- Elizabeth Hargrave, NORC	45
Part D benefit design: plan analysis -- Rachel Schmidt	78
Public Comment	117
Moving toward bundling payment around hospitalization -- Anne Mutti and Craig Lisk	124
Preliminary findings on SNF payment refinement -- Carol Carter -- Bowen Garrett and Doug Wissoker, Urban Institute	180
Medicare's hospice benefit: access and implications for payment system reform -- Jim Mathews	207
Creating incentives to improve dialysis quality and providers' efficiency -- Nancy Ray	248
Delivery system reform -- David Glass and Jeff Stensland	269
Public Comment	306

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

2 MR. HACKBARTH: Welcome to our guests in the  
3 audience. The first subject today is increasing  
4 participation in the Medicare savings programs and low-  
5 income drug subsidy.

6 DR. SOKOLOVSKY: Good morning, everyone.

7 Congress has established a number of programs to  
8 provide financial assistance to Medicare beneficiaries with  
9 limited incomes. Although programs like the Medicare  
10 savings program and the low-income drug subsidy provide  
11 significant savings to individuals, the majority of eligible  
12 beneficiaries do not participate.

13 In September, we discussed these programs and  
14 suggested some reasons why participation rates are not  
15 higher. In today's presentation we will present three draft  
16 recommendations for your consideration that are designed to  
17 increase participation.

18 In response to some of your comments in September,  
19 Hannah will provide some context for our discussion of the  
20 Medicare savings program and drug subsidy by examining the  
21 income and out-of-pocket health expenditures of the Medicare  
22 population. She will also present findings from a survey on

1 beneficiary avoidance of health care services because of  
2 cost. Our key finding from this work was that Medicare  
3 beneficiaries typically have lower incomes and higher out-  
4 of-pocket health costs than the rest of the population.  
5 Then I will review reasons for low participation in the  
6 Medicare savings program, or MSP, and present some possible  
7 recommendations that could increase participation.

8           We found that increasing participation in programs  
9 that provide help to beneficiaries with limited incomes has  
10 proven quite difficult. Targeted outreach and  
11 administrative simplification can be effective strategies.

12           MS. NEPRASH: In general, Medicare beneficiaries  
13 have lower incomes than individuals under age 65. At  
14 \$17,045, the median annual individual income of the 65-and-  
15 over population is roughly \$11,000 less than that of their  
16 younger counterparts.

17           Individuals aged 65 and over are like more likely  
18 to be poor or near-poor than those under 65. Roughly 35  
19 percent of the 65-and-over population has an annual income  
20 between \$10,000 and \$19,000, compared to slightly more than  
21 15 percent of their younger counterparts with a similar  
22 income.

1           Within Medicare, older beneficiaries are even more  
2 likely than younger beneficiaries to be poor or near-poor,  
3 with over 40 percent of beneficiaries aged 75 and older  
4 receiving an annual income between \$10,000 and \$19,000.  
5 This difference is due in part to the predominance of non-  
6 married women in the older age bracket.

7           It's worth noting the difficulty of finding  
8 reliable income and asset data for the disabled Medicare  
9 eligible population. The numbers we found show that  
10 disabled Medicare beneficiaries were twice as likely as the  
11 65-and-over population to have incomes below the poverty  
12 line and this chance increases with mental impairment.

13           Medicare beneficiaries are most likely to rely on  
14 Social Security as their major source of income. Asset  
15 income is the next most common source, however most  
16 beneficiaries get little income from this source, the  
17 majority of which is earned from personal savings. The  
18 median annual amount of interest earned on personal savings  
19 was only \$438 in 2004. Medicare beneficiaries with higher  
20 incomes were more likely to have income from assets.

21           Although Medicare provides insurance for the 65-  
22 and-over population, they have higher out-of-pocket health

1 care expenses than those under 65 because of poor health  
2 status and the structure of the Medicare benefit package, a  
3 topic that Rachel discussed at the September meeting. In a  
4 report issued this fall, researchers from the Kaiser Family  
5 Foundation found that Medicare beneficiaries have average  
6 annual health care expenditures nearly three times the  
7 amount of the under-65 population. These out-of-pocket  
8 health care expenditures represented 12.5 percent of income  
9 for seniors compared to 2.2 percent of annual income for the  
10 under-65 population.

11 An article by the same researchers in the most  
12 recent issue of Health Affairs reported that out-of-pocket  
13 health care expenditures represented roughly 22 percent of  
14 income for beneficiaries below 200 percent of poverty.

15 Note that even when you exclude prescription drug  
16 spending -- and remember this survey was done before  
17 implementation of the Medicare drug benefit -- Medicare  
18 beneficiaries have higher out-of-pocket spending compared to  
19 the under-65 population.

20 Because of lower incomes and greater out-of-pocket  
21 health care expenditures, Medicare beneficiaries,  
22 particularly those near the poverty line, may avoid

1 necessary health care. Medicare savings program, or MSP,  
2 enrollment seems to have a protective effect against such  
3 care avoidance. Using self-reported survey data on health  
4 care avoidance researchers analyzed rates of avoidance due  
5 to cost among low-income seniors. Roughly 30 percent of  
6 low-income seniors reported having avoided visiting a  
7 physician because it cost too much.

8           After controlling for demographic and health  
9 status differences, researchers found that qualified  
10 Medicare beneficiary, or QMB, enrollees were half as likely  
11 to avoid physician care than similarly low-income  
12 beneficiaries who were not enrolled in the QMB program.

13           QMB enrollment did not have a significant effect  
14 on hospital visit or prescription drug avoidance -- and  
15 again keep in mind this survey occurred before the Medicare  
16 drug benefit -- but non-QMBs were more likely to use the  
17 emergency room.

18           Joan will now discuss three draft recommendations  
19 designed to increase participation in that Medicare savings  
20 program and the low-income drug subsidy.

21           DR. SOKOLOVSKY: For the MSP programs, as for  
22 other means-tested programs for the elderly, less than half

1 the population that is eligible participates. Analysts  
2 estimate that about one-third of those eligible for QMB, not  
3 counting dual eligibles, are enrolled. The rates are even  
4 lower for SLMBs and the QI population. Participation in the  
5 low-income drug subsidy is higher, but still less than half  
6 the eligible population -- excluding once again the dual  
7 population -- has enrolled. There are many reasons why  
8 individuals might choose not to take advantage of these  
9 programs but researchers have found that the main barriers  
10 to enrollment are beneficiaries' lack of knowledge of the  
11 programs and the complexity of the application processes.

12 In addition, eligible non-enrollees tend to be  
13 more isolated, they can be homebound, they may live in very  
14 rural areas, or have cognitive difficulties.

15 Finally, the perceived stigma of applying for aid  
16 at a state Medicaid office may keep some beneficiaries from  
17 seeking help.

18 In the past decade there have been a number of  
19 public and private campaigns to increase participation in  
20 the programs. Most have achieved small but significant  
21 success. Perhaps the most prominent effort was that  
22 undertaken by the RWJ and Commonwealth Fund, which sponsored



1 grants to entities in five states to increase MSP  
2 participation. Each grantee used the money in a different  
3 way.

4 Data suggests that the most successful outreach  
5 strategies carefully targeted eligible individuals and gave  
6 very specific information on how and where to get help with  
7 enrollment. To give you two examples, Minnesota trained 50  
8 State Health Insurance Assistance Program, or SHIP,  
9 volunteers to work with the Indian Health Service to find  
10 and enroll eligible beneficiaries in regions where  
11 reservations were located. MSP enrollment in these areas  
12 increased 43 percent in two years.

13 Louisiana Medicaid, another grantee, developed  
14 partnerships with SHIPs, Meals on Wheels, physicians,  
15 pharmacists, and home health providers. Their outreach and  
16 other administrative changes to the programs resulted in a  
17 44 percent enrollment increase. Overall, MSP participation  
18 in all five of the states that received grants increased.

19 The Federal government provides funds for Medicare  
20 beneficiary education and counseling through the National  
21 Medicare Education Program. The funding supports the 1-800-  
22 Medicare call center, the beneficiary handbook, the website,

1 multimedia campaigns, SHIPs, and community-based outreach.

2 SHIPs are state-based organizations that provide  
3 information and personal counseling to Medicare  
4 beneficiaries. They are the only part of the Federal  
5 program that provides one-on-one counseling to beneficiaries  
6 and research has shown that beneficiaries respond best to  
7 this kind of personal contact.

8 State SHIPs vary in the amount of resources and  
9 expertise available to them. Most depend upon a limited  
10 number of paid employees and volunteers. There are many  
11 ways that they could use additional resources to find and  
12 counsel low-income beneficiaries. SHIPs could train  
13 volunteers and community organizers on MSP eligibility and  
14 how to enroll beneficiaries in the low-income drug subsidy  
15 and MSP. They could employ an individual who was dedicated  
16 to resolving Part D or MSP issues. They could increase  
17 outreach to more isolated communities, including rural  
18 areas, non-English speaking beneficiaries, or those with  
19 other kinds of difficulties. They could update their  
20 computer systems to make it possible for them to submit  
21 applications for qualified beneficiaries from the field.  
22 They could also use the funds to support the work of

1 community-based organizations in places like public housing  
2 sites, churches, or even -- as Nancy suggested last month --  
3 beauty parlors.

4 SHIPs receive about \$30 million annually from the  
5 Medicare education program. That's down from a high of  
6 about \$33 million in 2005 when they were teaching about Part  
7 D. Their current funding limits their ability to do more  
8 targeted outreach to low-income beneficiaries.

9 So draft recommendation one reads: the Secretary  
10 should increase SHIP funding and the SHIPs should use the  
11 additional money to support work to increase participation  
12 in programs targeted to low-income Medicare beneficiaries.

13 Increased funding for SHIPs and other groups that  
14 provide expertise and individual counseling will permit more  
15 beneficiaries to learn about and apply for programs for  
16 which they are eligible.

17 This recommendation should increase participation  
18 in MSP and LIS. The budget implication here is  
19 indeterminate since we haven't given a specific number. To  
20 the extent that participation increases, spending by the  
21 Federal government and the states would increase.  
22 Beneficiaries with limited incomes would save money.

1           Before I move on to the next issue, I want to  
2 briefly remind you of the criterion for the MSP programs and  
3 LIS. Recall that there are three Medicare savings programs.  
4 Benefits include payment of the Part B premium and, for  
5 QMBs, payment of the Medicare deductible and coinsurance for  
6 Medicare covered surfaces. In addition, anyone enrolled in  
7 a Medicare savings program is automatically eligible for the  
8 Part D low-income subsidy. All programs have an asset limit  
9 of \$4,000 for an individual or \$6,000 for a couple.

10           The third program, QI, or qualifying individual,  
11 is a block grant program that is funded entirely by the  
12 Federal government, for individuals meeting the same asset  
13 criteria and with incomes of up to 135 percent of poverty.

14           This slide shows the eligibility criteria for the  
15 low-income drug subsidy, or LIS. The subsidy provides  
16 coverage of Part D premiums for qualifying plans,  
17 deductibles, and limits cost-sharing, depending upon the  
18 beneficiaries' income and assets. As you can see, the two  
19 programs, while targeting largely the same population, have  
20 different income and asset requirements. Note that the  
21 income limit for the subsidy goes up to 150 percent of  
22 poverty and beneficiaries at this income can receive a

1 limited subsidy if they have assets of up to \$11,700 for an  
2 individual or \$23,420 for a couple.

3 More targeted outreach, as called for in draft  
4 recommendation one, while helpful, is likely to have only a  
5 limited effect on participation if the application process  
6 is too complicated and documentation requirements are too  
7 onerous. State eligibility and application and retention  
8 procedures have a major effect on how simple or difficult it  
9 is for beneficiaries and those helping them to apply for  
10 MSP.

11 Although the MSP asset limit has not changed since  
12 1989 when QMB was first established, states have a lot of  
13 flexibility in using these criteria. Some states, eight  
14 now, have used their flexibility to effectively raise MSP --  
15 well, more states have used this flexibility to effectively  
16 raise MSP income or asset limits. For example, eight states  
17 disregard all assets for some or all of the programs.

18 Eliminating or raising the asset limit is  
19 important, less because it makes more people eligible than  
20 because it can make application and enrollment easier.  
21 That's because, as Hanna mentioned, it's very hard to  
22 document assets and for state workers to verify the asset

1 values.

2           For example, before Arizona eliminated its asset  
3 test in 2001, it analyzed the number of beneficiaries who  
4 applied for the programs the previous year and would have  
5 qualified if there had been no asset test. They found that  
6 only 475 applicants would have become eligible if assets  
7 were not counted. Again, this is because beneficiaries with  
8 significant assets, as Hannah showed you, generally have  
9 enough income from those assets to be disqualified for MSP.  
10 On the other hand, the state calculated that they would  
11 realize cost savings from less postage, fewer forms, and  
12 especially less employee labor time verifying assets.

13           While the Congress set the income and asset limit  
14 for LIS in the MMA, it set them at a higher level than MSP  
15 recognizing that people with incomes below 150 percent of  
16 poverty could have difficulty paying their out-of-pocket  
17 health care costs. If Congress raised the income and asset  
18 level for MSP to coincide with LIS, administrative savings  
19 would be lower than if you eliminated an asset test but  
20 alignment with LIS would still permit one eligibility  
21 determination and enrollment process for both programs.

22           This leads to draft recommendation two: the

1 Congress should raise MSP income and asset criteria to  
2 conform to LIS criteria. That means essentially that  
3 beneficiaries with incomes of up to 150 percent of poverty  
4 would be eligible for the QI benefits. If income and asset  
5 levels were the same for both MSP and LIS, beneficiaries  
6 could be screened and enrolled for both programs  
7 simultaneously. Beneficiaries would find the process  
8 simpler and the government would realize administrative  
9 savings.

10           This recommendation should increase participation  
11 in MSP programs. To the extent that participation  
12 increased, it would increase Federal and state programs.  
13 When we tried to figure out the cost of this, talking to  
14 CBO, the QI program is a block grant that has to be extended  
15 every year. Therefore, CBO would put the cost of the  
16 recommendation as less than \$50 million for one year and  
17 less than \$1 billion over five years under current law.  
18 However, if the program continues, as we expect it to, then  
19 it would cost between \$250 million and \$750 million for one  
20 year -- that's our bucket -- and between \$1 billion and \$5  
21 billion over five years.

22           They emphasize that the main cost of this is

1 really the extension of the QI program which the block grant  
2 has been about \$400 million each year.

3 Beneficiaries with limited incomes would save  
4 money.

5 The Social Security Administration is responsible  
6 for determining eligibility for the low-income subsidy for  
7 those individuals who are not deemed eligible.

8 Beneficiaries can apply for LIS without facing the possible  
9 stigma associated with going for help at a state Medicaid  
10 office. Under the law, beneficiaries who apply for LIS at a  
11 state Medicaid office must be screened for other programs  
12 like MSP that they might be entitled to. Social Security  
13 Administration does not have this responsibility.

14 However, currently more than 30 states have  
15 contracts with the Social Security Administration to  
16 determine Medicaid eligibility for SSI beneficiaries. Thus,  
17 the Agency has the experience to conduct eligibility  
18 determinations. If MSP and LIS eligibility were based on  
19 the same criteria, SSA could screen and enroll beneficiaries  
20 for both programs at the same time.

21 This leads to draft recommendation three: the  
22 Congress should change program requirements so that SSA



1 screens LIS applicants for Federal -- and this is Federal,  
2 not individual state -- but Federal MSP eligibility and  
3 enrolls them if they qualify.

4 This recommendation would simplify application and  
5 enrollment for beneficiaries and counselors. SSA could use  
6 one application for both programs. It would increase  
7 participation in MSP by beneficiaries who have heard of the  
8 drug subsidy. It is unlikely to increase enrollment by  
9 beneficiaries who do not know about the drug subsidy.

10 If MSP and LIS criteria were the same, it would  
11 limit the increased SSA workload. But it's obvious that if  
12 this recommendation was implemented, SSA would need more  
13 resources to get a system in place.

14 This recommendation would increase participation  
15 in MSP. To the extent that participation increased, it  
16 would increase Federal spending. But we don't yet have an  
17 estimate of what the cost would be, although we're working  
18 on that. Beneficiaries with limited incomes would save  
19 money.

20 We look forward to your comments on the paper and  
21 especially the recommendations.

22 MR. HACKBARTH: Good job.

1           For the audience, let me just say a word about the  
2 context for this discussion. Getting support to low-income  
3 beneficiaries is important in its own right. An added  
4 reason, however, for our looking at this is that this has  
5 become a topic of discussion in the context of Medicare  
6 Advantage, where some have argued that one of the benefits  
7 of the current Medicare Advantage program and payment levels  
8 is that plans are able to provide access to better coverage  
9 for beneficiaries with low incomes. And so one of the  
10 questions is if that's a goal, how do we accomplish it most  
11 effectively and effectively, and not just for people who are  
12 in Medicare Advantage plans but for Medicare beneficiaries  
13 as a group?

14           So questions, comments on the presentation?

15           DR. KANE: One question I had was do we have a  
16 sense of the extent to which of the low-income elders who  
17 don't have this -- aren't in savings plans, affect the  
18 Medicare bad debt piece? And to what extent, if we enrolled  
19 them, would that reduce -- it may be just impossible to find  
20 out. But it just seems like these people would be the ones  
21 who would be most likely to incur bad debt and be unable to  
22 pay it. And I didn't know if that was something we could

1 connect the dots to.

2           So part one, I am interested in that because of  
3 the potential of an offset to the increase in cost. Part  
4 two is if they are actually incurring bad debt, are they  
5 protected from the kind of debt collection activity that the  
6 under-65 population has been exposed to? Or are they also  
7 subject to having liens put on their homes and harassed by  
8 debt collectors?

9           It's a big issue for the under-65 population.

10           DR. SOKOLOVSKY: That's a great question and, of  
11 course, I don't have the answer. But I do have three little  
12 pieces of information that might help. First, in this  
13 survey that compares MSP with MSP-eligible population, they  
14 found that the use of hospitals was the same for both  
15 populations but the use of emergency departments was higher  
16 for the people without the program.

17           Secondly, we found that -- particularly before  
18 these big outreach projects -- one of the main ways that  
19 people got into MSP was when they were hospitalized and then  
20 the hospital went to get them enrolled because possibly of  
21 trying to alleviate bad debt.

22           As far as protection from bad debt, I don't know

1 of anything that would give them any protection from that if  
2 they're not enrolled in this program.

3 DR. REISCHAUER: Just to explore another aspect of  
4 this, do we know anything about Medigap participation among  
5 those who are not on MSP but could be?

6 DR. SOKOLOVSKY: I don't have any information  
7 that.

8 DR. REISCHAUER: Because this would feed into that  
9 issue but...

10 DR. SOKOLOVSKY: I really don't have the  
11 information on that.

12 DR. STUART: I have a question about this draft  
13 recommendation three in light of the fact that the states  
14 have the flexibility to set MSP asset levels. And that is  
15 if you were to increase the Federal MSP asset level to be  
16 equivalent to the current asset requirements under the low-  
17 income subsidy, in states that currently have MSP limits  
18 that are above that, would they still be missed by this  
19 recommendation? In other words, if SSA were to be doing the  
20 asset -- were to be examining program participation  
21 eligibility in a state that had an MSP asset level above the  
22 Federal level, they would not be enrolled?

1 DR. SOKOLOVSKY: Of course, we could set this  
2 however you all wanted. But the way that we scored it and  
3 the way that it was thought of in my mind is kind of  
4 symbiotic with the way the low-income drug subsidy works  
5 now, where in a state you would be -- whatever the MSP  
6 requirements were. If you got in with even 185 percent of  
7 poverty, as they have it in Maine, then you were qualified  
8 for the low-income subsidy.

9 So my assumption was that this sets a limit that  
10 they use -- that SSA could use. But that if you go to the  
11 state Medicaid office they still use their own.

12 DR. SCANLON: First a question and then a comment.  
13 The question is whether we know anything about any  
14 geographic pattern to the participation rates in the savings  
15 programs? I asked that because my motivation is that the  
16 demonstration that you're talking about, that was funded by  
17 RWJ, shows that you can influence participation. And  
18 there's a question of whether or not this is a function of  
19 how much states are willing to invest in terms of recruiting  
20 people to be in their savings programs.

21 That leads me to my comment, which is that this is  
22 really a recommendation about a Medicaid benefit, which is

1 called Medicare savings. So we we're making a  
2 recommendation about the Medicaid -- this would be making a  
3 recommendation about the Medicaid program. And I think we  
4 need to think about this in the context of Medicaid, that  
5 it's become the largest single program within state budgets,  
6 that there is variation among the states in terms of a big  
7 that is, and then there's also the problem that states face  
8 in terms of their cyclical changes in revenues and that they  
9 -- with one exception -- operate under balanced budget  
10 requirements.

11 So we periodically see states in the position of  
12 having to reduce the growth in Medicaid spending, if not  
13 reduce their absolute level of Medicaid spending. The  
14 question is where does this fit into that? What would  
15 happen on a cyclical basis? And even if the savings  
16 programs were retained as whole, who would be the people  
17 that would be affected when the state is seeking their  
18 Medicaid savings?

19 So given that context, I think that there is a  
20 question of what is the appropriate Federal role here? This  
21 is something that's come up with respect to Medicare and  
22 Medicaid in other contexts as well, particularly since Glenn

1 raised the whole issue of the bigger context. And there's  
2 the argument that why should Medicaid do something that's  
3 going to generate savings for the Medicare program?

4           The low-income subsidy provides, in some respects,  
5 a very graphic example of a very different model in terms of  
6 how an issue is being addressed in that it is purely Federal  
7 and it is all within the context of Medicare. As opposed to  
8 the savings program which are targeting a similar population  
9 that definitely needs assistance but doing it through the  
10 Medicaid program, through a joint Federal relationship.

11           The last point I would make is to raise the  
12 question of how effective simply expanding the savings  
13 program would be since for the people that are above poverty  
14 what we're talking about is subsidizing their premium, not  
15 their copayments. And so we're going to have an income  
16 effect in terms of influencing their access to services or  
17 their use of services but we're not having the price effect  
18 that would come about if you actually were to change and  
19 subsidize their copays.

20           The income effect may be important for people with  
21 such low incomes but it's going to be different than if we  
22 were to say we're going to either reduce their copays to

1 nominal levels or we're going to reduce them to zero.

2 MR. HACKBARTH: Let's just focus a second on the  
3 idea of -- as opposed to working through the MSP structure -  
4 - work through a system like the LIS support under the drug  
5 benefit and provide support not just in the Part D but for  
6 all Medicare covered services through an LIS-type program.  
7 Any thoughts, Joan, about the issues that that would raise?

8 DR. SOKOLOVSKY: Well, cost obviously would be an  
9 issue here and I have no sense of what the cost would be.  
10 As far as the MSP part, at least as CBO thinks of it, well  
11 over 80 percent of the cost they assume is to the QI  
12 program, which is entirely Federal. That's the only thing I  
13 can bring to bear on that, really.

14 MR. HACKBARTH: Pursuing the LIS model for a  
15 second, one of the elements of that program was the so-  
16 called clawback from the states to minimize the incremental  
17 cost of the Federal budget. There was an effort made to  
18 capture, if you will, the money that the states had already  
19 been spending on this population. So one question would be  
20 if you went down this path would you have a clawback sort of  
21 provision?

22 Other thoughts about this approach? And issues it



1 would raise?

2 MR. EBELER: Just on this in particular, it is  
3 certainly worth looking at. I know when we look at this  
4 issue on a NASI panel a couple years ago, this is sort of a  
5 structural options that's worth discussing. I guess the  
6 concern I have is -- and it's personally attractive in a lot  
7 of ways. The difficulty is it's a very expensive option and  
8 the question is can you kind of stage the discussion. What  
9 I would be concerned about is setting aside shorter-term  
10 approaches to try to fix things as well as we can within the  
11 construct of the current situation while we tease apart  
12 these very complicated financing issues about clawbacks and  
13 things like that.

14 I guess in my mind if we're going to take up those  
15 broader financing federalism questions about who pays,  
16 that's fine. It just strikes me that's a longer-term policy  
17 agenda than the ability to try to make some recommendations  
18 in the short term about how to make this better for a bunch  
19 of folks for whom it's not working real well.

20 MR. HACKBARTH: I see your point there.

21 Joan, just remind me for a second. I know this  
22 information is in the papers but I can't quickly call it up.

1 Remind me what the difference is in the participation rates  
2 between the Part D LIS program versus the MSP programs?

3 DR. SOKOLOVSKY: If you take out the people who  
4 are deemed eligible for the low-income drug subsidy they  
5 estimate the participation rate is about 45 percent. For  
6 the QMB population, which is the one with the highest  
7 participation rate and the lowest income, the participation  
8 rate is about 33 percent.

9 MR. HACKBARTH: For the other MSP programs it goes  
10 down from there? Qualified individual was like 13 percent?

11 DR. SOKOLOVSKY: SLMB is 13 percent. I don't even  
12 think there's a number for QI.

13 MS. HANSEN: I think Jack was able to capture the  
14 whole sense of there are bigger issues. But in reading the  
15 recommendations I do think that these would be really useful  
16 to implement on the shorter-term basis, but I'm always aware  
17 one, of what the costs -- long-range impacts are. But I  
18 just would probably move toward looking at the expediting  
19 these kinds of recommendations at this stage given what we  
20 seem to know just because of the complications that it  
21 really creates for the individuals and the barriers of a 15  
22 percent range of difference in the poverty level, as well as

1 the ability to use existing -- if 30 states are already  
2 doing this through the SSA -- and mind you, I think we all  
3 are aware of some recent reports of how short-staffed from  
4 an execution level some of the SSA offices are apparently  
5 under. But it just seems that these are some natural ways  
6 to kind of almost look at the anthropology of what happens  
7 to regular people.

8 I also do support this movement toward having the  
9 money go toward SHIPs as a whole. I'm also aware that  
10 SHIPs, like any system, would have some variation in perhaps  
11 their ability to deliver the quality of services. So  
12 perhaps, if this recommendation does go forward, the ability  
13 to have an evaluation built-in, to their effectiveness.

14 Which leads me to a related thing more on the LIS  
15 side. I know that the recommendation is for the funds to go  
16 to the SHIPs per se, but I think in the LIS program some of  
17 these targeted outreach efforts were done perhaps by other  
18 kinds of organizations like some of the minority aging  
19 organizations that had some especially effective ones. I  
20 happened to hear, just since the last meeting, for example,  
21 the Asian Pacific Islander one with the Part D was able to  
22 generate 40,000 calls over the course of, I think, about

1 three months for its particular population. So there are  
2 probably alternate ways, rather than perhaps proscribing  
3 only SHIPs as ways to reach vulnerable populations who  
4 normally would be qualified but don't have access.

5 Thank you.

6 MR. EBELER: Thank you, Joan. This is very  
7 helpful and recommendations one and two are really terrific.  
8 As is three, but a question about three.

9 Do you envision an option for states not to  
10 contract with SSA to allow them to determine eligibility for  
11 the MSP programs? Because it is a process where that  
12 eligibility determination process triggers the spending of  
13 both state and Federal money and the traditional  
14 relationship, we adjudicate that between the two.

15 DR. SOKOLOVSKY: I hadn't thought about it that  
16 way. I hadn't thought about this. Two is a floor that  
17 everybody would have to use. But that the states -- if  
18 people went to the state Medicaid office -- the states can  
19 still use higher if they have in place higher things like  
20 eliminating the asset altogether. They would still be able  
21 to do it but that you couldn't expect Social Security to  
22 know about every state differences and how they count

1 things. But it could be written in different ways.

2 MR. EBELER: It might be worth just exploring that  
3 a little bit just to see how that would work  
4 administratively.

5 DR. STUART: I was going to ask the question about  
6 what the states have done with respect to MSP asset and  
7 income levels since MMA. Because it strikes me, in somewhat  
8 contrast to what Bill was saying, is that the MMA gives the  
9 states the opportunity to change Federal regulations, in  
10 essence. Because if somebody is deemed eligible for LIS  
11 because of MSP enrollment and the state increases the MSP  
12 eligibility level then the states have the power to increase  
13 the LIS eligibility level. And so my question again is how  
14 many states have taken advantage of that?

15 DR. SOKOLOVSKY: I don't know if they can quantify  
16 it specifically but there is general agreement that since  
17 MMA state outreach and state changes in administration has,  
18 in general, increased. And states that have State Pharmacy  
19 Assistance Programs -- and there are more than 20 that still  
20 have some program that wraps around the Medicare benefit --  
21 they obviously save a lot of money if people in their  
22 program are eligible for the low-income subsidy. And those

1 states have worked very hard to get more people in MSP so  
2 they can be deemed eligible for the low-income subsidy.

3 I think I included in the paper the seven states  
4 that had more than 50 percent increase in one year and every  
5 one of them had a State Pharmacy Assistance Program.

6 DR. MILLER: I want to go to Jack's point for just  
7 a second. When I was listening to this question I thought  
8 what we were thinking -- and we can explore the mechanics of  
9 how this works -- but it wouldn't be an option that SSA  
10 would say we think that you're eligible for MSP and then the  
11 state may have different requirements. But it wouldn't be  
12 necessarily an option for the state to be asking SSA to make  
13 this determination.

14 Or were you asking for the -- well, I didn't see  
15 it as an option and maybe I didn't understand your question.

16 MR. HACKBARTH: States couldn't opt out. SSA  
17 would be determining eligibility. That sort of takes us  
18 back to Bill's question that you have the Federal government  
19 imposing costs on the states.

20 MR. EBELER: It's just worth sort of walking down  
21 that path a little bit with some folks who were involved in  
22 Federal and state administration of these programs because,

1 again, you were having -- this would make a lot better. I'm  
2 not arguing against this on policy grounds. It's just that  
3 the model you're describing stems from the federalization of  
4 SSI in 1974 where some states contracted with Social  
5 Security to determine Medicaid eligibility. But states have  
6 always retained the option not to do that and you can run  
7 into a hornet's nest with a Federal agency saying these  
8 people are eligible for a program that triggers state  
9 matching and how you get to that implementation stage is  
10 just worth a little more detail with the folks who manage  
11 that kind of thing.

12 I don't challenge policy direction. It's use just  
13 the process of implementation, because of the nature of the  
14 Federal/state program, until you get to the type of long-  
15 term issue that Bill mentioned, is just awkward and I would  
16 just want to talk with those folks.

17 DR. MILLER: I just wanted to understand a little  
18 better.

19 DR. BORMAN: Joan and Hannah, this was really  
20 nice.

21 In trying to look to generalize this to thinking  
22 about other facets of the program, as well, a question

1 occurred to me that maybe is my naivete that would help me  
2 to think about this. And also because, as you pointed out,  
3 so many people in the growing segment of this are older,  
4 unmarried women and I'm going to be one of those little old  
5 ladies? So this has some special meaning to me.

6           And so part of the question that I have for you is  
7 when we do the comparison of the median income for the folks  
8 above and below 65, do we also have a methodology that  
9 adjusts for what the median expenses of those two categories  
10 of folks might be, in that presumably many of those folks  
11 over 65 may, in fact, have paid mortgages, have fewer cars,  
12 whatever it may be. Their daily living expenses may be  
13 somewhat less. I'm not trying to make the argument that any  
14 of the people covered in these programs are flush, but  
15 trying to parse out here if we're going to make some  
16 generalizations about this, the 21st century beneficiary and  
17 that sort of thing, I think we need to know our beneficiary.

18           So my simple question is when we make those  
19 comparisons, do we have a corresponding expense comparison  
20 for the under-65 group?

21           DR. SOKOLOVSKY: That's a really good question. I  
22 don't know of such data, but I can certainly look for it.



1 DR. REISCHAUER: This actually follows a bit on  
2 Karen's question. I forget about the detail of the Desmond  
3 article in your discussion of out-of-pocket health care  
4 spending. But does that article count as out-of-pocket  
5 premiums paid by employees for the under-65 and Medigap and  
6 Medicare premiums paid?

7 MS. NEPRASH: Out-of-pocket health care spending  
8 is including premiums and all other expenditures, including  
9 drug spending.

10 DR. REISCHAUER: That's very helpful. But my  
11 observation would be I'm not sure the median is the point we  
12 should be looking at in this, particularly because in the  
13 under-65 population you have probably two groups, people  
14 under 30 and people let's say over 50 kind of thing is where  
15 the concentration is. And the former have close to zero.  
16 It would be nice to look at this sort of at the 75th  
17 percentile or something. But that's fine as it is.

18 I was wondering if there was another term we could  
19 use in the discussion rather than health care avoidance,  
20 which strikes me as having the wrong connotation. It's sort  
21 of like risk avoidance or something like that. I know it's  
22 a term that's used but it's had inartful term, I would

1 think, and if we could choose something better.

2 Then I have a question about the QI program. It  
3 has a phase-out, doesn't it, of the fraction of the premium  
4 that's paid as you go from 120 to 135 or not?

5 DR. SOKOLOVSKY: No I think it's Part B premium.

6 DR. REISCHAUER: It's all or nothing?

7 DR. SOKOLOVSKY: I think so.

8 DR. REISCHAUER: If we ever get into the details  
9 we have to think about --

10 DR. SOKOLOVSKY: On the subsidy there is more.  
11 The low-income drug subsidy changes as it goes up.

12 DR. REISCHAUER: What I was thinking is how you  
13 coordinate these two methods.

14 DR. WOLTER: I just wanted to say from a  
15 clinician's standpoint these issues are so complicated and  
16 all these interacting policies between Federal and state are  
17 so hard to understand. I imagine that you can count the  
18 number of people in the United States who understand these  
19 things. Joan, you've done an incredibly good job of putting  
20 this together in a way that does create some clarity around  
21 the issues.

22 I would say that the recommendations are spot on

1 in terms of what's right for people and what's right for  
2 beneficiaries. So the issue is how do we get there,  
3 recognizing that is it our role to make a recommendation  
4 about something that affects the states and Medicaid and  
5 that sort of thing. But how can we work through that?  
6 Because this is the right thing to do. There's no question  
7 about it. I hope we can find a way to say something about  
8 even recommendation three because if you're focused on  
9 what's right for these folks it really would be the right  
10 way to go.

11 I would hate to see us get back into clawback or  
12 anything that would create an increasing conflict between  
13 how the states and the Federal government look at these  
14 issues. I don't think that would be healthy.

15 Does that mean we should try to move in a  
16 direction that is more like the Federal coverage in the LIS  
17 program? Quite possibly, in my view. It hasn't been raised  
18 but, as Jack said, there are some longer-term policy  
19 implications here. And at what point do we also need to  
20 talk about sort of a different premium structure for high  
21 income beneficiaries in terms of how we look at the whole  
22 package of what has happen as the program looks at its cost

1 issues in the years ahead?

2 DR. SCANLON: Just to set the record, I think that  
3 we should keep in mind that the clawback was a financing  
4 mechanism. That if the budget resolution had put \$500  
5 billion dollars on the table when they were debating the  
6 MMA, there might not have been a clawback. It's not, in any  
7 way, sort of a necessary component of a model that says  
8 we're going to do something federally or we're going to do  
9 it through -- as opposed to doing it through a Federal/state  
10 sort of program. So those two decisions should be kept  
11 separate.

12 There is going to be a financing issue if they  
13 decide to do something federally. But how it's addressed,  
14 there's a range of options there.

15 MR. HACKBARTH: And so your point is that the  
16 particular history of the clawback was that they were  
17 dealing with this \$500 billion constraint?

18 DR. SCANLON: The \$400 billion they wanted to  
19 spend all this money and they had to make the thing work but  
20 they only had \$400 billion.

21 MR. HACKBARTH: But having said that, there  
22 obviously still is a general issue about the Federal budget

1 and -- okay.

2 All right, we need to move on now.

3 DR. MILLER: If there's no other comments from the  
4 commissioners, and I wanted to have this conversation with  
5 you, we have to come back next month with a set of  
6 recommendations and eventually come to a vote. So if I had  
7 to do something now, which I do, what I'm hearing is -- I  
8 feel like I'm hearing a consensus around the set of  
9 recommendations with looking underneath a couple of things  
10 that were raised. And perhaps to address the larger issue  
11 of federalization, a real strong discussion underneath these  
12 recommendations about those sets of issues and how this  
13 could be conceived -- other ways to conceive this.

14 But I'm still hearing consensus on these  
15 recommendations. That's the question.

16 DR. KANE: Doesn't recommendation two require that  
17 you understand who's going to finance it?

18 DR. MILLER: That's what I'm saying, is that -- so  
19 let me say this one more time. This federalization issue  
20 has been raised. Why not make it entirely Federal? I  
21 thought I heard from a couple of comments without  
22 implicating that let's move ahead, which would mean that you

1 would keep the financing as it stands, which would impose a  
2 burden on the states. And then discuss underneath that the  
3 notion that there is a federalization option here. It would  
4 be more expensive, it has these kinds of ins and outs, as  
5 opposed to recasting the recommendation as a federalized  
6 program.

7 And I'm trying to just capture the preponderance  
8 of comments that I thought I heard.

9 MR. HACKBARTH: Bill, do you want to react to  
10 that?

11 DR. SCANLON: I don't feel that I'm an advocate  
12 for the full federalization. I just think it's something  
13 that should be on the table in terms of the discussion  
14 because of the fact that is going to be -- if we don't do  
15 that, there is an impact on the states. There's the kinds  
16 of trade-offs that I talked about in terms of either other  
17 populations over time besides the dual eligibles, as well as  
18 I think what we don't recognize enough with respect to the  
19 Medicaid program is the cyclical problems that exist and the  
20 fact that there are some very strong adjustments that are  
21 made on a cyclical basis.

22 I'm also in agreement with the sentiment that I've

1 heard here about the fact that this is a population that's  
2 vulnerable and we should be doing something about trying to  
3 address that need that they have. But it's this question of  
4 what's the best way. I guess I saw Jack's argument as  
5 saying do something immediately because the problem is  
6 pressing immediately, but also think about the bigger  
7 picture. And I'm not uncomfortable with that, as well.

8 MR. HACKBARTH: You said you're not uncomfortable  
9 with that?

10 DR. SCANLON: Right.

11 DR. REISCHAUER: I think we're sort of whistling  
12 past the graveyard here. I don't think we can avoid dealing  
13 with this in a more straightforward way in the sense that we  
14 got into this by saying participation varies rather  
15 significantly. It varies across states because of states'  
16 fiscal pressures and not wanting -- that's one of the  
17 aspects of it.

18 And then we're going to up the ante tremendously  
19 and we have a third recommendation that I think is supposed  
20 to save us and that's that SSA -- and the recommendation  
21 says could screen and enroll. It doesn't say must.

22 And so I would think if there's any state

1 flexibility here at all, they'll say I don't want SSA. I  
2 still want to hold on to the levers here. And future MedPAC  
3 commissions will come back and good lord, look at the  
4 variation is really huge and it goes up down with the cycle.

5 MR. HACKBARTH: I'm just a little confused.

6 Recommendation three is not could. It says that SSA would  
7 screen and enroll them if they qualify. It's not an option.

8 DR. REISCHAUER: I'm reading the wrong page here.  
9 So then we're doing a mandate on the states.

10 MR. HACKBARTH: Which is part of Bill's issue.

11 One approach is these recommendations, with some  
12 discussion saying that in the long-term we may want to  
13 examine and move towards a Federal model.

14 I guess the other approach would be to not  
15 recommend anything along these lines and just have a broader  
16 high level -- more of a conceptual recommendation that we  
17 think that providing support for low-income beneficiaries is  
18 important and it needs to be simplified and we ought to look  
19 at the Federal model. So skip over this as a short-term  
20 step.

21 I think those are the two paths that I can see out  
22 of this.



1 DR. KANE: Is there a way to just estimate how  
2 that might just actually save money, too? Again, it's the  
3 Medicare bad debt or the fact that they come in earlier and  
4 don't use the emergency room. Are there offsets to this  
5 that we can talk about, too, so that it's not all just bad  
6 news for the budget? That's why I was getting at the bad  
7 debt piece.

8 DR. SCANLON: I guess I would also remember that  
9 you also raised the efficiency argument in terms of if we  
10 are concerned that what we're doing now with the  
11 overpayments to MA plans is that we are helping some of this  
12 population. If that's our concern, is we want to make sure  
13 that help low-income people, that there are more effective  
14 ways of targeting.

15 Your second option also opens up the possibility  
16 of thinking about something other than the model of the  
17 savings programs in terms of the kinds of benefits the  
18 savings programs offer. To get back to the point I made  
19 about the difference between just subsidizing their premiums  
20 versus subsidizing some of the cost-sharing. I think that  
21 actually may be an important point because when you're  
22 deciding to use a service that price of the service is maybe

1 a big determinant regardless of this bump up that you've  
2 gotten in income.

3 So in terms of overall effectiveness, the savings  
4 programs may not be the best model with respect to what  
5 you're trying to accomplish.

6 MR. HACKBARTH: We need to move on in a second,  
7 but I want to try to get a sense of where people are with  
8 the path that Mark proposed, which was this in the short  
9 run, raise Bill's issues and talk about federalization as a  
10 long-term possibility.

11 DR. STUART: This is a quick one. In the paper  
12 there were no cost estimates in terms of what this would  
13 raise. It seems to me that there is this philosophical  
14 issue but there is also a real cost issue. And if it turns  
15 out that the real costs are minor -- and it strikes me that  
16 they may be. I mean, if most of the states, in fact, have  
17 already done something like this and it's really only a  
18 question of trying to make sure that you get people into the  
19 system, then that's one thing. If it turns out that this is  
20 going to be a multibillion-dollar program over several  
21 years, then I think that's something else.

22 So the question is if we're voting in December on

1 this are we going to have the cost estimates by that time?

2 DR. SOKOLOVSKY: We have them for the second  
3 recommendation. We'll never get them for the first because  
4 it's too high level. It doesn't say how much. I expect to  
5 have them for the third.

6 DR. MILLER: I think he's focusing it just a  
7 little bit. The key question is the second one. And I  
8 think his point is can we know the difference between number  
9 two as proposed and number two as if it were federalized?

10 We were aware that this could potentially come up  
11 and we're still pressing on that. So we have the estimate  
12 for the first version. We can certainly have it for the  
13 second. I don't want to put Joan in a bad place here, but  
14 I'm pretty sure we can do that.

15 DR. SOKOLOVSKY: Yes.

16 DR. MILLER: The key is that difference on the  
17 second one.

18 And your point is taken. We expect it to be  
19 larger but I'm not sure we have a good sense of how much at  
20 this point.

21 MR. DURENBERGER: I guess there's little doubt  
22 that by 2009 somebody's going to be trying to do better

1 coverage policy than we currently do, whether it's in  
2 Medicare, Medicaid, or something else. And we're going to  
3 work on the Federal/state relations and things like that.

4 I can't recall, in the 20-plus years we've been  
5 QMB-ing and SLMB-ing and all the rest of that sort of thing,  
6 that anybody ever made the argument it was really good  
7 policy. It was always made in the budget neutral context of  
8 some kind to expand access through some existing program,  
9 but we didn't want to use the existing program, we want to  
10 modify it in terms of eligibility and things like that.

11 So I think it is our responsibility to articulate  
12 what would be good policy. And maybe we don't get to an  
13 recommendation but we ought to present them with an analysis  
14 of it. But in the shorter term, as you've said in terms of  
15 your options, I think this is a responsible way to go. I  
16 hope we don't forgo the latter.

17 MR. EBELER: I think the combination Mark  
18 articulated makes sense, in part because it gives people  
19 some grist in the short-term to try to improve things.

20 The other thing is my experience with this issue  
21 is the way you get people to begin grappling with the  
22 longer-term issue that Bill mentioned, that Bob talks about,

1 is in fact to have to grind through some of the shorter term  
2 stuff. So a general statement of policy just doesn't get us  
3 -- so I like the two-part approach for both those reasons.

4 MR. HACKBARTH: Is there anybody who objects  
5 strongly to that approach?

6 Okay, so that's the track that we'll be on for the  
7 December meeting.

8 Nice job, Hannah and Joan. Thank you very much.

9 Next is Part D benefit design and analysis of  
10 formulary. Rachel, do you want to introduce our guests?

11 DR. SCHMIDT: Next we have two presentations back  
12 to back about Part D. First, we're pleased to have with us  
13 Jack Hoadley of Georgetown University and Elizabeth Hargrave  
14 of NORC. And along with Katie Merrell of NORC, they've been  
15 doing some work for MedPAC looking at Part D plan  
16 formularies that were used during 2006 and 2007.

17 Formularies are one of the most important tools  
18 plans have to help manage the use of prescription drugs. A  
19 formulary is a list of drugs that plans cover and the terms  
20 under which they will cover them, whether it's tiered cost-  
21 sharing requirements for specific drugs or utilization  
22 management tools like prior authorization.

1           We asked these researchers to compare plan  
2     formularies for us and look at the stability of formularies,  
3     both within a given year and across years. The answers  
4     should reveal some important information about the sort of  
5     balance that plans are striking between providing access to  
6     medications and controlling growth in drug spending.

7           DR. HOADLEY: Thank you. I'm pleased to be here  
8     to speak with you about this research and pleased that  
9     MedPAC supported us in doing this research.

10           Just to reemphasize what Rachel said, formulary  
11     really is a list of drugs. And it is not necessarily the  
12     same as the drugs that are covered because a drug that is on  
13     formulary may not be covered if certain restrictions are  
14     applied like prior authorization or particularly high copay.  
15     A drug that is off the formulary may be covered if somebody  
16     goes through an exceptions process or an appeals process to  
17     get that drug. That's sort of an important consideration to  
18     go forward with.

19           For the analysis we did, we worked with the CMS  
20     formulary files to do an analysis of the formularies for the  
21     Part D program for 2007 and also for 2006. We did analysis  
22     both on the stand-alone PDPs and on the Medicare Advantage

1 plans. Most of the results we're going to present here are  
2 for the January 2007 formularies. So the formularies that  
3 were in place at the beginning of the current year. We do  
4 some comparisons with 2006 and some comparisons with a  
5 second point in time in 2007. Most of the tables you're  
6 going to see are weighted by enrollment. So we're talking  
7 about a weighted enrollment analysis.

8           When we presented some information to you a year  
9 or more ago about formularies, we had a discussion at the  
10 time about the basic question of how do you go about  
11 counting the drugs on a formulary? Which takes us back to  
12 the question of what is a drug? I don't want to spend a lot  
13 of time on this, but sort of point out that talking about  
14 what is a drug can be done at various levels.

15           We took the drug paroxetine, also sold under the  
16 brand name of Paxil, as the example here. You can talk  
17 about a drug as the basic chemical entity of paroxetine.  
18 You can talk about it as that chemical entity that comes in  
19 both a branded and a generic version, and that's something  
20 we often talk about. We can also talk about it at the level  
21 of all the different trade names and descriptions that it's  
22 sold under. So in this case would be the generic

1 paroxetine. It would be Paxil under the brand name. It  
2 would be Paxil CR when it's sold as a continuous release  
3 form of the drug. Or Pexeva, which is another variant of  
4 the drug that is made by a different company and sold under  
5 a different -- has a different patent and sold under a  
6 different name.

7           So we have the option of looking at that level or  
8 we even have the option of going down to the NDC code level,  
9 all of the individual forms and strengths of this drug, of  
10 which there are 13.

11           Now for the most part in this analysis we're going  
12 to use the concept of the chemical entity. But let me show  
13 you -- and this has got a lot of small information on this  
14 slide and I'm not going to go through it in detail. But  
15 this kind of gives you an example for all of the 13 NDC  
16 codes that represent this drug. And there are actually more  
17 than this. This is the 13 that appear on the CMS reference  
18 file and the plans have to designate their coverage by  
19 reporting on which of these they cover.

20           You actually can see that at every NDC code level  
21 there's a somewhat different number of plans that cover that  
22 particular drug. If you look at it at the NDC level you can



1 see differences just within the different strengths.  
2 There's a few plans that for whatever reason cover the 30  
3 milligram strength but not the 20. There are plans that --  
4 a lot fewer plans -- that cover the branded version of  
5 Paxil. But in the case of the suspension, the liquid  
6 suspension, there apparently is not a generic version so  
7 plans do cover this.

8 I should add that paroxetine is an antidepressant  
9 and it's one of drugs in the protected classes. So plans  
10 are required to cover this drug, but not required to cover  
11 all the different variants that you see here.

12 So you can see if we wanted to report on how many  
13 plans cover this drug we would get different answers  
14 depending on those different levels. We are choosing the  
15 chemical entity level. So in this case 100 percent of the  
16 plans, as required, do in fact cover this drug. So that's  
17 the basis, for the most part, of what you're going to see  
18 hereafter.

19 Here I just illustrate the effect you would get by  
20 looking at it at these different levels. If we just do what  
21 we're going to do and talk about chemical entities, the  
22 average beneficiary is enrolled in a plan that includes on

1 its formulary 87 percent of all of the chemical entities  
2 that CMS lists in the reference file. Only 81 percent of  
3 the branded and generic versions of those chemical entities  
4 and only 77 percent of all the different trade names of  
5 drugs that are out there. So as you break down at those  
6 different levels -- I didn't put it on this slide but if you  
7 look at the NDC level it's also 77 percent. So you can see  
8 it makes a difference and you see minimums and maximums on  
9 this graph as well. And so you can see how it really does  
10 matter.

11 But again, we will use chemical entities here as  
12 the basis of our comparisons.

13 So as I showed you before, 87 percent in the  
14 average PDP -- the average enrollee in a PDP sees 87 percent  
15 of all the potential drugs listed on his plan's formulary.  
16 Those who are in Medicare Advantage plans is very similar,  
17 86 percent.

18 The other part of this is to look at the benefit  
19 designs that the plans use. The most common plan design  
20 being used is a three-tier formulary in both 2006 and 2007,  
21 for that matter continuing on into 2008.

22 Just to take a moment to go through what this

1 graphic shows you, the segment that looks orange up there on  
2 the screen is the plans that have the three-tier formulary.  
3 that's a generic tier, a preferred brand tier, and a non-  
4 preferred tier. In fact, they mostly also have a specialty  
5 tier, but I've left those off for the purposes of this  
6 graphic. The blue band there are the plans, 30 percent of  
7 plans in 2006 on the PDP side, who use a two-tier formulary.  
8 They just have a generic and a brand tier. They don't break  
9 it out between preferred and nonpreferred.

10 The light colored bar at the bottom of each of  
11 these is the segment of plans that use the defined standard  
12 benefit in the law that's 25 percent coinsurance for all  
13 drugs. And there's a small slice at the very top for plans  
14 that use something other than these basic two and three-tier  
15 designs or the 25 percent standard plan.

16 So you can see that the proportion using three  
17 tiers was high to start with. It's risen from the first  
18 year of the program to the second. And it's even a bit  
19 higher on the Medicare Advantage side. So the three-tier  
20 formulary really has become sort of the standard.

21 Furthermore, the standard has come to include a  
22 specialty tier. Now specialty tier, just remind to you, is

1 the tier that's set aside for some of the most expensive  
2 drugs. CMS set a general guideline of \$500 or more for a  
3 monthly supply of a drug in 2007. It goes up to \$600 in  
4 2008. They're typically the biologic drugs, the  
5 injectables, other kinds of expensive drugs.

6           The other special characteristic of these  
7 specialty tiers is that the beneficiaries are limited in the  
8 kinds of appeals they can apply to these tiers. They can't  
9 ask for an exception to switch the coverage of this drug  
10 down to a lower tier.

11           So we've gone from a situation in 2006 where 60  
12 percent of the plans used these specialty tiers to 2007  
13 where that number rose to 80 percent, 82 percent for the  
14 PDPs. In fact, it's closer to all plans than it looks like  
15 here because many of the rest of the plans use the standard  
16 25 percent coinsurance models so they don't even have a tier  
17 structure. And a few of the others that are in that 18  
18 percent that are not covered actually have a percentage  
19 based coinsurance that provides a similar level of cost-  
20 sharing to what the plans that use a specialty tier provide.

21           But what we've really seen here is that there is a  
22 convergence towards using specialty tiers. This has several

1 implications. One is that it's going to make these drugs  
2 pretty expensive to beneficiaries, as I'll show you on the  
3 next slide in a second. It also reduces some of their  
4 options for appealing, as I noted. But it's also, from the  
5 point of view of the plans in the program, it cuts out some  
6 of the potential for risk selection. If there was a plan  
7 that didn't use one, it had the potential to attract the  
8 beneficiaries, the sicker beneficiaries that use these  
9 expensive drugs. So I suspect that's why we've seen this  
10 convergence.

11           The next slide goes into the cost-sharing levels  
12 that are associated with these arrangements. So I've used  
13 here the three-tier structure with the specialty tier added.  
14 These are the median monthly copay levels that beneficiaries  
15 face. And you can see it's about a \$5 copay for generic  
16 drugs. The numbers underneath are the lowest and the  
17 highest that plans do offer. So there are some plans that  
18 have considerably higher and considerably lower than these  
19 \$5 amounts for generics.

20           The preferred tier is a little under \$30. The  
21 nonpreferred tier is about twice that. And the specialty  
22 tier runs 25 percent, on the MA side 30 percent. On the PDP

1 side there's actually a range in both cases of generally  
2 from 25 percent to 33 percent.

3 I would note that the several cells where the  
4 asterisk appear are the ones that represent an increase from  
5 2006. And so you'll see, for example, on the nonpreferred  
6 tier that the median copay in 2006 was \$55 and it went up to  
7 \$60 in 2007.

8 So coming back to how many drugs are listed, it's  
9 the three-tiered structures that really do come along with  
10 more drugs listed. What you see here is 89 percent for the  
11 typical three-tier structure 89 percent of the drugs are  
12 listed on formulary. However, only 52 percent of those  
13 drugs were unrestricted. So what you're really getting when  
14 you compare the two-tier plans and the three-tier plans,  
15 you've added additional drugs to fill in that third tier but  
16 they do have some kind of restriction in coverage, either  
17 restriction in being in that nonpreferred tier with a higher  
18 copay or having some kind of prior authorization or other  
19 kind of restriction that I'll talk about in a moment.

20 Basically, if you look at how often these  
21 restrictions occur, these are the kinds of restrictions that  
22 apply to a drug that's on the formulary but where dispensing

1 the drug requires some kind of step be taken. So 18 percent  
2 of listed drugs have some kind of a utilization management  
3 flag applied to them. Eight percent of listed drugs -- and  
4 this is the same whether it's the PDPs or the MA-PDs -- have  
5 prior authorization, where you have to get kind of approval  
6 before the drug is dispensed. Would normally involve some  
7 kind of additional filing by the physician. One percent of  
8 drugs require step therapy. That means a different drug has  
9 to be tried before this given drug is approved. Normally  
10 it's a less expensive therapy, has to be tested first before  
11 a more expensive or more challenging therapy is used.

12           And 12 percent of the listed drugs had some kind  
13 of quantity limit. This can occur say for a migraine  
14 medication were you don't dispense 30 in a month. You limit  
15 it to six or eight or 10 drugs per month. And it can be  
16 used in a couple of different ways.

17           Here you see some sense of how formulary listings  
18 vary by plan. There really is a substantial variation, as  
19 you look across the plans. You see here on one side two of  
20 the largest -- the two largest PDPs that are stand-alone  
21 PDPs, really have formularies that list all of the drugs  
22 although some drugs do have restrictions applied to them.

1 And you see across the bars here for some of the largest  
2 plans on both the PDP side and the MA side how that varies.

3 But you notice that more of the variation is in  
4 how much they restrict the drugs than it is on how many  
5 unrestricted drugs they list. So a plan like Kaiser  
6 Permanente which, for most of the drugs it does list they  
7 are listed in an unrestricted basis. In a plan like that  
8 the physicians can essentially create their own exceptions  
9 to drugs and get additional drugs covered when it's  
10 important for a particular patient.

11 Other plans may have larger numbers of restricted  
12 drugs and either use tiered copay or prior authorization are  
13 other kinds of restrictions to limit access to those  
14 different kinds of drugs. But I think the biggest message  
15 here is that it really does vary a lot by plan.

16 It also varies by some of the other  
17 characteristics of plans a bit systematically. Here we're  
18 looking at the plans that are eligible for auto-enrollment.  
19 That means when the low-income beneficiaries who don't  
20 choose plans for themselves, they can be assigned to plans  
21 that have lower premiums for the basic benefit.

22 On the right there you have the proportion of



1 drugs listed for the plans that are eligible for auto-  
2 enrollment and the two bars there add up to 87 percent  
3 versus 91 percent for the plans that are not eligible for  
4 auto-enrollment. So there's a slight difference of plans  
5 eligible for the low income folks having somewhat fewer  
6 drugs listed. But that difference is pretty small here. In  
7 fact, the number of unrestricted drugs they have access to  
8 is actually higher.

9           Of course, some of the restrictions that have to  
10 do with copay tiers may not be relevant to the low-income  
11 population.

12           Here we look at how the drugs are rated across the  
13 tiers in the typical situation. Let me take a moment here  
14 to sort of walk you through the steps in these bars. In the  
15 two-tier model, again you have a generic tier, a brand tier,  
16 and a specialty tier. The yellow segment of that bar says  
17 that 35 percent of their listed drugs are in the generic  
18 tier, 22 percent of their listed drugs are in the brand  
19 tier, and 12 percent are in specialty tiers.

20           With the three-tier plan, it's similar for the  
21 generics, slightly larger, and the preferred brand tier is  
22 kind of parallel to the single brand tier for the two-tier.

1 So 18 percent of the typical three-tier plan's drugs are in  
2 their preferred tier. And really the extra drugs that they  
3 add to their formulary are the ones that show up there in  
4 the blue segment of the nonpreferred tier. They have a  
5 rather similar specialty tier.

6 The 25 percent coinsurance plans that we looked at  
7 typically actually have larger formularies than the other  
8 plans and because of the nature of that they don't come with  
9 any kind of tiering.

10 So finally, we want to look at two aspects of  
11 whether formularies changed first within the year. This is  
12 relevant to the question that a lot of people were concerned  
13 about early in this benefit of once I signed up for a plan  
14 and I'm locked in for the year, am I going to look at the  
15 formulary that's making a lot of changes? The simple answer  
16 to that is no.

17 From January to June of 2007, looking across all  
18 PDPs, the average PDP was covering 1,160 drugs in January.  
19 In June they were at 1,103. That was down by 26, up by 13.  
20 But basically what we're seeing here are drugs that are new  
21 to the market being added. That's probably what those 13.  
22 We took a look at those and they really are mostly new

1 drugs. And the minus 26 appears that they're mostly  
2 adjustments that CMS made to the reference file. So it's  
3 not really a question of sort of significant drugs that you  
4 would have heard of being taken off plan formularies. In  
5 fact, plans were generally restricted from doing that. In  
6 fact, these are just adjustments to the underlying reference  
7 file the plans have to report to.

8           You can see that the numbers are fairly similar as  
9 you go, to pick a number of the larger PDPs to look at, the  
10 number deleted simply gets smaller when plans started out  
11 with smaller formularies. So some of those drugs that were  
12 leaving just weren't in their formularies in the first  
13 place.

14           So I think here we generally have a picture of  
15 good stability within year.

16           Across year it's a little more complicated to do  
17 this. From 2006 to 2007, CMS really changed its reporting  
18 process of how plans had to submit their formularies. In  
19 2006 they could basically list as many NDCs as they wanted  
20 to. They could either list a smaller set and say these  
21 represent all the drugs that we're covering. Or they could  
22 represent all of the NDCs that we are actually covering.

1 Plans, in fact, submitted anywhere from just a few thousand  
2 NDC codes to represent their formulary to like 36,000 NDC  
3 codes to represent their formulary.

4           So what we had to do is try to mix and match to  
5 compare the listings from 2006 to 2007, and it's a challenge  
6 to do that. But I think we've got something that tells the  
7 story, which is that if you look from 2006 to 2007, you  
8 really see evidence that very few drugs were dropped from  
9 the typical plan's formulary from the first year to the  
10 second. This, of course, is relevant not to a beneficiary  
11 who's locked in to their benefit but to a beneficiary who is  
12 shopping to decide whether I need to switch plans. Am I  
13 facing a formulary that's much changed from last year? And  
14 for the most part, and there would be of course exceptions  
15 to this, the average plan only dropped less than 1 percent  
16 of their drugs between the first year and the second year.

17           On the add side we saw numbers that were  
18 substantially higher but we're not quite sure how to  
19 interpret those because we think they're actually a mixture  
20 of new drugs being added to plan formularies because they're  
21 new to the market, the effects of the new rules which says  
22 once you have this reference set of drugs that you use to

1 submit your formulary, some plans are essentially saying oh,  
2 I meant to cover that. Here, I'm now telling you about it  
3 in a clear way. Even though they may have covered that drug  
4 in real practice, we can't match them up in the way the  
5 files are structured.

6           And then third, there may be some evidence of  
7 actually broader formularies. We think, as we look through  
8 this analysis, we think there were at least some subset of  
9 plans that really did broaden substantially their  
10 formularies from the first year to second year. More  
11 evidence of broadening formularies than there was of  
12 shrinking formularies.

13           So with that I'll stop and I think that's a  
14 picture of some of the ways both the benefit designs and the  
15 formularies look in 2007 and some of the ways they're  
16 switching.

17           I should only add that we're beginning to do a  
18 separate analysis for the Kaiser Family Foundation of what  
19 the formularies -- at least for the larger plans -- look  
20 like for 2008. And we should have results on that out which  
21 we can share with the Commission, within a few weeks.

22           MR. HACKBARTH: Thank you very much. Bruce?

1 DR. STUART: Jack, I have a question on slide 11  
2 on utilization management. It looks like the predominant  
3 form of utilization management is quantity limits. And you  
4 gave an example of a drug that presumably is taken as needed  
5 and the quantity limit referred to the number of pills that  
6 the person could get per month.

7 Is that the typical form of a quantity limit? Or  
8 are there other circumstances in which duration of therapy  
9 is an issue in terms of the number of months in which a drug  
10 would be prescribed, number of refills?

11 DR. HOADLEY: There are definitely those  
12 variations. Unfortunately, there's no flag that's in the  
13 public formulary files to tell us why a particular drug has  
14 a quantity limit or even what the limit is. So we're sort  
15 of left looking at what we know from just general  
16 experience.

17 Certainly, those examples you used are part of  
18 what happens. There may be a drug that they only want to  
19 give you a 30-day supply because that's a drug you shouldn't  
20 necessarily be taking for longer than that without  
21 reentering.

22 But we think there are some plans that simply

1 designate a 30-day supply at retail because they want to  
2 encourage use of mail order for the longer prescriptions.  
3 And so that may increase the number of quantity limits.  
4 It's possible that, in terms of things that are real  
5 restrictions on people getting their drugs, that some of  
6 these quantity limits are more technical limits. But some  
7 of them clearly are these clinical -- again many of which  
8 are appropriate limits for safety and effectiveness reasons.

9 DR. CROSSON: I have one major point but I just  
10 point out to Brice that there's at least one class of drugs  
11 where the question of what a 30-day supply is is still in  
12 question. Those are drugs you see often advertised on TV  
13 during football games.

14 [Laughter.]

15 DR. HOADLEY: Which are not covered by Medicare  
16 any more.

17 DR. CROSSON: And there are also some gender  
18 differences about the opinion about the 30-day supply which  
19 I won't get into.

20 But actually, the question I have relates to the  
21 fundamental issue here which is are the beneficiaries  
22 getting the access to the drugs that they need? I could see

1 in the discussion you had that the analysis, while it's  
2 useful, is a bit of a blunt tool to get to that answer from  
3 two perspectives. Number one, the extent to which the  
4 exception process is used -- and you mentioned that that's a  
5 tool that we use, as we certainly do, because the physicians  
6 can use that. But also, to the extent that the utilization  
7 processes that you described are actually ending up  
8 interfering with the access that the beneficiaries need.

9           So the question is as we advance this topic, is  
10 there a way that we can get to that fundamental question,  
11 which is including the use of the exception process and the  
12 impact of utilization management, what really is the impact  
13 on beneficiary access? And is there a way over time that we  
14 can answer that question? Because it may turn out that we'd  
15 learn a lot more thorough an analysis of that kind?

16           DR. SCHMIDT: I think that CMS is in the process  
17 of collecting some exceptions data. But to your main  
18 question, I would say that please stay tuned for a  
19 discussion of prescription drug event data in the next  
20 presentation because I think it's going to take getting that  
21 sort of information to get to answering the sorts of  
22 questions that you're raising.



1 DR. HOADLEY: I would simply add that one of the  
2 reasons we state a lot of things the way we do is exactly as  
3 you've noted. To say that these drugs are listed is not the  
4 same as saying people have access to them in either  
5 direction. You can get access to drugs that are off  
6 formulary, you can fail to get access to drugs are on  
7 formulary. This is simply the starting point and we clearly  
8 do need other kinds of data.

9 The one observation I would make from some of the  
10 focus groups that we've conducted for MedPAC over the last  
11 few months where we have been focus groups with  
12 beneficiaries, with pharmacists, and with physicians is to  
13 note that when we hear from -- particularly from the  
14 pharmacists and the physicians, when some of these  
15 restrictions appear like a prior authorization request, the  
16 response of a lot of doctors is okay, so tell me what other  
17 drug I can provide. They don't want to go through those  
18 kinds of processes. So that's where some of these  
19 restrictions do turn out to be -- now in many cases they say  
20 yes, and the other drug that we provide is just as good. So  
21 that's the real challenge is deciding whether we've actually  
22 -- if we move somebody to switching to a different drug or

1 if somebody has simply failed to fill a prescription because  
2 it's a process when they do go in for an exception, it's  
3 something that's going to take time even to get a prior  
4 authorizations means they don't leave the pharmacy that day  
5 with their prescription in hand.

6           And some people clearly don't go back or, if they  
7 have to pay the higher cost for a nonpreferred tier, can't  
8 afford to buy that drug. What we really need to know is  
9 whether that is restricting access to the therapies people  
10 really need. And that's the part that right now we can't do  
11 by just looking at these formulary files.

12           DR. REISCHAUER: Jack, this is really very  
13 interesting and, in a way, quite reassuring to those who had  
14 a lot of concerns when the MMA was being approved.

15           I was wondering if we had any comparative  
16 information, this set of formularies and management  
17 utilization compared to what the average American has  
18 through their employer. We're sort of setting up an  
19 absolute standard here as opposed to a relative one. And  
20 what do we know?

21           DR. HOADLEY: It's a great question. A couple of  
22 years ago we had a project funded by HHS that asked us to

1 look -- before Part D was actually in place -- that asked us  
2 to try to look at what formularies looked like in the  
3 private sector. The first problem we had was simply getting  
4 hold of copies of the formularies. We were taking PDF files  
5 off the web and trying to convert them into datasets. Any  
6 of you that have ever tried to do manipulation of something  
7 like that, take text versions of drug names and translate  
8 them into comparable things to compare.

9           It would really be a good project to try to get  
10 access to some files of formularies that are used in the  
11 commercial sector. Medicaid would be more possible, but  
12 that's not really, in a lot of ways, the most interesting  
13 comparison. We can look at things like benefit design. In  
14 some of the work we're doing for Kaiser we're going to  
15 compare cost-sharing levels and tier structures. But that  
16 doesn't really get to the question of how many drugs are  
17 covered and how many restrictions are out there.

18           We know that a lot of these same companies are  
19 operating in both spheres. What we don't know is we hear  
20 some anecdotes from physicians and pharmacists who are  
21 saying the Medicare plans are higher. They're more  
22 restrictive than the commercial ones.

1           MR. BERTKO: Can I just add to that? It is  
2 anecdotal but my recollection in 2005, as we were going into  
3 2006 with 146 categories was a little bit of the opposite,  
4 that many commercial -- that is under-65 formularies had  
5 fewer classes than the 146. And there was some worry that  
6 that would increase it.

7           My guess is that it would be about the same level,  
8 maybe slightly more restrictive. But the big change has  
9 been to the tiering policies and using that not only to  
10 direct to cheaper drugs but also to increase the rebates,  
11 thus lowering the premiums overall and the cost to the  
12 program.

13           MS. BEHROOZI: My first question was actually  
14 going to be Bob's and I think that might get a little bit to  
15 Jay's point, as well, trying to figure out whether people  
16 are getting at least relatively what they need.

17           The second question was just in light of one of  
18 the presentations I guess at our last meeting. I don't know  
19 that you have the answer to this question now but maybe for  
20 further research. Do you know whether any of these  
21 formularies are so-called value-based design, I guess  
22 formularies, where they're actually encouraging utilization

1 of not just what's good for the insurance company providing  
2 it in terms of the pricing but getting people to take  
3 preventive therapies and things like that?

4 DR. SCHMIDT: No, they're not. That's the short  
5 answer. All of the enrollees in any given plan face the  
6 same cost-sharing requirements with the exception of the  
7 low-income subsidy enrollees.

8 DR. HOADLEY: Though I have heard at least one  
9 case of a plan in the stand-alone PDP market that had a  
10 program outside of its tier structure that was actually  
11 trying to go out and identify beneficiaries who were not  
12 using a particular drug. I thought it was interesting  
13 because it was a case where, in a stand-alone PDP if they  
14 get people to add a drug they're not taking it, it is adding  
15 cost to their plan that they're at risk for. But that's  
16 something that's obviously outside of the tiering. I  
17 haven't seen any of the sort of more complicated value-based  
18 kind of designs either.

19 MS. THOMAS: We were visited by one SNP who was  
20 organized around chronic condition where they said that they  
21 had structured their formulary to make certain drugs that  
22 treated that chronic condition to be more inexpensive to

1 their members. But it was an N of one.

2 DR. HOADLEY: If it just meant putting them on  
3 their preferred, as opposed to a non-preferred tier, we  
4 wouldn't be able to pick that up directly.

5 MR. HACKBARTH: In the non-MA piece of the program  
6 you have the program that many of the savings would accrue  
7 to traditional Medicare, as opposed to the plan doing the  
8 value-based benefit design. So there's a disconnect in the  
9 incentives.

10 DR. CASTELLANOS: Jack, you really brought up a  
11 lot of points. I happen to be a physician so I'm going to  
12 talk from the physician viewpoint.

13 However, I really want to emphasize Jay's point.  
14 Are the patients really getting what the physician ordered?  
15 The real question here is who is in a better position to  
16 make that decision, the physician taking care of the patient  
17 on a daily, weekly, monthly, yearly basis? Or the 800 busy  
18 number that you can't get a hold of and ask for a call back  
19 and you can never get a call back and there's always a delay  
20 in treating that patient?

21 I agree, 90 percent of the plans, no problems.  
22 They really are. They are easy. They have improved. It's

1 the 1 or 2 percent that really cause difficult problems, not  
2 just to the physician but, more important, to the patient.

3           You're familiar with -- we can use this step  
4 therapy. That can be dangerous, as you well know. I can  
5 give you examples if you want but I think it would be  
6 superfluous to do that now.

7           The other question I really have more than  
8 anything else is as far as the patient goes, he or she  
9 trusts the doctor. And then when another person who that  
10 the patient doesn't know, comes and tries to tell that  
11 individual that what the doctor ordered is probably not in  
12 the best benefit, either a cost benefit for the patient, it  
13 really be kind of breaks up the patient/doctor relationship.  
14 And I'm telling you from a practitioner viewpoint, this  
15 causes a tremendous amount of work in my practice that's  
16 uncompensated. But we do it because we're there to take  
17 care of the patient.

18           DR. HOADLEY: I can say that in the focus groups  
19 that I referred to we certainly heard, in our physician  
20 focus groups, very similar comments. And from the  
21 pharmacists, we hear their side of the story. And they feel  
22 like they're the ones who often get caught in the crossfire

1 because they're the ones delivering the message to the  
2 patient directly. And that they are not in a position to  
3 make the corrections. And they only can deliver the message  
4 and say well, we can help try to contact your doctor or  
5 you'll have to go talk to your doctor.

6 DR. CASTELLANOS: Is there an answer?

7 DR. HOADLEY: There are potential policy things  
8 that could be done, obviously.

9 MR. HACKBARTH: Here again, we have a disconnect.  
10 The design of Part D is you put plans at risk, financial  
11 risk. It's mitigated somewhat by the rules of the game  
12 currently. But they're still basically at risk. So  
13 physicians are making decisions to, for example, prescribe a  
14 more expensive drug. The physician doesn't pay the bill.  
15 They are externalizing that cost to somebody else.

16 Whereas in Kaiser Permanente, where you have an  
17 integrated system, you can give physicians more freedom  
18 because they're part of an overall system that shares  
19 financial responsibility.

20 So whenever you have this disconnect, one person  
21 making a decision and somebody else bearing the financial  
22 risk, you're going to have rules. And it's an imperfect



1 system and it can lead to problems. But it's more or less  
2 inevitable.

3 DR. DEAN: I think this discussion really speaks  
4 to the importance of the whole comparative effectiveness  
5 approach because we put these drugs in classes and sometimes  
6 all of the members of a class really are equivalent. And in  
7 other cases, they are not equivalent, even though they  
8 basically do the same thing but several members of the class  
9 may have different characteristics or different effects. I  
10 think that's probably what Ron is talking about, that they  
11 may be technically in the same class but they may not be  
12 totally equivalent.

13 Unfortunately, the manufacturers do their best to  
14 confuse this issue because they love to point out the  
15 differences in their particular product and why it's better.  
16 And it tends more often to confuse the situation than it  
17 does to help it.

18 It doesn't help the problem right now but  
19 hopefully we can move toward getting more objective data  
20 about which classes really are equivalent -- all the members  
21 are equivalent -- and which ones really do have unique  
22 characteristics where there may be a reason that even though

1 they're in the same class there may be reasons to move from  
2 one to another.

3           The other question I had is the whole issue of  
4 formularies hopefully the idea is to rationalize drug  
5 therapy a bit and hopefully save some money along the way.  
6 Is there any evidence that that's happening? I don't know  
7 if you can get to that question.

8           DR. HOADLEY: It's not something we can get to  
9 just with this analysis. The questions of whether money is  
10 being saved goes both to utilization, what drugs are being  
11 used. It goes to what John mentioned, the kind of pricing  
12 that results from it. Are better prices being obtained  
13 because of some of the techniques?

14           To your first point, I think one of the things  
15 that we started to do a little bit -- I didn't present  
16 anything from in here -- is start to look at the formularies  
17 within classes. And to the extent that there was good  
18 evidence out there to tell us which drugs are the -- which  
19 classes are drugs relatively equivalent and doctors would  
20 agree that they're pretty interchangeable, and which classes  
21 is that not true. We could look and, again, you could judge  
22 it in a class where you don't really care which one you

1 prescribed. If there are fewer drugs by a typical plan that  
2 are included and it's used to try to get a better price,  
3 that's something that you may not be bothered by.

4 In a class where the kind of subtle differences --  
5 antidepressants or some of the other mental health drugs  
6 certainly is one that comes to mind where it matters a lot.  
7 And of course, those are the categories that CMS has  
8 protected because of that reason.

9 But if you could start identify which of the  
10 classes where those distinctions matter, you can start to  
11 look at this kind of analysis we've done within those  
12 classes and see if the formulary variation occurs more in  
13 the classes where clinically it may not be as significant a  
14 difference.

15 MR. EBELER: Just quickly, I think Jay captures  
16 the patient access question. Another area for future  
17 analysis is on the insurance side, which is whether we're  
18 going to know at some point how patients are sorting among  
19 this 9,600 plans that we have out there based on the  
20 characteristics of the formulary and the risk status of the  
21 patient. How is the risk pool sorting out? Do we have any  
22 work underway that will help us answer that?

1 DR. HOADLEY: One slide that I didn't use in the  
2 presentation looked at the formulary size by enrollment  
3 levels. Of course, that's a two-sided thing. The price of  
4 the premium for the particular plan needs to be figured in  
5 that. But in fact, the most popular plans, those that had  
6 more than 10 percent of the enrollment in their particular  
7 region, on average had 97 percent of the drugs listed on  
8 their formularies. The least popular plans, the ones that  
9 attractive less than 1 percent of the enrollment in their  
10 region, had 81 percent of the drugs in their plans.

11 So that's either a sense that the people are, in  
12 fact, seeking out those plans -- of course they do possibly  
13 correlate some by premium. But it does look to me, and this  
14 is sort of the multivariate kind of analysis we haven't  
15 tried to do, that this may be a stronger trend than just  
16 price driven.

17 So that's a start in that direction.

18 MR. EBELER: It's just worth looking how the risk  
19 pool is getting fragmented and what those risk scores of  
20 those patients are.

21 DR. HOADLEY: Absolutely. If we had risk scores  
22 to work with for the plans, that would be great.

1 DR. STUART: Just a quick point. We all recognize  
2 that we're looking at the supply side and not the demand  
3 side. But I think the point that was made about whether, in  
4 fact, the drugs that are prescribed by physicians are  
5 actually picked up by patients is something that we should  
6 not lose sight of. We know we don't have the Part D drug  
7 data, and everybody is upset about that who wants to use  
8 these data.

9 But I think the other part is once you get those  
10 data you're still not going to know what was prescribed.

11 But another part of the MMA plan is physician  
12 order entry. And this is not something we should take  
13 lightly. This is something that I think we should be  
14 proactive about. Because that technically is going to make  
15 it possible to know what drugs are prescribed. And then you  
16 can compare what drugs are actually filled, so that we'd  
17 have a much better sense of what behavior occurs both at the  
18 physician level and then ultimately at the patient level in  
19 terms of filling these prescriptions.

20 MR. HACKBARTH: Thank you very much. Well done,  
21 as always. Look forward to seeing you next time.

22 From talking about formularies, we're going to

1 move to Part D benefit design and analysis of the different  
2 plans.

3 DR. SCHMIDT: Jack has just given you an analysis  
4 of the formularies that Part D plans used in 2006 and 2007.  
5 Now my presentation looks at other aspects of Part D that  
6 we've been learning about, enrollment trends for 2007 and  
7 the benefit offerings and premiums available for 2008.

8 Remember that the open season for Part D runs from  
9 November 15th through the end of the year. So now is the  
10 time of year when beneficiaries have the opportunity to  
11 switch plans or enroll if they haven't done so already.

12 Let's start with a look at where we are in 2007.  
13 Before Part D, estimates were that about 75 percent of  
14 Medicare beneficiaries had drug coverage. Today CMS  
15 estimates that about 90 percent of beneficiaries either have  
16 Part D or another source of drug coverage that's at least as  
17 generous. That's called creditable coverage. The 10  
18 percent of beneficiaries who either have no coverage at all  
19 or coverage that is of lesser value are shown in kind of the  
20 light area on the top part of that pie chart.

21 You've seen similar slides to this before so I'm  
22 just going to quickly mention the three groups of

1 beneficiaries that we're going to focus on in the rest of  
2 this presentation. Out of about 43 million Medicare  
3 beneficiaries, around 26 percent voluntarily enrolled in  
4 stand-alone prescription drug plans, PDPs. Fourteen percent  
5 were automatically enrolled because they are dually eligible  
6 for Medicaid and Medicare. And about 15 percent are in  
7 Medicare Advantage prescription drug plans. So we've got  
8 about 17 million beneficiaries in stand-alone PDPs and about  
9 half of those were auto-enrolled into a plan. About 7  
10 million beneficiaries in Medicare Advantage prescription  
11 drug plans.

12           The market shares of Part D sponsors are pretty  
13 concentrated and have been fairly stable since the start of  
14 the Part D program. Among PDP enrollees, which are in the  
15 left pie charts, the top two plan sponsors -- United  
16 Healthcare and Humana -- make up nearly half of total  
17 enrollment. Remember that United offers plans in every  
18 region under the AARP name and Humana entered Part D in 2006  
19 with some of the lowest premiums plans, which attracted a  
20 lot of enrollment.

21           I might point out also that Universal American is  
22 acquiring MemberHealth, and if you look at the combination

1 of their two chunks of the pie, that adds up to about 10  
2 percent of the market share.

3 Among MA-PD enrollees, which are the right-hand  
4 pie, the top three -- United, Humana, and Kaiser -- make up  
5 more than 40 percent of total enrollment.

6 Remember that Part D was designed to use  
7 competition for enrollees to provide incentives for  
8 controlling growth in drug spending. There are two ways in  
9 which competition is supposed to play out. One is that  
10 individuals shop around to choose a plan. So they look at  
11 whether their drugs are on a plan's formularies, the  
12 premiums, the pharmacy networks, and so on, and pick a plan.  
13 The other way has to do with the annual process that CMS  
14 goes through to set the maximum amount that Medicare will  
15 pay for a Part D premium on behalf of enrollees who receive  
16 the low-income subsidies. So there's some competition each  
17 year among plans to keep their premiums below these regional  
18 thresholds that are based on plan bids.

19 The fact that market shares haven't changed much  
20 since the start of Part D could suggest that in the first  
21 form of competition beneficiaries haven't yet switched plans  
22 very much and we'll have to wait and see what happens for



1 2008.

2 In the second type of competition, last year CMS  
3 set the regional thresholds in a way that led to little  
4 turnover among plans that had premiums below the thresholds.  
5 For 2008, there's more turnover and more beneficiaries  
6 affected. So we're going to see some change in these market  
7 shares as a result.

8 In this slide, we're going to take a look at  
9 enrollment trends for 2007. So for 2007, enrollees in  
10 Medicare Advantage drug plans are much more likely to be in  
11 an enhanced plan than a plan with basic benefits. Remember  
12 that enhanced plans have a higher average benefit value than  
13 basic benefits. For example, a plan might have no  
14 deductible or it might include coverage of generic drugs  
15 within the coverage gap. This reflects the fact that MA-PDs  
16 can use some of the difference between their bid for  
17 providing Part A and Part B services and their benchmark  
18 payments -- called rebate dollars -- towards additional  
19 benefits for their enrollees. And this could include  
20 lowering the Part D cost-sharing and premiums.

21 Also remember that most beneficiaries who receive  
22 low-income subsidies were automatically enrolled into stand-

1 alone PDPs rather than MA-PDs, which explains why the share  
2 in enhanced plans of PDP enrollees is so much lower than for  
3 MA-PDs. So something on the order of half of all PDP  
4 enrollees were initially auto-assigned into basic plans.

5 Medicare beneficiaries have shown a strong  
6 preference for plans that did not have deductibles. And  
7 also most Part D enrollees are in plans that do not offer  
8 coverage in the coverage gap. MA-PD enrollees are more  
9 likely to be in plans that have gap coverage than PDP  
10 enrollees. But even so, two thirds of MA-PD enrollees have  
11 no gap coverage.

12 When thinking about the 90 percent of PDP  
13 enrollees in plans that have no gap coverage, it's important  
14 to keep in mind that about half of all PDP enrollees are  
15 recipients of the low-income subsidy, which effectively  
16 fills in that gap.

17 So we've been talking about enrollment patterns  
18 for this year and now I'm going to turn to what plan  
19 sponsors are offering in the way of benefits for 2008. This  
20 slide looks at PDP benefit designs.

21 So first, the total number of plans has declined  
22 slightly, just about 2 percent from 2007 levels. Most

1 beneficiaries will still have about 50 to 60 PDPs available  
2 to choose among, in addition to any MA-PDs, in their area.  
3 There are about 17 organizations that are offering PDPs in  
4 each of the 34 regions across the country and those  
5 organizations are accounting for the vast bulk of all PDPs,  
6 87 percent.

7 I'm not going over everything on the slide but in  
8 terms of gap coverage, the distribution of PDPs available  
9 for 2008 looks very similar to that for 2007. Only about 30  
10 percent include some coverage and almost all of that is made  
11 up of plans that are only covering generics in the gap.

12 Over the past couple of years we've seen a few  
13 plans try offering brand-name coverage in the gap, only to  
14 retreat very quickly when beneficiaries figured out who they  
15 were. Today there's only one plan that's doing so in one  
16 PDP region.

17 Now we're going to look at the MA-PD offerings for  
18 2008. There are 19 percent more MA-PDs for 2008 than last  
19 year. Here we're counting plans that are broadly available  
20 to beneficiaries. So we've excluded some categories, such  
21 as employer groups and special needs plans. The growth in  
22 numbers would be larger if we included those, as well. HMOs

1 make up a little more than half, 53 percent of the MA-PDs,  
2 in the set of plans that we analyzed. But the share made up  
3 of private fee-for-service plans grew the fastest, making up  
4 more than a quarter of all the MA-PDs for 2008.

5 We're seeing a sizable increase in the percentage  
6 of MA-PDs offering enhanced benefits. It rose to 89 percent  
7 for 2008, compared to about 75 percent for this year.

8 And just over half of MA-PDs in 2008 offer some  
9 coverage in the gap. But of that amount most are plans that  
10 are only offering generics.

11 This chart gives you a sense of how premiums are  
12 changing for 2008. The short answer is that they're going  
13 on. The bars to the left of each pair show what the average  
14 enrollee paid in 2007. The bars to the right show our  
15 estimates of what enrollees would pay if they remained in  
16 the same plan for 2008. We know for certain that some  
17 beneficiaries are going to change plans. For example,  
18 people who received low-income subsidies and their current  
19 plan's premiums are above the current threshold for how much  
20 Medicare will reimburse in premiums will have to change  
21 plans. So that's a caveat to this analysis. Nevertheless,  
22 this gives you a sense of what the average cost to the

1 beneficiary is for staying in the same plan.

2           So on the far left, you can see that the average  
3 enrollee in a PDP paid about \$27 per month in 2007. That's  
4 for basic and enhanced benefits combined. If they remain in  
5 the same plan, the enrollees can expect to pay nearly \$32 or  
6 over \$4 more per month.

7           MA-PDs enrollees pay a combined premium that  
8 covers both Part D benefits and their regular medical  
9 benefits. If we just look at the portion of that combined  
10 premium that's attributable to their drug coverage, we  
11 estimate that the average MA-PD enrollee will pay about \$12  
12 per month in 2008. Again, that's basic and enhanced  
13 benefits combined.

14           So obviously MA-PD premiums are a lot lower than  
15 PDP premiums. And this could be that some MA plans could be  
16 managing their benefits better. But the difference also  
17 reflects what we also talked about before, the fact that MA-  
18 PDs can use some of these so called rebate dollars to lower  
19 their premiums.

20           In the interest of time, I'm are going to skip  
21 over to the far right-hand pair of bars. The average  
22 enrollee across all types of enrollees, all types of

1 benefits, paid about \$23 per month for Part D coverage in  
2 2007. If they stay in the same plan, their premium will  
3 increase by about \$4 next year.

4           So there are several reasons for these increases.  
5 One relates to what we talked about last year, the fact that  
6 CMS chose not to follow the method that the law calls for in  
7 setting plan payments and premiums in 2007. Rather than  
8 lowering Medicare's subsidy to the 74.5 percent that's  
9 called for in law all at once in 2007, CMS is phasing this  
10 subsidy down over time. So for 2008, as CMS brings down the  
11 subsidy a bit more, this has the effect of lowering plan  
12 payments and raising enrollee premiums relative to the  
13 method it used last year.

14           A second reason for the increase has to do with  
15 risk scores. CMS assigns a risk score to Part D enrollees  
16 based on their health status and spending under Parts A and  
17 B. So over time, these risk scores have crept up because of  
18 changes in how providers code their services. CMS has found  
19 that the average beneficiary now has a Part D risk score  
20 greater than 1.0. So in order to avoid paying more than it  
21 should for a beneficiary of average health, CMS adjusted  
22 2008 payments downward. This means that beneficiary

1 premiums have to increase somewhat to cover plans overall  
2 bids.

3 A third factor may be that Part D's risk corridors  
4 are scheduled to widen in 2008. What I mean by that is that  
5 plans have to start bearing more insurance risk than they  
6 did in the first two years of the program. This may have  
7 led some plans to bid more cautiously than before.

8 And finally, the bidding behavior of some of the  
9 larger sponsors may be changing over time. For example,  
10 when Part D was first getting off the ground, some sponsors  
11 had relatively low bids and premiums and got a lot of  
12 enrollees. Now that we're two years down the road, those  
13 sponsors may not have to bid as aggressively as they did at  
14 first.

15 About 9 million Part D enrollees receive low-  
16 income subsidies, which pay for their premiums and much of  
17 their cost-sharing. As we've talked about, not all plans  
18 qualify to be premium-free to these low-income subsidy  
19 enrollees. CMS sets the maximum amount that Medicare will  
20 pay in premiums for LIS enrollees in each region based on  
21 plan bids. That methodology takes into account bids from  
22 both PDPs and MA-PDs. As we saw a couple of slides ago, MA-

1 PDs tend to have much lower premiums.

2 Even so, this chart shows you that across the  
3 country there are still at least five PDPs available in each  
4 premium with premiums under those thresholds. However  
5 that's not to say that the same PDPs are qualifying from  
6 year to year. There's been some annual turnover in  
7 qualifying plans.

8 So Part D uses this annual process for setting  
9 regional thresholds as a means of providing incentives for  
10 controlling growth in spending. So long as the risk  
11 adjuster for low-income subsidy beneficiaries is good, plans  
12 all are going to want to bid low so that they can remain  
13 premium-free to this group of enrollees. But an outcome of  
14 this process is that there's turnover among these qualifying  
15 plans, which means that some low-income subsidy enrollees  
16 have to switch plans from year to year.

17 For 2008, about 2.6 million beneficiaries will be  
18 affected by this turnover. This number is a little bit  
19 higher than the numbers that were in your mailing materials  
20 because some more recent data has become available. CMS  
21 will reassign two groups of beneficiaries directly into  
22 plans, 1.2 million into plans offered by a different sponsor



1 than the beneficiary had this year, and one million into  
2 plans offered by the same sponsor. This distinction is  
3 important because the second group will likely be in a plan  
4 that has the same formulary as their current plan. Another  
5 440,000 beneficiaries picked a plan on their own rather than  
6 being automatically assigned to one by CMS. So CMS notified  
7 them that their current plan no longer qualifies for 2008,  
8 but it's up to these individuals to enroll in a new  
9 qualifying plan themselves or began paying part of the  
10 premium to stay in the same plan.

11 For 2007, CMS ultimately only reassigned about  
12 250,000 beneficiaries. There are a couple of reasons why  
13 the turnover of qualifying plans and the number of enrollees  
14 affected is higher for 2008. One is similar to what we  
15 talked about with respect to the premium increases. Last  
16 year CMS chose not to follow the law when it set regional  
17 premium thresholds for 2007. The Agency is using general  
18 demonstration authority to phase in its approach of  
19 weighting plan premiums by enrollment over time. So this  
20 year CMS took enrollment into account partially when it set  
21 these thresholds. This led to greater turnover among the  
22 qualifying plans and affects more beneficiaries.

1 CMS also changed its de minimus policy for 2008.  
2 Last year the Agency said that plans with premiums up to \$2  
3 higher than these regional thresholds could remain premium-  
4 free to their enrollees who get the low-income subsidies.  
5 This year CMS lowered this to \$1, which again means more  
6 turnover among qualifying plans.

7 You may have read in the press that CMS expects to  
8 collect billions back from Part D plans not that it has  
9 reconciled payments for 2006. So I thought we should  
10 explain this a little bit. Part D plans get prospective  
11 payment that come in at least three pieces. One is the  
12 direct subsidy, a per member per month payment that's set  
13 from a percentage of the national average among the plan  
14 bids. It's risk-adjusted.

15 A second piece is that Medicare pays individual  
16 reinsurance. In other words, it's paying a larger  
17 proportion of the catastrophic spending for those enrollees  
18 that have very high drug spending. So when plans are  
19 submitting bids to CMS, they estimate how much on average  
20 Medicare is going to have to pay them for this individual  
21 reinsurance and Medicare makes those payments prospectively  
22 to the plan.

1 CMS also pays premiums and expected levels of  
2 cost-sharing for the plan enrollees that are recipients of  
3 low-income subsidies.

4 So after the end of the benefit year, CMS and the  
5 plans reconcile these pieces. They have to go over actual  
6 levels of enrollment, including how many of those  
7 beneficiaries receive the extra help, and actual amounts of  
8 individual reinsurance that Medicare should pay for those  
9 with high drug spending. And then CMS looks at the risk  
10 corridors for each plan. Under the risk corridors, CMS  
11 compares a plan's actual costs to its bid, and Medicare  
12 shares the risk for costs that were much harder than  
13 expected and limits plan profits when costs were a lot lower  
14 than expected.

15 So for 2006, most plans owe money to Medicare and  
16 some are receiving money, but on net CMS expects to receive  
17 \$4.3 billion. Most of this amount comes from limits on plan  
18 profits through the risk corridors. Another major reason is  
19 that the prospective payments for the individual reinsurance  
20 were too high.

21 So both of these pieces reflect the fact that plan  
22 sponsors simply bid too high for 2006, and that's shown in

1 this chart. Before 2006, many plans didn't have a reliable  
2 basis for predicting which beneficiaries they would enroll  
3 and what the spending of those beneficiaries would look  
4 like.

5 So this chart is showing you the average amounts  
6 of prospective payments plans received from Medicare. The  
7 bottom two colors are showing you the direct subsidies and  
8 individual reinsurance and enrollee premiums are on the top.  
9 So in 2006 plans bid, on average, that it would cost a total  
10 of \$126 per enrollee per month to provide basic Part D  
11 benefits. It turns out that this average bid was simply too  
12 high. In addition to not having very good information on  
13 which to base those bids, some analysts believe that the  
14 plans have been more successful than they anticipated in  
15 switching enrollees to generic drugs, which kept costs down.  
16 As you can see, the average bid came down in 2007 and was  
17 only slightly higher than 2007 for 2008.

18 A concern of the Commission is that Congressional  
19 support agencies and other actors obtain access to Part D  
20 claims data in a timely manner. The Commission needs drug  
21 claims to help us carry out our mandate of advising the  
22 Congress on Medicare policy. In fact, I've heard many

1 comments around the table this morning on how you think  
2 there are particular projects we should be undertaking in  
3 order to promote program evaluation here.

4           So there are some very important basic questions  
5 we can't answer without claims data, such as on many Part D  
6 enrollees are entering the coverage gap and whether the  
7 higher cost-sharing in the gap is affecting adherence to  
8 drug therapy. Nor can we analyze whether certain types of  
9 Part D benefit designs are better able to encourage  
10 appropriate use of drugs and others. Federal agencies such  
11 as the FDA could use the claims information to watch for  
12 trends in disease prevalence and to conduct post-marketing  
13 surveillance to monitor drug safety.

14           CMS has not been clear about whether it had  
15 authority to use Part D data for purposes other than  
16 payment. In other words, it wasn't even clear that other  
17 parts of CMS that conduct evaluations and research would be  
18 able to have access to the claims data.

19           In October of 2006, CMS issued a proposed rule  
20 that would rely on the Agency's authority to add additional  
21 terms to its contracts with plans to make claims data  
22 available to other parties so long as they sign data use

1 agreements. This proposed rule has not moved forward and  
2 prevents us and other organizations from evaluating Part D  
3 as well as we can.

4           While many private researchers and other  
5 government agencies support the rule, some stakeholders have  
6 opposed it because of concerns about privacy and the  
7 possibility of revealing proprietary information. We  
8 believe it's possible for CMS to protect privacy and  
9 mitigate these concerns. However, even if the proposed rule  
10 moves forward, stakeholders could challenge it in court.

11           There's been related legislative language  
12 introduced on both the House and Senate side that would  
13 direct the Secretary to make drug data available under  
14 appropriate data use agreements.

15           Two years ago the Commission supported a  
16 recommendation that said the following: "The Secretary  
17 should have a process in place for timely delivery of Part D  
18 data to Congressional support agencies to enable them to  
19 report to the Congress on the drug benefit's impact on cost,  
20 quality, and access."

21           Given that the proposed rule has not moved forward  
22 and could potentially be challenged, you may want to

1 consider the following draft recommendation: that Congress  
2 should direct the Secretary to make Part D claims available  
3 regularly and in a timely manner to Congressional support  
4 agencies and selected Executive Branch agencies for purposes  
5 of program evaluation, public health and safety.

6 Beneficiaries could benefit from this to the  
7 extent that Executive Branch and Congressional agencies are  
8 able to improve the Part D program. Research conducted by  
9 these actors using Part D claims could also benefit public  
10 health and better ensure drug safety.

11 Stakeholders will object to the extent that they  
12 have concerns about protecting patient and provider privacy  
13 and also proprietary information, but once again we believe  
14 that CMS could provide claims data in a way that addresses  
15 these concerns.

16 MR. HACKBARTH: Thank you, Rachel. Questions or  
17 comments?

18 MR. EBELER: I think the recommendation makes a  
19 lot of sense. This is data we need.

20 The one area that I would probe more earlier in  
21 the presentation of these 2.6 million people who were being  
22 bounced around and whether there are policy options for what

1 to do about that. So some of that is structural within the  
2 nature of a bidding and payment process. But it just  
3 strikes me as difficult just to observe that.

4 I guess are there options such as possibly longer  
5 term relationships with some of the health plans that may be  
6 willing to commit to certain pricing to provide some  
7 stability in that market? If not, at a minimum, a sense of  
8 some studying of what happens with those people over the  
9 next several months as they shift, as they encounter new  
10 formularies, as they go to see their doctor who has to deal  
11 with another -- it's a lot of unanticipated movement that  
12 you certainly would like to, at a minimum, know more about  
13 and hopefully if there were approaches to do something about  
14 it.

15 DR. SCHMIDT: That's an interesting idea of  
16 longer-term relationships. It's not an idea that we've  
17 explored before.

18 MR. BERTKO: Just to add to that though, Jack, to  
19 your question there is some of it is inevitable until the  
20 benchmarking is fully enrollment weighted because that's a  
21 large part of what's been driving the change here. And so  
22 when you say long-term arrangements, then you'd begin to



1 involve budgetary impacts.

2           And so hopefully, in another year we'll be done  
3 with that part, which should then begin minimizing the  
4 amount of changeover. You'd have to come into play on a  
5 budget act if you actually wanted to do that this year.

6           DR. REISCHAUER: Rachel, you talked about the  
7 repayments that are going to be required, and the number is  
8 a pretty big number, \$4.3 billion. There are some reasons  
9 why the repayment for 2006 might be expected to be bigger  
10 than future years but I don't really know if that is going  
11 to be true. I was wondering since there is sort of an over  
12 one year lag between the time the over payments are made --  
13 or under payments as well -- and the time that there's a  
14 recouping of this, whether there was any provision in the  
15 law that interest would be paid on this, received from  
16 those?

17           DR. SCHMIDT: I don't believe that's the case.

18           DR. REISCHAUER: This as a big revenue source, it  
19 strikes me.

20           DR. SCHMIDT: There was an IG study that just came  
21 out that was suggesting that perhaps CMS should consider  
22 interim reconciliation steps. I don't think that CMS was

1 willing to do that at this point. But no, I don't think  
2 there were was provision for interest payments.

3 MR. BERTKO: Bob correctly assumed that 2007  
4 should have smaller ones. From my surveillance of the Wall  
5 Street analysts and the firms, the amounts accrued for these  
6 kind of things have diminished greatly in 2007.

7 DR. SCHMIDT: I think if you look at this slide  
8 once again, a lot of it does have to do the overbidding, I  
9 believe. It looks, at least for 2007-2008, the levels are  
10 much more stable. So I would expect it to be a lower amount  
11 next year.

12 DR. BORMAN: This was really a nice juxtaposition  
13 of information. Do we have -- alluding to something that  
14 John said a minute ago -- do we have a sense of where the  
15 clear time endpoint will be for full enrollment weighting?  
16 Because I think that in the interim, there's this continuous  
17 evolution possibility to which we will never get to the  
18 ability to draw any conclusions. And that's not okay.

19 Given the state of all the various trust funds in  
20 the program, it's not okay to sort of continuously put that  
21 off without dealing with it. So my first piece would be do  
22 we have a firm endpoint? Or is this just an option that CMS

1 can continue to exercise? We're going to fool with this  
2 enrollment weighting over the long-term?

3 DR. SCHMIDT: In the wording of CMS's  
4 demonstrations, they didn't delineate an exact timeline. If  
5 you look at some budget documents, there are some guesses in  
6 there and that sort of thing.

7 DR. BORMAN: Because I think there would be some  
8 value to sort of pushing to know that when the endpoint hits  
9 here on this rather huge thing. Given that we don't know  
10 that, even if we did, this amount is going down that plans  
11 are holding. But what's really bothersome is that's a  
12 really big leap in the number of people that are going to be  
13 shifted across programs. There has to be an enormous  
14 administrative cost associated with that, much less the  
15 hardship to the individuals that fall over to the providers  
16 and so forth.

17 Can we put any even guesstimate number on just  
18 what this administrative cost must look like? And again are  
19 there options, as Jack brought up, to mitigate this?  
20 Because we don't have clear benchmark ending in sight, which  
21 is the ultimate solution. This is not okay. At a similar  
22 rate, we're talking 2.5 million or more people next year.

1 And these are just costs and activities. They're not good  
2 for patients and we can't afford to sustain.

3 So do we have a sense of what the amount is? I  
4 would agree with Jack, that advocating for some other  
5 options in this would be very important for us to think  
6 about.

7 DR. SCHMIDT: I don't have a direct answer to your  
8 question. You could try to look for information on, for  
9 example, the fact that plans are supposed to have transition  
10 policies in place. So if you get a new enrollee who's been  
11 on a different drug, they're supposed to have a 30-day  
12 window in which they have access to the previous medicine  
13 they have been on, even if it's not on the preferred tier of  
14 their new plan, and that sort of thing.

15 So one might be able to take a look at that but  
16 that's only partial. It's not dealing with hassle factors  
17 or the fundamental questions of whether the patients are  
18 getting the drugs that are appropriate to them.

19 MR. HACKBARTH: Rachel, if I understood you  
20 correctly, you said you might be able to infer from budget  
21 documents and other sources what sort of a timeline is  
22 envisioned. Could you just elaborate on that?

1 DR. SCHMIDT: I'm trying to dig this out of my  
2 memory, but I believe in the President's budget there were  
3 some assumptions about over how many years there would be  
4 demonstrations underway. I think it was something on the  
5 order of four or five years total, including this current  
6 year.

7 MR. HACKBARTH: Is it reasonable to assume, as  
8 Karen suggested, that the level of reassignment would be in  
9 this 2.5 million range? Or might that decline over time?

10 DR. SCHMIDT: It's hard to say exactly. One issue  
11 that I've seen some researchers raise has to do with the  
12 combination of including both Medicare Advantage drug bids  
13 with PDP bids in setting the premium levels in these --  
14 setting these regional thresholds.

15 So if you look around the country, for example, in  
16 areas of the country where there's greater penetration of MA  
17 plans, you can see that there are actually fewer qualifying  
18 plans in those areas. Some people take issue with the fact  
19 that because MA-PDs are able to use these rebate dollars to  
20 have lower premiums that that should not be included in the  
21 calculation. That's one point of view I've heard.

22 And it is potentially possible to take pre-rebate

1 dollar premiums into account in setting these thresholds.

2 I'm sure plans might have a different point of view as to

3 whether or not that's an appropriate thing to do.

4 DR. KANE: As I recall, we had a lot of discussion

5 about the impact of Part D on nursing home patients. Is

6 there any new information about how the nursing home

7 population, in particular, is faring under these changes,

8 especially the LIS changes?

9 DR. SCHMIDT: I do not have a sense of how many of

10 the 2.6 million are in long-term care facilities. It's

11 possible that with a little more time and analysis I might

12 be able to dig that out of enrollment data but it's very

13 difficult to obtain. But I will certainly look into that

14 for you.

15 DR. KANE: Is it possible just to even get data

16 from the nursing home industry about what's happening? I

17 don't know, maybe that's too much work.

18 DR. SCHMIDT: It's not an issue of the work. We

19 can certainly ask around and get a sense of that.

20 DR. CROSSON: With respect to the draft

21 recommendation, I think as you laid out pretty clearly there

22 is, in this consideration, perhaps a set of conflicting

1 values or conflicting interests anyway relating to the need  
2 for data to evaluate the program versus some concerns about  
3 perhaps confidentiality, patient confidentiality. But  
4 certainly, issues of proprietary nature, and particularly  
5 those that relate to the relationship between data about the  
6 utilization of drugs and then the ability to contract  
7 assertively for acquisition costs. That's one of those  
8 issues.

9 I just probably would wonder and would ask that if  
10 we move forward with this -- and I think, in general, I  
11 would support this -- that we get a little bit more  
12 information later about how those concerns would be  
13 mitigated. And what might that look like and how that  
14 relates to issues about public accessibility to information  
15 once it has been acquired by CMS and other things so that  
16 that is a little bit clearer when we move forward with the  
17 consideration.

18 DR. SCHMIDT: I will tell you that Mark has been  
19 prompting me to do just that.

20 MR. HACKBARTH: One of the reasons for crafting  
21 this recommendation narrowly is to try to mitigate some of  
22 those concerns. So as opposed to the recommendation

1 including researchers and others, we said let's do it on a  
2 very limited basis for Federal agencies and Congressional  
3 support agencies.

4           Having said that, I agree with your point that we  
5 ought to raise some of these broader issues in the text as  
6 well.

7           MR. BERTKO: Just a quick comment to also support  
8 some recommendation of this part. I think with the proper  
9 data use agreement following what's available in the A/B  
10 types of data, that particularly the post-market  
11 surveillance here could serve to inform people down the  
12 road, the private sector, about how to do placement inside  
13 the tiers. So I think he could be extremely valuable done  
14 through Federal agencies.

15           DR. STUART: I have two questions. One is a  
16 follow up on this. That's whether anybody at the Commission  
17 has talked with the Administrator at CMS, in terms of trying  
18 to find out what their plans are with respect to the  
19 proposed rule?

20           DR. MILLER: We've had a series of ongoing  
21 conversations with CMS. We have not spoken to the new  
22 Administrator, if that's what you meant. The best



1 characterization is -- actually within the last 24 hours or  
2 even 12 hours, I can't remember, was it's in clearance,  
3 which is as much as we can get. Some of us understand the  
4 clearance process in more detail than others.

5 MR. HACKBARTH: How long has it been in clearance?

6 DR. MILLER: This has been in play for -- I want  
7 to say eight months.

8 DR. SCHMIDT: Since October of 2006 and the close  
9 of comments was the end of last year, I believe.

10 DR. MILLER: So there's that.

11 And then the additional concern that I have on top  
12 of that is now other people have finally -- some other  
13 agencies have kind of woken up to the issue, which hadn't  
14 been the case say a year ago. Legal counsels in different  
15 agencies are starting to talk. And even if the reg got out  
16 the concern is that somebody could just bring a legal  
17 challenge. And so even if it got out, I'm now no longer  
18 convinced that we would still see it within a timely way,  
19 which is why I'm...

20 DR. STUART: My second question actually goes back  
21 to Rachel's slide number seven. This has always been  
22 perplexing to me, and I'm sure to others, in terms of how

1 plans can offer enhanced benefits at a cheaper rate than the  
2 basic plan. And it looks like in 2008 that there's going to  
3 be a \$2 or \$3 or \$4 difference in the median plan. Could  
4 you help us there? And also, to relate this to the Federal  
5 regulations regarding the true out-of-pocket payment  
6 obligation on beneficiaries.

7 DR. SCHMIDT: With respect to the bars on  
8 comparing any basic to any enhanced, this really has to do  
9 with the fact that if you look at what types of enrollees  
10 are in enhanced plans, it's by and large MA-PD enrollees.  
11 So the difference here is reflecting once again the fact  
12 that you can use these so-called rebate dollars to lower the  
13 drug component of the MA premium. So that's essentially  
14 what you're seeing there.

15 I'm not quite sure I'm understanding the second  
16 part of your question.

17 DR. STUART: The second part was in an enhanced  
18 plan the benefits are provided that are more than the  
19 standard benefit, by definition. But there are also  
20 requirements that individuals meet certain out-of-pocket  
21 obligations before the catastrophic benefits can be made  
22 available to them. So it's really a question about how that

1 enhancement works and still stays true to the obligation for  
2 beneficiaries.

3 DR. SCHMIDT: Essentially, the true out-of-pocket  
4 approach means that the beneficiary's own dollars are what  
5 counts towards that catastrophic protection. So insofar as  
6 the plan is covering more of those benefits, that's not  
7 bringing the person closer to TrOOP. It's not their out-of-  
8 pocket cost-sharing. They are paying at presumably higher  
9 premiums. But I don't believe that counts towards the TrOOP  
10 levels. I'm not sure whether that helps or not.

11 DR. REISCHAUER: [off microphone] It takes them  
12 longer to get to the catastrophic coverage.

13 DR. STUART: I'm still confused, and I study this  
14 stuff. It's really the question about the premium and the  
15 reinsurance that comes in for people that have met that  
16 catastrophic cap. My understanding is that if there's  
17 enhancement during the gap, then that pushes up the  
18 threshold at which the catastrophic coverage would come into  
19 play. And that would obviously effect the reinsurance that  
20 the plan would obtain.

21 So it sounds to me that if you offer this kind of  
22 coverage, that it's going to cost the plan more. If it has

1 the same kind of enrollee mix that you would have without  
2 that kind of coverage.

3 DR. SCHMIDT: It's essentially costing the  
4 enrollee more. The enrollee has to pay that incremental  
5 supplemental premium that's on top of their basic benefits.  
6 But the way you described the operation of it is exactly  
7 right, the kind of threshold at which the individual  
8 reinsurance and the catastrophic protection kicks in is  
9 higher by the amount of the --

10 DR. STUART: Maybe this gets back to the question  
11 of terminology. If that's the case, then where is the  
12 enhancement? In other words, if you have individuals who  
13 are actually not going to be eligible for catastrophic  
14 coverage because they got enhancement during the early part  
15 of the gap, then that enhancement -- if they're really  
16 expensive -- than that enhancement is really not worth  
17 anything.

18 DR. SCHMIDT: I think a lot of enhanced benefits  
19 are the fact that people do not like to pay a deductible and  
20 it's taking that form.

21 MR. HACKBARTH: By definition, the enhanced  
22 benefit has a higher actuarial value predicted expenditure,

1 taking into account all of these factors and the delayed  
2 access to the catastrophic.

3 We need to get to our final few here.

4 MS. HANSEN: I just want to pick up, there was a  
5 second part about the impact to the switching for the people  
6 who have to get automatically switched. Are we going to be  
7 doing some more ink on that issue? Or are other groups  
8 doing some studies to talk about the impact of having to be  
9 switched? That's one question.

10 The second one has to do with the value-based  
11 insurance design that we were exposed to, I think, last time  
12 which I found extremely intriguing. So it was interesting  
13 to hear I think, Sarah, you're saying that actually one PDP  
14 is actually testing this?

15 MS. THOMAS: It's a SNP so it's already targeted  
16 to a particular set of chronic conditions.

17 MS. HANSEN: This is such an area that I just  
18 wonder how this flows into this particular mix right now in  
19 terms of our ability to look at some of the plans who may  
20 eventually choose to go this route.

21 DR. SCHMIDT: In terms of further research on  
22 transition issues and the effects on those particular

1 enrollees, a few years ago before Part D began we started  
2 looking at what happens in the private sector when people  
3 needed to switch among plans. We got a sense from  
4 interviewing stakeholders, including some people who were  
5 covered by those policies, what the effects look like. So  
6 one interesting thing to do might be to look at go back and  
7 look at that chapter. But in terms of these particular  
8 enrollees, we can certainly do a little bit more work to try  
9 and follow them and see what has happened to their use of  
10 services.

11           Once again though, claims information would be  
12 very helpful in getting to a more detailed analysis. Jack,  
13 do you know of any other studies that are underway on those  
14 populations?

15           DR. HOADLEY: No, because we've only known  
16 obviously in the last few weeks what the magnitude would be.  
17 Last year the numbers were smaller and so it seemed less  
18 urgent to study. But I think there may be some people who  
19 will try to look at it now that we know that's out there.

20           DR. SCHMIDT: And on the value-based insurance  
21 design, I think we were envisioning that more as a portion  
22 of a chapter in our June 2008 report dealing with benefit

1 design more generally. With the exception that Sarah has  
2 raised, I think we're primarily going to have to look at  
3 private sector examples of that. But we can do some  
4 envisioning for what it might look like in Medicare in some  
5 years to come.

6 MR. DURENBERGER: I, too, wanted to accomplish you  
7 not just on the presentation but on all of the analysis that  
8 we were provided as part of this. It's really, really very  
9 good. As one who looked at the MMA as the proverbial  
10 sausage, they did a pretty good job in the design to  
11 facilitate the implementation. But my question, I guess of  
12 all of us, is the policy goal here. I think we all  
13 understand the policy goal about expanding coverage and  
14 things like that.

15 But to the extent that the articulated policy goal  
16 for competition among plans is to provide an incentive to  
17 manage growth in drug spending, I'm assuming that can be  
18 accomplished in several different ways. It can be done in  
19 the basic benefit design, and we're looking at a lot of  
20 that, and we've just been speaking to that.

21 It also will come in the nature of competition,  
22 which I don't know that I would agree that we've gotten

1 into. But I look at this and I see the predominance of  
2 national players and what appears to be very little "local"  
3 competition or local plan, either PDP or MA competition at a  
4 local level. And I don't have an answer for is this good or  
5 bad. I'm simply suggesting that in that whole area the  
6 nature of the competition is something we ought to be  
7 keeping an eye on from time to time.

8           And the third one has been raised by the  
9 physicians here and that is the role of the prescribing  
10 physician in achieving the ultimate goal, which relates to  
11 reducing growth or providing incentives to reduce the  
12 growth. That gets into a related issue which would be  
13 physician compensation or maybe some others I don't know  
14 anything about.

15           But it strikes me would be well for us to keep our  
16 analytic focus as we're going through this on the policy  
17 goal which relates to incentivizing appropriate use of the  
18 medically necessary and appropriate drugs. And that will  
19 come in at least three different forms.

20           DR. DEAN: The data that you have, does that give  
21 you any information about geographic access to pharmacy  
22 services? Because obviously that's a real concern that I



1 have. Pharmacies in small communities are very different  
2 entities than they are in bigger communities. They are at a  
3 disadvantage for several different reasons. First of all,  
4 they don't have the purchasing leverage with suppliers. And  
5 second of all, they are much more dependent on the income  
6 from pharmaceuticals for their survival than is Walgreens or  
7 Wal-Mart that have huge big stores and lots of other stuff  
8 they sell. These folks are, a lot of times 90 percent of  
9 their income comes from pharmaceuticals. And if those  
10 margins get squeezed they may not be there. In my  
11 particular case, if we lose our local pharmacy, the next one  
12 is 50 miles away. And that's going to present some major  
13 problems.

14           We've been extremely fortunate in our community,  
15 and I don't think we're all that usual, of having  
16 pharmacists -- the other thing they face is that pharmacists  
17 that are coming out of training now really are not  
18 interested, for the most part, in running small town retail  
19 stores.

20           But we've had extremely cooperative people and  
21 they've been very supportive and felt a responsibility to  
22 their community to keep the service available. I'm not sure

1 how much longer it's going to be there. These kind of  
2 changes have really put the squeeze on them.

3 So I think it needs to be tracked somehow. I  
4 guess the question is does this data help us to understand  
5 how big a problem that is? I perceive it's a big problem.

6 DR. SCHMIDT: Not really.

7 DR. DEAN: That's what I was afraid of.

8 DR. SCHMIDT: CMS does have access standards, both  
9 for urban and rural areas, in terms of how the pharmacy  
10 networks are supposed to look for plans. But again this is  
11 an example of one of the benefits of having claims data  
12 available. We might be able to do a similar sort of  
13 analysis if we did have access to that.

14 DR. DEAN: What are those standards now? I guess  
15 I'm not really familiar with what CMS would require.

16 DR. SCHMIDT: I don't have them off the top of my  
17 head. They're similar to what's used in the TRI-CARE  
18 program. Do you know John? I'd be happy to make those  
19 available to you.

20 DR. DEAN: Thank you.

21 DR. REISCHAUER: I think we maybe should think  
22 about developing, if not just analysis, some recommendation

1 along the lines that Rachel hinted at with respect to the  
2 inclusion of the subsidized premiums and MA PDP plans in the  
3 calculation of the threshold for plans available to those  
4 who are in low-income subsidies. Because if you think about  
5 this, and you look at your map on chart nine, you see  
6 California, Florida, two pretty big states.

7           If you think about this two or three years out and  
8 there's large participation in MA plans. And so they are  
9 really determining everything. You could end up with only a  
10 couple of plans in stand-alone PDP that are available. And  
11 then you might get into a situation where you have huge  
12 shifts in numbers of people from year to year caused by some  
13 PDP deciding well, I'd like to get a million of those people  
14 in California flipped into my plan. And so we are creating  
15 a source, I think, of significant instability in these  
16 areas.

17           And if you think that some of this might be being  
18 driven by MA-PD plans associated with private fee-for-  
19 service, then the logic behind this is completely perverse,  
20 I think.

21           DR. SCHMIDT: In the context of thinking about  
22 whether you want that as a recommendation or not, it might

1 be important to raise the fact that your existing  
2 recommendation of bringing payment rates for MA to  
3 equivalent levels for average fee-for-service costs would  
4 tend to address that.

5 DR. REISCHAUER: If you want to put your money on  
6 that horse, you can.

7 DR. SCHMIDT: I thought I should state that for  
8 the record.

9 DR. REISCHAUER: I thought we maybe should have  
10 two horses in the race.

11 DR. MILLER: By the same group that opposes the  
12 first will oppose the second one, too.

13 DR. SCHMIDT: Something else to keep in mind --  
14 Jack slipped me a note here, let me know here, thank you --  
15 is that we do have some work underway looking at the notion  
16 of beneficiary-centered assignment where, if you recall from  
17 the spring presentation that Jack gave, it's a potential  
18 method of assigning people who would be reassigned into a  
19 plan into one where the formulary more closely matches the  
20 drugs that they're currently taking. So that's another  
21 policy option to consider.

22 MR. HACKBARTH: Okay, before we break, it sounds

1 like people are comfortable with the draft recommendation  
2 and so we will be voting on that, I guess in December, next  
3 meeting.

4 Okay, well done everybody. Thank you.

5 Before we break for lunch, we'll have a brief  
6 public comment period. And the usual ground rules which are  
7 number one, identify yourself. Number two, keep your  
8 comment to no more than a couple of minutes. And number  
9 three, if somebody before you has already made the comment  
10 you want to make, you can just say me, too.

11 MR. BEDLIN: Thank you. My name is Howard Bedlin.  
12 I'm with the National Council on Aging.

13 I want to first thank the Commission and the staff  
14 for your discussion initially this morning on the low-income  
15 beneficiary issues.

16 We strongly support the three recommendations that  
17 were made, think they have significant potential for  
18 increasing participation in these programs. We've been very  
19 involved in this issue over the last five years, both on the  
20 ground, performing access to benefits coalitions, doing some  
21 benchmarking analysis of best practices and costs for  
22 enrollment, and also making recommendations very similar to

1 the ones today.

2 I wanted to make two brief comments on the  
3 recommendations and one on the longer term issues for future  
4 consideration. First, I want to highlight and agree with  
5 Jennie Hansen's observation that in many communities  
6 trusted, familiar, local nongovernmental organizations such  
7 as faith-based organizations, minority groups, low-income  
8 housing facilities, senior centers, et cetera, are  
9 critically important to finding and enrolling hard-to-reach  
10 low-income populations.

11 As you may know, a recent Kaiser Foundation survey  
12 found that 48 percent of Medicare beneficiaries with incomes  
13 below 150 percent of poverty were not aware of the  
14 prescription drug low-income subsidy. To reach these  
15 beneficiaries we need to go beyond SHIPs and fund local  
16 groups who have greater flexibility to tailor messages and  
17 use new and innovative methods for outreach. Increased  
18 targeted funding for SHIPs is necessary but not sufficient  
19 if we're going to be successful.

20 I also want to make the Commission members aware  
21 of an opportunity that's new that exists under authority  
22 created last year under the Older Americans Act for a

1 National Center on Senior Benefits Outreach and Enrollment,  
2 which is designed to apply innovative best practices and  
3 lessons learned and help fund local efforts by community  
4 organizations and coalitions.

5           With regard to recommendation number two, aligning  
6 the LIS and MSP programs makes enormous sense as a first  
7 step to simplifying these very complex programs. There's no  
8 good policy rationale for having different eligibility  
9 criterion for low-income protections under Medicare Part D  
10 versus those available under Parts A and B.

11           But one other recommendation that I urge the  
12 Commission to consider is making the QI or Qualified  
13 Individual program permanent. Again, no policy rationale  
14 exists as to why QMB and SLMB and LIS programs are  
15 guaranteed but the QI program is a block grant subject to  
16 waiting lists and unmet needs, as well as to the vagaries  
17 and uncertainties of the Federal appropriations process.

18           Finally, two issues I urge the Commission to  
19 consider, preferably in the near term but at least in the  
20 context of the broader federalism issues that have been  
21 raised. First, as Bill Scanlon articulated, we hope you  
22 will consider aligning LIS and MSP benefits by expanding the

1 QMB cost-sharing to 150 percent of poverty.

2 And second, to consider eliminating the asset test  
3 as a criterion for eligibility for these programs. We  
4 shouldn't be penalizing seniors who did the right thing by  
5 saving during their working years to create a modest nest  
6 egg. I would note a piece of work that was done for Kaiser  
7 by Tom Rice that found -- this was done in 2005. Half the  
8 people who failed the asset test for LIS had excess assets  
9 of \$35,000 or less. They tended to be older, female,  
10 widowed, living alone. What happened is often when the  
11 husband died, the wife's income was significantly reduced  
12 but still had the modest assets that were accumulated during  
13 the marriage.

14 So thank you again and look forward to additional  
15 discussions on these issues of great importance to  
16 beneficiaries in greatest need.

17 Thanks.

18 MS. FRIED: I'll be shorter.

19 I'm Leslie Fried. I direct the Medicare Advocacy  
20 Project for the Alzheimer's Association, which is also a  
21 joint project with the American Bar Association Commission  
22 on Law and Aging. I have two quick comments about slide 10,



1 the last slide 10.

2           Actually, we're very concerned about the 2.6  
3 million beneficiaries who are going to get switched again.  
4 I had sort of two questions. One is last year CMS upped the  
5 number to \$2 for the threshold if a PDP or a plan came in  
6 over threshold for the regional benchmark. It would be  
7 interesting to find out how many plans would have fit into  
8 that threshold if CMS had done what they did last year  
9 instead of reducing it to \$1, as they did this year.

10           Because last year they did it because less LIS  
11 beneficiaries would have to get switched. So I'm wondering  
12 why they didn't do that this year, given that there's so  
13 many more folks who are going to be affected. Does that  
14 make sense?

15           The second question is, which you mentioned that  
16 there were 440,000 people who are going to be -- they're  
17 called choosers. Because when they were auto-enrolled they  
18 didn't like the plan they were in for whatever reason and  
19 switched to a different LIS plan. These people will not be  
20 auto-assigned. They're going to get this chooser letter  
21 that says you have to choose a different plan. Or if you  
22 don't choose another plan, you're going to have to pay the

1 additional premium.

2 A lot of us are very concerned about what will  
3 happen to those 440,000. And I hate to put more work on you  
4 but if there's any way of looking at the data to figure out  
5 what actually happens to those people because it's so big  
6 this year.

7 Thank you.

8 MS. GOTTLICH: I'm Vicki Gottlich at the Center  
9 for Medicare Advocacy. We're a national non-profit  
10 organization that represents Medicare beneficiaries. In  
11 addition to the comments that Howard and Leslie raised, I  
12 wanted to make two, as well.

13 We hope that MedPAC would consider recommending  
14 that the benchmark threshold be calculated without taking  
15 into consideration the rebates to Medicare Advantage plans.  
16 We support your recommendation about a level playing field.  
17 We agree with Mr. Miller's comments that that may be a long  
18 way off. And recalculating the LIS benchmark premium may go  
19 farther in helping the 2.6 million people who are being  
20 reassigned this year, many of whom were reassigned last  
21 year.

22 We would also ask MedPAC to take a look at what's

1 happening with costs in Part D plans for beneficiaries. Our  
2 clients are seeing large increased costs not only in  
3 premiums but in the cost-sharing that they have to pay.

4           The cost-sharing on tiers are going up. We are  
5 seeing, in our home state of Connecticut, four and five  
6 tiered plans, including plans that distinguish between  
7 preferred generic drugs and nonpreferred generic drugs. We  
8 have at least one plan in our home state of Connecticut that  
9 charges \$76 for a nonpreferred generic drug. That's a large  
10 amount of money for Medicare beneficiaries.

11           As we see more people going into the doughnut  
12 hole, we're getting concerned that Part D is providing less  
13 and less assistance for individuals and we hope that MedPAC  
14 would take a look at that.

15           Thank you.

16           MR. HACKBARTH: Okay. We will reconvene at 1:15.

17           [Whereupon, at 12:17 p.m., the meeting was  
18 recessed, to reconvene at 1:15 p.m. this same day.]

19

20

21

22



1 physician spending numbers are a little bit higher than what  
2 we showed you last time.

3 After reviewing these numbers, I will address some  
4 questions you had for us last time on our analysis. After  
5 I'm through, Anne will go on to discuss how Medicare could  
6 move to some type of bundled payment for services  
7 surrounding a hospitalization.

8 In our analysis, we examined two type of episodes:  
9 the hospital stay only, combining hospital and physician  
10 payments together. The second is the hospital stay plus  
11 services provided 15 days after discharge, which includes  
12 hospital readmissions, post-acute care, and physician and  
13 outpatient services. Our analysis focused on five  
14 relatively high volume conditions, listed above on the  
15 slide. The spending numbers we report reflect rates,  
16 national rates. So our numbers do not reflect differences  
17 in payment rates that may be attributable to the wage index,  
18 the IME and DSH adjustments for hospitals or physician  
19 GPCIs, for example.

20 We've also risk adjusted our spending numbers  
21 using APR-DRGs to control for differences in spending that  
22 may be attributable to patient severity.

1           This next slide shows average risk-adjusted  
2 spending during a hospital stay for CHF patients and shows  
3 spending for the bottom quartile, the case level average,  
4 and the top quartile of providers, broken down by hospital  
5 and physician spending.

6           You saw a similar slide last time but this one  
7 corrects for the problem I just mentioned on the physician  
8 spending which is, again, a little bit higher than we showed  
9 you in October.

10           The basic story though is essentially the same, as  
11 we reported last time. If we focus on just the hospital  
12 stay we see relatively small differences in spending between  
13 the top quartile and average. As you can see for CHF  
14 patients, spending in the top quartile are just 5.6 percent  
15 higher than average. Most of this is due to differences in  
16 physician spending, which is 37 percent higher for the top  
17 quartile hospitals compared to the average. Most of these  
18 differences were due to greater number of physician  
19 services.

20           We see the same general relationship across four  
21 of the five conditions we are examining in our analysis.  
22 Most of the spending variation is due to higher physician

1 spending during the hospital stay. And most of this is due  
2 to differences in the number of physician services.

3           This next slide shows the spending for CHF for the  
4 hospital stay plus the services provided 15 days after  
5 discharge. The physician services here are for physician  
6 services during the hospital stay. The things below the  
7 bottom line are for the services provided after the hospital  
8 stay: readmissions, including the physician services  
9 provided during the readmissions; post-acute care; and other  
10 services, which are generally outpatient care and physician  
11 services provided outside of the inpatient hospital setting.

12           So when we expand this episode to cover a larger  
13 bundle of services, we see bigger differences than if we  
14 focused only on the hospital stay. Spending in the top  
15 quartile here is 15 percent higher than average or \$1,141  
16 higher. We see this variation ranging from 7 to 18 percent  
17 for the five conditions that we have in terms of the total  
18 spending.

19           The biggest factors contributing to the higher  
20 spending in the top quartile for CHF were hospital  
21 readmissions followed by spending on post-acute care. We  
22 find the same pattern across the five conditions we examined

1 with either readmission spending or post-acute care spending  
2 the leading factors in explaining the higher spending in the  
3 top quartile of providers. This again is driven by higher  
4 readmission rates, greater use of post-acute care, and use  
5 of more expensive types of post-acute care settings.

6 So now I want to move on and try to answer some  
7 questions you had at the last meeting. One of those  
8 questions concerned how physician service use varied for the  
9 top quartile and whether differences in spending might be  
10 attributable to greater use of consultants and other  
11 services.

12 MR. HACKBARTH: Just a clarification, Craig. As I  
13 understand the analysis, what we're looking at for the  
14 hospital piece is the Medicare hospital payments, as opposed  
15 to the underlying hospital cost?

16 MR. LISK: That is correct.

17 MR. HACKBARTH: Once you strip out the wage and  
18 the policy adjustments, that's going to reduce the variation  
19 attributable to the hospital, other than the readmission  
20 piece.

21 MR. LISK: That is correct.

22 MR. HACKBARTH: If you looked at hospital costs,



1 as opposed to payment, you might find more hospital  
2 variation within the admission?

3 MR. HACKBARTH: Yes. Thank you, yes.

4 So one of your questions concerned variation in  
5 physician services and what type of physician services were  
6 being used. Table two in your appendix provides a summary  
7 of that across the five conditions, for each of the  
8 conditions during the hospital stay.

9 Hospital visits are generally the largest factor  
10 in explaining spending differences, accounting for between  
11 40 and 60 percent of the higher physician spending in the  
12 top quartile of hospitals. That translates to, for the  
13 different conditions, \$100 to \$215 more spending in the top  
14 quartile compared to the average.

15 Consults are the second biggest factor in  
16 explaining spending differences for the two medical  
17 conditions we examined, with the top quartile spending \$70  
18 to \$80 more for those two conditions than on average.

19 Procedures generally are the second biggest factor  
20 for the three surgical conditions we accounted for, \$177  
21 more spending for the CABG patients but less than the other  
22 two surgical conditions.

1           Imaging and tests are a small factor in explaining  
2 the higher physician spending in the top quartile,  
3 contributing 10 percent or less to the higher physician  
4 spending here.

5           Interestingly, we find the physician spending to  
6 be slightly lower in major teaching hospitals, a possible  
7 indication that residents might be substituting for certain  
8 billed physician services. That was generally for the  
9 physician visits and the consults. Despite this lower  
10 spending, we did actually slightly higher spending for these  
11 physician services for tests and imaging in teaching and  
12 that's consistent with what we know in the IME context of  
13 teaching hospitals potentially providing more tests. And  
14 that would reflect the physicians looking and giving their  
15 readings on the tests and the imaging.

16           Another question concerned the characteristics of  
17 hospitals in the top spending group and whether we saw any  
18 consistent hospital characteristics. If we look at the  
19 hospital-only episodes we found across the five conditions  
20 the hospitals in the top quartile are more likely to be from  
21 the Middle Atlantic states but less likely to be from New  
22 England. We also generally see that hospitals in the top

1 spending quartile are more likely to be proprietary and less  
2 likely to be rural or major teaching. Again, differences in  
3 physician spending are what are attributing to these  
4 differences.

5           Now if we look at the hospital stay plus 15 days  
6 though, we find higher spending on post-acute care to be a  
7 factor that put a larger than proportionate share of  
8 hospitals in the Middle Atlantic, New England, and the West  
9 South Central census divisions -- West South Central  
10 includes Texas and Oklahoma, for example -- to be in the top  
11 spending quartile.

12           Rural hospitals, on the other hand, were less  
13 likely to be in the top spending quartile across four of the  
14 conditions. And this generally was because of lower  
15 spending on physician services and on post-acute care.

16           We saw no consistent patterns, though, if we look  
17 by ownership and teaching status when we expanded the window  
18 to include the services provided 15 days after discharge.

19           Finally, to get a better handle on the similarity  
20 of the relationships across conditions and whether the same  
21 hospitals that were in the top spending quartile for one  
22 condition were also in the top spending quartile for another

1 condition, we examined what share of hospitals had this  
2 pattern. So we looked at pairs of conditions to see what  
3 percent are in the top quartile for both, assuming the  
4 hospitals provide care in both conditions. Looking across  
5 both types of episodes, we basically find that a high  
6 spending on one condition is not necessarily an indicator of  
7 higher spending on another condition.

8 More specifically, if we look at the hospital stay  
9 plus 15 day episodes, we find from 31 to 43 percent of  
10 hospitals in the top spending quartile for one condition are  
11 also in the top spending quartile for one of the other  
12 conditions. If we had a perfect relationship here between  
13 the two conditions we'd see it being 100 percent. So we see  
14 some relationship. We don't see as high a relationship as  
15 maybe we might have expected here.

16 With that, we'll go on to Anne, and I'll be happy  
17 to answer questions at the end, if you have any.

18 MS. MUTTI: At the last meeting, we used this  
19 decision tree to explore some of the design issues for  
20 bundling and we heard some consensus from you on a few  
21 issues. We certainly won't hold you to it, if you change  
22 your mind.

1           One was that you tended to favor bundling for an  
2 episode longer than just a hospital stay. Another was that  
3 the voluntary bundling seemed unworkable given the selection  
4 effects, so we might want to focus more on mandatory  
5 bundling or virtual bundling. The third thought we heard  
6 was the importance of thinking through an incremental path  
7 toward bundling.

8           So with that feedback in mind, we've structured  
9 this presentation today so that we'll first focus on  
10 mandatory bundling and virtual bundling, talking about some  
11 of the implementation challenges. And then we'll walk  
12 through a number of ways to consider a more incremental path  
13 to bundling.

14           We're also assuming throughout this presentation  
15 that the episode extends beyond the hospital stay. And for  
16 just illustrative purposes, we're assuming in the back of  
17 our minds that it's the stay plus 15 days. This just helps  
18 us start to think through some of the interaction of the  
19 policy design choices. Certainly, there's other ways to  
20 think of how you might want to define an episode, and we can  
21 get into that in the future.

22           First, a brief summary of our two implementation

1 options. Under mandatory bundling, which I'll now simply  
2 call bundled payment, Medicare would make a single payment  
3 to a joint entity, something like a physician-hospital  
4 organization, in an amount intended to cover the costs of  
5 providing all A and B services needed during the episode of  
6 care. The incentive is clear, providers able to deliver  
7 services at a cost below the payment will keep the  
8 difference as profit. Just to remind you, because the  
9 payment is mandatory, providers not able to accept the  
10 bundled payment -- those that weren't able to form that  
11 joint entity that could accept the payment -- would not be  
12 paid for these services.

13 In contrast, virtual bundling retains the current  
14 policy of Medicare setting rates and paying providers  
15 separately but would now allow Medicare to adjust those  
16 payments to each provider based on the combined services  
17 delivered across the episode. So for example, Medicare  
18 would reduce payment to providers involved in episodes with  
19 higher-than-expected spending and may even offer some kind  
20 of reward for those that had conservative spending. The  
21 expected spending may be based on a national average or a  
22 regional average spending amount.

1           Accountability for quality is important for either  
2 approach. We do not want to solely motivate providers to  
3 limit the amount of services they use in providing care. We  
4 want them to also consider the likelihood that those  
5 resources will improve the health and well-being of  
6 beneficiaries. So for this reason any bundling proposal --  
7 including the two we're talking about here -- must be paired  
8 with a pay-for-performance program.

9           Also, under both options we assume that IME and  
10 DSH and other Medicare subsidies would continue but be  
11 separate from bundled payment calculations or payment  
12 adjustments under virtual bundling.

13           Now we'll focus more specifically on the bundled  
14 payment option. There is a strong rationale for pursuing  
15 this policy. First, bundled payments would give providers  
16 the incentive and flexibility to figure out the most  
17 efficient mix of services to meet patients needs. So here  
18 you might imagine that providers would be motivated to  
19 educate beneficiaries about self-care, perhaps invest in  
20 remote monitoring in order to prevent readmissions. Or  
21 perhaps providers might find that adherence to clinical  
22 pathways reduces the need for physician consults during the

1 stay.

2           As such, bundled payment begins to break down the  
3 delivery system silos that have been reinforced by the  
4 payment structure and that contribute to the fragmentation  
5 in care that we see today. Providers should have much  
6 greater incentive to work together and collaborate and may  
7 find that integration is key to excelling under this payment  
8 method.

9           Also under a bundled payment, providers will have  
10 the incentive to help reduce the operating costs of their  
11 partners because providers will have shared accountability.  
12 Or put another way, they will have the ability to gain  
13 share. With this flexibility we might see physicians  
14 motivated to help contain hospital costs by using fewer ICU  
15 services or surgical supplies or even reduce length of stay.

16           With these potential efficiencies, however, come a  
17 host of implementation issues, the resolution of which can  
18 be very critical to the success of the policy. Risk  
19 adjustment is first among the payment issues and is  
20 particularly an issue for an episode that extends beyond the  
21 hospital stay. We are pretty good at risk adjusting during  
22 the stay but really are not nearly as good at figuring out



1 how to predict the costs in that post- discharge period.  
2 Part of the challenge is that the need for care can vary due  
3 to such things as the availability of informal care, and  
4 also that current spending is influenced by the geographic  
5 variation and the availability of post-acute care services.  
6 This problem could be viewed as so serious that we wouldn't  
7 want to go forward with bundling in a post-discharge kind of  
8 episode.

9           Alternatively, you could say that it may be that  
10 only with a bundled payment for care will we create the  
11 right incentives that will, in turn, enable us to learn and  
12 better predict the efficient costs of care in the post-  
13 discharge period. So that while the transition will be  
14 difficult, it may under this view be a needed step to  
15 improve payment accuracy.

16           IME and DSH subsidies also present a problem to  
17 the extent that they create an unlevel playing field as  
18 hospitals compete for physicians. I went into this a little  
19 bit in the last meeting. Bundled payment means, in a way,  
20 that hospitals can freely share payments that had previously  
21 been intended to cover their costs with physicians. So in a  
22 situation where hospitals are receiving IME and DSH payments

1 that we have talked about not being particularly well  
2 targeted or above an empirical amount, they may be in a far  
3 better position to financially attract physicians,  
4 especially those that are performing high-margin services.  
5 So you might find that some hospitals are at a disadvantage.  
6 And for those beneficiaries who rely on those hospitals, it  
7 could really present a problem in terms of access and  
8 quality.

9           Another payment issue concerns the need to revise  
10 payment systems for services that start during the  
11 hospitalization episode but continue beyond the somewhat  
12 arbitrary episode duration we're illustrating here of this  
13 15 days. If we now pay for 15 days of post-acute care in  
14 the hospital bundle, Medicare would need to recalibrate how  
15 it pays for the services that are beyond the bundle. This  
16 problem is linked to how we define the episode. It may not  
17 be such a problem if you define the episode differently.  
18 For example, like a real episode of care that we've talked  
19 about with episode groupers. So it's an example of where  
20 some intersection of our design issues point out some  
21 issues.

22           Also, because bundled payment allows for shared

1 accountability, physicians might now have the opportunity to  
2 reduce hospital operating costs so Medicare would need to  
3 figure out how it would share in those savings. One  
4 possibility is to have reduced annual updates in the future  
5 to share in that.

6           The risk of providers not participating is another  
7 policy challenge. It is possible that hospitals and  
8 physicians will not be able to come together to accept the  
9 bundled payment. Because Medicare would not pay for those  
10 services, beneficiaries who don't have an easy alternative  
11 to care will face access problems.

12           Bundling payment would also require a number of  
13 new administrative requirements and expenses that could  
14 begin to erode the intended efficiencies of the policy.  
15 First, providers would have to negotiate with one another to  
16 agree how they would share that payment. And it wouldn't  
17 only be was just a limited number of providers. It really  
18 could be quite a range of providers, including those that  
19 are at some geographic distance but are providing care in  
20 that post-discharge period.

21           There's also a second layer of administrative  
22 activities because these joint entities are also, in a

1 sense, acting as payers for Medicare. So for example, we  
2 might need some assurance that this joint entity that gets  
3 the bundled payment is only paying Medicare approved  
4 providers, those that have certain certification  
5 requirements, that kind of thing.

6 Bundling payments will also require that providers  
7 consider how much flexibility they want to allow providers  
8 in defining the benefit and how much uniformity they want to  
9 ensure. They will also need to determine how beneficiary  
10 cost-sharing should be adjusted under the bundled payment.  
11 I talked about this a little bit more in the paper. It does  
12 perhaps present some opportunities but there are a lot of  
13 thorny issues that would need to be resolved in the course  
14 of that.

15 Another issue is the concern that bundled payment  
16 can create the incentive for providers to produce more  
17 bundles, more admissions, particularly high-margin  
18 admissions. Here we talk about a range of solutions from  
19 regulating the financial arrangements between hospitals and  
20 physicians to another opportunity to maybe consider how you  
21 might measure admission rates and hold providers accountable  
22 for admission rates. A lot of other more technical issues

1 would need to be explored in pursuing that option.

2           Now I'll turn to virtual bundling. Again, this is  
3 where Medicare is still paying providers separately but  
4 starting to adjust their payments based on the aggregate  
5 services delivered in the episode. Again, there could be  
6 penalties or rewards in this construct.

7           This policy would encourage providers to review  
8 information about the characteristics of their high and low  
9 episodes. Presumably Medicare could be helpful in providing  
10 that kind of information feedback loop to them. Then  
11 providers would have the incentive to work together to adopt  
12 the efficient patterns of care. They could also choose to  
13 abandon their current partners and seek out more efficient  
14 partners. Either way they avoid the payment penalty.

15           Of course, the size of the penalty will influence  
16 the effectiveness of this policy. If too small, some  
17 physicians may prefer to get the additional income  
18 associated with the additional services provided, absorbing  
19 the penalty and making no change to their practice patterns.  
20 If too large, the penalty may discourage providers from  
21 participating because they would be having to take on too  
22 great a risk. Especially since we don't have great risk

1 adjustment, that may seem a little daunting to them.

2           So as a first step, we're kind of thinking that  
3 the penalty would be a relatively modest one.

4           So in comparison to bundled payments therefore,  
5 virtual bundling has somewhat weaker incentives. The  
6 magnitude of the potential loss or gain is smaller. If the  
7 prohibition on shared accountability gainsharing continues,  
8 there is no additional incentive for providers to contain  
9 unit costs than currently exists.

10           On the other hand, virtual bundling raises fewer  
11 concerns and is less administratively complex than bundled  
12 payment. Still, several concerns are important, although  
13 there are probably less serious than under bundled payment.  
14 Our imperfect ability to accurately risk adjust continues to  
15 be an issue in virtual bundling. We would be setting a  
16 benchmark spending amount and this would need to be  
17 calculated for each type of patient. To the extent we're  
18 unable to accurately predict the resources beneficiaries  
19 will need, some providers will be subject to penalties when,  
20 in fact, the costs associated with their patient population  
21 were not reasonably accounted for.

22           Because virtual bundling allows providers to be

1 rewarded for hospitalization episodes that use relatively  
2 few episodes, it also creates an incentive for providers to  
3 admit low severity patients who will not require a lot of  
4 resources rather than treating them on an outpatient basis.  
5 This incentive could be eliminated by removing the  
6 possibility of a reward for low resource use and instead  
7 focusing solely on analyzing high resource use providers.

8           Unbundling is also a concern here. And by this we  
9 mean the possibility that providers would delay needed care  
10 beyond the specified episode. This might harm quality and  
11 it could also result in Medicare paying twice for the same  
12 service.

13           So now we're assuming possibly that you might like  
14 the potential of bundled payment, its potential to change  
15 the delivery system, but that you might be concerned about  
16 the breadth of the implementation issues. And given that,  
17 you might want to consider some incremental approaches to  
18 get us in that direction a little bit slower. In fact, that  
19 you might want to use as a precursor to full bundled payment  
20 virtual bundling. So over the course of the next few  
21 slides, we'll illustrate a couple of approaches to virtual  
22 bundling, then look at actual bundled payment, and lastly

1 talk about a hybrid between bundled payment and virtually  
2 bundling. Hopefully that will make a little bit more sense  
3 as we go through it.

4 To illustrate the first approach, we call it an  
5 episode-specific approach to virtual bundling, imagine that  
6 hospital A has treated 11 -- as it turns out we have 11 dots  
7 here -- CHF patients, each with the same severity. Each one  
8 is represented by a dot. Where it appears along the  
9 vertical line reflects the relative cost to Medicare of the  
10 episode. So you can see at the top that dot might look  
11 something like this. There would be an initial  
12 hospitalization, of course, with three hospital visits  
13 during the stay, represented by the Xs. This patient  
14 required a rehab hospital stay and a readmission, as well as  
15 more physician visits within the 15 day discharge.

16 An episode at the bottom might look something like  
17 this, a hospital stay with physician visits during and after  
18 the hospital stay and a home health episode but no  
19 readmission.

20 Under one approach to virtual bundling, the  
21 providers involved in the top episode would have their  
22 individual payment amounts reduced because resource use



1 across the episode is so high. In contrast, the specific  
2 providers involved in the lower cost episode might even  
3 receive a bonus payment on top of their base payment,  
4 depending on design, because their resource use was  
5 conservative.

6 This design, as I mentioned, creates the incentive  
7 for providers to partner with other efficient, high-quality  
8 providers in caring for their patients. The motivator here  
9 is a financial penalty but also has a peer pressure element  
10 to it.

11 While this design could provide a sufficient  
12 incentive for providers to amend their practice style, it  
13 could be a missed opportunity to engage all providers in a  
14 group to improve overall efficiency. It would be a missed  
15 opportunity because to the extent that efficient providers  
16 are consistently involved in efficient episodes -- the  
17 bottom one -- they would have no incentive to counsel other  
18 providers on how to improve their efficiency or participate  
19 in creating systems that help replicate their efficient  
20 practice patterns. So if you feel that that is a problem,  
21 you might want to incorporate an incentive for efficient  
22 providers to be engaged in the overall performance of the

1 system. We call this one a system level approach.

2 Under this approach, if on average the episodes in  
3 the hospital cost more than expected, all providers would  
4 face the same penalty. And if the episodes cost less than  
5 was expected across the whole hospital, all providers would  
6 be eligible for a reward. In the case of hospital A on this  
7 slide, which has high average costs -- you can see that  
8 because more of those dots are above the \$6,500 line than  
9 below -- all providers in the top and the bottom episodes  
10 would be subject to a penalty. In this way, even  
11 consistently efficient providers would be motivated to work  
12 with less efficient providers to improve their efficiency.

13 On this slide, we illustrate bundled payment for  
14 the full episode. Here both the high and the low cost  
15 episodes would receive a bundled payment for \$6,500. As I  
16 mentioned, the incentive here is clearly to have more low-  
17 cost episodes and fewer high-cost ones.

18 Under a hybrid approach, Medicare would bundle  
19 payment for the hospitalization and then adjust the bundled  
20 payment based on the relative service use post-discharge.  
21 So in the case of high resource use beyond the discharge, as  
22 is illustrated on this top dot here, the bundled payment

1 would be reduced.

2           In contrast, the low post-discharge volume could  
3 warrant a reward. So in the low one the bundled payment is  
4 made for the hospitalization. Because there is low resource  
5 use in that post-discharge period there is a reward.

6           This approach would align hospitals and physicians  
7 to contain both volume and costs during the admission and be  
8 jointly invested in the course of post-discharge care.  
9 Because post-discharge care is not part of the bundled  
10 payment, however, it alleviates some of the concerns about  
11 administrative and payment complexities and risk adjustment  
12 limitations.

13           So you could see choosing among these policies and  
14 then staging them, easing toward bundled payment. For  
15 example, one path may be the virtual binding bundling that  
16 uses the episode-specific approach, moving on over time to a  
17 virtual bundling that relies on the system level approach,  
18 and finally getting you to mandatory bundling. Another  
19 approach might sidestep the system-level approach and  
20 instead go toward a hybrid approach and end up at mandatory  
21 bundling. For either of these approaches you might imagine  
22 -- I didn't put it here -- but that a first step might be

1 just feeding back information to providers before you start  
2 holding them accountable financially.

3           There are other aspects in creating paths that I  
4 haven't illustrated here, obviously, that you might want to  
5 keep in mind. First, you might want to think about starting  
6 with the stay only and then lengthening the episode to that  
7 post discharge period. We kind of hint at that in the  
8 hybrid approach, where we just do the bundle for the stay.

9           Another thought in virtual bundling is to hold  
10 providers accountable only for readmissions rather than  
11 across the whole episode, including post-acute care. That  
12 might be important if you were concerned about stinting on  
13 post-acute care.

14           So we certainly welcome any questions,  
15 clarifications that we can offer, and then we'd love your  
16 opinions on how daunting implementations might seem to you  
17 and what sequence of incremental steps holds the most  
18 appeal.

19           MR. HACKBARTH: Any questions, comments?

20           DR. WOLTER: Well, as far as the daunting nature  
21 of the policy implementation, you've done a very nice job  
22 describing that. So thank you for that.

1 [Laughter.]

2 DR. WOLTER: But it's important, there's no  
3 question about it.

4 I have quite a few thoughts. I'll try to cover  
5 them quickly. Number one is I think we need to be very  
6 explicit as we work through this thinking about the  
7 importance of the regulatory changes that will be needed,  
8 whether it's Stark, anti-kickback, civil monetary penalties,  
9 antitrust. There are so many barriers to this happening  
10 that if they don't get dealt with in some fashion the policy  
11 payment incentives will have a very hard time creating any  
12 action.

13 And then I would be a strong advocate of focusing  
14 on the high-volume/high-cost areas initially rather than  
15 going to some global system approach to this, for a whole  
16 variety of reasons which I could elaborate at another time.

17 I wanted to draw the distinction between the way I  
18 think of system level approaches, which I really take out of  
19 the quality literature. Quality is a system property; i.e.,  
20 if you're going to reduce postoperative infections, it  
21 requires system approaches to the timing of antibiotic  
22 delivery or sterilization or whatever it might be. So that

1 system property can be applied to very focused specific  
2 episodes of care. It's not to be used in the sense of  
3 system means everything that goes on in the organization.

4           And I think that's an important definition for us  
5 to play with because if we did start with high volume-high  
6 cost areas, we'd still want to be using the term system  
7 property in the sense of how we deal with the efficiency and  
8 quality as opposed to thinking of it as we're going to  
9 include everything that goes on, all the episodes that a  
10 group of doctors and hospitals might be involved in.

11           And then I'm wondering if it wouldn't be possible  
12 to consider the bundling approach and the virtual bundling  
13 approach being started at the same time. Because there are  
14 a handful of organizations that would be ready to step into  
15 a full bundling approach to these episodes really anytime.  
16 And then there are others that might be much better off to  
17 start with virtual bundling because they haven't gotten  
18 organized yet. But you'd hate to hold back on working on  
19 this with the organizations that might be ready to go.

20           I also wonder about transition potentials with  
21 something like this. Could it be voluntary in years one and  
22 two and three, but there may be some financial update

1 differentials if you don't volunteer for these very specific  
2 episodes I'm speaking now. And then over three or four or  
3 five years it's very clear that where we're going is  
4 everybody's going to have to play.

5           On the Medicare savings issue, I don't think we  
6 should forget that as we look at readmissions and admission  
7 rates there is a savings issue on the other side of the coin  
8 which is how do providers who reduce admissions and reduce  
9 readmissions deal with the financial effects of that because  
10 they really don't see any gains from that. In fact, some of  
11 the investment it takes to do this work by doctors and  
12 hospitals to reduce admission or reduce readmissions is  
13 significant. And so I think we need to think about that  
14 pretty carefully.

15           On that point, the issue of admission rates and  
16 readmission rates is huge. And if we could ever get our  
17 arms around that there is a lot, both on savings and quality  
18 improvement, that could be done there. Because you're  
19 absolutely right, the bundle per se, if there are still  
20 inducements to increase the number of episodes, isn't really  
21 where we want to go. We want to get sort of appropriate  
22 care there, to say the least.

1           And then I was wondering on the payment design --  
2   and maybe I didn't understand this right. But instead of  
3   adjusting the payment for any one episode up or down  
4   depending on its individual resource use, would we want to  
5   look at all the episodes that a virtual organization or ACO  
6   participates in over the course of the year and look at how  
7   they do on average with all those episodes, and then adjust  
8   the payment up or down the next year. And would that make  
9   more sense in terms of sort of statistical validity of how  
10  well they're doing, rather than trying to look at just one  
11  episode.

12           I think we would need some kind of guidelines on  
13  this physician payment issue because we don't really want  
14  physicians to be bought, so to speak, to help increase the  
15  volume of episodes that might have high profitability. But  
16  we wouldn't want to micromanage that, either. So how do you  
17  create guidelines about what is appropriate sort of payment  
18  modeling that is at least attractive enough to have  
19  physicians participate but not something that would be seen  
20  as out of bounds?

21           Remembering that the issue we're dealing with here  
22  is we have fragmentation and we want tighter relationships



1 between physicians and hospitals. Right now regulation and  
2 other things are driving that in the opposite direction,  
3 which is why we're having this conversation.

4 I was going to say, Craig, that there may be a  
5 reason why there's some inconsistency. Some hospitals look  
6 good with some episodes and not others. Well, if one of the  
7 big cost reimbursement difference issues is the position  
8 side of it, that may be actually almost expected and that's  
9 maybe why we're seeing that.

10 That's probably enough for now.

11 MR. HACKBARTH: Could I just pick up on Nick's  
12 comment about the different meanings of different usages of  
13 the word system? Can I get you to go to page 17. I wasn't  
14 sure that I understood the system level approach to  
15 bundling.

16 The way I interpret this picture is that the  
17 penalties and rewards are equal across all providers, sort  
18 of like the SGR. All types of providers are adjusted up or  
19 down.

20 MS. MUTTI: Yes, and I guess just by all types of  
21 providers, I think this gets to what Nick was saying that he  
22 would want to hold people accountable not just for a

1 specific episode but for their overall performance on  
2 episodes. So this is trying to get at that.

3 MR. HACKBARTH: I thought that was the preceding  
4 page.

5 MS. MUTTI: The preceding page was a more episode  
6 specific level.

7 MR. HACKBARTH: I see. So you're not averaging --

8 MS. MUTTI: That would be the system level.

9 DR. WOLTER: Maybe I wasn't real clear but what I  
10 was worried about was that if you have a group of physicians  
11 in the hospital coming together to work on this, and every  
12 one of the physicians sees some decrease in reimbursement  
13 related to episodes for which they have no involvement,  
14 that's sort of hard for me to imagine it working very well.

15 And then to be real clear, to me you could have  
16 system-level approaches to efficiency and quality that are  
17 about a very focused episode. In other words, it takes  
18 system redesign to reduce post-op infections or to reduce  
19 CHF admissions.

20 So in my mind I think of system-level in the  
21 quality literature as about how systems design approaches to  
22 specific issues, not about lumping every episode together

1 and then trying to look at it that way. I don't know if I'm  
2 being clear.

3 I think this aggregate, trying to do a whole bunch  
4 of episodes out of the blocks, for a whole variety of  
5 reasons, including how people would look at it in the  
6 incentive sense, I think it's really -- I mean the policy  
7 challenges are huge enough. And maybe we could start in a  
8 little more focused way.

9 DR. MILLER: If I could just draw a couple things  
10 out. You made a couple of comments about focusing -- and I  
11 can't remember what the precise words -- but high volume-  
12 high something areas. But when you said that, you meant  
13 episodes, as opposed to geographic areas?

14 DR. WOLTER: I mean CHF.

15 DR. MILLER: I just wanted to draw that out for  
16 the public because I think we all understood what you meant,  
17 but I'm not sure a listener would. So the point is CHF,  
18 COPD, whatever the case may be.

19 And then just to try and draw those final two  
20 thoughts together that you're making there, this could be a  
21 CHF -- this could be an aggregation of all the CHF episodes  
22 in that hospital. And your systemness point was and I have

1 to have a specific approach on how I avoid infections in CHF  
2 admissions. I'm trying to restate what you're --

3 DR. WOLTER: What's your total cost for a CHF  
4 admission over all the CHF admissions for a year? And how  
5 do your quality measures look, the P4P part of this, on  
6 those CHF admissions, on all those patients in the course of  
7 a year might be a way to look -- and then in the next year  
8 the payment for that particular episode for this particular  
9 ACO or virtual bundled group is adjusted up or down  
10 depending on the annual performance.

11 DR. MILLER: That's what she was trying to  
12 describe in 17.

13 DR. WOLTER: Great.

14 DR. KANE: We didn't talk much about how there  
15 might be an effort to first develop a risk adjustment system  
16 for the post-acute, but I didn't get a sense of how  
17 impossible that was. But it seems like that might be a  
18 wise, at least be doing it contiguously or something. I  
19 don't know how hard it is but it seems like that's something  
20 to really be thinking about because I think the splitting,  
21 it's just going to be a nightmare to try to figure this out  
22 and just sort of watch and see what happens. Think that's

1 very hard to implement policy that way. We're going to do  
2 this and then see what happens and then adjust, is kind of  
3 scary and I think politically hard to imagine how you'd sell  
4 that.

5 So one is I think we ought to look into what it  
6 would take to create a system for risk adjusting the post-  
7 acute.

8 MR. HACKBARTH: Each of the post-acute payment  
9 systems has a risk adjustment feature within it. But this  
10 is a risk adjustment to address the propensity to use post-  
11 acute care.

12 DR. KANE: Sort of the rate of use and the site of  
13 use for that particular type.

14 The other thing I just thought we ought to talk  
15 about a little bit, this would be along the magnitude of  
16 implementing DRGs if you really want that far. Yes, worse.  
17 It took, as I recall, because I was in rate setting in 1976  
18 and we were looking at DRGs then. It took eight years  
19 perhaps, eight years to really get the groundwork in place  
20 to really implement DRGs. And then the implementation  
21 itself took four or five years of phasing in and sort of  
22 going from the hospital specific to the national level. I

1 think it was about 1988 or 1989 before the system really  
2 came in place.

3 I guess it would be useful to think about what's  
4 the realistic time frame and whether along the way, as I  
5 recall DRGs there were demonstrations in New Jersey. There  
6 shouldn't be perhaps demonstrations of this, but certainly  
7 not a national roll out or something that we're not real  
8 comfortable with.

9 Much as I'd love to see it happen tomorrow, I  
10 think we need to think about what's a reasonable timeframe?  
11 How do we get there? It might very well be a 10-year  
12 rollout. I don't know if we're able to even suggest things  
13 like that but I don't see how it can be much shorter than a  
14 DRG implementation timetable.

15 MR. HACKBARTH: Whether it's 10 years or some  
16 other interval, I don't know. I agree with your basic point  
17 though, that this is not the sort of thing that you would do  
18 overnight, that you would do a series of steps. You could  
19 have features that I don't think we really talked about  
20 here, sort of risk sharing to mitigate the risk. For  
21 example, in particular around the propensity to use post-  
22 acute services. You could gradually increase the amount of

1 incentive payment there over time.

2           So yes, definitely this is a longer-term sort of  
3 project as opposed to a shorter term project.

4           On the other hand, some of the issues raised here,  
5 to me, are reminiscent of DRGs. Oh, if you do this,  
6 terrible things are going to happen. For example, the  
7 incentive to increase admissions. I'm old enough to  
8 remember that was a big debating point. Julian remembers  
9 that well, about DRGs. Oh, there's going to be incentive to  
10 increase admissions. It didn't happen.

11           So some of these things -- in fact, Bob and I were  
12 talking about the drug benefit. And it was very easy for  
13 all of us to figure out terrible things were going to  
14 happen, these theoretical logical possibilities. And many  
15 of them, in fact most of them, didn't materialize. And so I  
16 think we need to be prudent but not frightened of our own  
17 shadows. We need to find a middle ground there.

18           DR. STUART: I have a question about the nature of  
19 the problem here and it really gets back to your example  
20 that you have on slides three and four. I looked at the  
21 source of the variation in slide three which is, as you  
22 stated, which is on the physician side. And then I looked

1 at the source of the variation on slide four. And there's  
2 very little physician variation.

3 And so I'm thinking maybe this is one of those  
4 cases where you pay me now or you pay me later, and that  
5 maybe one of the reasons that you have less variation in the  
6 post-acute care case is that the physicians were spending  
7 more during the care or during the hospitalization and that  
8 reduced the need for care. So that was one thing that I  
9 wondered whether you'd had a chance to look at.

10 But then the other peculiarity, and it may be just  
11 because I don't understand the data source, if you look at  
12 the average spending on physicians in your example -- on  
13 chart three it's \$813 for within the episode. But if you  
14 turn the page and you look at average physician spending  
15 both within and after the episode, it's \$100 less.

16 MR. LISK: And there is an explanation for that  
17 and that came up in our walk-through. Thank you, Mark. So  
18 we're prepared on this one.

19 What happens is how we define the episode here.  
20 On the hospitals we have a hospital stay and it's the  
21 hospital episode. So each individual CHF admission is an  
22 episode.



1           When we go to the extended stay we have the  
2 hospital stay plus 15 days. If there was a readmission  
3 within that 15 days, that new readmission is not counted --  
4 it may be a CHF readmission -- and it's not counted as a new  
5 stay. So the service differential reflects the differences  
6 in how physician services are distributed if you look at all  
7 CHF cases versus the extended stay. So it's not really the  
8 same set of hospital cases in the two sets. That's the  
9 difference.

10           DR. MILLER: There's a physician point in post-  
11 acute care. On the other line.

12           MR. LISK: And the physician spending in the  
13 others --- the physicians spending on both set of tables is  
14 just physician spending in the hospital. So he's doing the  
15 right comparison there, Mark.

16           DR. MILLER: Before you were asking about -- on  
17 four, you were asking about the physician services. There  
18 are physician services after the admission but they're  
19 counted in the other line.

20           MR. LISK: Right.

21           DR. STUART: But let's get back to my initial  
22 point, which is that there's much less variation within the

1 physician category when you're just looking at the hospital  
2 episode, as opposed to the longer episode.

3 MR. LISK: Right, that is true. That is true.

4 DR. CASTELLANOS: A couple of things. Again, the  
5 first point is you mentioned table two, it was on page 26.  
6 Some of that doesn't make sense because a lot of these are  
7 bundled, coronary bypass, large and small bowel and hip, you  
8 have E&M charges and there shouldn't be any E&M charges  
9 because these are bundled.

10 MR. LISK: But those would not necessarily be for  
11 -- the surgeon fee, in terms of the procedures would be for  
12 the surgical. But that would be if you had a hospitalist  
13 coming in and seeing the patient or an internist seeing the  
14 patient, that would be under the E&M visit.

15 DR. CASTELLANOS: I think you broke that out with  
16 consultants on that.

17 MR. LISK: And then consultants would be another  
18 specialist who comes in who meets the consulting definition  
19 for that type of case, who would not normally be the  
20 attending physician in the hospital. Those are some of the  
21 differences that are there.

22 DR. CASTELLANOS: I had a question on that and I

1 wanted to get some explanation.

2 I don't want to get lost here. I think we're not  
3 seeing the forest, we're looking at the trees and sometimes  
4 we get kind of lost. At least what I perceive we're trying  
5 to do is get the hospitals and the physicians working  
6 together, having them both accept risk and benefit, and both  
7 working for quality. I think we need to really stress that.  
8 What we're really trying to do here is to get some form of  
9 coordination of care.

10 Nick's point is that at the present time under the  
11 regulatory apparatus we have we're going in an opposite  
12 direction on that. It has not been addressed either last  
13 time or this time, and I think we need to think or start  
14 thinking about addressing that issue.

15 The organization is a really important thing. I  
16 think Nick's group is ready to go and I think Jay's group is  
17 ready to go. But I can think 85 percent of the physicians  
18 in the United States have no organization schedule at all.

19 So to implement this, it's going to be pretty hard  
20 right off the get go. I think Nick will be able to do it  
21 and I think Jay and his organization will be doing it. I  
22 don't know about Karen. We'll have to ask her how she feels

1 about that. But I can tell you the organization is going to  
2 be difficult.

3           The other thing I'm a little concerned about the  
4 hospital and physician is in my community over half the  
5 doctors don't work in the hospitals anymore. How are you  
6 going to capture that? There has been no address about non-  
7 hospital -- especially today, the internists are not going  
8 to the hospital. They have hospitalists. The primary care  
9 guys are not not doing that. The medical home people are  
10 not really going to the hospital.

11           I think we need to somehow think about  
12 incorporating the non-hospital-based physicians.

13           Again, this is going to sound maybe a little crass  
14 or a little hard, but it seems to me that we have a problem  
15 and there's no question we have a problem. A lot of times  
16 we have a problem, you're the problem, and we're going to  
17 fix you.

18           I think a better answer to that is we have a  
19 problem, let's reach out and try to get help, especially the  
20 physician community. I think you're going to find the  
21 physician community has a lot of untapped resources that, in  
22 my opinion, has not really been addressed.

1           The risk adjustment, a lot of this is going to be  
2 highly implemented on risk adjustment. I think we've talked  
3 a little bit about risk adjustment but perhaps not all.

4           And the last point is this, and I remember it from  
5 Nick's conversation last year about the demonstration  
6 project that he is in. He mentioned to us that he wasn't  
7 sure if his organization was even going to break even on  
8 that, would probably lose some money on that. What's  
9 happening is there's many startup costs on doing this, EMR,  
10 the physician assistant. I mean, there's tremendous set up  
11 costs that the hospital or some organization is going to  
12 have. The government is not helping to contribute to those  
13 start up costs, and right from the get-go they're taking a  
14 part of the profit.

15           So I think it needs to be kind of cost adjusted a  
16 little bit on the startup phase.

17           MR. BERTKO: The first of many then.

18           A quick question there is the -- or observation  
19 about what I'll call the Miami versus Minneapolis problem.  
20 You can have a town with two hospital systems and get the  
21 same average payment rate. And one behaves like Minneapolis  
22 and one behaves like Miami. Does that mean you need to also

1 then have a membership assignment in some way or another so  
2 you know how to treat the rate of admission type of things?  
3 And does that mean that it's an advanced one? I was trying  
4 to think that one through. It seems like you've got to have  
5 a beneficiary assignment.

6           The second quick observation, kind of following up  
7 on Nancy's, looking at the DRG stuff as the difficulty of  
8 doing it. But does there also need to be some kind of  
9 feedback loop ahead of time? And while I can see FIs  
10 adapting to a new DRG type of system for these bundles, I  
11 don't know that there's any organization to do the feedback  
12 loop at this point to show where it is to solve the problem.  
13 Nick's group probably could figure that out by thinking  
14 about it but, as Ron was saying, other folks will need to  
15 see where the issues are.

16           MR. EBELER: To follow up a little bit on what  
17 Nick said and what Anne hinted at, which is sort of a  
18 question here is where you start. I think the idea of a  
19 selected number of high volume procedures where there is a  
20 large set of transactions among the hospitals and physicians  
21 is a very logical way to parse this.

22           The other you hinted at with the hybrid approach,

1 Anne, is maybe starting with just the hospitalization.  
2 While we did say at the last meeting one wants to lean  
3 towards the time period outside that, and I think we do, it  
4 may well be starting there might also free up some ways of  
5 thinking about getting going down this road. I think part  
6 of what -- I would reinforce what Glenn said, I don't think  
7 we want to be overwhelmed with the complexity here. We want  
8 to get started and, in part, we want to signal to the field  
9 that this is a direction in which people should start  
10 thinking out there because it's coming down the pike.

11 DR. BORMAN: First, I would reiterate the piece  
12 about the regulatory obstacles and making sure that we make  
13 a reasonably strong statement about that, because I think  
14 this is so important that -- although we've said it a number  
15 of times, we need to reiterate that. It is, on the provider  
16 side, a big piece of what will enable this in a sort of a  
17 very dichotomous kind of yes/no way.

18 The second thing would be that I would follow up a  
19 little bit on some of Jack's thoughts, and Nick saying we've  
20 got to start somewhere and let's get going on some things.  
21 There are some groups like Nick's that are very prepared to  
22 do the full A/B whole deal. There are people who are

1 woefully unprepared to do anything, and that's the majority  
2 group. I would suggest, as Jack said, breaking this down  
3 into some smaller pieces might offer some opportunities.

4           For example, it would be feasible to take those  
5 same high-volume conditions and take only the outpatient  
6 care of them, whether it's pneumonia, CHF, whatever it is,  
7 bundle up those things, just the patient piece, just the  
8 inpatient piece. Maybe just start with the inpatient piece  
9 because hospitalist practice has become so prevalent. There  
10 are people that are already working with their hospitals by  
11 and large because many of them are employed. Maybe start  
12 there as for the folks who aren't prepared to do the whole  
13 deal. We could identify some places to start I think pretty  
14 credibly in that.

15           I think another way to start for the masses of us  
16 that are unprepared is start to -- give us our data and  
17 particularly give the outliers their data. And after a year  
18 of having your outlier data, then you get virtually bundled  
19 for your practice. Because now you've seen your outlier  
20 data and now we move you forward to virtual bundling.  
21 That's a group where there's more rationale to say we  
22 started out with sort of information, and if anything had a



1 least not a carrot or a stick, we gave you information to  
2 act on. And if you're smart, you'll act on it.

3 Then we follow that to virtual bundling of that  
4 individual. Then potentially, if they remain outliers, then  
5 you move them to mandatory bundling. I think that's  
6 something that the community could accept more readily as a  
7 staged project and a rational one. So I would just throw  
8 that out.

9 And then finally, there was a part in the paper  
10 that talked about the hospitals are on a cost basis rather  
11 than PPS, and the exemption for the CAHs and some of that  
12 kind of thing. I would just say I certainly understand  
13 where some of that comes from. But I would suggest that  
14 maybe there's opportunities to hold them to different  
15 targets. I wouldn't make this just sort of a wholesale buy  
16 that you don't have to be part of the effort, but  
17 recognizing that those groups of hospitals may, in fact,  
18 need different kinds of targets or incentive. But don't  
19 just leave them entirely out of this consideration.

20 DR. MILSTEIN: A couple comments. First, there's  
21 a whole body of social science research on something called  
22 status quo bias. It's an inclination on the part of all of

1 us to attach more value to the status quo than to some  
2 hypothesized change. I guess I lean towards Glen's  
3 position.

4           Based on what we know about the current  
5 equilibrium, I think my inclination would be to lean toward  
6 faster change, acknowledging and respecting some of the  
7 comments made about move too quickly you can get into  
8 problems. But all other things being equal, I would favor a  
9 more rapid movement. And I think the staged pathway one  
10 looks very good to me. It spares you a lot of the very  
11 difficult -- a lot of the very difficult administrative  
12 changes you'd have to make and that Bill has explained to us  
13 that CMS is very ill-equipped to implement in even  
14 intermediate timeframes.

15           I like this idea of maybe having a grace period  
16 for those that feel unable, they wouldn't be penalized right  
17 away for holding back. But within a reasonably short period  
18 of time, given how bad the current equilibrium is, we  
19 wouldn't want to tolerate long procrastinators. That would  
20 be at least my perspective.

21           Secondly, I think Nancy's point about risk  
22 adjustment is important. And I think one way of

1 substantially reducing that barrier would be to reconsider  
2 this using longer longitudinal frames of reference for which  
3 others have preceded us in building these risk adjustments.

4           For example, I think one of the advantages of  
5 using an episode that begins with the hospitalization is  
6 that we have 15 years of development of episode adjusted  
7 profiling and tests of the degree to which varying degrees  
8 of severity of illness adjustment do or do not make a  
9 difference that we could build on rather than picking an  
10 arbitrary hospitalization plus 15 days. Now have a bundle  
11 around which nobody's ever studied risk adjustment. Where  
12 if you pick a bundle for which there's already been a lot of  
13 preceding risk adjustment research, we could get going to  
14 that.

15           I think what appeals to me is for acute illness  
16 related admissions like hip fractures, something like using  
17 the episode-based software makes a lot of sense to me. I  
18 think per the point that Elliott Fisher made when was here  
19 the last time, maybe for chronic illness care we have to be  
20 a little bit more expansive in the bundle that have in mind  
21 because we do have a lot of prior research, actually  
22 courtesy of Elliott and others, that begin to tell us if a

1 Medicare patient has had an admission within a certain  
2 period of time? How much money did they spend in the  
3 subsequent 12 or 24 month period? We can reduce the  
4 challenge of starting from ground zero on risk adjustment if  
5 we build upon other research and other bundling models.

6           And then last, but not least, one minor point, but  
7 in relation to your comment about virtual bundling, one of  
8 its disadvantages is weaker incentives. But as I think  
9 about it, that's not necessarily true. It just depends on  
10 how bold you in building the amount of payment variation  
11 associated with virtual bundling.

12           DR. SCANLON: I don't want this to be interpreted  
13 as defending the status quo. I think we often have had the  
14 luxury of ignoring what's going on in different markets.  
15 Even though John referred to the Minneapolis, Minnesota  
16 example, we focused there on differences in utilization and  
17 we're not focused as much on differences in economic power  
18 which is reflected more in the price. And that there are  
19 really very significant differences in the economic power of  
20 providers versus insurers. And then among the providers,  
21 physicians versus hospitals.

22           There's the GAO report of a couple of years ago,

1 that even after you adjust for wages, which Medicare does,  
2 there's a twofold variation in the price that physicians are  
3 getting per RVU and a threefold variation in the price that  
4 hospitals are getting per DRG.

5 That, to me, sort of raises the question of it's  
6 not just an issue of is someone ready to do this? The  
7 question of are they motivated to do this?

8 What we'd be talking about is potentially in  
9 various markets bringing together people to say you need to  
10 cooperate. But their interest in cooperation is going to be  
11 very different. And while it's potentially good to change  
12 the balance of power that exists, this is not going to be  
13 the mechanism that's going to do that.

14 The virtual bundling for me, I think, has  
15 potentially more opportunity of combining what we've taken  
16 advantage of in the past, which is Medicare's huge  
17 purchasing power. Medicare is able to ignore some of these  
18 market differences and still get access, and at the same  
19 time create incentives for the hospitals and the physicians  
20 to cooperate. But the incentives, in some respects, have to  
21 be on different channels. Because if it's just a single  
22 reward out there and it's up to them to divvy it up, then

1 the divvying it up part is going to be a function of what's  
2 the balance of power between these two entities in this  
3 particular market? In some places it's going to work  
4 wonderfully. Other places it's not good work at all. And  
5 if we want to think about a path that's going to move us to  
6 do this on as much of a national basis as we can think of, I  
7 think we have to take into account that right now we've got  
8 some very skewed markets.

9 To finish in terms of not defending the status  
10 quo, we should be dealing with the fundamental market  
11 problems we've got here, which are a reflection of the  
12 concentration that exists in these markets. Because we are  
13 so far beyond what one might think of as monopoly power in  
14 various his markets that this is a part of our health care  
15 cost problem that's well beyond Medicare but it's something  
16 that should be taught about.

17 DR. CROSSON: I guess I'm sort of in the  
18 Glen/Arnie go for it category of thought. Again, this is  
19 another aspect of our general theme of discussions, which is  
20 how can we use the payment system to try to improve quality  
21 and try to improve the appropriateness of services? I'm not  
22 sure about the startup issues. I think there's probably 20

1 different ways you could do this. Starting with high volume  
2 is one way. Broader probably would be a little bit more  
3 complicated but might work also. Starting with information  
4 sharing, going to virtual, mandatory or Nick's idea of doing  
5 it multipronged, I think all of those things have arguments  
6 pro and con to them.

7 I agree this is probably going to take a  
8 significant amount of time.

9 But I think that if it's going to work and make a  
10 significant dent in the size of the problem that we're  
11 dealing with, particularly about appropriateness of  
12 services, it has to be a pretty significant set of  
13 incentives. And it draws me a again, and I won't take this  
14 too far, but it draws me again to the question about whether  
15 or not the update system to physicians and hospitals might  
16 need to be part of this because of the power of the  
17 cumulative impact of year after year differences in updates  
18 being larger than the impact of the changes of payment for  
19 single services, for example.

20 I think it also needs to be, connected to that,  
21 its going to have to have a certain inexorability built into  
22 it. Because, as Ron noted, I think that for the

1 organizations that are going to need to have to change to  
2 actually do it, the incentives need to be large and it needs  
3 to be something that seems like a Mack truck or a  
4 steamroller coming down. Because it's going to require  
5 significant changes in culture between physicians and  
6 hospitals. Its going to require changes in governance.  
7 That physicians are only going to want to do this if they  
8 sense that there is some process by which they can have a  
9 share in the decision-making process that goes on in the  
10 hospitals and that they're going to be treated fairly and  
11 equitably. That's going to take some changes, for sure.

12           It's probably going to take changes in structure  
13 and certainly changes in the financial arrangements between  
14 physicians and hospitals. And it's going to take some time  
15 for all parties to learn how to do this. We saw in the  
16 1990s that when a similar process was speeded up and sort of  
17 stuffed down people's throats it didn't work. And some  
18 succeeded, but many failed.

19           So there's going to have to be an investment made  
20 in teaching people, institutions, and providers how to do  
21 this. And that's only going to occur, again, if over time  
22 it's seen that there's enough reason to do this. And that



1 has to do with the intensity of the incentives over time and  
2 the sense of inexorability.

3 DR. REISCHAUER: This is a little like a formal  
4 debate, we have one from one side and one from the other  
5 side. I'm going to reiterate where Nancy started off and  
6 I'm going to sound like somebody with a terminal case of  
7 status quo bias. I apologize for that. It's not that I'm  
8 not attracted to the theoretical aspects of this. And if we  
9 were not dealing with the real world, I'd say go for it,  
10 too.

11 But I'm worried about the practicality of this,  
12 and I think, Anne and Craig, I really appreciate what you've  
13 done, laying out the little dots and the lines and the X's  
14 and all of that. I think that is good. But I'd like to go  
15 one step further so we can think more clearly about how this  
16 thing really would work. You can imagine one of your charts  
17 with the dots and all that as a single hospital experience  
18 during a year for all of its CHF. And let's take a medium-  
19 sized hospital, suburban, Sibley, something like that. How  
20 many CHF cases for Medicare does it have a year? 150? I  
21 don't know.

22 The one common element of this is the hospital.

1 Then we have post-acute. How many different post-acute  
2 facilities do they deal with for these 150? And then, of  
3 course, some of them have no post-acute. How many different  
4 physicians are represented by those little axes?

5 And then let's think, how do you get this sort of  
6 very complicated "team" working together, communicating  
7 together, taking orders? Can you?

8 And then let's go one step further and say okay,  
9 and what exactly is the coinsurance that each of the  
10 participants in this 150 are going to have to pay for this?  
11 And then ask ourselves well, is it time to say yes, full  
12 speed ahead, let's have the Mack truck or the steamroller  
13 headed down the line? Because they might be so many sort of  
14 practical problems with this that I end up where Nancy does  
15 which is let's do it for one condition in one area and see  
16 if it can be done and see if it produces the kind of  
17 incentives that we all, in theory, want.

18 We're trying to reinvent capitation without having  
19 capitation, and it gets very, very convoluted, I think.

20 MR. HACKBARTH: Anne and Craig, I think you guys  
21 have done a terrific job in sort of laying out the basic  
22 parameters of this. Clearly, we need to move from that

1 phase one to trying to figure out how to address the myriad  
2 the issues that have come up. I don't think that -- I know  
3 I'm not smart enough to figure out what the path is based on  
4 this conversation.

5           So what I propose to do is we'll look at the  
6 transcript and try to come up with sort of a systematic way  
7 of framing questions to try to elucidate a reasonable path.

8           Bob, I think your points are very well taken about  
9 all the different actors that are involved and many actors  
10 means complexity.

11           The other side of that coin is that's precisely  
12 the problem. We've got all these independent actors that we  
13 have reinforced with our payment silos. And so the task is  
14 very large indeed. And I'm sure Nancy is, if anything,  
15 conservative in saying we're talking about a decade's time  
16 frame. But I do think that you can lay out steps that would  
17 start to move people in the right direction. That's the  
18 challenge that we have. I think you can do that and we'll  
19 see how good we are at that over the next few discussions on  
20 this.

21           Great job, Anne and Craig, and more on this later.

22           Next up is preliminary findings on SNF payment

1 refinement.

2 DR. CARTER: I have a couple of introductions for  
3 everybody. I'm here today with two researchers from the  
4 Urban Institute. To my far left is Doug Wissoker, who is a  
5 Senior Research Associate in the Statistical Methodology  
6 Group. And to my immediate left is Bowen Garrett, who is  
7 also an economist and also a Senior Research Associate, he's  
8 in the Health Policy Group.

9 Both have been very involved in the work that the  
10 Urban Institute did for CMS on the SNF refinements and  
11 reform, and we're really glad that they're working on this  
12 project with us.

13 Before I get started, I wanted to acknowledge the  
14 fine work that Korbin Liu did on this important topic. We,  
15 at the Commission, benefitted from his leadership and  
16 excellence in his work on SNFs and from his work throughout  
17 his career on long-term care. The three of us wanted to  
18 express how much we miss the depth and breadth of his  
19 expertise and his collegueship.

20 We've previously talked about two key problems  
21 with the Medicare's prospective payment system for SNFs.  
22 First, it does not adequately adjust payments to reflect the

1 variation in providers' costs for non-therapy ancillary  
2 services. These are things like respiratory care, IV  
3 medications, and drugs.

4           Second, payments vary with the amount of therapy  
5 furnished, creating an incentive to provide therapy for  
6 financial reasons.

7           In our June report this year, we described  
8 research that the Urban Institute had conducted to improve  
9 the accuracy of the SNF payments. Based on this work, we  
10 concluded that the current PPS could be designed to better  
11 target payments for NTA services and to improve provider  
12 incentives by paying for therapy based on predicted care  
13 needs rather than on services delivered. In the spring we  
14 contracted with the Urban Institute to continue its work  
15 refining these alternative designs and today we're updating  
16 you on this work.

17           Just a quick overview for those of you who are  
18 sort of new to this topic. SNFs are paid a daily rate that  
19 consists of three separate payments: for nursing, therapy  
20 and sort of a room and board. These three components can  
21 added up. Research Utilization Groups, or RUGs, are used to  
22 case-mix adjust payments. One key feature of RUGs is that

1 they use therapy minutes to group stays.

2           The problems, as I mentioned before, with the PPS  
3 is that it does not adequately adjust payments to reflect  
4 the variation in NTA costs. These services make up, on  
5 average, 16 percent of total daily cost. That costs of NTA  
6 services are included in the nursing component so that  
7 payments for these services vary only to the extent that  
8 nursing costs vary.

9           there are two problems with this. First, NTA  
10 costs don't always vary with nursing costs and they're much  
11 more variable than nursing costs. NTA costs vary nine times  
12 as much as nursing costs.

13           So while we have nursing payments varying, they  
14 don't vary enough to account for the range in NTA costs. As  
15 a result, while payments, in aggregate, are more than  
16 adequate they are not sufficiently targeted. As evidence  
17 that payments are too low for beneficiaries who need  
18 services, the OIG has found that hospital discharge planners  
19 report problems placing patients who need expensive drugs,  
20 IV antibiotics, or ventilator care.

21           The second key problem is that payments vary with  
22 the amount of therapy delivered, creating a financial

1 incentive to furnish these services. Over time, the number  
2 of beneficiaries receiving therapy and the amount that they  
3 receive have both increased. For days grouped into  
4 rehabilitation RUGs -- and that's about 80 percent of days -  
5 - therapy costs make up between 16 and 60 percent of their  
6 daily payments, depending on the RUG.

7           The reform approaches that we're going to talk  
8 about today try to improve PPS components that establish  
9 payments for NTA services and for therapy services. To  
10 improve the accuracy of payments for NTA services, we're  
11 looking at reforms that add a fourth component to the PPS.  
12 For the therapy reforms, we're looking at replacing the  
13 current therapy component. We want to move to a prospective  
14 approach that uses stay and patient characteristics to  
15 predict a patient's need for therapy and not base payments  
16 based on the amount of therapy that was furnished.

17           We've used four criteria to look at our  
18 alternatives. The first is how good is the model at  
19 predicting costs? If a design doesn't account for a  
20 reasonable share of the variation in costs across patients,  
21 it will encourage providers to select certain types of  
22 patients or to provide certain types of services.

1           Another measure of accuracy is how well does it  
2 predict high-cost cases?

3           Another criterion is whether the design results in  
4 facility payments that are proportional to a facilities'  
5 costs. When increased costs are offset by proportional  
6 increases in payments, there's no gain to treating certain  
7 types of patients or providing certain kinds of services.

8           A third criterion is the data requirements that  
9 are needed to implement either of the components.

10           And last, we're looking at the ease of  
11 implementation.

12           We've used a variety of patient and stay  
13 characteristics in the alternatives that we will be  
14 presenting today. Patient characteristics include things  
15 like age and physical and mental status, their abilities to  
16 perform ADLs, things like that.

17           On the stay side, we've tried to characterize the  
18 stay using the broad state stay classification. In the NTA  
19 design, we used the broad RUG category, and that would be  
20 like rehabilitation or expensive services or clinically  
21 complex.

22           In the therapy designs, we used an indicator of



1 whether the patient received more than the minimum amount of  
2 therapy required to get grouped into a rehabilitation RUG,  
3 and that's 45 minutes a week. While this indicator still  
4 reaches back to look at the services that were provided, so  
5 it's not completely divorced from service use, it would not  
6 result in increased payment as the amount of therapy  
7 increased above this 45 minute threshold. This differs from  
8 the current system that uses therapy minutes to group  
9 patients into five tiers and payments increase for each  
10 tier.

11 Like the current RUGs, we also used IV medications  
12 and respiratory care to see whether those were furnished to  
13 predict costs. These are expensive services, so including  
14 an indicator that they were provided improves our ability to  
15 predict costs.

16 In each of the sets of models that we'll be  
17 presenting today, I want to remind you that we're really  
18 trying to predict, on the one case, NTA costs and in the  
19 other predicting therapy costs. We have not put them  
20 together to predict total costs. We'll come back to you at  
21 a future time and present that analysis.

22 In each set of alternatives, we've looked at a

1 full model that includes all the patient and stay  
2 characteristics that we settled on and a selective model  
3 that excludes certain variables that would be easier to  
4 implement.

5           First, several predictors are based on diagnostic  
6 information from the patient's preceding hospital stay  
7 because the quality of SNF diagnosis coding is very poor.  
8 While improving how well the models predict costs, including  
9 these hospital variables would make them harder to  
10 implement.

11           We were also concerned that the provision of IV  
12 medications can be manipulated by providers where there is a  
13 financial advantage to doing so. But excluding this  
14 variable could result in a design that underpays providers  
15 that treat a higher than average share of patients who  
16 require expensive IV medications.

17           Including age in the designs would make them more  
18 accurate. However, if the estimate of age that's affecting  
19 cost is inaccurate, providers may be selective about who  
20 they admit. That said, age is used in risk adjustments for  
21 other PPSs and for the MA plan payments.

22           So let's start with the models to predict NTA

1 costs. A new component would substantially improve payment  
2 for these services over the current design. As a basis for  
3 comparison, we looked at the ability of the current nursing  
4 weights to predict NTA costs. That's in the first column.  
5 As we expected, we found that they are a pretty poor  
6 predictor, explaining only 5 percent of stay level NTA costs  
7 per day. Moving down, we see that only 25 percent of high-  
8 cost cases -- that is the cases that were in the top 10  
9 percent of costs -- were actually predicted to be high-cost.

10

11 At the facility level, our model explained 13  
12 percent of the variation in costs. We also found that the  
13 current model does not result in payments that are  
14 proportional to facilities' costs. A CMI coefficient of one  
15 would mean that a facilities' expected cost to furnish NTA  
16 services is proportional to the payments that they would  
17 receive. And here you see a coefficient of 2.34.

18 So what we're seeing here is that facilities with  
19 a more than costly NTA case-mix are underpaid for the  
20 services that they provide, while facilities with a below-  
21 average cost are overpaid. This is consistent with what  
22 we've heard from the field, that facilities have a financial

1 incentive to avoid cases with high levels of NTA costs.

2           Moving to the next column, which is the full  
3 model, we see a dramatic improvement -- there, you can see  
4 it's highlighted differently -- explaining 23 percent of  
5 costs at the state level, and at the facility level 31  
6 percent of costs. Although payments are not perfectly  
7 proportional to costs, and you see the CMI index of 1.15,  
8 they are substantially more so than the current payment  
9 system. The full model would distribute payments for NTA  
10 costs much more in line with their costs and therefore would  
11 reduce the incentives to avoid these cases.

12           In our selective model, we find that it retains a  
13 lot of the predictive ability of a full model and is a  
14 considerable improvement over current payment policy. It  
15 substantially improves our predictive ability and payments  
16 are more proportional to cost. In addition, because this  
17 model would be easier to implement because it doesn't use  
18 any of the hospital information that would need to get  
19 transferred from the SNF to the hospital.

20           Turning to the therapy cost model. One of the  
21 problems we faced in judging a good therapy design is that  
22 we're not sure that being able to predict current therapy

1 costs is the right standard because the level of services  
2 provided may reflect financial incentives rather than  
3 patient care needs. We tried to develop predictive models  
4 that substantially reduce the incentives to furnish services  
5 and align payments for therapy with patient characteristics  
6 such as diagnoses.

7           That said, diagnostic information alone didn't do  
8 a great job of predicting costs, so we did add the therapy  
9 indicator to the model. That reflects some use of service  
10 but to much less degree than the current system. Again, the  
11 rehab indicator retains the current incentive to furnish at  
12 least 45 minutes of therapy a week to qualify a patient into  
13 rehab RUG, but would not increase payments for increasing  
14 amounts of therapy, which the current system does.

15           Again, let's start at the far left with the  
16 current policy. The current weights do a good job  
17 explaining stay and facility level variation in per day  
18 therapy costs. This is not surprising since therapy  
19 payments in the current system are based on actual or  
20 expected numbers of therapy minutes. The current payment  
21 system, however, does not result in payments that are  
22 proportional to costs. Here you see that with a CMI index

1 of 0.79. The current payment system tends to overpay  
2 facilities with above average therapy costs and underpay  
3 facilities with below average costs. That's again what  
4 we've heard from talking to providers in the field.

5           Turning to the full model, we included many  
6 patient and stay characteristics but we did not include in  
7 this full model any indicator of whether a patient was in a  
8 rehab RUG. Its ability to predict costs at the stay and  
9 facility level is considerably lower than the current  
10 design. This is not surprising, given the current  
11 incentives to furnish therapy that may be unrelated to a  
12 patient's characteristics and care needs.

13           Like the current payment weights with a CMI below  
14 one, the full model would tend to overpay facilities with  
15 therapy costs that were above average.

16           When we add in the rehab indicator, the model's  
17 ability to predict costs is much higher. As I mentioned  
18 earlier, this isn't necessarily the optimal amount of  
19 therapy, since levels of therapy in the cost structure  
20 reflect incentives of the current system. This model's  
21 ability to explain therapy cost differences at the patient  
22 and facility level is only slightly less than current

1 policy, but we now have a design that considerably reduces  
2 the incentives to furnish therapy services.

3 In addition, this model results in payments at the  
4 facility level that are nearly proportional to the average  
5 facilities' costs. This near proportionality indicates that  
6 there would be little incentive for providers to adjust  
7 their mix of cases for financial gain.

8 The last column showing the selective model  
9 indicates that we're retaining most of the explanatory power  
10 and the near proportionality of the more inclusive model.  
11 But because it doesn't include the hospital information, it  
12 would be easier to implement.

13 These results show that it is possible to replace  
14 the current therapy component with one that excludes much of  
15 the financial incentive to furnish therapy services yet  
16 still explain cost differences with reasonable accuracy.  
17 However, like any PPS, because facilities would be paid for  
18 one level of care even that they provided fewer services,  
19 the models create incentives for SNFs to under provide  
20 services. CMS could lower the risk of stinting by linking  
21 quality measures to payments.

22 The Commission has supported the use of two short-

1 stay quality measures -- these are the rates and discharge  
2 to the community and potentially avoidable  
3 rehospitalizations -- to measure quality. Changes in  
4 functional status would be another measure that would gauge  
5 patient improvement. However, for this last measure to  
6 accurately reflect the care furnished to short stay  
7 patients, providers would have to assess patients at  
8 admission and at discharge. The Commission has repeatedly  
9 made this recommendation to CMS.

10 CMS is fairly far along in planning a pay-for-  
11 performance demonstration and is waiting for OMB clearance  
12 to pursue state participation and hopes to have  
13 participating states and nursing homes identified by the  
14 fall of 2008.

15 Now turning to the implementation requirements.  
16 For CMS, they would need to change several aspects of its  
17 payment calculations, including revising therapy component  
18 and adding a new component for the NTA services. It would  
19 need to make conforming changes to the claims and cost  
20 report in sync with the new design. Depending on what  
21 predictors were included in the final design, CMS would need  
22 to verify that IV medications and respiratory care were



1 furnished during the SNF stay. We found that this can be  
2 reasonably approximated by merging SNF claims data and MDS  
3 data.

4           If hospital information were used, CMS would need  
5 to gather this information from the hospital claim with the  
6 stay associated with the preceding hospitalization  
7 associated with the SNF stay.

8           For short SNF stays, there could be a delay in  
9 payments as CMS waits for the hospital information it would  
10 need in order to calculate the SNF payment. While these  
11 burdens should not be minimized, we believe that they are  
12 outweighed by having the PPS with better provider incentives  
13 and more accurate NTA payments.

14           Now for providers, none of the alternative designs  
15 require providers to gather any new information. The  
16 refinements would require providers to learn about the new  
17 NTA component and, if the MDS were modified, they would have  
18 to train their assessors on these changes. Depending on the  
19 alternative adopted, hospital diagnostic information may  
20 need to be transferred from the SNF -- from the hospital to  
21 the SNF and to CMS in a timely manner. Many SNFs already  
22 have a way that they routinely get information about the

1 status of incoming patients, for example some SNFs get  
2 information faxed to them from the referring hospital.

3 One benefit of establishing such a mechanism would  
4 be that SNFs would get information on every beneficiary that  
5 could be useful for care planning purposes. The need for  
6 information transfers between providers highlights the need  
7 for information technology industry-wide.

8 The next steps for us are to include the NTA in  
9 therapy models and see how well the models predict total  
10 ancillary costs and then to estimate the impacts on various  
11 different provider groups. In the future work, we plan to  
12 examine an outlier policy, again building on the previous  
13 work that the Urban Institute did for CMS. And we'll bring  
14 these results back to you at a future meeting.

15 That's it and we're glad to listen to your  
16 discussion of this.

17 MR. EBELER: Thank you, very much. This is very  
18 helpful. If you would turn to slide seven, where you talk  
19 about the elements one that might exclude in the selective  
20 model, it seems to me there's three different types there,  
21 the age, the IV medications, and the hospital data.

22 The IV medications is a classic case of something

1 that can be gamed. It's the variable you might be trying to  
2 control. So I sort of understand concern about that one.

3 The other two, I think, are different. In  
4 particular, the variable based on hospital data. Carol, you  
5 just captured it at the end. Rather than thinking of that  
6 administrative constraint of that data transfer by the  
7 hospital as a problem, it strikes me as an objective of the  
8 payment change is to assure that that data transfer takes  
9 place. Because that's the classic patient handoff.

10 So I guess that one, in particular, it just takes  
11 me that one wants to drive to a system that requires those  
12 data exchanges rather than a system that adapts around the  
13 lack of those data exchanges.

14 MS. BEHROOZI: Thanks very much.

15 It's a clear case, I guess, for why it's important  
16 for us, consistent with everything else we're thinking about  
17 in terms of reducing the incentives to grow volume of  
18 services, to change the way therapy services are paid. So  
19 you make that case very well.

20 But in light of the New York Times article that I  
21 guess we all know about in September on private equity  
22 buyouts of nursing home chains and their cost-cutting

1 measures that directly cut into patient care, it's very  
2 important, very, very critically important that we don't  
3 create another incentive for them to further stint on care.  
4 And you've acknowledged that with the prior positions that  
5 the Commission has taken with respect to the quality  
6 measures in SNFs and adding patient assessment.

7           But the evidence that was brought out in that  
8 article directly pointed to the reduction of staffing, in  
9 particular, as one of the ways that the new ownership  
10 structures seek to contain their costs and very directly  
11 undermine patient care.

12           And going back to the work that's been presented  
13 here in connection with pay-for-performance measures and  
14 quality measures by Dr. Kramer pointing to the direct  
15 correlation between staffing levels and quality, I really  
16 urge the Commission to consider staffing levels as a  
17 structural measure of whether SNFs are meeting the standards  
18 required to -- whether it's participate in Medicare or be  
19 penalized or whatever. But I think that point has been made  
20 over and over again and we really have to be careful moving  
21 toward a system that is not volume based, that it doesn't  
22 become further inducement to stint.

1 DR. CARTER: I did want to just add that in the  
2 CMS demonstration that they are in the process of planning,  
3 staffing measures are one of the four domains that they will  
4 be using in their pay-for-performance demo.

5 DR. SCANLON: I think you've done an incredible  
6 job of moving the system forward in a very positive way and  
7 operating under, I guess, two what I think of as extreme  
8 constraints. One, the data you've referenced several times,  
9 the fact that it's tainted by the incentives that we have in  
10 the current system and therefore we can't really observe  
11 what might be needed.

12 And then I think the second constraint is one that  
13 maybe we're all somewhat guilty of, which is that we live  
14 with our mindset of the PPS model. I've often thought that  
15 our success on the hospital side, in some respects, hasn't  
16 made us wary enough of whether or not it works in other  
17 contexts.

18 Toward the end you were talking about the whole  
19 issue of if we create this incentive, which is the right  
20 thing based upon predicting sort of a person's need but then  
21 worry about whether or not they get the services and we'll  
22 use pay-for-performance as a safety valve, I have the same

1 concerns here that I had with respect to home health pay-  
2 for-performance, which is we don't have good measures for  
3 the person who is not going to get better. And we don't  
4 want to discriminate against that type of patient.

5           And nursing homes, as states introduced case-mix  
6 systems over the past 15 to 20 years, nursing homes  
7 demonstrated that there were very good at inquiring about  
8 what exactly a patient was going to be like before they  
9 admitted them. It wasn't something that this was a standard  
10 procedure until the case-mix system was there. And then  
11 once it was there, there were all kinds of inquiries related  
12 to how am I going to be paid for this person? So I think we  
13 do need to be concerned about that.

14           So I think while this moves us forward, there's  
15 also a question of whether we should be thinking longer-term  
16 about how we pay and whether modifications to prospective  
17 payment -- and I happen to be a fan of some kind of risk  
18 corridors as a way of dealing with the incentives that would  
19 penalize people for too much under provision, protect them  
20 for the riskiness that's associated with the fact that we  
21 can't always predict exactly what people are going to need,  
22 and in the process hopefully generate information that we

1 would then use for recalibration of rates over time so that  
2 we would have better experience to draw upon in terms of the  
3 calculation of rates.

4 I think what we've seen with Part D is that it was  
5 possible to go back and to do some reconciliation. Arnie's  
6 right that I have been one that has said CMS is incredibly  
7 overstretched and therefore has very great difficulty doing  
8 certain things. But again we've got to think about this  
9 from an investment perspective. If we don't invest in the  
10 administrative resources, if we keep the payment system  
11 simple enough that they match what administrative resources  
12 that we do have, we may end up paying much more out over  
13 time than if we were to make the investment in the greater  
14 sophistication of resources and improve our payment methods.

15 And related to the last point is the whole issue  
16 of data. I agree with Jack that we should be thinking about  
17 what it is that would be the data that we really want to  
18 have with respect to both payments as well as the care of  
19 these individuals and be setting out those standards. And  
20 even if they are an increase in terms of what we're asking  
21 for from homes now, that's okay, because we are spending a  
22 lot of money on this. There's a lot of people that are at

1 risk and it should be something that we're willing to spend  
2 the money on.

3 MS. HANSEN: This is more of a question to help me  
4 clarify something I may be confusing, and it's going back to  
5 the same page seven about the third variable about age that  
6 was discussed. I know, from some of my own previous  
7 comments, I've always kind of noted that sometimes extreme  
8 age, say 85-plus, oftentimes creates some greater needs. I  
9 just recall that I've said that.

10 But on the flip side of this, just wondering if  
11 there is any concern in any of this modeling that there  
12 would be, in some ways, discrimination of not taking people  
13 who might be -- if they looked at something as age, is that  
14 one of the things that might be a caution in looking at this  
15 as a variable?

16 It's more, actually, two sides of me kind of going  
17 and perhaps you could help me appreciate whether or not this  
18 is an issue that should be of concern. The bottom line is I  
19 want both the fair treatment of services, but I also want  
20 the facility to be paid appropriately at the same time. So  
21 how do we achieve that?

22 DR. CARTER: I'll take a crack at it, and you guys



1 might want to add in.

2           Age for this service actually decreases -- the  
3 cost of treating older and older patients decrease. And so  
4 if our coefficients or the things that we're using in our  
5 models aren't accurate, the incentive would actually be to  
6 discriminate against younger patients because the costs  
7 actually decline as patients get older. I assume a lot of  
8 that is because older patients get less therapy and can't  
9 tolerate the therapy.

10           So that at least is part of -- including age in  
11 the model would improve our predictive ability and leaving  
12 it out might, if our models aren't accurate, could lead to  
13 discrimination. But it would be on the younger patients,  
14 not on the older patients.

15           MS. HANSEN: Now I recall that comment from an  
16 earlier meeting that we had because I know that kind of  
17 threw me a little bit because my whole life has been working  
18 with the 85-plus population. So it may be just something  
19 that's more subtle that it's possible that people just don't  
20 get treated when they're really older. But that's something  
21 that we can't really, frankly, measure through this. That's  
22 what I think the actual data surprised me a little bit.

1 Probably there's some more information.

2 DR. CASTELLANOS: Just to carry on what Mitra was  
3 saying, in the real world, Carol, you mentioned providers  
4 may be selective in who they admit. I'm going to be honest,  
5 they are selective in who they admit.

6 And there's a real access problem. For these very  
7 high complex patients, or we call them train wrecks, we  
8 can't get them admitted to a private service. You really  
9 have to wait for the hospital SNF to have a bed available  
10 because nobody else will take them. They require a  
11 tremendous amount of work and it's a cost.

12 Now, of course, the hospital has an incentive to  
13 get them out of the hospital so maybe that's why they take  
14 them. But to be honest, with this new payment system maybe  
15 we're paying more adequately and appropriately for these  
16 high-risk patients.

17 DR. STUART: I think it's an issue that goes  
18 beyond just simply selection of patients. It's the kind of  
19 care that they get once they're admitted.

20 I think focusing on the NTA cost actually is  
21 important. We've done some recent work, and there's a  
22 summary of that is published on the ASPE website earlier

1 this year, that looked at medication administration data for  
2 beneficiaries who were in a SNF qualified stay compared to  
3 contiguous days in which they were non-SNF qualified. What  
4 we found is -- and during the SNF qualified months, the  
5 number of administrations, medication administrations,  
6 during the month was 7 to 30 percent lower than during  
7 months in which there was only nonqualified stays.

8           Now I don't know whether the medication was  
9 necessary or unnecessary and it was a relatively small  
10 sample size so it doesn't get into the type of medications.  
11 But at least it raises the question about what the incentive  
12 is -- well, we know what the incentive is. The incentive is  
13 if you're just paid a flat amount, is to minimize what's  
14 being offered. But this suggests that it gets down into  
15 that level of the actual medications that they're being  
16 provided.

17           And I'd be happy to give you the information to  
18 get that cite. We've done a little work after that. So if  
19 you'd like it, I'd be happy to get that to you.

20           DR. WOLTER: I really like this chapter and  
21 although I don't pretend to understand the statistical  
22 evaluation of the different approaches that we might take

1 here. But I just wanted to connect it to my own admittedly  
2 biased world view, which is I think we had a presentation  
3 earlier this year in the spring that did suggest that in  
4 hospital-based SNF there tend to be sicker patients. We've  
5 had 35 percent or so of those SNFs close over the last four  
6 years. And in many communities, these types of patients,  
7 it's very, very hard to find a place for them out in the  
8 community. And for those of us that did LTCH visits a few  
9 years ago, we certainly heard that anecdotally in just about  
10 every community that we visited.

11           And then the other thing is we've been wrangling  
12 ever since I've been on the Commission about whether the  
13 negative 85 percent margins in hospital-based SNFs are cost  
14 accounting issues or those rooms were better use for acute  
15 care or whatever it is. But I do think we have a group of  
16 patients for whom the current payment system is not  
17 adequately covering what needs to be done. And I think it  
18 has affected some decisionmaking. I'm really happy to see  
19 us really trying to tackle this and see if we can't bring  
20 something to bear that might serve those patients a little  
21 bit better. Whether it will be too little, too late I'm not  
22 sure yet but this is good work and I look forward to the

1 next version.

2 DR. CARTER: We will be bringing back impact

3 analysis

4 next month, so you'll be able to see some of that.

5 MR. HACKBARTH: Bill's comments had set me to

6 trying to think through this. Pardon me for plodding along,

7 but what I heard Bill say was that a SNF payment is tricky

8 because there are unmeasured differences in the patients,

9 and that inclined you to think in terms of risk corridors as

10 opposed to a strict fully prospective amount, some sharing

11 of the risk that would attenuate problems if we're not

12 measuring the patient case-mix exactly right. That makes

13 sense to me. I assume that's part of the outlier thinking.

14 Outlier is an insurance policy for institutions that do get

15 tougher cases. So pursuing the outlier analysis and

16 thinking that through makes sense to me.

17 In the context of home health, one of the things

18 that we did to try to get a feel for whether there was a

19 bias was look at the profitability by case-mix adjusted.

20 Are there particular cases where we see higher profits than

21 others? Have we done something like that for SNF?

22 DR. CARTER: We haven't. I know when I worked at

1 GAO we had heard, at least anecdotally, that for the rehab  
2 groups the highest rehab groups were less profitable than  
3 the high and very high -- which is different from the ultra  
4 high. So sort of the middle level rehab groups were more  
5 profitable than the low and the very high. And that the  
6 other patients were less profitable, but I think that was  
7 really more anecdotal information. And we have not done the  
8 RUG level profitability analysis.

9 DR. SCANLON: There's the third issue that was  
10 working against you in this, in the fact that with SNFs what  
11 we're talking about is Medicare being this 10 percent on  
12 average share?

13 DR. CARTER: A little higher, but under 15.

14 DR. SCANLON: So you've got this cost variation  
15 that is largely driven by the rest of the business, a major  
16 part of it which is not related to care but, in some  
17 respects, the quality of the facility. And so when one  
18 tries to do -- and this has gone on for years -- cost  
19 analysis of nursing homes, it's often very hard to identify  
20 what are the drivers of costs, particularly when you're  
21 trying to look at it from a care perspective.

22 MR. HACKBARTH: Okay, thank you very much. Good

1 work.

2 Next is hospice.

3 DR. MATHEWS: Thank you.

4 At our last meeting I discussed a preliminary  
5 analyses relating to the so-called hospice cap, the limit on  
6 the aggregate average payment for beneficiary that a hospice  
7 can receive from Medicare. This afternoon I'd like to  
8 present the results of our refined model and other data to  
9 help characterize Medicare beneficiary access to hospice  
10 care.

11 The refinements to the cap calculation part of the  
12 model, for the most part, involve changes to the way  
13 beneficiaries are counted. For example, we now are able to  
14 allocate hospice use by beneficiaries who use more than one  
15 hospice provider for purposes of calculating the cap. To  
16 evaluate access, especially in light of the effects of the  
17 cap, we examined changes in hospice utilization by Medicare  
18 beneficiaries and changes in the supply of hospice  
19 providers. We also developed an illustration of the  
20 financial incentives under the current payment system that  
21 may provide an additional impetus for hospices to admit  
22 patients who are likely to have longer lengths of stay.

1           Lastly, we identified a number of policy  
2 considerations that the Commission may wish to address in  
3 deliberating potential changes to the hospice payment  
4 system.

5           We reported previously that a small but growing  
6 number of hospices reach the cap each year. That finding  
7 still holds, but we do now estimate that a larger number of  
8 hospices are reaching the cap than we reported previously.  
9 We now believe about 220 hospices, or 7.8 percent of the  
10 total number of providers, reached the cap in 2005. The  
11 dollars have also increased as a share of total Medicare  
12 payments, about \$166 million in cap overpayments in 2005,  
13 off a base of about \$8.2 billion.

14           While the number of providers reaching the cap has  
15 increased relative to our earlier parliamentary estimate,  
16 the characteristics of cap hospices is pretty much the same.  
17 Ownership and facility type continue to be highly correlated  
18 with cap status. In all years from 2002 to 2005, about 90  
19 percent of hospices that reached the cap were proprietary,  
20 and over 90 percent of hospices that reached the cap were  
21 freestanding facilities.

22           As we showed previously, hospices that reached the



1 cap are smaller than non-cap hospices in terms of caseload.  
2 On average, they had about 137 patients in 2005 compared to  
3 nearly 300 for non-cap hospices. Additionally, they have  
4 much longer length of stay, as we showed previously, on  
5 average about 139 days for cap hospices versus 68 days for  
6 non-cap hospices in 2005.

7 Using the new counts of hospices, we again looked  
8 at cap versus non-cap hospice length of stay in great detail  
9 using claims data because length of stay is indeed the  
10 strongest driver in whether or not a hospice reaches the  
11 payment cap.

12 As I mentioned a moment ago, the patterns we  
13 observed previously regarding length of stay persisted with  
14 the new counts. Patients at cap hospices had median lengths  
15 of stay of over three times that of patients at non-cap  
16 hospices and about double the mean length of stay relative  
17 to non-cap providers. Further, the length of stay greater  
18 than 180 days -- which you will recall is the six month  
19 presumptive eligibility period for hospice -- represented  
20 about 40 percent -- just under 40 percent of episodes at cap  
21 hospices compared to less than 15 percent of episodes with  
22 non-cap providers.

1           So again, while the number of hospices has changed  
2 relative to our preliminary results, the overall picture is  
3 pretty much consistent with the earlier results.

4           Previously, when we looked at diagnosis that was  
5 the primary reason for a hospice admission, we presented  
6 data on the top eight diagnoses comparing length of stay and  
7 the share of total cases represented by those diagnoses for  
8 cap hospices and non-cap hospices. At your request, we  
9 aggregated all of the diagnoses, all of the claims for 2005  
10 into more general disease categories. Those results are  
11 presented here.

12           The results are a little bit mixed, relative to  
13 what we presented previously, most notably in that when we  
14 aggregate by disease category we do now see pronounced  
15 differences in the mix of cases treated by Cap hospices  
16 compared to non-cap providers.

17           You may recall that the last time I presented  
18 results, only one diagnosis of cancer appeared on the top  
19 eight. That was lung cancer. But when we aggregate all  
20 diagnoses of cancer into a general category, this gives a  
21 much more complete picture of the contribution of cancer to  
22 the overall mix of cap and non-cap providers. In short, cap

1 providers have a much smaller share of cancer cases as a  
2 function of their case-mix than do non-cap providers.

3           The second major point of this slide is consistent  
4 with the results that we presented previously, which is that  
5 cap hospices again had significantly longer lengths of stay  
6 across all diagnoses, ranging from 23 percent longer for  
7 lung cancer to 122 percent longer for patients with  
8 circulatory disease other than heart failure.

9           So in short, there are differences in the case-mix  
10 between cap hospices compared to non-cap providers, but  
11 these differences do not fully explain why some hospices  
12 reach the cap and others do not. Hospices reaching the cap  
13 have lengths of stay that are longer than non-cap hospices  
14 for all conditions. Even if cap hospices had the same mix  
15 of patients as those that did not reach the cap, their  
16 length of stay and thus the odds of reaching the cap would  
17 be greater.

18           So then we asked whether or not the growing  
19 effects of the cap are impeding Medicare beneficiary access  
20 to hospice care. Again, we looked at access to answer this  
21 question by both beneficiary utilization of services and by  
22 the supply of providers.

1           In the aggregate, you'll recall from last time,  
2 Medicare spending for hospice has grown about 23 percent  
3 annually between 2000 and 2005 and spending is projected to  
4 reach about \$10 billion in fiscal year 2008.

5           Spending is a function of both greater numbers of  
6 beneficiaries electing hospice and more spending per hospice  
7 patient. Both of those measures grew by about 11 percent a  
8 year, on average, between 2000 and 2005. There is an  
9 additional increase of about 7.5 percent in terms of the  
10 number of beneficiaries using hospice between calendar year  
11 2005 and 2006. We do not yet have fiscal year numbers.

12           As you know from your paper, we examined the  
13 growth in hospice utilization by a number of different  
14 groupings of Medicare decedent beneficiaries. We looked at  
15 utilization by age groups, by sex, race and ethnicity,  
16 Medicare eligibility status, and Medicare insurance  
17 coverage. I won't go into the detailed results here because  
18 the short story is that hospice utilization by Medicare  
19 decedents increased by roughly 50 percent in the aggregate  
20 between 2000 and 2005. Basically the rate of utilization  
21 increased across every strata of the Medicare beneficiary  
22 population that we looked at.

1           One detail that was of interest was that the  
2 increases in utilization were particularly pronounced among  
3 Native American beneficiaries. Their rate of utilization  
4 doubled between 2000 and 2005.

5           Utilization continues to be higher for managed  
6 care decedents than for fee-for-service. Over 40 percent of  
7 Medicare decedents who had been in a managed care plan used  
8 hospice in 2005, compared to about one-third of fee-for-  
9 service decedents. However, the rate of increase in hospice  
10 use by fee-for-service decedents was almost double that for  
11 managed care enrollees during this time, so the differential  
12 is less in 2005 than was in 2000. The differences between  
13 fee-for-service and managed-care utilization raise a couple  
14 of interesting policy questions that I'll loop back to at  
15 the end of this presentation.

16           We also attempted to get a sense of access to  
17 hospice care by looking at the supply of providers. During  
18 the period from 2000 to 2006 in this slide, we see a pretty  
19 robust growth, about 5 percent on average annually through  
20 this time. This is also the period of time, you'll recall,  
21 that hospices began to receive the re-payment notices with  
22 respect to their overpayments.

1           What's interesting here is that the number of  
2 nonprofit and government run hospices has been stable over  
3 this time, with virtually no growth, whereas I think almost  
4 all of the growth between 2000 and 2006 has been due to an  
5 increase in the number of proprietary providers which has  
6 grown at about 12.5 percent annually over this time.

7           Again, it's the for-profit hospices that are  
8 disproportionately affected by the hospice cap, so this was  
9 a little bit of a surprising finding. We felt that if the  
10 cap had been having the impact on providers' willingness to  
11 enter into Medicare, we would have seen it here.

12           We also looked at the number of hospices newly  
13 participating in Medicare compared to those that voluntarily  
14 left the market. As you can see here, the number of new  
15 entrants exceeds the number of voluntary closures,  
16 especially beginning in 2004. About six times as many  
17 hospices began to participate in Medicare as closed between  
18 2004 and 2006. I also want to point out here that closures  
19 that we've portrayed here also include mergers. So these  
20 aren't necessarily hospices that have left the Medicare  
21 market altogether. And there is a fair amount of merger  
22 activity that has been going on in recent years.

1           So again, if the cap is having an impact on  
2 hospices' willingness to participate in Medicare, it doesn't  
3 readily show up in data up to the present time.

4           We also kind of drilled down on this issue a  
5 little bit further, looking at hospice access in those areas  
6 of the country that had the highest proportion of hospices  
7 exceeding the Medicare payment limit. We looked at the  
8 ratio of hospices to Medicare beneficiaries in the five  
9 states that had the highest rates of hospices reaching the  
10 cap in 2005 compared to those states with the lowest rates.

11           Interestingly, access as defined by this measure,  
12 was highest in the states with the highest share of hospices  
13 reaching the cap. Access was highest in Oklahoma, with 2.9  
14 hospices per 10,000 beneficiaries, 14 times higher than the  
15 ratio of hospices to beneficiaries in New York. Further,  
16 the states with the high rates of hospices reaching the cap  
17 also experienced much higher rates of growth in the number  
18 of providers on average between 2000 and 2005 than did  
19 states with no hospices reaching the cap.

20           It's possible that the high rates of growth  
21 resulting in high numbers of hospices per capita have  
22 created localized instances of market saturation that help

1 explain the patterns we've observed. I'll come back to this  
2 point shortly.

3 But in short, it's true that greater numbers of  
4 hospices are reaching the cap. The effects of the cap can  
5 be very hard on individual providers. But when we look at  
6 the growth in the number of hospice providers, growth in  
7 beneficiary use of hospice, and the geographic concentration  
8 of the effects of the cap, at the moment we do not see that  
9 the cap is causing a general problem with Medicare  
10 beneficiary access to hospice care.

11 At the moment we still have no analytically solid  
12 explanation for the difference in length of stay between cap  
13 and non-cap hospices. There is a financial incentive that  
14 may serve as an inducement for longer lengths of stay. We  
15 mentioned this briefly at the last meeting. I've presented  
16 a rough sketch of these incentives here and in your paper.  
17 We assume higher cost at the beginning and end of an  
18 admission, as we've demonstrated previously, and a constant  
19 cost across all of the intervening days. We're also  
20 assuming a constant level of payment per day per episode for  
21 purposes of simplifying the illustration.

22 In general, the longer the length to stay, the



1 higher the Medicare margins, with the largest rate of return  
2 in this example coming from the move from a 10-day to a 45-  
3 day stay. The rate of margin increase diminishes as the  
4 stay becomes very long because the payment-to-cost  
5 relationship is dominated by the days in the middle of the  
6 episode. These patterns would vary, of course, under  
7 different costs and payment assumptions.

8           So at this point, we kind of asked ourselves what  
9 does the fact that a greater numbers of hospices are  
10 reaching the cap actually mean with respect to beneficiary  
11 access? Remember that the cap is driven largely by length  
12 of stay, so the short answer is that it means that length of  
13 stay at these hospices is getting longer. The financial  
14 incentive that I just described likely explains part of this  
15 increase but not all of it. There are also local market  
16 dynamics at work here as well and I'd like to take a little  
17 bit of time to discuss this point.

18           We have observed, as you'll recall from a few  
19 slides ago, that there are differences in the case-mix of  
20 patients served by cap versus non-cap hospices. Hospices  
21 affected by the cap argue that this is because they are  
22 admitting patients who more accurately mirror the decedent

1 population in their communities and include patients with  
2 longer lengths of stay. Hospices that do not reach the cap,  
3 located in these same communities as cap hospices, have a  
4 different mix of patients with higher shares of cancer  
5 patients, on average. But we do not know which group  
6 actually mirrors the mortality profile in any given  
7 community. So we don't know if the non-cap hospices are  
8 playing it extremely safe with respect to their patient mix  
9 or whether the hospices that are hitting the cap are  
10 expanding the patients that they are taking in.

11           However, it's important to remember here that  
12 case-mix does not fully explain the differences in length of  
13 stay. Cap hospices have longer length of stay for all  
14 disease categories and thus appear to be doing something  
15 different with respect to their admissions practices.

16           It's possible that the patterns we observe with  
17 respect to length of stay reflect differences in new  
18 entrants versus established hospices in a given market.  
19 Hospices that have long operated in a market may have  
20 established referral networks that ensure their admissions  
21 have lengths of stay that allow them to remain comfortably  
22 under the aggregate payment cap.

1           New hospices in the market, which tend to be  
2           proprietary, do not automatically benefit from these kinds  
3           of referral networks and thus may have to seek a different  
4           patient population in order to generate revenues. This may  
5           take the form of identifying patients with nontraditional  
6           end of life conditions, which might explain the move away  
7           from cancer as a predominant diagnosis. This could reflect  
8           an increase in access to hospice care.

9           However, it has also been suggested that new  
10          hospices in a market could also compensate for a lack of a  
11          referral network by taking patients who might nominally meet  
12          the admission criteria but who are more likely to live  
13          beyond the six month presumptive eligibility period than  
14          other patients. We see evidence for this possibility in cap  
15          hospices longer length of stay across the board and in their  
16          higher percentage of patients who live beyond 180 days.

17          If such practices resulted in a longer length of  
18          stay for patients who have had traditionally short stays,  
19          this could be seen as increasing access. MedPAC has  
20          previously stated that extremely short stay patients are  
21          unlikely to benefit fully from hospice end of life care.  
22          But this hasn't been the case. Length of stay at the median

1 or has been persistently in the range of about two weeks  
2 since 2000. All of the increase in utilization, as measured  
3 by length of stay, has been for patients with stays above  
4 the media, those who have already been getting more care  
5 than half of the Medicare population enrolled in hospice.

6           So where do we go from here? In the short term,  
7 staff are developing information on Medicare's payments to  
8 hospices, an analysis of hospice costs, and a brief overview  
9 as to whether or not hospice saves money relative to  
10 conventional curative end-of-life care. Over the longer  
11 term, the Commission may wish to consider a number of policy  
12 issues including an evaluation of the eligibility criteria  
13 for admitting patients to hospice. Here the question is  
14 both cap and non-cap hospices are using identical admissions  
15 criteria but admit patients who turn out to have very, very  
16 different lengths of stay. So do the criteria need to be  
17 tightened? And if so, how should this be done?

18           It's an important issue because without resolving  
19 this question it's looking like hospice is starting to stray  
20 into the realm of a long-term care benefit. Currently, 8  
21 percent of Medicare hospice enrollees do not die within the  
22 benefit in a given year, up from 4 percent in 2000.

1           Beneficiaries who do not die in a given year also  
 2 have a much longer length of stay, a median of 236 days in  
 3 2005, up from a medium of 179 days in 2000. Length of stay  
 4 for all decedents at the 90th percentile of the distribution  
 5 was 168 days for all patients across all hospices in 2005  
 6 but it approaches 300 days for some freestanding hospices --  
 7 cap hospices in that year.

8           At the same time, as I mentioned a moment ago,  
 9 stays below the median have persisted at the two week range  
 10 since 2000. So patients who appear to need extra hospice  
 11 care the most aren't necessarily getting it.

12           Length of stay also relates to the incentives in  
 13 the current per diem payment system. The incentive is to  
 14 provide longer lengths of stay but what is the right length  
 15 of stay? If we can't figure that problem out, what are the  
 16 alternatives to the current per diem-based payment system?

17           Third, given the differences in length of stay,  
 18 the question arises as to whether or not hospice payments --  
 19 or as has been proposed -- should the hospice cap be  
 20 adjusted for case-mix? If so, I think we need to consider  
 21 the kinds of coding incentives that could come into play if  
 22 such a change were implemented, given some of the rapid

1 changes in the mix of patients who are using hospice that  
2 we've seen over the course of the last several years.

3           Lastly is an issue that we haven't detailed in  
4 your paper but relates to the managed-care point that I  
5 raised several slides ago. We're going to look into the  
6 factors that account for the higher rate of hospice  
7 utilization among managed care enrollees and try and figure  
8 out whether this higher use rate relates to the fact that  
9 hospice is carved out of the managed care benefit. It's the  
10 only part of the Medicare benefit that's treated in this  
11 manner and you may want to look at that issue closely to see  
12 if it makes sense to do so.

13           At this point I'd like to conclude my presentation  
14 and stand by to answer any questions that you might have or  
15 otherwise facilitate the discussion.

16           MR. HACKBARTH: Help me, Jim, set the stage here.  
17 I think everybody would agree this is important benefit and  
18 the payment system is one that's overdue for some careful  
19 reevaluation. At this point, we're not facing any mandated  
20 studies or anything like that that would drive us to address  
21 particular issues right now?

22           DR. MATHEWS: No.

1           MR. HACKBARTH: At what point or will we at some  
2 point be able to look systematically at hospice margins?  
3 How far is that in the future?

4           DR. MATHEWS: I would defer to Mark.

5           DR. MILLER: We have the data. We've been  
6 grinding through the data. It's hard to put a specific date  
7 on it because this is the first time through it. We're  
8 still understanding some of the properties of it. We're  
9 still seeing patterns in it that we're not quite sure what  
10 we're looking at. There's still some technical things that  
11 we feel like we have to work through. We were hoping a  
12 November/December type of time range, but now I'm not as  
13 sure. Like I said, we've just kind of entered into the data  
14 analysis. It will be a question of how far we can get when  
15 we start feeling comfortable.

16          MR. HACKBARTH: The reason I ask is that margin  
17 analysis isn't the end all of payment analysis but certainly  
18 it's a staple of what we do when we're trying to examine the  
19 impact of a payment system. And to leap ahead and start  
20 proposing changes in a payment system without looking at  
21 basic information like that just seems like it's putting the  
22 cart before the horse.

1 DR. REISCHAUER: But I would think that, in some  
2 respects, that's a fine place for the cart. When you see  
3 proprietary organizations entering a market at a very rapid  
4 pace, it doesn't suggest that there are large negative  
5 margins.

6 MR. HACKBARTH: And I think that's probably a  
7 reasonable inference. Certainly that's the inference that  
8 we often draw in other payment systems when we see rapid  
9 entry, and when we do our payment adequacy analysis, we  
10 think that that's an indicator that's pointing towards  
11 adequate or more than adequate payment. So I would not  
12 disagree with that.

13 But again, my point is where do you start in  
14 trying to make payment changes? And what information do you  
15 need to do that? I agree with your inference but I'm not  
16 sure what payment changes I would make based on that  
17 inference at this point.

18 MS. DePARLE: Thanks. I wanted to go back to the  
19 average length of stay or the length of stay questions you  
20 raise, which I think are fascinating. The chart on page  
21 six, I think is where -- it's sort of hard to read.

22 As I read this, whether for hospices that have hit



1 the cap or those that haven't, the average lengths of stay  
2 are still well below six months. And at the end, you cited  
3 some numbers, 8 percent I think you said, that were above  
4 patients who lived beyond 180 days. Is that right?

5 DR. MATHEWS: Yes. I'll give you a couple of  
6 numbers again related to the 180 day. With respect to cap  
7 hospices, 40 percent of their episodes extend beyond 180  
8 days. In non-cap kept hospices, the number is up 15  
9 percent. The number I mentioned in the end, 8 percent -- is  
10 that what you just mentioned?

11 MS. DePARLE: Yes. I thought you said 8 percent  
12 live beyond 180 days? Was that a different --

13 DR. MATHEWS: That number was 8 percent of  
14 patients enrolled in hospice do not die in hospice in 2005.

15 MS. DePARLE: That year. Are you looking at --  
16 are you suggesting that they were a hospice patient for more  
17 than 12 months? Or is it simply you're saying that they  
18 enrolled and you could enroll in December of 2006 and die in  
19 January of 2007?

20 DR. MATHEWS: Yes. It's a function of both  
21 factors.

22 MS. DePARLE: So you don't know really that they

1 stayed in for 12 months?

2 DR. MATHEWS: That's correct.

3 MS. DePARLE: Because I'd be interested in seeing  
4 that. Is this the data on the number of days and the  
5 agencies where they were staying beyond 180 days, is that in  
6 a table in our text document or not? Because I'd like to  
7 stare at that a bit. That, to me, is really interesting.

8 DR. MATHEWS: This chart here?

9 MS. DePARLE: Yes, but I guess I'd like to see it  
10 broken down some. I'd like to see a little more of the  
11 detail below that. Because it seems to me that's kind of  
12 getting at the issue. As I said, as I look at page six,  
13 what I see there doesn't concern me or actually makes me  
14 think still that we -- and some of the things you suggested  
15 make me think still that we continue to have a problem with  
16 the benefit really being accessed at the appropriate time by  
17 patients.

18 I don't know, but I would think being in hospice  
19 for two weeks -- hopefully it's better than not having had  
20 the benefit. But you're not getting much benefit. It's not  
21 the ideal. It's not what the vision was for this benefit.

22 DR. MATHEWS: That is correct. And it is

1 interesting that that measure has not moved by more than a  
2 day up and down over the course of the last six years, while  
3 all of the change in length of stay has been above the  
4 median. And that length of stay has increased dramatically.  
5 So trying to figure what to do about the short lengths of  
6 stay is indeed a problem and we're just now starting to try  
7 and figure out why that is happening, why that short length  
8 of stay is so persistent, and what kind of things might be  
9 able to be done about it.

10 MS. DePARLE: Yes, and on the flip side, in the  
11 1990s there were some fairly isolated but persistent  
12 instances that the OIG did some work on with hospices where  
13 average length of stay was six years and things like that.  
14 If that's what we're talking about, to me that's a problem  
15 and we need to know about it. But that's a different  
16 problem than any suggestion that the average length of stay  
17 is inappropriately increasing overall. That wouldn't give  
18 me the data I would need to understand that this benefit was  
19 somehow being used inappropriately in the places where it  
20 was above 180 days. Because to me the numbers on page six  
21 at least don't indicate a problem in that direction. If  
22 anything, what you said would lead me to think it's below

1 that.

2           Anyway, I'd just like to see more detail on this  
3 because, Jim, I think you're right, that is the crux of the  
4 issue here.

5           Just two other questions. On the chart that you  
6 presented, I guess it's the last chart, the states with the  
7 most hospices per capita have the highest hospice cap rate.  
8 First, when you say number of hospices, is that the number  
9 of entities that have a hospice license? Or is that number  
10 of beds in some way?

11           DR. MATHEWS: These are number of unique provider  
12 numbers in the state.

13           MS. DePARLE: So do we know if they're actually  
14 providing care? Because it could be -- I guess in hospice  
15 you have to be to get your license. So they have to be  
16 providing care to somebody.

17           DR. MATHEWS: These are all active providers, yes.

18           MS. DePARLE: They could have a very low census,  
19 though. I guess we don't know.

20           DR. MATHEWS: Many of them do.

21           MS. DePARLE: You were trying to answer the  
22 question about access. To me, in order to understand that,

1 I have to know a little bit more, I think, about how many  
2 patients they're actually serving. And maybe you then have  
3 to look by state, and in some way get a proxy for how many  
4 decedents there were in a state during a period of time,  
5 Medicare decedents, to kind of get an idea of what kind of  
6 access there is. This really gets layers of an onion, but  
7 that seems to me to be something we want to look at.

8           And I notice that New Mexico isn't in here and we  
9 had an article that was given to us as part of our materials  
10 that said that 29 percent -- according to Palmetto, I guess,  
11 the intermediary, 29 percent of the hospices in New Mexico  
12 were hitting the cap in 2005. And yet, it's not on here.  
13 So I kind of wondered.

14           DR. MATHEWS: The issue there is there are a set  
15 of numbers floating around that are attributed to Palmetto  
16 that do provide these percentages. The issue there is that  
17 Palmetto doesn't necessarily serve all of the hospices in  
18 the states to which they were assigned. So when you look at  
19 all of the hospices in the state, the percentages are much -  
20 - not much different but they are off by a noticeable  
21 amount.

22           MS. DePARLE: Okay, that makes sense.

1 DR. MATHEWS: That said, if I recall correctly,  
2 New Mexico is probably number six or seven on this.

3 MS. DePARLE: So they just fell a little bit  
4 below.

5 DR. MATHEWS: Yes.

6 MS. DePARLE: And you don't have 2006 data,  
7 because I've also heard suggestions that for 2006 it will be  
8 a dramatically higher number. That is plausible, given that  
9 in 1999 or 2000 it was zero and now it's something big. But  
10 I don't know if that's correct or not.

11 DR. MATHEWS: None of the FIs have completed their  
12 2006 cap calculations. Some of them have only just now  
13 started. One of the FIs that I have talked to is  
14 anticipating a significant increase. None of the others are  
15 estimating major changes from 2005 to 2006.

16 MS. DePARLE: Thanks.

17 Glenn, if we are going to take the time, as you  
18 suggested, for really delve into this, I'd be really  
19 interested in hearing from a panel of clinicians about some  
20 of these issues. We've talked about do we really know what  
21 the benefit is? What's being provided? What's ideal?

22 Back when the benefit was first conceived, the

1 notion was six months. I don't know what the right thing is  
2 and it would be interesting to hear -- if we can't do it  
3 here, maybe that could be something the staff would have  
4 time to do at some point.

5 DR. MILLER: If I could say one thing. The  
6 implication of the state table, you were saying we wanted to  
7 know whether people were getting more served? Was that your  
8 point?

9 MS. DePARLE: The question Jim tabled was are  
10 there issues of access to the hospice benefit related to the  
11 cap? And he presented some data to get at that. But I  
12 think I need to know more than just the numbers of hospices.  
13 I need to know what is their census, compare that to the  
14 number of decedents in a state with a certain diagnosis.

15 DR. MILLER: I got that. But Jim, the part you  
16 went through in summary here -- but it's detailed in a paper  
17 -- is the number of people being served; is that correct?  
18 When you went through by demographics, insurance status, and  
19 all that?

20 DR. MATHEWS: That was in the aggregate, but I did  
21 not do that demographic analysis where you looked at  
22 ethnicity and age and insurance status, then further broken

1 down by state and cap/non-cap.

2 DR. MILLER: I got that, but I just wanted to be  
3 clear that at least at those cuts -- and we looked at it in  
4 some detail -- all across the board, increases in the number  
5 of people being served. I just didn't want that point to  
6 get lost.

7 MS. DePARLE: Yes, I got that.

8 DR. MILLER: He blew through it here because it  
9 was too many charts.

10 MS. DePARLE: Yes, it would make sense. There are  
11 more people being served. The question, though, is is it  
12 the right number? Or are people who need the benefit able  
13 to access it? I don't have any reason to think they aren't,  
14 but if we're going to look at that I want to make sure I  
15 have all the information.

16 MS. BEHROOZI: Jim, there's so much information in  
17 here, so I hate to ask for more. But kind of following up  
18 on the subject about margins, you asked the question in the  
19 paper whether -- what are some of the factors that are  
20 driving the reaching of the cap? Could it be an altruistic  
21 desire for patients to have the benefit of hospice care or a  
22 response to profit incentives? And then you make the point



1 later, at a certain point there's a tipping point where the  
2 cap starts eating into the margins.

3           And not even being an economist, I get it, that a  
4 proprietary provider is not going to go into this business  
5 if they don't think they can somehow manage to that tipping  
6 point. So two things I'd like to know. I guess one would  
7 be just a point of information that I might have missed in  
8 the materials. That is what tools do they have to manage to  
9 that tipping point besides patient selection and condition  
10 selection and things like that?

11           And then the second thing is on the data, can you  
12 look at by how much certain types of providers exceed the  
13 cap? Like do proprietary providers just get over the line  
14 so that they don't exceed the tipping point too much and  
15 start digging into the margin somehow better than not-for-  
16 profit providers who might be more altruistically motivated  
17 or something like that?

18           I don't know if that's possible or not.

19           MR. HACKBARTH: And a related question would be  
20 looking at a given provider, do they go across the cap every  
21 year? Or is it a one time event? Any information on that  
22 would also be helpful.

1 DR. MATHEWS: Sure. I can investigate the  
2 question of the tools that providers have to manage the cap  
3 and come back with additional information right now. But at  
4 the moment, short of discharging a patient who is  
5 approaching that payment limit, I think probably they are  
6 very, very careful about who they admit. That might be a  
7 function of their ability to establish relationships with  
8 acute care hospitals and are thus able to have a full set of  
9 clinical information about patients they admit and that sort  
10 of thing.

11 Glenn, I have some preliminary information about  
12 hospices that repeatedly hit the cap, but I will make sure  
13 that's solid before I discuss it publicly.

14 DR. CROSSON: I was glad to see that the chair and  
15 the vice chair can be on different sides of the go for it  
16 issue, given the nature of the issue.

17 But I wanted to step back a bit from the details  
18 and talk a little bit about how broad or how narrow we want  
19 to go. It seems to me that the cap is a mechanism to try to  
20 prevent -- as was said -- the hospice benefit which, when it  
21 was created had a pretty clear purpose in mind, from eroding  
22 into a long-term care benefit. Not that there isn't a need

1 for long-term care, it's just that this is probably not the  
2 way to do it.

3 So it sort of raises the question in my mind is is  
4 there a better tool? Is there a better way? Do we know  
5 anything about better ways to manage this kind of benefit?

6 So I was looking for that in the paper and I found  
7 this sentence that I chose to interpret the way I wanted it.  
8 It says "Given this strong incentive, that is for longer  
9 lengths of stay, the Commission may wish to consider moving  
10 away from a per diem-based system towards a system that  
11 links payment to the resources that an efficient provider  
12 would use to treat a given patient."

13 So that raises the question of whether prospective  
14 payment by diagnosis might at least attack the length of  
15 stay issue. I'm not sure about how necessarily how to get  
16 at the question of the different diagnoses going on here.

17 But I think there's also another consideration for  
18 this that would play into this and I would second what Nancy  
19 said about us, in one way or the other, getting some  
20 information from providers. Because I think, just in my own  
21 experience, that the original notion of hospice that I  
22 remember very well from about 20 years ago is not the notion

1 now. I don't know whether this is -- I think it would be an  
2 overstatement to say this is a change in science as much as  
3 it is a change in the thinking about what dying people need.

4           So now we talk more about palliative care. And  
5 the folks who are the leaders in palliative care have a very  
6 different notion about what's needed for patients,  
7 beneficiaries, than the original hospice movement. So the  
8 hospice movement had the notion that for people you could  
9 determine at some point whether treatment was no longer  
10 going to be of value. And that there would be a cliff and  
11 the person would go into a set of interventions that were  
12 designed to relieve pain and fear and provide comfort and  
13 the like.

14           Whereas, the palliative care movement, which is  
15 gaining a lot of adherence in the country now, is predicated  
16 on the idea that that cliff is really not reflective of  
17 reality. In fact, for many patients anyway there needs to  
18 be a gradual withdrawal of treatment and a gradual movement  
19 towards what we would have considered hospice sorts of care.  
20 And that requires a good deal of flexibility and judgment  
21 and is in conflict, actually, with the hospice benefit as it  
22 currently exists.

1           So I could imagine, depending on how much time and  
2 resources we have, that we would want to take a look at the  
3 hospice benefit, at the payment part certainly, but even  
4 some more fundamental notions about whether the hospice  
5 benefit really now fits with the science or the direction of  
6 care for dying people and whether it needs to be reworked in  
7 some fundamental way. And prospective payment by diagnosis  
8 might be part of that.

9           MR. HACKBARTH: Didn't we have an analysis a  
10 couple of years ago that in a very preliminary way looked at  
11 the relationship -- the potential for using case-mix and a  
12 prospective system?

13           DR. MATHEWS: We did obtain encounter data and  
14 claims data from a large proprietary chain and we contracted  
15 with RAND to analyze that data. They found that there was  
16 no significant relationship between the patient's diagnoses  
17 and their costs that was not wholly explained by the  
18 patients length of stay.

19           DR. MILLER: As I recall, it was somewhat, the  
20 analytical design is somewhat frustrated by the data that  
21 they have and the payment system which was driving a per  
22 diem type of behavior. And then they were trying to look at

1 diagnosis, which didn't really matter to payment. And so  
2 they were kind of coming to that conclusion and saying given  
3 the payment system and the data it's very hard to reach any  
4 other conclusion.

5 DR. MATHEWS: That's correct.

6 DR. MILLER: It was a fair amount of frustrating.

7 DR. CROSSON: I'm not quite sure I followed that.

8 So would that not argue for looking at prospective payment?  
9 What am I missing?

10 MR. HACKBARTH: In my interpretation of this --  
11 and feel free to correct me, Jim, was if you had a hospital  
12 prospective payment system model in your head where you can  
13 say there's a diagnosis and we can set a payment rate for a  
14 patient with a given diagnoses, that they cluster around a  
15 certain number of costs per case, based on the limited data  
16 that we had available to us that pattern doesn't seem to  
17 follow with hospice. It's not diagnosis driven. For a  
18 given diagnoses, you've got a wide variation in the amount  
19 of utilization.

20 And so it's the diagnoses based per case payment  
21 model you've got in your head. Right now the data don't  
22 seem to --

1 DR. MATHEWS: That's correct. The only data that  
2 we would have to develop a case-mix system right now would  
3 be the length of stay associated with each diagnosis and  
4 there is a lot of variability there. So if you were to go  
5 down that track, it would solve both your short stay problem  
6 and your long stay problem in terms of the incentives built  
7 into a per diem payment system. The problems that you would  
8 have to deal with before you could get to that point would  
9 be one, the current distribution of length of stay does  
10 indeed reflect the incentives to provide more care. So  
11 that's the circular aspect that Mark mentioned.

12 The second is you looked at the growth of some of  
13 the non-specific diagnoses in recent years and you would  
14 have to come up with some reasonable controls regarding how  
15 a patient's terminal disease was coded for purposes of  
16 admission to hospice. Is it going to be a chronic heart  
17 failure? Or is it going to be the adult failure to thrive  
18 that dominates for purposes of putting the patient in the  
19 group?

20 Another point is that you'll recall we discussed  
21 last time CMS is beginning to implement a data collection  
22 effort from the hospice providers that would require them to

1 report information on the actual number of visits that they  
2 provided during the course of an episode and the kinds of  
3 clinical staff who conducted those visits. So you could use  
4 that kind of information in conjunction with what you know  
5 about length of stay to begin to fill in some of those gaps  
6 and get to payments based on resource use rather than simply  
7 payments based on a duration of time.

8 But again, that's a little bit off into the  
9 future.

10 DR. DEAN: I guess I just had a question. I was  
11 really struck by the variation in the states. Is there  
12 differences in licensure by states? Do you have any  
13 indication of why there's a tenfold difference in incidence  
14 of hospices per beneficiary in these states as opposed to in  
15 the high versus the low ones? Are there unique state  
16 issues?

17 DR. MATHEWS: The effect of state certificate of  
18 need requirements are, indeed, very significant here. New  
19 York and Florida, for example, as I recall, do have fairly  
20 stringent CON requirements whereas the states that have  
21 extremely high growth do not.

22 MR. DURENBERGER: What is it about New York or



1 someplace like that? Politics?

2 What is the impact of certificate of need?

3 MR. HACKBARTH: Typically you associate  
4 certificate of need with major capital investment, bricks  
5 and mortar, and trying to prevent people from making  
6 investments like that, which will in turn generate  
7 utilization. Hospice doesn't quite fit the traditional CON  
8 model.

9 MR. DURENBERGER: So the question is the flipside  
10 of that is if this palliative benefit is a very valuable  
11 benefit, not just as expressed in Mississippi, Alabama,  
12 Oklahoma, et cetera, but just generally, how can certificate  
13 of need be used against the development of hospice in places  
14 like New York, et cetera?

15 DR. BORMAN: Just to this point, as I recall, some  
16 of this variation was mirrored in the map we had in a  
17 session about long-term acute care. And this distribution  
18 is very similar. And I think it reflects the geographic  
19 variation and the mix of the post-acute resources. And so -  
20 - we have a fair number of people, for example in  
21 Mississippi, that do go to long-term acute, go to these  
22 ventilator specialty hospitals and so forth.

1           One could envision some of that same population  
2 going to hospice because they would have a less than six  
3 month projected life span related to the very significant  
4 inpatient illnesses that they have. So I think, at least  
5 for that West South Central region, that there's a lot of  
6 overlap there and it also reflects that. I can't speak to  
7 the certificate of need piece but I think there is  
8 significant overlap with that map.

9           MS. HANSEN: I think that I was observing some of  
10 the shift. Many of us were part of the whole period of time  
11 when hospice first started and seeing some of the changes  
12 that are reflected here. So I do think that this whole  
13 question of is this turning a little bit more into a two  
14 level program: one in kind of the shorter stay, too week  
15 kind of constant that we've been seeing over time? In fact  
16 -- and I'm not the hospice expert at all -- but I think even  
17 earlier it used to be seven days. So that it's always been  
18 fairly short. And having had a family member who has used  
19 hospice, I know what more of a personal dynamic that often  
20 happens to patients and their families about that.

21           But the longer stay does really speak to the  
22 palliative direction and the fact of people with especially

1 dementia which are really noted in this chart. So defining  
2 what the program has become is probably a very helpful  
3 component.

4           The other thing is, going back to related to the  
5 certificate of need, I just wonder if there's a way as we  
6 look at this to define some of these programs that Nancy  
7 asked, like how big are the programs? Also, are we able to  
8 tease out the difference of hospice beneficiaries being  
9 treated at their own home, as compared to almost a bricks  
10 and mortar type of location?

11           And then third of all, the nursing homes. Because  
12 the other thing about growth -- and again this is just  
13 observation or perception -- it seemed to me that the growth  
14 of hospice of people who are in nursing home locations had a  
15 growth spurt for a period of time. And that was something  
16 that's quite different when you basically use the service of  
17 hospice or the funding of hospice but for people who are  
18 actually residents in nursing homes, as compared to the way  
19 the program used to be in the early 1980s when it was both  
20 in their own personal home or possibly in a small location  
21 where there were beds that were staffed by people.

22           So just understanding the morphology of this over

1 time.

2 And then just getting a sense of cross-relating  
3 that to especially the past five years of growth. That  
4 would be helpful. Thank you.

5 DR. MILSTEIN: This well illustrates our prior  
6 discussion of if only we had better information we could  
7 make better decisions. Along that line, are there any  
8 health services researchers that are examining issues like  
9 impact on quality of life, impact on total Medicare spending  
10 associated with this mix of patients, the subset of patients  
11 that seems to be growing within the benefit? In other  
12 words, the long stay patients with diagnoses not previously  
13 associated with the benefit?

14 If there is any relevant health services research  
15 on the relative patient perceived benefit and an impact on  
16 total Medicare spending associated with the subset of  
17 patients it would probably -- at least personally speaking -  
18 - enable me to make a better vote on this issue.

19 MR. HACKBARTH: I think you told us last time,  
20 Jim, that there have been a number of studies that tried to  
21 look at the total cost for patients receiving hospice  
22 services versus those that don't, and the studies have sort

1 of pointed in different directions.

2 DR. MATHEWS: That is correct, and I did commit to  
3 providing a synthesis of that literature. In my own mind, I  
4 had been thinking it would go well with the margins  
5 discussion when we do start talking about what do hospices'  
6 costs look like, what is the cost benefit analysis. But if  
7 that doesn't play out timely, I can get the other  
8 information to you as a separate package.

9 DR. MILSTEIN: Thank you. It would be especially  
10 valuable, obviously, if that prior research data could be  
11 segmented for the subset of patients that we're thinking  
12 about.

13 MR. HACKBARTH: Any others?

14 DR. REISCHAUER: This is sort of a description of  
15 the cart, and maybe you'll provide the horses later which  
16 will refute what I have to say or suggest that there's some  
17 rationality to it.

18 If you hypothesize that service utilization or  
19 costs per day rise gradually from the point of entry until  
20 death, maybe spike a little at the very end, then the profit  
21 maximizing or margin maximizing point for bringing somebody  
22 into a hospice is the point that produces a length of stay -

1 - an average length of stay that ends you up \$1 short of the  
2 cap. So it's the longest conceivable length of stay you can  
3 have.

4           Now if you're small your ability -- first of all,  
5 the further away you go from the actual point of death, the  
6 less your ability is to predict exactly when that's going to  
7 occur. And the smaller you are, the less ability you have  
8 to use large numbers to average this out and the more likely  
9 it is that you're going to miss and go over the cliff at the  
10 end.

11           So I think the rise in the number of hospices  
12 which are hitting the cap is perfectly consistent and is a  
13 result of the payment incentive structure that we have. And  
14 the question you have to ask, every business there's risk of  
15 making a profit or losing. And in the outside world for  
16 other entities we don't really care how many widget  
17 manufacturers there are. What we ask is are there  
18 sufficient numbers of widgets at an efficient price for the  
19 people?

20           And so what you want to do is look at the places  
21 where significant numbers of hospices are hitting the cap  
22 and ask is there an access problem developing in those

1 areas? Rather than get worried about the individual  
2 hospices going under or having to pay money back.

3 That's the hard-hearted economist analysis.

4 MR. HACKBARTH: Setting aside whether if you  
5 started with a clean piece of paper you would design this  
6 particular payment system and all its features including the  
7 cap, set that aside for a second. What I hear you saying is  
8 that the cap may fall on hospices that tend to be the most  
9 profitable in an industry that right now generally looks  
10 profitable.

11 DR. REISCHAUER: Are trying to be the most  
12 profitable, right.

13 MR. HACKBARTH: Bill, last word and then we need  
14 to move on.

15 DR. SCANLON: Continuing in the hard-hearted  
16 economist theme, there's the issue that we're talking  
17 largely here about revenues. We don't know what the cost  
18 side of this is because an additional day of --

19 DR. REISCHAUER: [off microphone] [inaudible.]

20 DR. SCANLON: I know but I meant I think this is a  
21 real big issue because for two different hospices, an  
22 additional day in hospice does not mean an additional cost

1 of the same amount, at all.

2           So what CMS is doing in terms of trying to collect  
3 information on actual services delivered, to Arnie's point,  
4 is critical to truly understanding what it is that's going  
5 on here and what should be a payment policy. Because the  
6 strategy of adjusting what you do in terms of once someone  
7 is in hospice is a very big part of what might be a coping  
8 strategy with the cap or a profit maximizing strategy.

9           MR. HACKBARTH: Okay, thank you, Jim. More on  
10 this later.

11           Let's see, next is dialysis, creating incentives  
12 to improve dialysis quality.

13           Nancy, you can go when ready.

14           MS. RAY: Good afternoon.

15           In past meetings, we have discussed quality of  
16 care among dialysis patients. We have noted areas where  
17 measures suggest that quality has improved, dialysis  
18 adequacy and anemia status, for example. In other areas it  
19 has not, nutritional status. I'm here today to discuss  
20 practices that may improve dialysis care.

21           As you listen to today's presentation, you may  
22 want to think about the different ways that Medicare can



1 affect the delivery of care. For example, Medicare could  
2 require that providers furnish the service as a condition of  
3 payment. Alternatively, Medicare could measure and reward  
4 providers' performance. Or Medicare could do some  
5 combination of both. We are not asking you to make any  
6 decisions today. This is a first step and we're here just  
7 to gauge your interest.

8           We looked at the potential for services to improve  
9 dialysis quality and efficiency. We started with  
10 nutritional care based on your discussion last year. Some  
11 commissioners raised concerns about the nutritional status  
12 of dialysis patients. We also looked at three other areas  
13 because there is some literature to suggest that the current  
14 state of care could be improved. That includes a vascular  
15 access care, preventive services, and case management.

16           To help us think through the issues here, we  
17 convened an expert panel of 10 medical providers,  
18 nephrologists and a dietitian, who care for dialysis  
19 patients, to get their input. And to be clear, we asked the  
20 panel to focus their discussion around these four areas.  
21 And we also reviewed the literature.

22           So the issue here is that the proportion of

1 dialysis patients who are malnourished is substantial. CMS  
2 data suggests that the proportion of affected patients has  
3 remained relatively constant over time. Patients who are  
4 malnourished are at higher risk of mortality and  
5 hospitalization than their counterparts.

6 Providing adequate nutrition is critical to  
7 prevent and treat nutrition. The expert panel discussed  
8 these four options and I'm going to focus on oral nutrition.  
9 The expert panel thought at least half of dialysis patients  
10 would benefit from oral supplements. However, it is not a  
11 Medicare covered service. The OIG prevents providers  
12 furnishing it for free. The anti-kickback statute prohibits  
13 providers from offering Medicare patients free services  
14 because it could influence patients' selection of a provider  
15 and could affect competition. It could also lead to overuse  
16 and overspending of Medicare covered services.

17 Some state programs do cover oral nutrition.  
18 Patients have to meet a clinical criteria and physicians  
19 have to submit clinical information to the state. It is  
20 also provided in an ESRD demonstration but this  
21 demonstration is ongoing, it is too soon to analyze the  
22 outcome of the participants.

1           There are measures available to identify patients  
2 who are malnourished and to track nutritional status. The  
3 panel talked about using several measures, serum albumin and  
4 change in weight loss and C-reactive protein levels. CMS  
5 tracks serum albumin levels nationally but not by provider.  
6 There is the potential to collect this information via  
7 claims. CMS's proposed conditions for coverage would  
8 require that facilities electronically report certain data  
9 for all patients and one of the measures would be serum  
10 albumin.

11           Moving on to vascular access, the issue here is  
12 that vascular access complications, such as infection and  
13 sepsis, increase risk of hospitalization and mortality and  
14 are costly. Complications are estimated to account for up  
15 to 25 percent of all dialysis hospital admissions annually.

16           There are three types of vascular access: a  
17 catheter, a graft, and a fistula. The fistula is considered  
18 the best for most patients because it lasts the longest and  
19 has fewer complications than catheters and grafts.

20           The expert panel talked about some options for  
21 improving vascular access care. These are up on the slides:  
22 routine monitoring of the vascular access site reduce

1 related complications. CMS reported recently that about  
2 one-third of patients with a graft or fistula did not have  
3 their accesses routinely monitored for stenosis. Some panel  
4 members thought lowering staff turnover would be one way to  
5 improve this aspect of care.

6           Some panelists also thought that having a vascular  
7 access coordinator would improve care. The coordinator  
8 could, for example, coordinate care between the facility,  
9 nephrologist, surgeon, interventional radiologist, and  
10 hospital, as well as provide education to patients and staff  
11 members.

12           The panel agreed that catheter use should be  
13 decreased and fistula use should be increased. Of course,  
14 not every patient may be a candidate for a fistula and it  
15 would not be appropriate for Medicare to require that. CMS  
16 does have a voluntary quality initiative called the Fistula  
17 First to increase the use of fistulas.

18           Measures are available to track the type of  
19 vascular access and complications, including the percent of  
20 patients with a catheter, fistula and graft, number of  
21 related hospitalizations. CMS currently measures vascular  
22 access care nationally but not by provider. And again, this

1 would be one of the measures that is in the proposed  
2 conditions for coverage that providers would have to report  
3 for all patients electronically.

4           There were some unresolved issues from the panel  
5 and these were focused on the measurement and implementing  
6 P4P in this area. There was disagreement among the panel  
7 members about whether payment should be linked to vascular  
8 access care for facilities and physicians treating dialysis  
9 patients. Some thought that facilities and physicians  
10 should equally be held accountable. Others thought that the  
11 physician has a greater role than facilities. Still others  
12 thought that surgeons in pre-ESRD care have a greater role.

13           Specifically to pre-ESRD care, the panel raised  
14 the issue that some dialysis patients -- and these would be  
15 the ones under age 65 -- may have limited access to needed  
16 care until the 91st day after starting dialysis when  
17 Medicare coverage begins.

18           We asked the panel to discuss preventive services  
19 that have a positive effect on patient survival and they  
20 identified two: diabetic foot checks and dental care, as  
21 such services. About half of all dialysis patients are  
22 diabetic. Amputations are common among dialysis patients.

1 Untreated dental disease is linked to poor outcomes among  
2 dialysis patients and is a barrier to obtaining a kidney  
3 transplant.

4           There are some unresolved issues, as well, here.  
5 As the next step we would need to think about with respect  
6 to diabetic foot checks, implementation issues such as who  
7 would furnish the foot checks, the facility staffers or  
8 physician. And how results would be communicated to other  
9 providers the patients see.

10           With respect to dental services, Medicare does not  
11 cover most dental services. As a next step, we would need  
12 to think about the cost and equity in covering services for  
13 dialysis patients and not for other patients.

14           Dialysis patients have multiple comorbidities.  
15 There is some hope that case management might better ensure  
16 patients get needed care and lead to improvements in  
17 outcomes. Both ESRD disease management demonstrations  
18 include a case manager, but again we don't have results from  
19 those demonstrations yet.

20           The panel, in particular, thought that a case  
21 manager might be particularly needed within the first 90  
22 days of dialysis when mortality rates spark. Of course, the

1 measure here would be rate of mortality at three, six, 12  
2 months and beyond.

3 In this discussion about case management, the  
4 panel also discussed the importance of advance care planning  
5 for dialysis patients. CMS's physician quality reporting  
6 initiative includes a measure on advance care planning.

7 So this table summarizes the major issues  
8 discussed by the panel and highlights key issues to consider  
9 in moving forward with nutrition, vascular access,  
10 preventive care, and case management.

11 As you move forward, again you can also think  
12 about the alternative ways to improve care, that Medicare  
13 could require providers to furnish the service and then  
14 measure and report outcomes on a provider level basis; or  
15 Medicare could just simply measure and report outcomes.

16 For nutrition, there would probably have to be  
17 some sort of change of law with this latter approach to  
18 allow providers to give out the cans for free or at reduced  
19 cost. And of course, either approach could be coupled with  
20 P4P.

21 Thank you.

22 DR. CASTELLANOS: Nancy, I think you did a good

1 job on this. I know we had the chance to discuss a couple  
2 of things.

3 One of the issues with this dialysis patient  
4 population is that they are a very unique set of patients  
5 that have significant problems not only related to their  
6 dialysis but to their comorbidities. And for the most part  
7 they are not being seen by physicians except in their  
8 dialysis unit. Even though if you get a care manager or a  
9 case manager, as suggested, and they can make arrangements  
10 for the patient to see somebody or do this, the patient in  
11 reality doesn't have a primary care doctor who is managing  
12 their care. That's the reality. And that's unfortunate.

13 Now the physician in the dialysis center bills  
14 under what they call a monthly capitated payment system. He  
15 or she gets paid for prescribing and monitoring the  
16 outpatient dialysis care. So during the dialysis, that  
17 physician is being paid for and he's monitoring the  
18 dialysis. Unfortunately, what happens is these patients  
19 have multiple comorbidities and are not seeing another  
20 doctor for that.

21 What I'm suggesting is two things. One, and we  
22 had a discussion on this, that one, they allow E&M billing



1 while the patient is in the dialysis center for the non-  
2 dialysis care, or just increase the bundle to provide that  
3 care by the nephrologist. I can tell you that most primary  
4 care doctors -- and I think Tom would agree -- that these  
5 patients are so complex, you don't know which medicines to  
6 put them on, you don't know the dosages of the medications,  
7 and they really prefer to defer that to a nephrologist.

8           It would increase access to care. It would help  
9 quality of care. And it would probably significantly  
10 decrease hospitalizations. For the average patient, they're  
11 admitted about twice a year, dialysis patients.

12           The other issue is a matter of coverages. Now for  
13 a person who's 65, that's not a problem. But for a person  
14 who's under 65, they have to be on dialysis or with chronic  
15 renal failure or some form of treatment for 91 days before  
16 they qualify. And then the physician has to permanently  
17 state that that patient has permanent renal failure.

18           We see a lot of patients -- I deal in dialysis and  
19 I deal with chronic renal failure. We see a lot of patients  
20 that have renal failure based on trauma, based on drug  
21 toxicity, overdose, acute illnesses that we start out on  
22 dialysis. And some of them can get off dialysis a month,

1 six months later. But as soon as they get off dialysis,  
2 they lose any coverage. But they still have significant  
3 residual damage. And these patients still need to be  
4 followed.

5           There's another issue on this I'm going to say in  
6 the same thing. It's very similar to the renal transplant  
7 patients. Once a person is transplanted and is on  
8 immunosuppressive drugs, Medicare covers that for a period  
9 of three years. After three years, Medicare does not cover  
10 those drugs anymore.

11           Now if the patient is 65 and has Part D or Part B,  
12 that's a different issue. But there's a lot of patients  
13 that we transplant that are below age 65. And they lose  
14 this benefit and it can cost up to \$12,000 a year for  
15 immunosuppressive drugs.

16           And so what happens? They stop their drugs, they  
17 reject their kidney, and they go back on treatment, which is  
18 \$75,000 a year.

19           So what I'm suggesting that perhaps some form of  
20 coverage is extended to these patients who were on dialysis,  
21 still have residual care but perhaps if properly managed can  
22 prevent end-stage renal disease and can say off dialysis.

1 And what I'm suggesting is that patients that have had  
2 transplant, perhaps we extend that period a little over  
3 three years.

4 MS. DePARLE: Thanks, Nancy. This is great. If  
5 Sheila Burke were here, she'd say thank you to because, as  
6 you'll recall, we had conversations about our frustration at  
7 the data that you presenting us with on nutrition, in  
8 particular and feeling that we're not really making any  
9 progress. So the next step, I think, is for us to decide to  
10 make some recommendations here. But this is very good work.

11

12 The clinical panel, by the way, Glenn, that's the  
13 kind of thing I was hoping we might be able to do in  
14 hospice. I think that would provide a lot of insight to all  
15 of us.

16 MR. EBELER: Thank you. This was very  
17 interesting.

18 I want to ask about this vascular issue and the  
19 catheter. It strikes me as interesting. It appears, as I  
20 read this, that there are a limited number of conditions  
21 under which that's clinically preferred and that one would  
22 want the other approaches more. It seems to me it's fine to

1 start with the voluntary Fistula First effort in that  
2 situation. But at some point, if we know other things are  
3 more clinically appropriate, and we know that has a higher  
4 complication rate, and we know that has higher costs, why  
5 would we pay it in situations when it's not clinically  
6 appropriate? There's going to be any number of cases where  
7 we just need to say that out loud.

8           So is there an option at some point down the road  
9 to simply say we won't be doing that any more because it's  
10 not good for people?

11           MS. RAY: Fistulas are better than catheters and  
12 grafts. I think what a clinician would say is that there  
13 still may be a minority of patients that, for whatever  
14 reason, may need a catheter. For example, a patient who is  
15 not receiving needed care before getting dialysis crashes in  
16 the emergency room, needs dialysis right away. They have to  
17 put a catheter in. So that is an example, I think, where --

18           MR. EBELER: And I would be totally deferential  
19 for those clinically appropriate situations. But as I read  
20 it, we have a third of the patients on those. It sounds  
21 like the paper is saying there's a lot more catheter use  
22 than is clinically appropriate. At some point we should say

1 we shouldn't be paying for stuff that's not clinically  
2 appropriate.

3 MS. RAY: And that's one way. I guess another way  
4 to think about it is perhaps some sort of P4P and reporting  
5 mechanism could also be looked at as an option.

6 DR. BORMAN: Just to the point of this particular  
7 question, the catheter usage is most often done and most  
8 appropriately done in the acutely changing circumstance, as  
9 Nancy said. This is also driven by some issues of when the  
10 patient presents and what the acuity for the dialysis is.

11 And it relatively seldom rests with the individual  
12 creating the initial access, whether it's by catheter or by  
13 graft. It represents the person who referred them, because  
14 it takes longer for the fistula to mature. And so if a  
15 patient needs dialysis even in a month, the odds of having a  
16 mature official are pretty small.

17 The other thing is that this Fistula First  
18 initiative, while it has all kinds of wonderful things  
19 around it, is also leading to some rather inappropriate  
20 things in that patients are being referred with a demand for  
21 primary arteriovenous fistula who don't have the veins who  
22 are really a candidate for it. Yet when somebody says

1 that's not the thing to do because it's not going to develop  
2 properly, there's this sort of rote insistence on we've got  
3 to meet this percentage DOKI standard and we need to do  
4 fistula first.

5           So you have to be a little bit careful about this  
6 and remember that your dissociating the people making the  
7 decision to refer the patient from the people doing it.  
8 You've got to be careful about who you not pay.

9           DR. CASTELLANOS: There's another issue and it's a  
10 financial issue. Physicians get paid higher for putting in  
11 a catheter rather than creating a fistula. Not very nice.

12           DR. KANE: This is a classic example of what's  
13 wrong with our system, if I can say so, just be blunt about  
14 it. It's fragmented care. The coverage drops at the wrong  
15 moment. It's like the dual eligibles a little bit. If you  
16 try to cure them and they go off coverage, they're going to  
17 be sick again.

18           This is so classic, it makes you want to just say  
19 throw the whole system out and start with universal  
20 coverage. But since we can do that --

21           [Laughter.]

22           MR. HACKBARTH: Do you want to make a

1 recommendation?

2 DR. KANE: I'd like to, but obviously that's not -  
3 - but I guess one of the things as I was starting with is  
4 saying let's not call it a dialysis payment bundle to start  
5 with, and maybe we'll get to the right direction. Call it a  
6 renal failure payment bundle, or even an approaching renal  
7 failure payment bundle. I don't know how you identify the  
8 people at risk but obviously diabetics are one population.

9 This is like where SNPs should be focused maybe,  
10 or a disease management group. To me, this is where you  
11 really want to encourage coordinated delivery systems of  
12 care that involve nephrologists and other physicians, the  
13 surgeon and all the people who know how to take care of  
14 this. This is just obscene what's going on, to me with a  
15 very complicated patient group. Who, by the way, some of  
16 them are emergencies. But an awful lot of these you know  
17 it's coming, especially half of them being diabetic. You  
18 know it's coming. I just can't understand why this wouldn't  
19 be a bundled renal failure -- why we wouldn't try to  
20 encourage our ESRD to be a bundled payment with a  
21 responsible disease management group and not just focused on  
22 them getting dialysis but on their disease and its proper

1 management.

2           So I would just, for a beginning, just rename it  
3 not dialysis payment bundle but renal failure payment bundle  
4 and think about how can we encourage coordinated systems of  
5 care.

6           Like I think Karen was talking about, there's a  
7 lot of coordinated specialized care around cardiac and  
8 maternal care. But why can't we encourage that in this one  
9 program. The one disease Medicare covers automatically  
10 regardless of age is just one of the most unfragmented non-  
11 systems of care I've ever seen.

12           MR. HACKBARTH: What percentage of these patients  
13 were not Medicare patients until they developed renal  
14 failure?

15           MS. RAY: About half are under 65, about half of  
16 all new patients are under 65.

17           DR. KANE: It's kind of like the dual eligible  
18 problem. You don't want them to go on Medicaid so you want  
19 to see them coming. Medicare would be better served to say  
20 if this person is at risk if they're under 65, enroll them  
21 and we'll pay for it. Because it's pretty clear that they  
22 crash into your system and they're going to get the



1 catheterization, they're going to get fragmented, they're  
2 not going to get the right drugs. This is insane.

3 We've got to look beyond our borders just to do  
4 what's humane in the hospitalization rate.

5 I don't know, is there a way to detect these  
6 people in the general -- I'm sure there is -- in the general  
7 population before they have total kidney failure and 91 days  
8 of -- who thought of that, 91 days of dialysis?

9 MR. DURENBERGER: A health service researcher or  
10 an economist.

11 [Laughter.]

12 MS. RAY: Just two follow up points. I can come  
13 back to you but there are ways for screening patients who  
14 are at risk. There are five stages of kidney disease. I  
15 won't bore you with that. But there are ways of screening  
16 patients. That's the first thing.

17 The 90-day waiting period, I think its intent was  
18 to ensure that the person is truly -- requires maintenance  
19 dialysis and not as an acute patient.

20 DR. KANE: But given what Ron just said, it  
21 doesn't seem to be doing that. I'm just wondering if it's  
22 not costing us more to wait 91 days to create a package of

1 services that keeps the Medicare quality up and costs down,  
2 even if they're not chronic forever, because you don't want  
3 them to be chronic forever. But they may need to be -- have  
4 a chronic disease management program forever.

5 MS. THOMAS: Just to add, not surprisingly, we've  
6 had a whole parade of SNPs coming through our offices and  
7 there are indeed SNFs that are targeted toward the ESRD  
8 population.

9 DR. BORMAN: Just a couple of quick things  
10 unrelated to the vascular access. One is that my  
11 recollection at being at the CPT Editorial Panel when things  
12 were brought forth about the CPT codes for dialytic care,  
13 that it was presented to us as a comprehensive service, not  
14 payment to monetary dialysis.

15 So I think that the panel we were under the  
16 understanding that what was being proposed was, in fact,  
17 comprehensive primary and secondary, tertiary -- whatever  
18 you want to call it -- care for these individuals. There  
19 could be some value to going back to the CPT Panel minutes,  
20 to the service descriptions provided to the RUC and other  
21 places because, with all due respect to the panel -- and I  
22 think you've presented them well -- that you convened, and

1 that was a great idea, I think there may be some reasons  
2 here to have sort of a selective view of history on this  
3 one. And there might be some clarity offered from the past.

4 Another piece of this relates to the management of  
5 infections, for example. There's a certain piece here that  
6 is patient dependent, that is the patient who has an early  
7 sign of vascular access infection and doesn't come to see  
8 anybody. So there is an uncontrollable piece of this.

9 There is also, in relation to whether it's the  
10 center or the physician or who it is, the surgeon who placed  
11 it, I think everybody has some responsibility. And how a  
12 dialysis technician sticks a fistula, puts in two fairly  
13 good sized needles, their devotion to prepping the site and  
14 how they care for it certainly influences the duration of  
15 the access. This is a multi-factorial problem.

16 My last comment I'd just like to touch on the  
17 nutrition piece here. I think that there are lots of good  
18 data out there that relate to the relative unsophistication  
19 of albumin as a measure. And I'm fascinated that this came  
20 up. I would be willing to speculate that it might not be  
21 possible to get an end-stage renal disease patient to a  
22 normal serum albumin level, even with the best medical

1 efforts and infusion of lots of albumin, because of their  
2 underlying disease. It certainly will relate to whether  
3 they have a protein losing nephropathy or not.

4           So while I support the nutrition is a factor here,  
5 I think that these measures that are being suggested are a  
6 ways away from being mature enough to incorporate as the  
7 foundation for any kind of policy recommendation.

8           MR. HACKBARTH: Others?

9           Nancy, I've been sitting here thinking about your  
10 comment, and it's a powerful one and resonates with me, and  
11 I suspect others. My understanding is actually that the  
12 current debate about this is deferring Medicare eligibility,  
13 pushing back eligibility and that's being actively  
14 discussed. I've heard from some employers who are very  
15 concerned about it.

16           MS. RAY: Right. That would be specifically for  
17 people who come into the program with employer-based  
18 coverage. That's right.

19           DR. KANE: Wouldn't you want to reverse that and  
20 say I'll tell you what, let Medicare take it over, put them  
21 in our own disease management program, and then do  
22 coordination of benefit with the employer for what they

1 would have paid otherwise. And you'll save money. It seems  
2 like you would save money and improve the quality of care  
3 than to try to shove something back onto an employer who may  
4 or may not have the proper coverage or disease management  
5 relationships. It just doesn't seem like it's working.

6 MS. BEHROOZI: Just on that, and not only would it  
7 save money for Medicare but overall, because Medicare pays a  
8 third of what private payers pay for the very same services.

9

10 MR. HACKBARTH: Okay, thank you, Nancy. Well  
11 done.

12 We are to our last one for today, delivery system  
13 reform.

14 I think David and Jeff have been anchors now a  
15 couple of meetings in a row here.

16 MR. GLASS: And tomorrow, as well.

17 MR. HACKBARTH: That's because we can count on you  
18 to bring it home strong.

19 MR. GLASS: That's one way of looking at it.

20 We're thinking of adding a chapter to the March  
21 report with ideas for improving program sustainability  
22 through payment and delivery system reform. The first

1 chapter of the report would be our traditional context  
2 chapter and this new material could follow the context  
3 chapter and present MedPAC's direction for delivery and  
4 payment system reform.

5           We want to know if there's consensus on these  
6 goals for reform, and the basic goal is to improve program  
7 sustainability. The evidence that the current system is  
8 unsustainable will be developed in chapter one and then the  
9 program -- and the basic evidence is the program is spending  
10 more but not getting better quality and taxpayers and  
11 beneficiaries will not be able to afford the program as it  
12 consumes an ever growing share of GDP and the Federal  
13 budget.

14           We would then develop, in chapter two, why solving  
15 that problem is going to require a change to more efficient  
16 delivery systems and why that means, in turn, we need  
17 fundamental changes to the Medicare payment systems to  
18 create the incentives for changes in the delivery system.

19           Even if reform increases quality and reduces cost  
20 growth substantially, sustainability could still be a  
21 problem. Other changes to Medicare financing or benefits  
22 might still be necessary but they're not the subject of this

1 briefing. So we're going to discuss some approaches for  
2 payment system reform but bear in mind that these are  
3 exploratory and will undoubtedly have been issues that would  
4 need to be worked through in the future.

5 This is the big picture for a long-term direction  
6 of payment and delivery system reform that we'd like you to  
7 consider. We're now in the first column, under current fee-  
8 for-service payment systems. The basic problem with all  
9 fee-for-service systems is that they reward increasing  
10 volume, although to varying degrees. In general, if you do  
11 more you get paid more. Also, because they're distinct and  
12 separate, there's a problem coordinating across payment  
13 systems.

14 The Commission has recommending using the tools in  
15 the middle column to try to overcome some of the problems in  
16 fee-for-service systems. A comparative effectiveness entity  
17 to give providers and payers information on what works best,  
18 pay-for-performance programs within existing fee-for-service  
19 payment systems to reward higher quality providers,  
20 reporting resource use to inform physicians of the  
21 consequence of their practice patterns and how they rank  
22 relative to their peers. And bundling of individual

1 services within a payment system, as is done using diagnosis  
2 resource groups in the inpatient PPS. That's to encourage  
3 efficiency within the bundle.

4           However, there are two important limitations to  
5 these tools. First, the marginal reward may not be  
6 sufficient to overcome the incentive for more volume in the  
7 fee-for-service system. A 2 percent quality bonus won't  
8 drive someone who is seeing five patients an hour to seeing  
9 only three.

10           Second, working with individual systems inhibits  
11 changes into the delivery systems that either cross borders  
12 or extend over time. For example, as Dr. Kaplan from  
13 Virginia Mason discussed with the Commission, physical  
14 therapy may be less costly, more effective, and provide  
15 greater patient satisfaction than an MRI for back pain but  
16 right now there's no reward for that substitution.

17           So we're exploring three approaches for overcoming  
18 these limitations. They pay for care that spans provider  
19 types and time, and hold providers accountable for quality  
20 and resource use.

21           These are potential approaches, and the first  
22 proposal would be to establish medical homes which would



1 emphasize primary care and increased care coordination.

2 These are two areas the Commission has encouraged in the  
3 past. Physicians wanting to be designated as medical homes  
4 would have to have some level of IT and means to provide  
5 care coordination, either within the practice or under  
6 contract. Looking over time, the goal would be to maintain  
7 patient's health and thus reduce unnecessary admissions.

8 One tough issue is whether beneficiaries should be  
9 required to opt into the medical home and possibly be locked  
10 in for some services. Many issues would have to be worked  
11 out, as we discussed in the June 2006 report.

12 Physician-hospital bundling would combine DRG  
13 hospital payments and inpatient physician payments into one  
14 payment. This would emphasize cooperation between hospitals  
15 and physicians who do inpatient work and increase efficiency  
16 during a hospital stay. It would be triggered by a hospital  
17 admission but could be extended to include a post-discharge  
18 period, readmissions, and possibly post-acute care.

19 So Anne presented several options for bundling  
20 earlier today. As she mentioned, one of the problems is it  
21 does not change the incentive for more bundles.

22 The broader concept is the accountable care

1 organization. That would be groups of physicians and  
2 possibly a hospital as well that would take responsibility  
3 for a population of patients for a broad services over some  
4 period of time or episode. They would be held accountable  
5 for performance and quality and resource use for that  
6 population and have an incentive to control volume. Payment  
7 could be fee-for-service with some add-on or possibly some  
8 form of capitation or even a virtual system. Of course,  
9 this would present many difficult issues of its own.

10           The goal of all of these approaches is increasing  
11 value for the Medicare program, its beneficiaries, and the  
12 taxpayers. The means is creating payment system incentives  
13 for providers that reward value and encourage closer  
14 provider integration which, in turn, would make the use of  
15 tools such as P4P even more beneficial. Each of these  
16 proposals will present many thorny issues to be resolved and  
17 will require careful consideration of unintended  
18 consequences. Nonetheless, because of the potential these  
19 proposals have to improve quality and reduce cost growth we  
20 think they may have value.

21           Jeff is now going to discuss the related issue of  
22 how physicians and hospitals might come together in response

1 to payment changes and what we will have learned from past  
2 experience.

3 DR. STENSLAND: There was a great deal of  
4 integration of physician and hospitals at different levels  
5 in the 1990s, we wanted to take a look at that experience  
6 and see what happened in the 1990s.

7 First, by bundling physician and hospital  
8 payments, as well as forming an accountable care  
9 organization, either of those are forms of payment  
10 integration. By tying physician and hospital payments  
11 together, Medicare would encourage new forms of physician-  
12 hospital entities. This could come in the form of  
13 employment to physicians, it could be a PHO, it could be in  
14 the form of doctors owning the hospital. All of these  
15 physician-hospital entities would be more attractive under a  
16 system of bundled physician and hospital payments.

17 During the 1990s, some physicians and hospitals  
18 successfully integrated their finances and their clinical  
19 processes. For example, many of these integrated systems  
20 now use a common electronic medical record. However, in  
21 other markets the physician-hospital organization collapsed  
22 as physicians and hospitals could not agree on how to share

1 payments. In another set of markets, we find some  
2 physician-hospital organizations survived but they had  
3 financial integration but they failed to ever really have  
4 much clinical integration.

5 To get physicians and hospitals to jointly focus  
6 on the quality of care delivered, we also may need to tie  
7 payments directly to outcomes. This is, as Anne said  
8 earlier, we might need have some sort of P4P program tied on  
9 to either the ACO or the bundling of payments.

10 If Medicare moved to a bundled payments or ACOs,  
11 we would probably see a diverse range of physician-hospital  
12 relationships spring up across the country. As we saw in  
13 the 1990s, some would be harmonious but others would be  
14 contentious. As Anne talked about earlier, the challenge is  
15 to get the physicians and the hospitals to work together and  
16 to really focus on creating value for the patient.

17 We now want to hear your thoughts on whether we've  
18 listed the right goals for payment and delivery system  
19 reform. First, we understand there is some consensus to  
20 improve efficiency and sustainability by promoting the tools  
21 you recommended. These are the first bullets we have at the  
22 top of this slide. Those tools being comparative

1 effectiveness, pay-for-performance, and measuring and  
2 reported resource use.

3           But the next question is whether you agree and  
4 whether there is consensus that new approaches are needed to  
5 integrate care across provider types and across time? And  
6 if so, how do you think we should continue to explore these  
7 three types of ideas such as the medical home, physician-  
8 hospital payment bundling, or ACOs. These approaches are  
9 not mutually exclusive. You may want to implement two or  
10 more approaches simultaneously. For example, as Anne said  
11 earlier, physician-hospital payment bundling creates an  
12 incentive to increase admissions. Therefore, you may want  
13 bundling to be accompanied by a counterbalancing incentive,  
14 such as the medical home or an ACO, which have a built-in  
15 incentive to constrain admissions or to keep the patients  
16 healthy enough so they don't have to go to the hospital.

17           Now we'd like to open it up to hear your thoughts  
18 on whether we have the right direction there for Nancy's 10-  
19 year plan.

20           MR. HACKBARTH: Before we leap into the specific  
21 comments, let's just spend another minute refreshing our  
22 recollection about why we're doing this and the context.

1           At the retreat we agreed that we needed to sort of  
2 thing longer term and outline a longer-term vision or  
3 strategy for how not just Medicare but maybe the broader  
4 system needed to evolve over time. And then consistent with  
5 that long-term direction, work through with the more  
6 specific details on how you take steps down that path.

7           And so the role of this paper, this chapter, is to  
8 lay out that longer-term vision, provide some examples of  
9 changes that might be consistent with it -- namely bundling  
10 and ACOs and medical home -- and then on a separate track,  
11 earlier today, we started to delve into the details around  
12 bundling and how you might actually do that and make it  
13 work.

14           So we did the detailed discussion earlier today on  
15 one of the issues. Now we're sort of stepping back and  
16 trying to think more high-level about the messages that we  
17 want to send to our large audience. So that's the context  
18 for all of this.

19           DR. KANE: First, I just wanted to modify my 10-  
20 year plan concept, which is I think it will take 10 years to  
21 get something good in place. But the question is how you  
22 get there? One way is to try to do things sort of in year

1 one, two and three, that actually could stop you from  
2 getting to year 10 because they're just rushed or they're  
3 not thought through or they're counterproductive.

4           That's why I was heading towards demonstrations  
5 and single episodes and not wholesale change until you  
6 really have a lot of research out there on how to do it  
7 right. So I kind of feel like we need to think where do we  
8 really want to be in 10 years? And how do we back up and  
9 get there? Rather than say how do we create risk adjustment  
10 for a hospital stay plus 15 days out, which may not be where  
11 we went to end up. We may want to end up that it's the  
12 episode in its entirety that we want to pay on the basis of.  
13 And so how do we get here? And then demonstrate and do  
14 research to get there in a way that makes sure that when  
15 we're there, it's the best possible system and hasn't gotten  
16 stopped along the way because we did something that just got  
17 such push back the way we did in the mid-90s that the whole  
18 thing kind of collapsed, like managed care.

19           I guess my point is a 10-year plan, I think,  
20 should have a big upfront investment in trying to understand  
21 where do we want to be in 10 years and how do we get there,  
22 not how do we get through the next three years trying to do

1 incremental things. In my mind. That's one topic that  
2 perhaps it would be great to talk about.

3           The other thing is on your questions for  
4 approaches, I would add a fourth bullet point, is how to get  
5 the MA plans to lead the way. Because right now they are  
6 not doing what they should be doing. Private fee-for-  
7 service does not take us in the direction we want to go.  
8 I'm not even sure the MA plans that aren't private fee-for-  
9 service are doing anything other than paying fee-for-  
10 service, especially with what's going on in terms of the  
11 excess payment. So I would add a fourth bullet, how do we  
12 make the MA plans lead the way since they are theoretically  
13 better organized than the traditional unmanaged system to  
14 create the kind of change we want to see?

15           MR. DURENBERGER: My friend on my right said why  
16 did we save the best for the end of today, the most  
17 challenging? But I think we were right when we said this is  
18 a really important thing for us to do this year. We're even  
19 more right in the context of the fact that a lot of  
20 politicians are talking about this for 2009.

21           As long as I have been involved, that even  
22 precedes going into the United States Senate way back in



1 1978, I've been looking for a book or a chapter that was  
2 entitled delivery system reform. Everything I've been  
3 involved in as, in one way or another, been delivery system  
4 reform. We did all of the rate setting, the regulatory  
5 approaches, when we did the price regulation, and we've done  
6 behavior modification, and managed care organizations. And  
7 it's all about changing behavior, which is basically what  
8 delivery system reform is all about.

9           So in a sense the title here, or even the vision  
10 that you spoke to, needs to be followed by something more  
11 than medical home, accountable care organization, and  
12 bundled payments.

13           And I think it needs to start with a set of goals  
14 that are perhaps a little bit broader or more definitive of  
15 the program's obligations to 43 million of us and the people  
16 that will follow us. And so if we express it in terms of --  
17 I think we would start with improving access, quality,  
18 effectiveness, productivity, those kind of things because I  
19 know that's how we want a delivery system to do. And we  
20 follow that -- I would suggest we follow that -- and I don't  
21 have the right words -- but the best way to change behavior  
22 in this system is to reincentivize all the professionals

1 that are in the system. That then gets us to what you have  
2 to do to change the financing in order to provide that.

3 But I remember old Walt McClure, way back before I  
4 ever thought about politics, saying that the U.S. medical  
5 system is remarkably inventive. And if you just point it in  
6 the right direction it will take you where you want to go  
7 better than any other business or industry in this country.  
8 It is a very unique profession and everybody that goes into  
9 this is very, very different. In theory, we've never  
10 captured that.

11 So anyway, I like that as a way in which to phrase  
12 the second goal because everything we talk about here is  
13 about how do you get the right incentives to get the kind of  
14 behavior that you want?

15 And then only thirdly would I come to  
16 sustainability, I suppose, and those kinds of issues. But  
17 that's about as far as -- I want to suggest because we are  
18 at the end of the day, I just think that if, in fact, we're  
19 going to continue with that chapter and we're going to try  
20 to get people to read about something more than things  
21 they've already heard about, that setting those goals in  
22 that way for what we want to follow in terms of financing

1 reform and things like that -- and I'm not saying we don't  
2 include the tools that we've been talking about. I'm just  
3 saying I'm just fearful, looking at this, that way we are  
4 missing an opportunity presented by the title and a lot of  
5 the other things that we would like to do there.

6 MR. HACKBARTH: I hear Dave and Nancy, in ways,  
7 saying something similar with a little different emphasis.  
8 What it sounds like to my ear is there's not enough careful  
9 thought to the buildup. We're sort of too quickly getting  
10 to some solutions without laying out more systematically  
11 here are the goals, here are the barriers that we see  
12 between us and achieving those goals, here are the sort of  
13 things that need to change in the system if we're going to  
14 be better able to achieve the goals. And then you talk  
15 about payment and other innovations that will help get you  
16 there. So it's a little more systematic buildup.

17 DR. KANE: Some of which we don't how they will  
18 work out in practice, so we need to try them out before we  
19 implement them in full.

20 DR. WOLTER: I just wanted to sort of reemphasize  
21 your introduction from my perspective. I think that, as I  
22 now am in my sixth year on this commission, and I watch how

1 health care policy evolves, there is really a pattern of  
2 annual responses to sort of the latest stuff or who now is  
3 in Congress and who isn't. And it's frustrating actually,  
4 to me. And I think that if you want to look at some of the  
5 things that have to happen, if we're going to fundamentally  
6 be able to deliver more value to beneficiaries, certainly  
7 the delivery system issues are very high on the list because  
8 of the fragmentation and lack of coordination, especially in  
9 those high volume-high cost areas. So obviously, I'm a huge  
10 supporter of laying out some principles that I hope we would  
11 go back to over and over and over again over 10 or 15 years.

12           That would be a huge contribution because  
13 generally speaking that's been hard to do in the evolution  
14 of health care policy just because of the way our democracy  
15 works. So I think that has a lot of value.

16           I think implicit in what Dave said, the delivery  
17 system, as Jay Crosson has said, delivery system matters.  
18 And when you have an organized delivery system, you have a  
19 chance to place some accountability in a different way than  
20 when you don't. And so that would be a major thrust,  
21 obviously, of what we'd want to do.

22           In the SGR report, if you eliminate the discussion

1 about the SGR itself, there were lots of other good things.  
2 Those had to do with pricing reform, evolution of pay-for-  
3 performance perhaps, so that we had system-level  
4 accountability as well as individual accountability,  
5 clinical effectiveness. I think there are some things in  
6 policy now that lead us in the direction of more  
7 fragmentation. Those would have to do with conflict of  
8 interest issues, hospitals doing joint ventures with  
9 physicians, which drive volume. And I think if we could  
10 address some of those things, as well, in terms of  
11 principles that would be good.

12           The regulatory reform issues that we mentioned  
13 earlier would be on the list of something that's going to  
14 take a long time. We talked about medical education. Is  
15 there training going on about quality, team play, system  
16 approaches to quality?

17           There's kind of a list that's maybe even a little  
18 more robust in a way than what's in here, I guess, and do we  
19 want to think about that as if we do want a framework that  
20 we could go back to over and over again over the years.

21           And then we all define our sort of mental model  
22 about tactics, I suppose, based on our life and professional

1 experiences. I would hate to get caught up in the analysis  
2 paralysis of a few more demos until we learn how to do  
3 something. And I really worry about that, Nancy, terribly.

4           Having said that, obviously we can't design this  
5 thing and launch it and make everybody do all the same  
6 things in a very short time period. That's clearly not ever  
7 going to work. And most transformational change does evolve  
8 out of current circumstances. I've sort of been interested  
9 over the years in complexity theory and how it applies to  
10 organizational development. And I think that in that you  
11 try to find where are the butterfly wings? Where are the  
12 trim tabs? What are two or three or four or five things we  
13 could do that are major signals that the world is going to  
14 be changing in terms of how we deliver health care in this  
15 country? I think some version of episode bundling would be  
16 one of those. And it will take five or six or seven or  
17 eight years to really work that through.

18           The pricing changes are another thing. What other  
19 disruptive innovations might there be that are practical but  
20 start to move this along?

21           And then of course, we can't design with perfect  
22 knowledge how this will look in 10 years. But we certainly

1 can start putting some things in place that will make it  
2 more likely than not that the evolution of this will lead us  
3 to a better place even though some of that is unpredictable  
4 today. But I think it takes persistence. Persistence is  
5 hard to come by in a political system where the  
6 environmental stuff changes so often. And if you can only  
7 imagine change around what currently exists, then you aren't  
8 going to have something different in five or 10 years.

9           So I'm obviously very supportive of this. I think  
10 it would be a huge contribution as the Commission continues  
11 to try to build on principles in the years ahead.

12           DR. CROSSON: I support this direction. I also  
13 support the notion of perhaps framing the issues better  
14 before we get to the -- I mean, for me it flows from the  
15 charge that we're given long-term. The charge, at least  
16 what I have in mind, is to try to improve the quality of  
17 care to beneficiaries and over time the sustainability of  
18 the program. That's the starting point.

19           I think a lot of the discussion we've had in the  
20 three-and-a-half years I've been on the Commission now  
21 suggest that there are two things -- at least two things  
22 missing that are obstacles to that. One is the lack of care

1 coordination that is inherent in the delivery system we have  
2 for most of the country.

3 And the second one, which relates more closely to  
4 the Medicare program, is the lack of incentives for  
5 appropriateness of care which is sort of the other way of  
6 saying inappropriate volume. Those are two things that if  
7 we could change would more likely get us to the goals, to  
8 the first two goals.

9 Now as we look at the notions here that we've got  
10 at the moment, I think you could argue that each one of them  
11 does it. I think they do it in ascending order of  
12 likelihood to promote care coordination and appropriateness  
13 of services. I think even in the presentation that was  
14 clear.

15 If you look at the impact of the medical home, I  
16 think that is a level of care coordination. It doesn't  
17 really, to me, extend much beyond the primary caregiver.  
18 But at least it is some care coordination.

19 The impact on appropriateness is probably limited  
20 to the improvement in volume of services related to quality  
21 improvement, which is what I think we said. And I agree.  
22 When we looked and we talked a lot about it earlier today,



1 the physician-hospital payment bundling issue, does then I  
2 think create incentives for coordination between some  
3 physicians and the hospitals. And it may have an impact on  
4 appropriateness of services by reducing inappropriate  
5 readmissions, which I think you also stressed.

6 But I think it's later, when we get to the idea of  
7 fully integrated organizations, integrated clinically and  
8 financially, that we get closest -- let me just say  
9 integrated clinically and financially combined with  
10 appropriate payment incentives -- that we get closest to a  
11 model or a set of models that drive care coordination and  
12 appropriate services.

13 And then I would just make one point about the  
14 paper in terms of describing the physician-hospital  
15 relationships. I think that I don't completely agree with  
16 describing this as a dichotomy between the PHO model on the  
17 one hand and physicians working for the hospital as  
18 employees of the other hand. Because I think it's likely,  
19 in the end, that we would end up ideally with something  
20 different. Because actually the model that you have, the  
21 dualistic model, doesn't describe my own organization  
22 because we're neither a PHO in the way it's described nor

1 are the physicians employed by the hospital.

2           When we actually have is a model of joint  
3 accountability and, to some degree, joint governance, joint  
4 responsibility for services. And I would think, I would  
5 hope, if it's actually going to work in the end that  
6 somewhere in the middle there needs to be a third model.

7           MS. HANSEN: I just would say basically for the  
8 bulk of the comments on the other side of the table I just  
9 would really both concur and ditto in capital. Because I  
10 think some of the things about the framing have been said.

11           The key words that I just would like to just  
12 triple ditto onto are the ability to say at the end of it --  
13 I think, Jay, you said it specifically -- it's about what's  
14 going to make a difference of having Medicare funding  
15 produce care for Medicare beneficiaries? And then from a  
16 financial standpoint what's going to make it sustainable?  
17 It's really almost as basic as that. If we can really put  
18 it at that high level, what is it going to take over 10  
19 years to do this?

20           The things that have been said, I concur. I would  
21 also just add one more than I didn't hear quite as  
22 explicitly stated, and that is the ability for all of our

1 care deliverers -- be they physicians or other staff -- have  
2 the competency of geriatric knowledge, which is not  
3 something that has been stated. And it's been again tossed  
4 around a bit when we talk about GME in the past.

5 But I'd really like to elevate that because I know  
6 there's all the specialty knowledge and people think that by  
7 virtue of the fact that you're dealing with elderly complex  
8 people, you know geriatrics. But people who understand the  
9 issues of complexity, of care coordination, and just how  
10 quickly people turn who are fragile individuals -- be they  
11 skin ulcers or dehydration.

12 There is a body of knowledge and increasingly  
13 maybe a body of science that really needs to be taught  
14 early. And it's hard for faculty who don't understand this  
15 and don't practice this to be the teachers of future  
16 generations. I just want to bring that, that if we're  
17 talking about preparation there's a content piece to people  
18 who are living longer, growing older. Again my theme of the  
19 fact that 85-plus age people are the fastest growing number  
20 of people. So there is a body of knowledge that we should  
21 really ask for some accountability for.

22 And then also, just the ability to understand

1 quality improvement and process improvement. I think it was  
2 brought up but that's something that is not taught in any of  
3 the professional schools and appreciated relative to  
4 delivery system improvements.

5           And then finally, as all these comments are being  
6 said, some of you know that I come from a 25-year history of  
7 a program that has actually even taken the anathema of  
8 bringing together Medicare and Medicaid coupled with  
9 changing the financial incentive system as well as the  
10 delivery system. Somebody said it takes patience and it  
11 really does. And people say that was -- and I'm just,  
12 frankly, glad that I had a personal opportunity to go  
13 through that needle in a haystack of timing because it was a  
14 very hard thing. People ask why does it happen? Why isn't  
15 it kind of replicated all over?

16           Basically, it's asking for changing the DNA of the  
17 way care might be provided to individuals in this category.  
18 So it does mean some really systemic issues of change that -  
19 - I've used the phrase of culture change in a way that's  
20 hopefully not taken lightly. But it does take that. It  
21 takes the 10,000 miles of doing this. And hopefully as a  
22 Commission and as a statement of being responsible for the

1 Medicare quality and solvency, that we really acknowledge we  
2 just have to really do some fundamental rethinking about  
3 this.

4 Much like, Nancy, you said earlier, and we all  
5 appreciated with both humor. But the reality of it's not  
6 just about dialysis. It's really about a system.

7 So however we can take that leadership role in  
8 this commission to do this, let's frame it, let's say that  
9 this is a long road and we do need a map to get there.

10 So that's my only major exhortation in the process  
11 of having this opportunity.

12 MR. BERTKO: Okay, my turn to be a contrarian.

13 First of all, I think we need the chapter again.  
14 But like Nick, I think we've said nearly everything we need  
15 to say about how to do it in principles in the SGR report.  
16 So the contrarian part says why don't we just become  
17 explicit? One part of that would be saying we need a carrot  
18 and a stick. The carrot is financial, you make more money  
19 if you do something right. The stick is you're stuck  
20 forever in SGR hell, whatever you turn that out to be.

21 [Laughter.]

22 MR. BERTKO: The second part is we're all smart

1 people, I enjoy listening to this. But frankly, we're not  
2 going to solve the problem.

3           And so my second suggestion is we ought to create  
4 -- and Nick will probably cringe at this -- a delivery  
5 system demo czar. And then let that go out and have a whole  
6 bunch of demos that are doing all kinds of things, from ones  
7 like Jennie's to Nick's to we heard the person up in  
8 Connecticut. And put a timeline on there, a recommended  
9 timeline, and say in five years we're going to choose a  
10 couple of days and it will be over. So just to try to get  
11 things kicked off and get done.

12           Probably impractical but again, anything we say  
13 that would be explicit about getting the fix started I think  
14 would be useful.

15           DR. MILSTEIN: The nice thing about going last is  
16 you just get to reinforce prior great comments.

17           I agree with this idea of getting clear on what we  
18 think success would look like and then working back, with  
19 Nancy's idea.

20           As I listened to what we've read about, at least  
21 in the last three years I've been here, the vision that we'd  
22 be trying to reverse engineer would suggest on a one-time

1 basis about a 35 percent reduction in spending, all other  
2 things being equal. That's if you believe Elliott Fisher  
3 and evidence of differences in production costs among  
4 providers for those services that are valuable. About a 40  
5 percent improvement in quality reliability, using adherence  
6 to evidence-based medicine as one of your indices. And  
7 about a 10 point jump in patient experience. We're now  
8 running, for most things, in the low to mid-80s. So at  
9 least 10 points higher.

10           And then how do you get there? I'm going to steal  
11 one of Jay's comments from a couple of sessions ago. It was  
12 sort of like look, the way that the laws work in the United  
13 States of America is the physician's pen governs 85 percent  
14 of the resource flow. And physicians also happen to have,  
15 by far and away, the most influence on patient behavior.

16           And so the first step in reengineering this is  
17 thinking about how do you create a psychological environment  
18 around physicians such that every day when physicians get up  
19 in the morning, of the three things that are on their worry  
20 list -- because most people don't have more than about three  
21 things on their worry list -- is the question of what  
22 innovation might I test in care delivery today that might

1 reduce total spending and improve quality and patient  
2 experience tomorrow? Right now that is not what's on the  
3 minds of physicians when they wake up.

4           And how what might we get there? This is now, I  
5 guess, a summary of prior comments made. First, we'd need  
6 to make provider payment, medical education payment, and  
7 insurance plan design much, much, much, much sensitive to  
8 superior clinical outcomes and conservative resource use.

9           We heard testimony about two years ago, I think  
10 from Sam Nussbaum and somebody from the hospital industry,  
11 saying what is the minimum amount of total physician and  
12 hospital comp that would have to be very exquisitely tied to  
13 performance on resource use and quality if you wanted to see  
14 major movement? I think the answer was no less than 10  
15 percent of total physician comp, not Medicare but total, and  
16 at least 2 percent of total hospital comp. Well, we aren't  
17 obviously anywhere near that in any of our recommendations.

18           The same with benefit design. In other words, I  
19 don't think that the payment lever alone is enough to cause  
20 that change in environment around our clinicians. I think  
21 we would also need patient flow to begin to tilt toward  
22 better performing providers to really be assured of reverse



1 engineering what we're looking for.

2           And then the second thing we would need is -- and  
3 I realize this is extremely controversial and difficult but  
4 I might as well say it -- is much, much better coordination  
5 between Medicare program incentives and incentives of other  
6 payers in the United States. If we're going to tolerate a  
7 Balkanized payment system, Federal laws govern these other  
8 plants, things like ERISA. You'd have to get more  
9 orchestration, as we recommended in principle. We'd have to  
10 get, I think, more specific about it.

11           And second to last, we'd need -- and this  
12 reinforces John's point. We need much faster knowledge  
13 turns in our payment innovations. In other words, right now  
14 the rate at which we test and then make judgments about  
15 payment innovations and benefit design innovations is  
16 exceedingly slow, nowhere near fast enough for us to  
17 continuously come up with policies that would drive towards  
18 that kind of a radically improved outcome. In other words,  
19 our rate of testing is just not fast enough.

20           And last but not least, and this gets to the  
21 earlier debate we had, is I think we would need much greater  
22 tolerance of policy failure. Right now, I won't repeat the

1 prior discussion but is it broken? Or is it not broken? If  
2 it's broken, I think it tilts you in favor of taking more  
3 risk with current payment policy. Whether you think it's  
4 broken or not may differ among us, but I'm on the side of  
5 it's not working very well.

6 DR. CASTELLANOS: Arnie, you said you wanted to be  
7 last. I'm going to let you be last.

8 The other issue is I think there have been so many  
9 good points said that anything I add to it is not going to  
10 emphasize it.

11 And last but not least, Arnie, you're absolutely  
12 correct. When I get up in the morning, that's not the first  
13 thing I think about.

14 [Laughter.]

15 MR. HACKBARTH: Karen, is that the first thing you  
16 think of?

17 DR. BORMAN: No. It probably earlier than my day.  
18 Just a couple of comments on the very fine discussion that's  
19 been going on.

20 First off, I would say that we all, I think, agree  
21 that there are problems and there are problems that we need  
22 to address. I'd like to maybe throw out a plea for let's

1 find a few positive things to say. We agree that for the  
2 population as it's evolved to with the baby boomer leading  
3 edge, the complexity of diseases, the multiplicity of  
4 therapies that we have to offer in drugs, that we're not  
5 doing as good a job as we would like to see ourselves do at  
6 this point in time and for the foreseeable future.

7           But I think we do have to acknowledge we've had  
8 some incredible successes in the world of medicine in this  
9 country. I think we need to be just maybe a little bit  
10 careful about being always negative and not pick out that  
11 there are some positives. And we may not intend that. But  
12 I have to tell you that for the average person listening or  
13 reading to some of our materials, it's pretty dark. And I  
14 think we need to maybe acknowledge that there are some  
15 things that we're doing well. And I want to be a little bit  
16 careful of eroding entirely people's notion that we have a  
17 system that's even worth setting in the door to be a part  
18 of. I would just offer that.

19           And there are some things that I would share,  
20 related to some recent comments, that I think or I hope you  
21 would consider helpful, are that I agree with Jennie and  
22 others about the education piece. I would suggest to you

1 that if we put it in the framework around a discussion, it  
2 really needs to be education of all kinds of providers at  
3 all kinds of levels. This isn't something that is because  
4 Medicare pays for GME, we now move into the GME curriculum.  
5 This is really an issue in nursing school, in pharmacy  
6 school, in medical school. It relates a little bit to  
7 perhaps even what we teach in undergraduate, in collegiate  
8 circles. I think we need to remember there's lots of pieces  
9 of Federal and other governmental monies that go into the  
10 medical system in a lot of ways through the NIH, through  
11 student loans, in addition to just the GME payment.

12           And so I think we do have the opportunity to ask  
13 of the system across a broad range of providers and levels  
14 of education that we set our priorities more appropriately  
15 and not just zero in just on the GME piece. But we ask lots  
16 of levels of education to get better.

17           I would point out that at least on the GME level  
18 that there is an increasing recognition of it, and that's  
19 embraced in the notion that many of you may be familiar  
20 with, the six general competencies, which was a fundamental  
21 rethinking in judging the quality of residencies for  
22 accreditation. I can tell you that certainly in lots of

1 programs, lots of things have been introduced that weren't  
2 there before.

3           For example, we ran our morbidity and mortality  
4 weekly discussion conference using the NSQIP reporting  
5 occurrences as a background for the discussion. Those of  
6 you who don't know, it's the National Surgical Quality  
7 Improvement Program. And it has a standardized list of  
8 complications. We used that every week. And if you don't  
9 think that that starts to inculcate in people some  
10 familiarity with a reporting system -- it may not be the one  
11 they use in 15 years. I'm here to tell you that repetition  
12 does some things. So I think that there are lots of  
13 initiatives that are going on. We're not going to see the  
14 fruit of those for a few years because of the longevity of  
15 the medical education pipeline.

16           And that doesn't mean to say we shouldn't keep  
17 pressing but there are initiatives going on. That's an  
18 example by what I mean of there are some positives out there  
19 that are current, not just history.

20           And I think that another potential piece is we've  
21 left out a little bit some considerations about the 21st  
22 century and maybe even beyond beneficiary here and sort of

1 what are their characteristics? What can we do to incent  
2 them to be partners in their care?

3 I don't doubt that my pen controls a lot of  
4 resources. But I've got to tell you, if my patients did  
5 everything I told you like some of you seem to believe is  
6 the case, then I could be a lot happier camper a lot of  
7 times with patients. And so I do want to encourage that we  
8 consider the beneficiary an active partner and that we  
9 encourage them to make positive choices and to also accept  
10 some responsibility and accountability in whatever system we  
11 go forward with.

12 In terms of sort of the big picture of how  
13 specific we get, I would look to, again staying on the  
14 strategic level, maybe a very, very large menu of potential  
15 tools rather than focusing on two or three. We can  
16 certainly highlight things we've already endorsed. I think  
17 there's a ton of things out there.

18 And one thing I did forget to mention as an  
19 encouraging thing -- Arnie, and I hope this one makes you  
20 feel better, there are places were the traditional lab  
21 research year or years where we've allowed residents and  
22 encouraged them to go off and get advanced degrees in health

1 policy, medical management, that kind of thing as a  
2 substitute for gene splicing. Both have their place. But  
3 that was not something that in my residency timeframe was an  
4 option.

5           So again another example of we are moving down  
6 this road, maybe not as fast as we'd want to and aren't  
7 there yet. But let's find a little bit of positive and  
8 let's create a broad range of tools and on medical home  
9 maybe sort out the features of that that make it positive  
10 and not necessarily constrain ourselves to a small  
11 definition in one set of providers.

12           And that's enough. Thanks.

13           MR. EBELER: This is a terrific discussion. I'm  
14 trying to think about what a chapter looks like --

15           [Laughter.]

16           MR. EBELER: You guys will take care of that;  
17 right?

18           The tension here is obviously the need and desire  
19 to articulate a long-term direction and set of goals,  
20 principles, whatever, which I think was a very important  
21 addition at the front end here, with what I would argue is  
22 an equal need to show how that frames our recent and

1 potential future recommendations. Which is I think what  
2 we've done here.

3 I guess I want to make sure we strike that  
4 balance. I think it's very important to be able to put the  
5 commission's recent recommendations, the tools here, in the  
6 context of this very useful strategic thinking which I agree  
7 should be added in here at the front end as well as pointing  
8 out, in addition to those things, the future steps that we  
9 think are coming down the pike.

10 What it really does is it gives people a way to  
11 think about what we're recommending in the long-term.

12 I'm not suggesting that it's bounded by the list  
13 that we've got here, but it just strikes me that the task  
14 here is to combine this very valuable longer term direction  
15 with a bit of a roadmap. There's a point where it's got to  
16 be a practical roadmap because otherwise we have a variety  
17 of audiences we're addressing here.

18 MR. HACKBARTH: Well put, Jack. I do think that  
19 what I hear in the conversation is concerns about balance.  
20 On the one hand, we have people who are worried that it will  
21 be too soft and vague and not very action oriented.

22 On the other hand, we have some people who are



1 concerned that we're going to leap to narrow solutions that  
2 may or may not be good solutions without any consideration  
3 of the big picture in a longer term agenda. We need to  
4 figure out a way to find the balance between those things,  
5 talk about long-term goals, what the system does well, what  
6 it does poorly, lay out a longer term direction that -- as  
7 Nick says -- allows us and others to maybe be persistent and  
8 consistent over time. But then also get to some specific  
9 policy steps consistent with those directions.

10           So we'll continue to work on the balance and how  
11 to refine those messages.

12           We've already started to delve into the bundling  
13 as one of our particular examples. And we've got lots of  
14 work to do. We had a very good discussion earlier today  
15 which identified many, many issues that we need to work  
16 through.

17           It's but one of even these three strategies that  
18 are policy approaches that we've laid out. I am, for one,  
19 particularly concerned about the primary care -- I'll use  
20 the crisis word for lack of a better one right now -- and  
21 developing some meaningful proposals to address that. And  
22 so I don't know if the medical home is a solution or not but

1 I'm very eager to begin addressing that piece of our system  
2 failure. And that will raise a whole bunch of other  
3 complicated issues and it raises a question for me about how  
4 much of this we can digest at once, how many of these things  
5 we can take on at once.

6 That's a rhetorical question but one that we'll  
7 need to be talking through, Mark.

8 Okay, enough on this for today. Thank you. We  
9 appreciate your doing a good job of being the last  
10 presenters in the day. Everybody was awake and  
11 contributing.

12 Now we'll have our public comment period with our  
13 usual ground rules. Before you begin, the ground rules are  
14 no more than a couple of minutes, please identify yourself  
15 before beginning.

16 MR. CHIANCHIANO: Thank you, Dolph Chianchiano  
17 from the National Kidney Foundation. I appreciate the very  
18 thoughtful discussion about approaches to improving the  
19 quality of care for dialysis patients.

20 And I wish to underscore some of the comments made  
21 by the commissioners to the effect that improving the care  
22 for dialysis patients is intricately connected to improving

1 pre-dialysis care. That's when decisions about vascular  
2 access are made. That's when malnutrition problems begin.  
3 And I appreciate the comments about a competence of approach  
4 to pre-dialysis care. We certainly would favor that. But  
5 two incremental suggestions.

6           First of all, there is on the books a Medicare  
7 benefit for medical nutrition therapy. This provides a  
8 payment for nutritional counseling for individuals with a  
9 GFR below 50, which is especially stage three or four, of  
10 chronic kidney disease. It's an underutilized Medicare  
11 benefit. It was created by the Benefits Improvement and  
12 Protection Act. I would encourage greater utilization of  
13 that benefit.

14           Secondly, we would also advocate the creation of a  
15 new benefit that would provide for education of patients in  
16 stage four kidney disease to give them the empowerment tools  
17 that they need to be a productive member of the health care  
18 team.

19           Thank you.

20           MR. HACKBARTH: Okay. We are adjourned until 9:30  
21 tomorrow.

22           [Whereupon, at 5:31 p.m., the meeting was

1 recessed, to reconvene at 9:30 a.m., on Friday, November 9,  
2 2007.]

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22

Friday, November 9, 2007

9:44 .m.

COMMISSIONERS PRESENT:

- GLENN M. HACKBARTH, J.D., Chair
- ROBERT D. REISCHAUER, Ph.D., Vice Chair
- MITRA BEHROOZI, J.D.
- JOHN M. BERTKO, F.S.A., M.A.A.A.
- KAREN R. BORMAN, M.D.
- RONALD D. CASTELLANOS, M.D.
- THOMAS M. DEAN, M.D.
- NANCY-ANN DePARLE, J.D.
- DAVID F. DURENBERGER, J.D.
- JACK M. EBELER, M.P.A.
- JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
- NANCY M. KANE, D.B.A.
- ARNOLD MILSTEIN, M.D., M.P.H.
- WILLIAM J. SCANLON, Ph.D.
- BRUCE STUART, PH.D.

1 NICHOLAS J. WOLTER, M.D.

1	AGENDA	PAGE
2		
3	Medicare Advantage quality findings	3
4	-- Carlos Zarabozo	
5		
6	Special needs plans	40
7	-- Jennifer Podulka	
8		
9	Hospital construction spending trends	93
10	-- Jeff Stensland and David Glass	
11		
12	Public Comment	116
13		



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

2 MR. HACKBARTH: I apologize for the late start.

3 The first topic this morning is Medicare Advantage  
4 and findings on quality of care. Carlos?

5 MR. ZARABOZO: Today I'll be giving you an update  
6 of recently released information on the quality of care that  
7 Medicare beneficiaries receive in private plans, along with  
8 some analysis that we've done using publicly available data  
9 on plan performance. I'll review the three major sources of  
10 data on quality in Medicare Advantage and discuss what the  
11 data from two of the sources show. Then I'll provide more  
12 detail on our findings for one particular set of data.  
13 These findings only pertain to Medicare Advantage plans, not  
14 to Part D drug plans.

15 The three major sources of data on quality in MA  
16 were described in detail in your mailing material. One  
17 source of detail is that Medicare Advantage CAHPS survey,  
18 which is a survey of members' experiences with their health  
19 plan and with their providers in the plan. CAHPS results  
20 are not included in this presentation because 2006 data are  
21 not yet available. However, CAHPS results should be  
22 available in time for this year's Medicare open enrollment

1 period, the Advantage open enrollment period beginning on  
2 November 15.

3 Another source of data is the Health Outcomes  
4 Survey or HOS. HOS is a longitudinal survey of MA  
5 enrollees' health status over a two year period. For HOS we  
6 do have summary results include data through 2006.

7 The primary source of information on quality in  
8 health plans is HEDIS data. Health plans report process  
9 measures and intermediate outcomes measures through HEDIS  
10 along with other types of information. HEDIS is a product  
11 of the National Committee for Quality Assurance, or NCQA.  
12 HEDIS is the most commonly used source of health plan  
13 performance measurements and is the basis of many report  
14 cards and rankings of health plans.

15 In Medicare, plans have been required to report  
16 HEDIS measures since 1997. However the Medicare  
17 Modernization Act of 2003 exempted private fee-for-service  
18 plans and medical savings account plans from the HEDIS  
19 reporting requirements. These plans also do not participate  
20 in the HOS surveys, which are a component of HEDIS.

21 However, there are CAHPS data on these two types of plans.

22 With regard to PPOs and what they have to report

1 for HEDIS, special rules apply. Medicare requires PPO plans  
2 to report on measures only for network providers and PPOs  
3 are not obligated to report on issues involving extracting  
4 of medical records.

5 I should note here that Medicare beneficiaries can  
6 obtain CAHPS information and HEDIS information about each  
7 plan through the Medicare.gov website or from 1-800-  
8 Medicare. In the past only five effectiveness of care HEDIS  
9 measures were displayed on the website for MA plans.  
10 However, CMS is revamping the website so that more HEDIS  
11 measures are shown for each plan, beginning with the  
12 upcoming enrollment period.

13 Evaluating the various data sources what we have  
14 found is that the most recent data on quality in MA plans  
15 show a need for improvement. They also show that there is  
16 substantial variability across plans in their performance  
17 and the performance of newer plans is generally poorer than  
18 the performance of older plans.

19 Beginning with a look at the HOS summary data,  
20 here is the table of HOS results for the seven cohort survey  
21 to date. This table is taken directly from the HOS website.  
22 Plan results are categorized based on the expected changes

1 in health status of enrollees. The health status categories  
2 are better health, poorer health, or unchanged status on  
3 physical and mental health measures over the two-year  
4 period. Plans are classified in terms of whether or not  
5 their enrollees fall within the expected ranges of health  
6 status. When results are reported, as in this table, a plan  
7 is deemed to have better or poorer outcomes if the plans'  
8 results are significantly different from the national  
9 average across all plans.

10 Looking at the most recent time period, shown in  
11 the last row, enrollee health status changes were within  
12 expected ranges from 2004 to 2006 for most plans. However,  
13 compared to earlier time periods or cohorts, more plans  
14 showed poorer health outcomes and fewer plans should  
15 improvement in health for their enrollees.

16 The number of reporting plans is about the same  
17 for each cohort after the first time period. As you can  
18 see, in the most recent time period, the entry in the bottom  
19 right-hand corner of the table shows that 13 plans have  
20 enrollees with poorer physical health than expected,  
21 compared to at most five in any prior time period. The next  
22 to last column shows that in the middle time period 20 or

1 more plans had better physical health among their enrollees  
2 than expected. For the 2004 to 2006 cohort, there are only  
3 two plans in the better physical health category. In mental  
4 health, five plans had enrollees with improved mental  
5 health, while in earlier cohorts there was a much higher  
6 number showing improved mental health. Seven plans had  
7 results indicating that the mental health of their enrollees  
8 was significantly worse than the national average.

9           Turning now to findings based on HEDIS, six weeks  
10 ago NCQA released this year's State of Health Care Quality  
11 Report, which is their annual report showing the performance  
12 of Medicare, Medicaid, and commercial plans. One issue that  
13 NCQA highlighted this year is that Medicare scores did not  
14 improve as much as the scores in other groups of plans.  
15 Medicare plans improved in seven out of 38 measures, far  
16 fewer than in the case of commercial or Medicaid plans.

17           For the 30 measures that are common commercial and  
18 Medicare plans, commercial plans had better scores on  
19 Medicare in 16 measures.

20           In releasing this year's report, NCQA stated the  
21 Medicare numbers for 2006 and similar results for last  
22 year's numbers highlight a need to refocus on quality

1 improvement efforts, as they put it, in the Medicare  
2 program.

3 We're using NCQA HEDIS findings displayed here to  
4 show whether there was improvement in Medicare scores  
5 between 2005 and 2006, and also to show how Medicare plans  
6 compared to commercial plans.

7 We've independently analyzed the HEDIS scores for  
8 Medicare plans in 2006, using public use files available  
9 from CMS. One of our findings is that, as NCQA has also  
10 noted, there is substantial variability in HEDIS scores  
11 across plans and I should mention that NCQA is looking at  
12 simple averages across plans and we're also looking at  
13 simple averages here.

14 In your mailing material, there was a table  
15 showing the range of scores across individual Medicare  
16 Advantage plans on different HEDIS measures, including the  
17 minimum and maximum scores and the median scores in 2006.  
18 The data showed a great deal of variability in plan scores.

19 Here we use one particular measure to illustrate  
20 the a degree of variability in Medicare HEDIS scores in  
21 2006. These are the scores showing the percent of enrollees  
22 with type 1 or type 2 diabetes continuously enrolled in the

1 plan during the measurement year who received a retinal eye  
2 exam in the year or who had an eye exam in the preceding  
3 year showing no retinopathy. The bar at the bottom of the  
4 graph shows that one-fourth of plans have rates under 50  
5 percent for this measurement. That is, fewer than 50  
6 percent of enrollees who needed the exam received the exam.  
7 At the individual plan level, the lowest rate was 15 percent  
8 and the highest rate was 91 percent. The median rate was 61  
9 percent across all the plans that reported on this measure.  
10 Nearly all plans reported on this measure. There were 276  
11 plans in our data and all but 17 of the 276 plans had a  
12 score for this measure.

13 In looking at the 2006 Medicare HEDIS data,  
14 another thing that we found in our analysis of that there  
15 were noticeable differences in the performance of newer  
16 plans compared to older plans. This graph shows the  
17 difference between older plans and newer plans on the eye  
18 exams measures. Here we are defining older plans as those  
19 operating in Medicare prior to January 1, 2004. Of the 276  
20 plans in the data, 155 were older plans, 121 are newer  
21 plans.

22 On this particular HEDIS measure, the bar at the

1 bottom of this graph shows that 45 percent of the newer  
2 plans have scores below 50 percent on this measure, compared  
3 to only 10 percent of older plans with rates below 50  
4 percent.

5 Looking at the top two score ranges, that is  
6 scores of 80 percent or higher at the very top and scores in  
7 the 70 to 80 percent range in the next grouping, older plans  
8 are much more likely to be in these higher ranges. 43  
9 percent of older plans have scores falling within these two  
10 highest ranges shown here, 14 percent at 80 or higher and 29  
11 percent at 70 to 80. By contrast only 11 percent of new  
12 plans have scores in these upper ranges with 3 percent at 80  
13 or higher and 8 percent between 70 and 80.

14 In analyzing 2006 HEDIS scores for older plans  
15 versus newer plans, we found that on almost all measures  
16 average scores for older plans were better than for newer  
17 plans. Looking at the 40 measures that we analyzed, which  
18 is 38 effectiveness care measures plus two measures on  
19 customer service, older plans had better scores on 35 out of  
20 the 40 measures.

21 An issue that we noted in the mailing material is  
22 that not all plans report on all measures and in some cases



1 only a small percentage of plans are reporting on a given  
2 measure. Newer plans are less likely to report on certain  
3 measures. Taking this into account, if you only look at the  
4 15 measures where at least three-quarters and new and old  
5 plans both reported scores, newer plans had a better score  
6 on only one of the 50 most frequently reported measures.  
7 Older plans were better on 14 of the measures. And for nine  
8 out of the 15 most frequently reported measures, the average  
9 scores of older plans were more than 5 percent higher than  
10 newer plans scores.

11 As I noted, looking at all 40 measures, newer  
12 plans do have better average scores than older plans on five  
13 measures. However, in the case of three of these five  
14 measures, only about 10 percent of new plans reported  
15 scores. This compares to 75 percent of older plans  
16 reporting on the three measures where new plan scores are  
17 better than old plan scores.

18 I'd like to mention a couple of points on how the  
19 new plans differ from the old plans. First, I should  
20 clarify that new in this context only means that the  
21 particular Medicare contract began on or after January 1st,  
22 2004. That does not necessarily mean that we're dealing

1 with entirely new startup organizations. Some of the  
2 contracts are with entirely new plans but some of the  
3 offerings are from established plans in given areas that are  
4 newly entering into Medicare contracts.

5           The newer plans do tend to be smaller plans and  
6 they are more likely to be PPOs. However, for most  
7 measures, PPO scores were higher than scores for new plans  
8 that were not PPOs. On the question of whether the plan  
9 size is the factor that explains why the newer plans had  
10 lower HEDIS scores, if you look only at plans with fewer  
11 than 10,000 enrollees, you find that the older small plans  
12 had better HEDIS scores across the board than the new plans  
13 with fewer than 10,000 enrollees.

14           Another point having to do with the size of the  
15 new plans is that overall enrollment in the new plans is  
16 much lower than in the old plans. For the HEDIS measurement  
17 year we're looking at, 2006, the 119 new plans -- I removed  
18 two private fee-for-service plans for this count -- had  
19 about 12 percent of the enrollment among all the plans  
20 reporting HEDIS measures for 2006. However, the enrollment  
21 of the newer plans is growing faster than enrollment in the  
22 older plans. The newer plans had enrollment growth of 22

1 percent in the past year, compared to enrollment growth of  
2 only 1 percent for the older plans.

3           Within the set of plans we're looking at, the new  
4 plans now comprise 15 percent of the enrollment as of last  
5 month, compared to 12 percent of the enrollment in 2006.

6           So to recap our findings, we found that the most  
7 recent publicly released data on quality in MA plans showed  
8 a need for improvement. Our analysis of plan level HEDIS  
9 scores shows there are significant variation in performance  
10 across plans and the performance of newer plans is generally  
11 poorer than the performance of older plans.

12           I'll conclude by reviewing what the Commission has  
13 said in the past about quality in Medicare Advantage. The  
14 Commission has said that the quality of care should be  
15 measured in both sectors of Medicare, the traditional fee-  
16 for-service program and the Medicare Advantage program. By  
17 having data on quality of care in each sector, beneficiaries  
18 can choose between the two sectors using quality as a factor  
19 in their decision. Currently, the collection of information  
20 on quality is more extensive in Medicare Advantage than in  
21 traditional program. Right now beneficiaries can really  
22 only judge differences in quality between one Medicare

1 Advantage plan and another without being able to compare MA  
2 quality to the quality of care in fee-for-service Medicare  
3 overall.

4           Having said that, not all plans in Medicare  
5 Advantage provide data on quality. Specifically by statute,  
6 as I noted before, private fee-for-service plans and MSA  
7 plans are exempt from the reporting requirements applicable  
8 to all other MA plans. In testimony before Congress and in  
9 our June report to the Congress, we called attention to this  
10 difference among plan types and have suggested that all MA  
11 plans should be subject to the same reporting requirements.

12           The other point to mention is that information on  
13 quality is a necessary component of pay-for-performance  
14 programs. The Commission has noted that MA already has the  
15 type of quality data necessary for a P4P program and the  
16 Commission has recommended a portion of plan payments be  
17 used to fund a P4P program in MA.

18           Thank you and I look forward to your comments and  
19 questions.

20           DR. MILSTEIN: That was wonderful, thank you.

21           I know that earlier in the program's evolution,  
22 the Health Outcomes Survey was applied to a random sample of

1 the Medicare fee-for-service population.

2 MR. ZARABOZO: Yes.

3 DR. MILSTEIN: Appreciating that we're looking --  
4 that the portrait of the Medicare+Choice, at that point,  
5 versus the fee-for-service program that, at this point may  
6 be five years dated or six years dated, if you had a chance  
7 to look at those comparisons in general on the Health  
8 Outcomes Survey which, from my perspective, is the bottom  
9 line in terms of what's the net impact of this delivery  
10 system on change in health status over two years for  
11 Medicare population. Did the Medicare+Choice plans  
12 significantly outperform, under perform or perform about the  
13 same as the Medicare fee-for-service plan?

14 MR. ZARABOZO: As you mentioned, there was a pilot  
15 to do fee-for-service Health Outcomes Survey. I did not  
16 look at the difference between Medicare Advantage -- or  
17 Medicare+Choice at the time -- and the fee-for-service  
18 population. But I can look at that.

19 DR. REISCHAUER: This is very interesting and  
20 thank you for the presentation and the chapter.

21 You made some references to differences between  
22 new and old PPO, new, non-PPO, old. I was wondering, did

1 you cut this at all by geography?

2 MR. ZARABOZO: No, I did not.

3 DR. REISCHAUER: To see if there were any  
4 patterns. Could we?

5 MR. ZARABOZO: Yes, that can be done.

6 DR. REISCHAUER: Should we? Maybe not.

7 MR. ZARABOZO: As I mentioned in the mailing  
8 material, the reporting unit is the H level or contract  
9 level or the R level, in the case of regional plans. So  
10 that, for example, a regional plan that has let's say 23  
11 states, for example, with one H number is reporting one  
12 number for all of those X number of states that are included  
13 in the R level. So it can be done.

14 MS. HANSEN: I was wondering about that.

15 MR. ZARABOZO: For looking at geography, the CAHPS  
16 information is better because it goes to smaller geographic  
17 units but there are plans that limit their service area to  
18 smaller geography.

19 DR. REISCHAUER: Thank you.

20 MR. EBELER: Thank you.

21 I actually find the data disappointing, as someone  
22 who comes out of this field, has worked at one of these

1 organizations, and has represented parts of this field.

2 This is not what one hopes for from here. It, in my mind,  
3 sort of really reinforces the recommendations that we've  
4 stressed.

5 It also suggests to me something Nancy mentioned  
6 yesterday that's sort of a need to look at this program sort  
7 of backward map almost, what we expected from this in the  
8 context of the delivery system reforms we discussed  
9 yesterday and where we're going.

10 One analytic question a little bit different to  
11 Bob's. There was a study, I think it was very Larry  
12 Casalino, that suggested that plans associated with  
13 organized delivery do better than plans that don't,  
14 particularly on the HEDIS measures. Is it possible to cut  
15 the data that way?

16 MR. ZARABOZO: Yes, we can do that.

17 MR. EBELER: I don't know what it will show in the  
18 new data but it would sure be worth knowing.

19 MR. ZARABOZO: Looking at the rankings that NCQA  
20 does and U.S. News and so on, Kaiser, for example, is very  
21 highly ranked and those kind of organizations are typically  
22 highly ranked and have higher scores.

1           MR. EBELER: The only other suggestion and the  
2 other question is how to present these data in a way that  
3 capture attention. One of the things I would suggest is  
4 pointing out not just the norms but the gap from where we  
5 are to where we should be, 95 percent or the 90th  
6 percentile, and pointing out how many people would be  
7 getting what they're supposed to be getting if we were at  
8 those levels.

9           You used an eye exam chart here, but the truth is  
10 when you're at 70 percent and we should be at 95 percent,  
11 tens of thousands of diabetics are not getting something.  
12 Just representing the data that way, just as a way to try to  
13 capture attention of the shortfall here.

14          MR. ZARABOZO: Assuming the identification, the  
15 denominator, that we know the denominator.

16          MR. EBELER: Yes, and we can only do that where  
17 you're comfortable. But even if there's just five examples.  
18 It's just that we get so used to norming against a norm  
19 that's mediocre that the goal is to sort of strive for  
20 something excellent. And not just for Medicare Advantage,  
21 in all of Medicare. If there's a way to do that I think it  
22 would be helpful to the audience.



1 DR. DEAN: These various measures, have they been  
2 -- and maybe this has already been answered. I'm not sure.  
3 But the various measures, are they internally consistent  
4 with each other? Do they really tell us -- I guess my  
5 question is do they really tell us what we need to now? In  
6 other words, do people who write or do programs who rate  
7 high with these particular measures, do their enrollees  
8 actually end up better off at the end of the year? As Arnie  
9 says, it's the outcomes that we're really after.

10 And what concerns me is that, having worked in the  
11 health care systems, if you're going to measure one thing,  
12 we'll improve that one thing. We'll refocus our attention.  
13 But unless we're very careful about what we pick, there's a  
14 limited amount of attention span and we're likely to not pay  
15 attention to something else.

16 And so picking the factors that we're going to  
17 report for the long-term is terribly important. And I know  
18 obviously HEDIS is widely used. And I just wonder, does it  
19 really tell us what we need to know?

20 And I guess a little bit of a second question, has  
21 there been any attention -- another problem, I think, with a  
22 lot of these programs is that the enrollee periods are short

1 enough and people are bouncing around from one program to  
2 another, there's not been a lot of incentive on the part of  
3 companies to invest the effort to get people to do things  
4 that will save the company money in the long -- save the  
5 insurance company money in the long run. But likely that  
6 enrollee won't be there in two or three years.

7 MR. HACKBARTH: I agree with Arnie's take and  
8 yours, that ultimately it's about outcomes. That's what we  
9 should care about. But there are short-term/long-term  
10 issues. Some outcomes, improved outcomes, may not show up  
11 for long periods of time. And so you use process measures  
12 to complement them, get people, reward people for doing the  
13 right things in the short run that in the long run we hope  
14 will improve outcomes.

15 For that to be a reasonable expectation, you need  
16 to make sure that you choose process measures that are  
17 evidence-based and linked to outcomes.

18 DR. DEAN: Right, exactly. And it's hard to do.

19 MR. HACKBARTH: But you wouldn't expect a perfect  
20 correlation in the short run between outcomes and process  
21 measures, just logically, because there are different time  
22 frames involved.

1           MR. EBELER: Glenn, what's interesting about these  
2 measures -- and again, I think what's disappointing about  
3 the results is these are not a series of measures that the  
4 regulatory process has foisted on the health plan community.  
5 These are a series of measures that the health plan  
6 community worked through NCQA to develop and be accountable  
7 for. So they are not been the big bad CMS doing this.  
8 These are things that folks signed up for.

9           MR. HACKBARTH: Another point that you mentioned  
10 was turnover in enrollment perhaps being a disruptive source  
11 and discouraging investment and long-term improvements.  
12 What are the data, Carlos, in terms of stability in  
13 enrollment? It used to be that was relatively stable --

14           MR. ZARABOZO: It is still relatively stable. Of  
15 course, now we have the lock-in, so that beginning with 2006  
16 people are locked in, essentially, to their plan for the  
17 year. This is the measurement year, 2006.

18           The particular measure, the eye exam measure, has  
19 been around since 1999. Again, as I mentioned, you had to  
20 be in the plan for the entire year to be included within the  
21 measure.

22           NCQA is continually updating, as Jack has

1 mentioned, the measures. The one measure that is going to  
2 be dropped is the beta blockers after heart attack measure  
3 because performance is so high and there's such little  
4 variability, so it gets to your point of when you measure  
5 something there is improvement. But again, the retinal eye  
6 measure has been around since 1999 so it's been there a  
7 while.

8 DR. KANE: I actually have more questions than  
9 comments. One is, is this the real rate of difference or is  
10 there a well known lack of documentation piece here? In  
11 other words, is this a measure of how well they're  
12 documenting their care or the fact that they're actually not  
13 delivering their care?

14 MR. ZARABOZO: The results are supposed to be  
15 audited. If there's some question about the measure being  
16 reported, it can be not reported as being not a valid  
17 measure. That's why this measure where almost over 90  
18 percent of the plans are reporting are the measures that I  
19 was principally working on.

20 DR. KANE: So this is actually just not giving the  
21 care is your sense? Or we should take it that way?

22 MR. ZARABOZO: It's possible that they were unable

1 to track that the care was given is the other thing.  
2 Particularly the eye exam measure is an administrative  
3 measure, not a medical records measure.

4 DR. KANE: So we don't know whether this was  
5 because the eye exam was given by an optometrist or an  
6 ophthalmologist and they haven't gotten the information  
7 system to connect it to their --

8 MR. ZARABOZO: It is supposed to be  
9 ophthalmologist actually. So there is a possibility of not  
10 having a record of this having happened.

11 DR. REISCHAUER: We've been tracking this  
12 information for a number of years and they know you're going  
13 to, they really have to be stupid not to try and collect it.

14 DR. KANE: Unless they're bringing in a population  
15 whose traditional systems of care are not yet tied into the  
16 -- in other words, it's a poor plan design. Because it does  
17 seem odd that they would be that bad, given a measure that  
18 they do well in on the commercial population.

19 The other question, I guess, and I don't know if  
20 you know the answer, is why were the two exemptions? Why  
21 were the private fee-for-service and medical savings, why  
22 were they exempted? Is it the feeling that they couldn't

1 get the documentation and that the other plans could?

2 MR. ZARABOZO: They're not network plans is, I  
3 guess, the reason essentially.

4 DR. KANE: Wouldn't they be able to -- just to  
5 push that, would you still be able, from the claims that  
6 you're paying, to know whether --

7 MR. ZARABOZO: Information that comes from claims,  
8 you can get that information, yes.

9 MR. HACKBARTH: Let me approach that same issue  
10 from a little different direction. Where do we stand,  
11 Carlos, in terms of being able to compare plan results to  
12 traditional Medicare results in the same areas?

13 MR. ZARABOZO: We were going to get the CAHPS  
14 information for fee-for-service, which again was fielded in  
15 2007, and compare that to the Medicare Advantage CAHPS  
16 information.

17 MR. HACKBARTH: Just the satisfaction results?

18 MR. ZARABOZO: The satisfaction and the flu shot  
19 rates and a couple of other things that come out of that.

20 MR. HACKBARTH: Where I'm going is probably  
21 obvious. I would think that for private fee-for-service  
22 plans, or even many of the big network HMO plans, the

1 primary determinant of their results is the quality of care  
2 in the community. Now since they're contracting with more  
3 or less everybody, or in the case of private fee-for-service  
4 they don't even have a limited network. So to say that  
5 these are plan results, in some sense, is a misnomer. They  
6 are a reflection of the state of care, for better or worse,  
7 in that particular community.

8           So to say we're going to hold private fee-for-  
9 service plans accountable for quality is, in a sense -- if  
10 the plan is, by definition, a free choice plan, the number  
11 of levers that they have to pull to improve quality is more  
12 limited than Kaiser Permanente or some of the other models.

13           DR. KANE: Yes, but they could still identify  
14 their diabetics and send them education and do outreach.

15           MR. HACKBARTH: Just to be clear, I'm not opposing  
16 the quality of the reporting requirements, but you need to  
17 think about what the results mean. I think for many plans,  
18 and not just private fee-for-service, they're as much a  
19 reflection of the state of local health care as they are of  
20 plan performance.

21           So I'd like to have Medicare numbers and the  
22 private fee-for-service numbers alongside and then Kaiser

1 Permanente's numbers alongside that. I think you'll  
2 consistently see Kaiser Permanente up towards the top and  
3 organized systems like them up towards the top.

4 DR. KANE: In our market, for instance, Harvard  
5 Community Health Plan, Harvard Pilgrim Health Plan, --  
6 dumped their old managed network plan and now only offer  
7 private fee-for-service. So they're taking the same people  
8 and they're flipping them into this -- I honestly don't  
9 understand what that -- I mean, I have some idea.

10 DR. STUART: And they are being paid more.

11 DR. KANE: That's why.

12 DR. STUART: I'd like to go back to Jack's point,  
13 and Glenn mentioned it too, is that ultimately we'd really  
14 like population-based measures for these.

15 Carlos, you may have already done this, but there  
16 is another data source. If you haven't, it's not quite as  
17 current but it does have a lot of this information in it,  
18 which is the Medicare Current Beneficiary Survey Access to  
19 Care. The currently available survey is 2005. 2006 should  
20 have been released by now. It hasn't been but it is due  
21 early in the year.

22 And every other year it has a panel of very



1 detailed questions regarding care for people with diabetes.  
2 That would be a natural way of comparing people in fee-for-  
3 service and in MA plans. And I believe in 2006 there is a  
4 distinction between MA plans that are managed care, as  
5 opposed to private fee-for-service. I'm not positive about  
6 that.

7 But at least you'd be able to address some of  
8 these questions for specific issues. You're not going to  
9 get A1C measures and some these others. But you will get  
10 other measures that you don't have in NCQA. It would  
11 provide at least a basis for comparison, like next year you  
12 could say well, we've got these 2007 figures that we  
13 presented to the Commission in November of 2007. And now  
14 next year we'll go back and we'll compare what we found in  
15 2007 in access to care.

16 And I think it would be just very useful to have  
17 this as a tagalong data source that would provide some  
18 additional information here.

19 MR. ZARABOZO: And it does carry the plan  
20 identifier, I believe, in MC BS information.

21 DR. STUART: You can get the plan identifier.

22 DR. MILSTEIN: Given that the Health Outcomes

1 Survey is an NCQA approved measure, what was or is the  
2 rationale, first of all, for ceasing its application to the  
3 Medicare fee-for-service population?

4 And secondly, for not making the results available  
5 to beneficiaries who are interested in selecting an MA plan?

6 MR. ZARABOZO: I'm not sure of the reason for the  
7 discontinuation of the fee-for-service HOS, but it seemed to  
8 me that the primary use of HOS in CMS is for the health plan  
9 improvement, working directly with health plans and through  
10 the QIOs at some point. Now I looked at the 8th scope of  
11 work for the QIOs and it's not specifically mentioned. But  
12 I think in the past that use the HOS data to work with the  
13 health plans.

14 DR. MILSTEIN: If it's possible, maybe in the  
15 interim, to find out why it's not -- I appreciate that it  
16 would be very useful for internal plan quality improvement  
17 purposes. But since I would be -- using my own parents as a  
18 frame of reference -- of extreme interest to them if they're  
19 trying to decide among MA plans or whether to switch to an  
20 MA plan, is there an explanation as to why it should not be  
21 made available to beneficiaries?

22 MR. HACKBARTH: Bob opened by saying that he was

1 interested in results, and then Jack said he was  
2 disappointed in the results. I'm struggling to get to  
3 disappointed. I'm more depressed than anything.

4 [Laughter.]

5 MR. HACKBARTH: And a number of things depress me  
6 about the results. But one of them is that I fear that  
7 we're going backwards. The policy changes that we've made  
8 in this program are converting Medicare Advantage from a  
9 program that's leading edge to where we reward organized  
10 systems that reduce costs and improve quality to we have  
11 such high payment levels that we're going to private fee-  
12 for-service, which has little potential to do either.

13 These results are just a reflection of our --  
14 we're not evolving. We're devolving, and moving away from  
15 better care for Medicare beneficiaries, more efficient care.

16 DR. WOLTER: I would certainly agree with that and  
17 I think that our position points up there are right on  
18 target, although we might want to be much stronger in the  
19 things that we say. One of the large private fee-for-  
20 service plans that's come into Montana, I saw a string of e-  
21 mails from a lot of the little small physician groups that  
22 were being burdened with all these requests for sending

1 copies of records. And it was primarily, I understand, so  
2 that they could get their severity information. It really  
3 wasn't focused on quality improvement activities.

4 And I think that to pay 15 or 20 percent above  
5 fee-for-service when there's absolutely no activity going on  
6 around looking at better coordinated care or focusing on  
7 high volume/high-cost disease, all the themes that we're  
8 trying to advance here, is very, very bad policy.

9 And so I think that if we really strengthened the  
10 notion that if we're going to pay Medicare Advantage, we  
11 really want not only reporting but we want performance. And  
12 that would be another way to move towards some -- as you  
13 know, Glenn, I think more national fee-for-service  
14 neutrality than county level. But I think we should be  
15 strong on this, short of just saying we should eliminate  
16 private fee-for-service, which many people think would be a  
17 very smart recommendation.

18 MR. DURENBERGER: Nick has clearly made the point  
19 better than I, as a practitioner. But to put a point on the  
20 conversation about the plan basically reflects the status of  
21 quality in a community, it is also -- even though I come  
22 from a community that has started to do this quality than a

1 long, long time ago through the Institute for Clinical  
2 Systems Improvement and a variety of other things like that,  
3 it's also a community in which the health plan is important  
4 to that effort. And it's basically, if you will, a kind of  
5 a partnership although people are not -- they work together  
6 in a larger sense, not in a specific sense.

7           But there has to be a motivation on the part of  
8 both the plan to press for improving quality in the  
9 community and a motivation on the part of the physician.  
10 And how that works is really key to the point I think you're  
11 making about Medicare Advantage.

12           And if, in fact, we continue a policy that simply  
13 rewards people for selling more policies and more plans  
14 without producing a result of some kind in the community,  
15 not like nationally are you this, that or the other thing,  
16 but community by community in which you're selling those  
17 plans, we're not making a contribution to improving access  
18 to the kind of high quality.

19           When I did my little informal survey that I  
20 reflected in my commentary, the plans in various of these  
21 states we come from all said they pay a lot of money to get  
22 accredited. They pay not quite as much, but a lot of money

1 to go through all of this process. And they do it because  
2 they know that part of their responsibility in the  
3 communities in which they sell these health plans  
4 commercially and Medicare and Medicaid and so forth is to  
5 assist the provider community in knowing what are the rules,  
6 what do we have to do, how do we get rewarded.

7 So that sense does not have to be unique to our  
8 part of the country. But unless we change -- from a  
9 Medicare standpoint, unless we change the rules about why  
10 are we paying you a subsidy and what do we expect by way of  
11 performance, then we're going to be in trouble.

12 MR. HACKBARTH: Other questions or comments for  
13 Carlos?

14 MR. EBELER: One question that we discussed  
15 yesterday that need the staff had identified for information  
16 on Part D that's hard to come for come by. Are there  
17 information needs on MA that we're bumping up against or  
18 not? It's just that -- it's not a guided question. I'm  
19 just wondering do we get the data that we need on what's  
20 happening at MA plans? Or do we need additional  
21 information?

22 MR. ZARABOZO: We're going to be getting the HOS

1 data through a data use agreement, and again the CAHPS data  
2 is also coming. On quality measures, I don't know that we  
3 are missing anything.

4 MR. EBELER: Are there any other areas?

5 MR. ZARABOZO: If Mark wants to address this?

6 DR. MILLER: First of all, are you asking about  
7 quality or the others?

8 MR. EBELER: I'm asking more broadly.

9 DR. MILLER: Because we do think that there are  
10 data and a couple of commissioners have raised the question  
11 about -- and we've had some discussions about the encounter  
12 data that's coming from managed care plans on the A/B, side,  
13 so that's why I was trying to figure out how broad the net  
14 was. So certainly that question has been raised and I think  
15 there's going to be some additional discussion about that  
16 even as soon as next month's meeting.

17 On the quality side, and I'm feeling my way here  
18 and so is every may -- I think we've said things about --  
19 and I'm not talking about new data sources here but trying  
20 to make sure that we're getting comparable data across sets  
21 of plans. Different plans have different reporting  
22 requirements. We've raised that issue. We've raised the

1 fee-for-service to managed care issue. And then we're going  
2 to talk about SNPs momentarily and special measures  
3 associated with them over and above the standard set.

4 Any of the analysts that work on MA, are there --

5 MR. ZARABOZO: As Sarah mentioned, we're dealing  
6 here with the H contract level data. If we could get plan  
7 level data on quality -- I don't know if that's possible  
8 actually -- it is possible. We are missing that. So the  
9 geography question, benefit package questions related to  
10 quality, those kinds of things could be answered with plan  
11 level data on quality.

12 DR. REISCHAUER: It strikes me the H level data  
13 isn't useful for almost any question one would want to  
14 answer.

15 DR. STUART: Carlos, you noted that there were a  
16 number smaller plans in particular that failed to report  
17 these data. What sanctions, if any, are imposed on plans  
18 who do not report these data?

19 MR. ZARABOZO: On the so-called not report, NR, I  
20 don't know. But in the state of California, for example,  
21 for the Medicaid plans, if you have an NR, they track it  
22 down. They say you cannot report this in the future. You



1 must be able to report this particular measure. So you have  
2 sort of a corrective action plan. A not report means you  
3 will report at some point and show us how you're going to be  
4 able to report this.

5 MR. HACKBARTH: But under the NCQA system, not  
6 reporting is an option. To the extent that we're relying on  
7 NCQA's analysis of the data, there may be plans that are  
8 complying with Federal requirements to report but the data  
9 aren't being analyzed by NCQA because they're not flowing  
10 through the NCQA system? That's a question. Is that a  
11 possibility?

12 MR. ZARABOZO: I think it's to Medicare and then  
13 to NCQA is the way it works, I think, CMS. But as I  
14 mentioned in the mailing material, the NR can either be we  
15 are unable to report this because the measure is not valid,  
16 there's something wrong with the sample or whatever. Or we  
17 are choosing not to report it. At the moment, CMS has said  
18 that they don't know when it is choosing not to report  
19 versus unable to report for technical reasons.

20 DR. MILLER: Just to add, we're not aware of any  
21 penalty if a person is not submitting to data, whichever way  
22 it ends up getting -- I think that was sort of the

1 overarching question there.

2 MR. ZARABOZO: I don't whether there is a penalty  
3 or not. John? No.

4 DR. DEAN: Maybe this is obvious, one of the  
5 things that makes this even more complicated is the whole  
6 issue of what the enrollee or the consumer views as quality  
7 and what we, as sort of the professionals, view as quality  
8 may be very different things. There is a data that show  
9 that if you ask people where they had a good experience,  
10 they'll give you one thing. If you evaluate that care from  
11 a technical point of view you may get a very different  
12 result. But they're both important. They are both  
13 crucially important. And how you merge those two  
14 measurements in a way that has some -- that will move us  
15 forward is a very difficult thing.

16 MR. HACKBARTH: I agree with that and I've always  
17 been, as a result, a bit ambivalent about the inclusion of  
18 satisfaction data in a pay-for-performance program. At one  
19 level, of course, patient satisfaction is important. And I  
20 think it's especially important when you're talking about  
21 satisfaction with the clinical activities and the access to  
22 physician and that sort of stuff, as opposed to satisfaction

1 with the plan, health plan features.

2 But right now we have a system in Medicare where  
3 there is ample reward for plans providing satisfaction in  
4 terms of free choice of provider and more benefits. That's  
5 what we're paying for right now. The problem the current  
6 system has is it doesn't reward excellent clinical  
7 performance which may not go hand-in-hand with high  
8 satisfaction results.

9 And so I've always felt, as I say, ambivalent. I  
10 think that to have both included in a pay-for-performance  
11 program could actually dilute what you care most about, the  
12 clinical performance, and sort of have a double reward for  
13 the stuff that's easy for patients to identify for  
14 themselves and they reward by voting with their dollars and  
15 their feet.

16 DR. KANE: But some of it's related to how fast  
17 the phones are answered or whether you got access to -- some  
18 of it's access information about how fast you get  
19 appointments.

20 MR. HACKBARTH: And those are things that patients  
21 pretty readily can figure out for themselves and they reward  
22 with their dollars and their enrollment decisions. Where

1 patients are less able to discern is often the clinical  
2 activity.

3 DR. KANE: Clinical if you can't access to the  
4 doctor. How long do you wait -- some of those satisfaction  
5 things are around how long did you wait on the phone.

6 MR. HACKBARTH: [off microphone] To experience  
7 them directly. They're visible. [inaudible.]

8 MS. BEHROOZI: People who aren't in the plan yet,  
9 who want to choose a plan.

10 DR. DEAN: But it also affects compliance with the  
11 things that we recommend. Some of it just convenience and  
12 those kind of things. But it also is going to have an  
13 impact on outcomes because even we can recommend all the  
14 right things. But if we do it in a rude manner or whatever,  
15 they're not going to do it. So everybody's wasting their  
16 time and money.

17 DR. REISCHAUER: [off microphone] We don't want to  
18 measure it twice.

19 MS. HANSEN: Glenn, if I could also weigh in on  
20 this, I do think that there are a lot of misunderstood  
21 access issues that perhaps whether these measures are the  
22 right measures in that way. Something has to be done. I

1 believe there is a not-for-profit organization called Health  
2 Grades that tries to bring this a little bit more together.  
3 Whether or not it's the best tool, but it's the concept of  
4 trying to merge these two in a way that brings some  
5 evidence-base side to it.

6           If we maybe could take a look at how to get to  
7 that, as you say not to discount it but understand what  
8 relevance it does mean to quality.

9           MR. HACKBARTH: As I say, my overwhelming feeling  
10 is one of ambivalence about this. I think it's a  
11 complicated issue to try to figure out exactly what you want  
12 to reward through a pay for performance. I think there are  
13 certainly patient elements of that. I just want to be clear  
14 about that. But I worry about just simply do CAHPS, which  
15 is a blend of different types of satisfaction measures and  
16 then weight that equally with clinical performance and  
17 you've got the optimal several measures? I'm not sure  
18 that's the case, is my point.

19           DR. STUART: I'd like to reiterate the potential  
20 payback that you could get from analysis of access to care  
21 data in the MCBS. Much of it is related specifically to MA  
22 plan questions in terms of did you get the right information

1 from this plan? It's not based on NCQA so you can't make  
2 that crossover. But by golly, there's more information in  
3 that database than any other source of information that I'm  
4 aware of.

5 MR. HACKBARTH: Okay, well done, Carlos. We need  
6 to move ahead.

7 Next, Jennifer is going to present on special need  
8 plans.

9 MS. PODULKA: Good morning. I'm here to continue  
10 our discussion from last month about Medicare Advantage  
11 special needs plans.

12 Special needs plans were added as a type of MA  
13 plan by the 2003 MMA and they are paid the same as other MA  
14 plans and are subject to the same requirements. The only  
15 differences are that all SNPs must cover the Part D drug  
16 benefit and they are allowed to limit their enrollment to  
17 their target population. This authority will lapse at the  
18 end of 2008 unless the Congress acts to extend it and SNPs  
19 targeted population includes three types of beneficiaries:  
20 those who are dually eligible for Medicare and Medicaid;  
21 those who reside in an institution or in the community but  
22 are nursing home certifiable; or the third group are those

1 who are chronically ill or disabled.

2           There are aspects of SNPs that raise concerns. We  
3 are concerned about the lack of Medicare requirements  
4 designed to ensure that special needs plans provide  
5 specialized care for their targeted populations and SNPs'  
6 resulting lack of accountability. This raises questions  
7 about the value of these plans to the Medicare program. For  
8 example, dual eligible SNPs are not required to coordinate  
9 benefits with Medicaid programs and many dual eligible SNPs  
10 operate without any state contracts.

11           Since they were introduced, SNPs have grown  
12 rapidly both in number and enrollment. Currently there are  
13 more than 400 SNPs and if all applications are improved next  
14 year there will be more than 700. By, by 2008, 95 percent  
15 of beneficiaries will live in an area served by a special  
16 needs plan. Currently, SNP enrollment has grown to more  
17 than 1 million.

18           Organizations that have entered the SNP market  
19 include those with specialized experience with Medicaid and  
20 special needs population but also include plans without this  
21 experience who have chosen to recently add SNPs to their  
22 menu of plans. A question is whether this represents a

1 marketing strategy or a real investment in providing  
2 specialized care to targeted populations.

3           This is a bit of catch-all but I thought there was  
4 a few things that you should know. First, all SNPs are  
5 required to be coordinated care plans. And SNPs, along with  
6 employer-sponsored plans, were the only source of MA  
7 enrollment growth in local HMOs and Medicare between 2006  
8 and 2007. I say this because this may be encouraging news,  
9 given the Commission's concerns about growth in less managed  
10 forms of MA plans. But on the downside, of course, this  
11 means that SNPs also receive the same additional payments as  
12 all MA plans.

13           Second, SNPs 2006 benchmarks and payments relative  
14 to fee-for-service are similar to regular HMOs, which I'll  
15 show you more on the next slide.

16           Third, one possible explanation for rapid SNP  
17 growth is that the risk adjustment system, which was fully  
18 phased in just last year, is not working like it should.  
19 First, it could lack precision in predicting resource use  
20 because it's based on a finite number of diagnoses, and  
21 there are degrees of variation within these. Or secondly,  
22 it might not accurately track relative resource use in a



1 managed care population.

2 To the extent that there is a problem with the  
3 current risk adjustment system, it would affect all MA plans  
4 and not just SNPs, and we will continue to evaluate this.

5 As I mentioned, SNPs' benchmarks and payments  
6 relative to fee-for-service look really good. They are  
7 similar to HMOs, as opposed to the private fee-for-service  
8 plans on the bottom line.

9 Which brings us to the overall question. SNPs, or  
10 at least their authority to limit their enrollment, expire  
11 at the end of 2008. The question of whether to allow them  
12 to continue comes down to whether SNPs need to limit their  
13 enrollment to do something special. In other words, can  
14 whatever SNPs do be accomplished just as well by regular MA  
15 plans?

16 A key motivation for creating SNPs still applies  
17 to allowing them to continue, and that is providing a big  
18 umbrella to cover all special types of plans and  
19 demonstrations. If CMS authority ceases, then some existing  
20 SNPs could change into regular MA plans. They wouldn't  
21 necessarily have to stop operating. Other SNPs could revert  
22 to or apply to become demonstrations. Of course, it would

1 mean that CMS or the Congress would need to continually  
2 reapproved these types of demonstrations and any new  
3 projects that wished to implement lessons learned from these  
4 would also need to apply.

5           If SNP authority is extended, then SNPs should be  
6 expected to provide specialized care for their enrollees  
7 that regular MA plans cannot provide as effectively or as  
8 efficiently. SNPs may be able to tailor unique benefit  
9 packages that allow them to provide more efficient, higher-  
10 quality care through specialization. However, there are  
11 SNPs that clearly do not meet the standard. Given that the  
12 MMA language that authorized SNPs was very general and CMS  
13 has done little to further focus SNPs, we suggest several  
14 aspects of the plans that should be refined if they are to  
15 continue.

16           By refining what we expect of SNPs in several key  
17 areas, we can help to ensure that there is sufficient  
18 oversight of these plans and that they serve their enrollees  
19 efficiently and effectively. The draft recommendations that  
20 will follow hopefully incorporate what we've learned from  
21 numerous discussions with stakeholders. But before I get  
22 into the SNP-specific recommendations I'd like to remind you

1 that SNPs are an MA plan type and therefore all the  
2 commission's MA recommendations apply to them such as the  
3 ones on payment and quality. And specifically on payment,  
4 remember that as long as Medicare continues into to overpay  
5 MA plan times, any extension of MA such as SNPs carries a  
6 budgetary cost. Some of the following draft recommendations  
7 may, in part, mitigate this cost but any extension bears  
8 that cost calculation.

9 Oh, and one other thing. These have been  
10 renumbered from the mailing materials so they're kind of  
11 flipped but hopefully we can keep track.

12 The authority for SNPs to limit enrollment is  
13 scheduled to expire at the end of next year. An evaluation  
14 by Mathematic Policy Research is due to CMS at the end of  
15 this year. But because most SNPs had only begun operating  
16 for a year or two by the time the study was conducted, there  
17 may be insufficient quality and other data on which to  
18 evaluate them. In light of SNPs' rapid growth in number and  
19 enrollment, we want a rigorous evaluation of SNPs upon which  
20 to base our decision before recommending that they be made a  
21 permanent MA option.

22 Therefore, draft recommendation one is the

1 Congress should extend the authority for special needs plans  
2 that meet the conditions specified in recommendations two  
3 through eight for three years. It should also require the  
4 Secretary to evaluate the plans on the basis of specialized  
5 and general performance measures, use of a health advisor or  
6 care coordinator, the health status of beneficiaries or risk  
7 adjustment, and any other criteria that the Secretary  
8 considers appropriate, and report the results within that  
9 time.

10 All SNPs hold the potential to improve care.  
11 However, the current evaluation will not give us enough data  
12 to assess these plans. Additional quality indicators, state  
13 contracts, and narrowed definitions of chronic diseases will  
14 improve oversight of these plans and we would like to  
15 reevaluate them when they meet these criteria before  
16 deciding whether they should become a permanent MA option.

17 In other words, the Secretary would need to  
18 implement all new rules, collect performance data from  
19 plans, evaluate their performance, and report the results  
20 within the three year time period. And this would inform  
21 future decisions about extending SNP authority.

22 A note about the spending implications here. I

1 will present on this slide the spending implications and  
2 that applies to the entire package. It's not necessarily  
3 just a straight extension, but the extension with the other  
4 recommendations. I can talk more about that on question.

5           So the spending implications are that it will  
6 increase Medicare spending relative to current law by \$50  
7 million and \$250 million for 2009 -- the first year it would  
8 take effect -- and by less than \$1 billion over five years.  
9 The beneficiary and plan implications are that the  
10 beneficiaries could continue to be enrolled in and plans  
11 could continue to operate during an additional evaluation  
12 period.

13           SNPs must measure and report the same quality  
14 measures as other MA plan types. If SNPs need to limit  
15 their enrollment to a target population to provide  
16 specialized care, then the quality of that specialized care  
17 should be measured by appropriate measures.

18           So draft recommendation two is that the Congress  
19 should require the Secretary to require special needs plans  
20 to report additional, tailored performance measures and  
21 evaluate their performance within three years.

22           The recommended performance measures should

1 include quality, resource use, consumer satisfaction, and  
2 any other aspects that the Secretary deems appropriate.  
3 Examples of these measures include those currently being  
4 developed by NCQA and CMS specifically designed for SNPs but  
5 might also include RAND's ACOVE measures which are designed  
6 for health problems specifically affecting seniors. All  
7 SNPs should be evaluated on some additional measures. While  
8 there are other measures that should be specific to SNP  
9 types, for example there are ESRD SNPs, and we would like to  
10 see these evaluated on the same measures applied to the ESRD  
11 demonstration so that we can get a comparison. All of these  
12 measures, together with existing measures that compare SNPs  
13 to other MA plans, should form the basis for a rigorous  
14 evaluation that would have decide whether SNPs should become  
15 a permanent MA option. The performance measures should be  
16 established, plan's performance on them should be evaluated  
17 and the Secretary should publicly report the results within  
18 a three-year period.

19           The implications are that beneficiaries should  
20 receive improved quality of care while plans would have the  
21 burden of reporting the information.

22           We are concerned that an existing lack of clear

1 information is an impediment to beneficiaries learning about  
2 and making an informed decision on joining a SNP. Because  
3 the CMS website template is structured to compare all MA  
4 plans in a consistent manner and CMS has not restructured  
5 the template to reflect SNP offerings, these plans are often  
6 not accurately describe. For example, the Medicare Compare  
7 website shows cost-sharing requirements for dual eligible  
8 SNPs that charge no enrollee out-of-pocket cost-sharing  
9 because it's paid for through state Medicaid programs.

10 So draft recommendation three is that the  
11 Secretary should provide accurate information on special  
12 needs plans that compares their benefits and other features  
13 to other MA plans. This information should be furnished to  
14 beneficiaries through the website and written materials.

15 The comparative SNP information could be included  
16 on the Medicare Compare website, for example as a drill-down  
17 option. However, because the majority of beneficiaries do  
18 not directly use the website or visit counseling programs  
19 that have used it, written comparative SNP information  
20 should be mailed to beneficiaries annually.

21 The implication is that the recommendation would  
22 improve beneficiaries' ability to make informed choices will

1 having minimal impact on SNPs because this information is  
2 already collected on the plans' benefit package they submit  
3 each year.

4           On draft recommendation four here, I believe Glenn  
5 has some comments but I'll set this up and you all can  
6 discuss it during the discussion period. If SNPs are  
7 allowed to limit their enrollment, then they should better  
8 manage the care of their enrollees than a regular MA plan.  
9 Linking enrollees with an individual responsible for  
10 coordinating their care would be a minimum step toward  
11 managing care and also allow CMS a quantifiable measure to  
12 collect during a survey.

13           So draft recommendation four is that the Congress  
14 should require special needs plans to link all enrollees  
15 with a personal health advisor or care coordinator and the  
16 Secretary to evaluate enrollees awareness of and  
17 satisfaction with this service within three years.

18           CMS should determine standards for who can qualify  
19 as a health advisor or care coordinator, for example a  
20 primary care physician, nurse, or social worker, and set  
21 standards such as minimum ratios of advisers and  
22 coordinators to enrollees. The nature of this care



1 coordination may differ by SNP type. For example, dual  
2 eligible SNPs might rely more on social workers to  
3 coordinate benefits than on medical personnel.

4 CMS should then survey SNP enrollees about their  
5 awareness of and use of their personal health advisor or  
6 care coordinator. Again, these data should be collected,  
7 evaluated, and reported within the three year time period.

8 Implications are that beneficiaries should receive  
9 improved quality of care while some plans, at least, might  
10 have to hire staff to perform this function. However, we've  
11 heard from a number of plans that they already use this and  
12 so the burden on them would be merely reporting.

13 Most SNPs limit their enrollment to their targeted  
14 special needs population exclusively. However, SNPs may  
15 apply to CMS for a waiver from this requirement to enroll  
16 any other beneficiaries as long as their total membership  
17 includes a disproportionate percentage of their targeted  
18 population. CMS has defined this so that the percentage of  
19 the target population in the plan must be greater than the  
20 percentage that occurs nationally in the Medicare program.  
21 Although there may be legitimate reasons for SNPs to enroll  
22 other beneficiaries, for example to allow members who

1 temporarily lose eligibility to remain enrolled, these  
2 exceptions should be limited and the current definition may  
3 be too liberal and untargeted.

4 For example, CMS has already made specific  
5 accommodations for beneficiaries who move in and out of  
6 Medicaid eligibility by letting plans know that they can  
7 continue to enroll them for several months.

8 So draft recommendation number five is that the  
9 Congress should require the Secretary to report annually on  
10 the number and circumstances of special needs plans that are  
11 granted a waiver to enroll a disproportionate share of their  
12 target population and to require them to enroll at least 95  
13 percent of their members from their targeted population.

14 We would expect plans to report on the use of the  
15 waiver and CMS to report on the waivers it has granted on an  
16 annual basis, and in its evaluation of SNPs, to be completed  
17 within the three year time period.

18 Implications are that some plans would either have  
19 to alter their enrollment or cease to be SNPs. They could,  
20 however, return or continue as regular MA plans. As a  
21 result of any plans shifting or changing, relatively few  
22 beneficiaries would have to switch plans or return to fee-

1 for-service and we think that any changes now could prevent  
2 larger changes and disruptions in the future.

3           Chronic condition SNPs are broadly defined. Not  
4 all chronic condition SNPs may be sufficiently specialized  
5 to warrant formation of delivery systems and disease  
6 management strategies. For example, there is a chronic  
7 condition SNP for beneficiaries with high cholesterol, which  
8 might be important to manage but it is a condition common  
9 enough that one would hope that all MA plans can effectively  
10 do so.

11           Therefore, draft recommendation six is that the  
12 Secretary should convene a panel of clinicians and other  
13 experts to create a list of chronic conditions and other  
14 criteria appropriate for chronic condition SNP designation.  
15 Chronic condition SNPs must serve only beneficiaries with  
16 complex -- this would be the recommendation -- with complex  
17 or advanced, late stage, chronic conditions that influence  
18 many other aspects of health; have a higher risk of  
19 hospitalization or other significant adverse health  
20 outcomes; and requires specialized delivery systems.

21           The list mentioned in the recommendation and any  
22 other criteria should be issued as a proposed rule with

1 comment and final rule within a three-year period, again to  
2 inform future decisions about continuing SNP authority.

3           Implications for beneficiaries should be minimal,  
4 however some plans may have to change their targeted  
5 conditions or cease to be SNPs. Again, they could return to  
6 the regular MA program.

7           Although they were intended to coordinate Medicare  
8 and Medicaid, dual eligible SNPs are not required to  
9 coordinate benefits with Medicaid programs and many dual  
10 eligible SNPs operate without any state contracts. Without  
11 a state contract to cover Medicaid benefits, it is unclear  
12 that a dual eligible SNP would behave any differently than a  
13 regular MA plan. However, based on our discussions with  
14 SNPs that do have a contract, it may reasonably take several  
15 years to establish one. Ideally, contracts would cover  
16 long-term care but we recognize this may be difficult as few  
17 SNPs with state contracts have taken risk for this high-cost  
18 service.

19           Therefore draft recommendation seven is that the  
20 Congress should require dual eligible special needs plans to  
21 contract with states in their service areas to coordinate  
22 Medicaid benefits within three years. The Congress should

1 require dual eligible special needs plans to limit  
2 enrollees' out-of-pocket cost-sharing to no more than  
3 Medicaid cost-sharing and bids should reflect actual  
4 negotiated rates and cost-sharing.

5 I want to note that recommending that all dual  
6 eligible SNPs should contract with states within three years  
7 means that by 2012 all existing and any new dual eligible  
8 SNPs could only begin operating as a SNP if they started  
9 with a contract in place.

10 Implications for beneficiaries are that they  
11 should enjoy greater coordination of Medicare and Medicaid  
12 benefits if they're enrolled in a plan. For plans, if they  
13 are unable to contract with the state, there would be a  
14 significant impact in that they would have to cease to be  
15 SNPs. However, they could continue as regular MA options.

16 Last one. I want to note here that this applies  
17 not just to SNPs, but to all MA plans, so it's somewhat  
18 unique.

19 Special needs beneficiaries have more  
20 opportunities to join or switch MA plans outside of the open  
21 enrollment period than regular beneficiaries. Dual eligible  
22 have a special election period which begins when they become

1 dually eligible and continues as long as they remain dually  
2 eligible. As a result, they can change plans on a monthly  
3 basis.

4 Presumably, dual eligibles were excepted from  
5 lock-in to give them greater protection than other  
6 beneficiaries. However, we find that the provision has had  
7 unintended consequences.

8 We are concerned about reports of marketing abuses  
9 directed at dual eligibles. One consequence of these is  
10 that beneficiaries can find themselves enrolled in MA plans,  
11 not just SNPs, where they are subject to much more cost-  
12 sharing than they would be under fee-for-service. And  
13 another consequence is that beneficiaries can be subject to  
14 month-to-month churning among plans, harming continuity of  
15 their care if their providers do not participate in each  
16 plan that they enroll in.

17 So draft recommendation eight is that the Congress  
18 should eliminate dual eligible beneficiaries' ability to  
19 enroll in Medicare Advantage plans outside of open  
20 enrollment, with the exception that they are allowed to  
21 disenroll and return to fee-for-service at anytime during  
22 the year.

1           The implications for beneficiaries are that they  
2 would receive greater protection from plan marketing abuses  
3 and it may have a significant impact on plans by reducing  
4 plan enrollment.

5           Those are the recommendations and I look forward  
6 to questions and comments.

7           MR. HACKBARTH: Nice job, Jennifer.

8           If I could, I'm going to go back to recommendation  
9 four. Jennifer mentioned that I had expressed some  
10 reservations about that. Before I go into my reservations,  
11 let me just say I support the overall thrust of the  
12 recommendations, which is to make sure that special needs  
13 plans have some content and substance and are truly useful  
14 to Medicare beneficiaries.

15           On draft recommendation four, which is the one  
16 requiring SNPs to link enrollees with a personal health  
17 advisor or care coordinator, I'm sympathetic with the goal.  
18 I think that the concept is a sound one. My reservation has  
19 to do with making it a legislative or regulatory  
20 requirement.

21           My own take on how this program should work is  
22 that we should have payment policies that basically require

1 organizations to be efficient in order to be successful, and  
2 then we ought to complement that with significant rewards  
3 for providing measurably better quality. And then we ought  
4 to leave it up to the organizations to figure out the best  
5 way to achieve those ends and not dictate particular  
6 organizational structural requirements because I think that  
7 there are potentially multiple different ways. And that's  
8 where the private sector can and should be left to innovate,  
9 as opposed to that being a government mandate.

10 I worry in particular that a requirement like  
11 this, of a personal health advisor or care coordinator, you  
12 run the risk that on one hand you either make the regulatory  
13 requirements so general that it becomes meaningless and is  
14 strictly formalism or alternatively you try to put real  
15 teeth in it and you become unduly restrictive and the  
16 message is we know the right way to do this when, in fact,  
17 there may be multiple right ways to do it.

18 And so rather than get into that business, the  
19 formalistic structural business, I would again say that the  
20 right thing for us to do is have payment systems that reward  
21 good results and let plans figure out how best to achieve  
22 those results.



1 DR. DEAN: On that particular point, as they were  
2 going over this, it brought to mind a patient of mine who  
3 just enrolled into the special needs plan we have in our  
4 area, which is a cardiovascular special needs plan. He gets  
5 part of this care from the VA, he sees me regularly to check  
6 his protimes and manage his heart failure and his  
7 anticoagulation. And he's happy as a clam with his new  
8 plan. It's given him a bunch of benefits he didn't have  
9 before.

10 But conceivably, if this applied, you would add  
11 yet a third directive. And here's this poor guy trying to  
12 do what the VA tells them, trying to do what I tell him, and  
13 also trying to do what this new person tells him. And I  
14 think we really don't gain anything. So I think it supports  
15 your point.

16 MR. HACKBARTH: Other comments on four? Why don't  
17 we just focus on that for a second.

18 DR. REISCHAUER: Glenn and I agree on this one but  
19 there has to be a conforming change to recommendation one,  
20 as well.

21 MR. HACKBARTH: Okay.

22 MS. DePARLE: I agree on this point but I do think

1 -- and I'm sitting here struggling given what Tom just said.  
2 We have said that we advocate something like a medical home,  
3 not just for chronically ill beneficiaries who are enrolled  
4 in Medicare Advantage plans but for all of Medicare  
5 beneficiaries. And so I'm sympathetic to the thinking  
6 behind this recommendation because I think that's part of  
7 what it was trying to achieve. Maybe there are multiple  
8 ways to achieve it. I'm thinking about your patient, Tom.  
9 I guess you're his medical home, which is fine.

10 DR. DEAN: I hope so.

11 MS. DePARLE: And that's good. But this is one of  
12 those things that is harder to do than it is to talk about.

13 I do think there is this idea that I've heard  
14 about requiring each of the special needs plans to do an  
15 individual plan for each of the patients that enrolls.  
16 Again, that may be one of those things that seems obvious,  
17 and of course they're doing it, but they're not. I would at  
18 least support having that, if not in the text, if not in the  
19 recommendation at least in the text, that that's one way of  
20 doing it. This might be another way. There are several  
21 ways to accomplish it.

22 DR. DEAN: I would say that I think we can't

1    assume that these people are living in a vacuum right now.  
2    They're all getting something somewhere.  And I think some  
3    sort of a requirement, and what you said may well be -- it  
4    needs to fit with and improve upon what they're currently  
5    getting.  But there's going to be a huge spectrum.  Some of  
6    these folks are getting good care and some are getting no  
7    care at all.

8                If they're not getting any kind of coordination,  
9    then this requirement applies well.

10               So some kind of individual plan, I think, would  
11    make a lot of sense.  Whether you could push the companies  
12    to do that, I don't know.  That would be a big headache.

13               MR. HACKBARTH:  Just to be clear, and pardon me  
14    for pounding on this, if I were running a plan I may well  
15    elect to do this.  That's not the issue.  The issue is  
16    whether regulation will be an effective tool for  
17    accomplishing the end.

18               So let's focus again on recommendation four.

19               MS. HANSEN:  Having run a plan, I do concur that  
20    there are ways to do it and that I would lean on what Nancy-  
21    Ann just had to make sure that there is a real dedicated  
22    focus for an assessment as to how they do it.  Because it

1 could be electronic record at this point to do it, to the  
2 complex of have really having a personal adviser. But  
3 that's really the judgment of the administrator being  
4 responsible for outcomes. And hopefully then the incentives  
5 for rewards would be tied to that. And so the whole  
6 question is how big the reward is and that's a different  
7 issue.

8 But I think the method of proscription would be a  
9 little bit too tight here.

10 MR. BERTKO: Just quickly, Glenn, to agree with  
11 what you said and to pick up on Nancy-Ann's suggestion for a  
12 care plan, that might fit within recommendation six well  
13 enough. That is you have certain ones that people have  
14 looked at and said in the text around that and this should  
15 include a care plan, which could be fairly generally like  
16 Jennie has described.

17 DR. SCANLON: I, too, have concerns about four  
18 being too specific. But at the same time I think we have to  
19 have something that suggests that there is some type of  
20 process or structural requirement to be a SNP. One of the  
21 things that we've gone from -- the history is we've gone  
22 from demonstrations, where possibly there was a model

1 specified in terms of getting a waiver that this is  
2 something that they were going to do. And in moving to the  
3 broader authority, we've said we don't ask you to do  
4 anything special. And the world in which we're going to  
5 reward results of the payment system is a world of the  
6 future. And we've got close to 800 SNPs for 2008. And I  
7 think we've got to think about is in that context.

8 In that context, I don't want to structural or  
9 process requirement should be but I think there needs to be  
10 something that we can hold people accountable immediately,  
11 as opposed to at some sort of future point.

12 DR. MILSTEIN: Along these lines, is  
13 recommendation two strong enough? In other words,  
14 recommendation two indicates that we recommend there should  
15 be some additional evaluation of these plans. Along the  
16 lines of what Bill was just suggesting, should we consider  
17 strengthening recommendations such that we signal that we  
18 believe that on quality measures that are common to regular  
19 MA plans and special needs plans, that for the populations  
20 that special needs plans have elected to serve, the special  
21 needs plans' performance ought to be significantly better  
22 than is the performance of regular Medicare Advantage plans

1 treating those same populations, since those populations are  
2 not only in special needs plans.

3 I hope that was comprehensible.

4 The right now it just says the Secretary shall  
5 additionally evaluate. But I personally think it might be a  
6 point to consider a stake in the ground and saying you  
7 actually have to do better on the population --

8 MR. HACKBARTH: So recommendation one is a time-  
9 limited extension coupled with evaluation. And so what I'm  
10 hearing Arnie say is as opposed to focus on structure, focus  
11 on results and say this program should only be reauthorized  
12 beyond that if these plans are demonstrating superior  
13 quality.

14 DR. REISCHAUER: Yes, but there's a lot of  
15 different dimensions to better. And one is clinical  
16 measures. Another is sort of ease of patient processing.  
17 Some of it's amenities. It could be all sorts of cost-  
18 sharing dimensions.

19 I'd hate to be the analyst who was forced to come  
20 up with the aggregate measure of better.

21 DR. MILSTEIN: Glenn, I think your idea I would  
22 support. But I was also thinking about whether it could

1 denominated on a plan specific basis, so that the  
2 continuation forward into the future would only be allowed  
3 to those plans that actually did better and then perhaps  
4 leave it to some poor analyst in the Secretary's office to  
5 figure it out.

6 DR. SCANLON: It's more than the poor analyst.  
7 It's the lawyers for the Secretary, too, that are going to  
8 have to litigate this because they're going to be challenged  
9 at every turn.

10 I guess the concern I have here is in terms of the  
11 extension and making the extension conditional is that we  
12 need to deal with the reality. You've already got 800 plans  
13 out there. And in some respects, it's a little bit like  
14 once you're there it's very hard to dislodge something. And  
15 if in three years we have 1,200 plans out there, it's going  
16 to be hard to come back with -- and while Arnie is right, in  
17 terms of they should have done something better, if they  
18 haven't done something better or if it's ambiguous whether  
19 they've done something better, it's going to be hard to say  
20 we're not going to extend this authority anymore. So I  
21 think we need more about requirements now.

22 MR. HACKBARTH: Certainly, we have ample evidence

1 in the Medicare Advantage program of momentum that's very  
2 difficult to reverse, although this may be a little bit  
3 different in that the loss of SNP certification, if you  
4 will, would not mean you go out of business or everybody's  
5 disenrolled. You just become a regular MA plan with the  
6 same rates.

7 DR. REISCHAUER: Most of them have a parent  
8 already. They're just a spinoff of something that already  
9 exists.

10 DR. SCANLON: But then why are we even debating  
11 this? It's kind of like why is there a spate in terms of  
12 reauthorization? The issue on our part should be the whole  
13 idea of trying to get something special.

14 On the other side of the coin, though, I think  
15 that the year-round marketing makes a huge difference in  
16 terms of the attractiveness of this. And I don't know,  
17 those who know plan operations better can tell me that  
18 there's something else that makes it attractive. But I know  
19 that there's an interest in continuing this authority. And  
20 the question is why? Why have we had such unusual interest?  
21 This was all so unexpected, that we would have had such  
22 intense interest on the part of the SNPs.



1           MR. HACKBARTH: Let me try to get some other  
2 people involved.

3           DR. WOLTER: I was starting out by just reacting  
4 to this recommendation but then I got a couple of other  
5 thoughts listening to all of this. I sort of agree not to  
6 mandate something like this.

7           Having said that, it's very clear that with these  
8 complex chronic disease patients -- which another  
9 recommendation addresses -- the care between the doctor this  
10 is what makes all the difference. And so some robust text  
11 discussion of chronic disease management and the  
12 infrastructure that's required to do it well is going to  
13 have a lot of value, which would connect back to the work we  
14 did a few years ago on chronic disease management. I think  
15 it was Karen Milgate that did that work.

16           And if you remember, we had some recommendations  
17 there about organized practices versus sort of virtual  
18 groups. But in both cases, there were ways for nurses and  
19 others to be sure that the care was being very well managed  
20 between physician visits.

21           And there's the Wagner chronic disease management  
22 model. This really isn't rocket science. I don't think

1 we're doing something ephemeral here in these  
2 recommendations.

3           As far as outcomes, you could look at remission  
4 rates, you could look at admission rates. There are  
5 tremendous things that we could be looking at. These plans  
6 can have a lot of value, both clinically and financially, if  
7 the appropriate structure is put on them. So this is really  
8 a good direction, maybe we can just flush it out a little  
9 bit more and connect back to some other work we've done in  
10 the past.

11           MR. HACKBARTH: So you're proposing to keep  
12 recommendation four or drop-it but beef up the textual  
13 discussion of --

14           DR. WOLTER: I'd be fine with not -- requiring  
15 this, you could meet this in some rote way and not  
16 necessarily be doing all the right work. But I think to  
17 point out that chronic disease management infrastructure and  
18 the management between visits that nurses and others do is  
19 really where the action occurs in terms of both dollar  
20 savings and better -- there's the SF6 and 12, the functional  
21 status things. There are measurements we could put in place  
22 that would tell us how well these plans are doing.

1           MR. HACKBARTH: Let's try to sum up on this  
2 particular one. I expressed my concern. It's not the end  
3 of the world to me one way or the other. And I'm happy to  
4 go where most of the group wants to go on it.

5           Can I just get a tentative show of hands, sort of  
6 a straw vote, not an official vote, on whether we want to  
7 keep this one or not?

8           DR. SCANLON: What about an alternative?

9           MR. HACKBARTH: Let me just ask about this one as  
10 worded and if there's not broad support for that, then we  
11 can talk about an alternative. Who would like to see it  
12 kept pretty much as it is? Nobody?

13          Go ahead, Bill, offer your alternative.

14          DR. SCANLON: The alternative is I think, going  
15 along the lines of what Nick was talking about in respect to  
16 the text, which is to say that we really want something real  
17 in this plan. And I don't know whether it's care  
18 management, care coordination, which is a process but it's  
19 not as specific as this one the way the wording is now. And  
20 I don't know what the right words are but it's along the  
21 lines of we really want there to be some kind of management.

22          MR. HACKBARTH: Unfortunately, we're at the point

1 were we need the right words.

2           And incidentally, I agree with Nick. That's just  
3 assume that we need to beef up the textual discussion as  
4 part of it and try to focus on what the wording of the  
5 recommendation is.

6           MS. BEHROOZI: This is one of those Nancy-Mitra  
7 things, I heard Nancy just say it aloud, that we require  
8 that they identify with their plan is, what their management  
9 plan -- is the words that Nancy used -- would be, whether  
10 it's doing assessments and care plans, whether it's having  
11 an individual care coordinator medical home kind of model.  
12 And then somebody has got to have the authority to deem that  
13 acceptable. But at least to make them come forward with  
14 something. How about that?

15           DR. REISCHAUER: The question here is do they have  
16 to do it for each individual --

17           MS. BEHROOZI: Yes.

18           DR. REISCHAUER: -- or a general strategy?

19           MS. BEHROOZI: Yes.

20           DR. REISCHAUER: And I think each individuals is  
21 where all are.

22           MS. BEHROOZI: Yes.

1 DR. REISCHAUER: But have it rather vague exactly  
2 what it is.

3 MS. BEHROOZI: Right. So they have to have a plan  
4 of how they will do that for each individual, yes.

5 DR. KANE: I like the idea of having that as part  
6 of six, as among the criteria that you have to meet this is  
7 one of the criteria, that you have to have a care plan for  
8 every individual.

9 MS. PODULKA: Six is only specific to the chronic  
10 condition SNP, so that would be excluding the other two  
11 types.

12 DR. KANE: We may want to talk about that, too,  
13 when we get to targeting.

14 DR. MILSTEIN: I spent seven years trying to  
15 enforce Federal structural requirements in health care  
16 delivery and the plans are -- I completely agree with the  
17 idea of a plan but I don't think it's enough. I think  
18 something along the lines of a plan and a mechanism for  
19 rapidly detecting and responding to deviations from plan  
20 would make -- because plans of care are everywhere to be  
21 found. It's the ability to react quickly when actual course  
22 of care deviates from plan that is missing.

1           MR. HACKBARTH: I agree with that, Arnie. And  
2 recommendation two is the one that's directed towards  
3 implementing a set of specific measures that allow us to  
4 detect whether, in fact, they're doing something better or  
5 not.

6           DR. MILSTEIN: But suggesting that the requirement  
7 be -- that you not only have a detection system but  
8 documentation that you respond quickly when your measurement  
9 system suggests deviation from plan.

10          MR. HACKBARTH: Mark has a solution to this.

11          DR. MILLER: No, no, no.

12          [Laughter.]

13          DR. MILLER: Although just before I say this, I  
14 think one concern raised at the outset of this is do you end  
15 up saying things that end up being unenforceable? So I  
16 think as much as we want to say all of this, we really have  
17 to think about how much it can be executed.

18                 But trying to build something from what is said,  
19 instead of making it congressional, direct it to the  
20 Secretary. It's a regulatory requirement. Put something  
21 out in notice and comment that has two components. You have  
22 to have an individual care plan. And in submitting their

1 application to be a SNP, they also have to describe and  
2 articulate how they will do coordinated chronic care  
3 management within their model specifically as one thing that  
4 they have to talk about and hurdle that they have to pass to  
5 be approved. And take it out of the Congressional thing.

6 But I think there's also the caveat at the onset  
7 of what does that really mean and how enforceable?

8 DR. REISCHAUER: Can I suggest that the plan has  
9 to be shared with the patient? That creates a certain  
10 enforcement mechanism right there.

11 DR. STUART: This is really quick and it gets back  
12 to the fact that the Commission is seeing these  
13 recommendations today. These are different from the ones  
14 that we had in the written materials.

15 And I think that in the interest of time, we're  
16 not going to get the wording of these things today. But if  
17 Mark and his staff could put together the basis of a new set  
18 of these things after we get a chance to discuss a couple of  
19 other of these recommendations. Because I think some of  
20 this is going to migrate from one recommendation to another.

21

22 MR. HACKBARTH: We can do that but just to remind

1 people, the original goal was to have recommendations for  
2 final vote at this meeting so that we could make our  
3 position known on this to the Congress.

4 DR. MILLER: Draft recommendations today.

5 MR. HACKBARTH: I'm sorry, I was thinking we did  
6 these draft at the last meeting. Okay. We do have  
7 additional time.

8 DR. STUART: I'd like to bring up item six because  
9 this is, I think, tied in in terms of these are the folks  
10 that you want to do it to. And I recognize the reason for  
11 this recommendation is that I think it was triggered by the  
12 SNP that was given authorization for lowering lipid levels.  
13 And we don't want to see somebody come in with a dandruff  
14 control SNP.

15 However, I am concerned about the language here,  
16 about -- it implies that the only people that can be brought  
17 into these plans are train wrecks. And I would think that  
18 what you really want to do is to capture some of these  
19 individuals before they become train wrecks. So I'm  
20 thinking, if I had a SNP that was focused on diabetes, I  
21 would not want to limit it just to the people that were  
22 diabetic and amputees. I'd want to get the people who were



1 at risk for these bad complications and it to show how, in  
2 fact, we could reduce the rate of complications over time.

3 Now maybe this was your intent. But depending  
4 upon the wording here, it doesn't come through. And so  
5 perhaps the way to do it would be to limit the SNPs to  
6 conditions for which there is a high risk of complex and  
7 expensive outcomes.

8 DR. REISCHAUER: The "late stage" words here,  
9 given Nancy's --

10 MR. HACKBARTH: So everybody see where we are on  
11 six? That sounds like a sensible modification.

12 MS. PODULKA: We've heard from anecdotes that  
13 without the advance or late stage -- advance or late stage  
14 is an "or" to complex. That the complex by itself, complex  
15 and risk of adverse health outcomes would actually apply to  
16 hyperlipidemia. So if you have high cholesterol, it's a  
17 complex condition that can affect many other aspects of the  
18 health and eventually lead to adverse health outcomes.  
19 We've really struggled with how to capture diabetes, even  
20 perhaps some early-stage diabetes, without letting in  
21 someone else, dandruff control.

22 DR. REISCHAUER: Wasn't the Secretary having a

1 panel that was going to look to see what conditions were  
2 really applicable, and so the dandruff and high cholesterol  
3 would drop out?

4 MR. HACKBARTH: I think this is maybe, in  
5 particular, an example of where it would be difficult for us  
6 to craft the magic words. And I think it's the sort of  
7 thing that a group of experts ought to draw the boundaries  
8 around.

9 I thought the issue around high cholesterol was  
10 not that it couldn't have important health implications but  
11 rather that it's so common that it really doesn't define a  
12 special needs population and all Medicare Advantage plans  
13 ought to be capable of addressing such a common medical  
14 problem.

15 And so part of it is the potential for severe  
16 consequences for the patient, but also part of the test is  
17 prevalence. Some things you don't need specialized  
18 organizations for.

19 DR. KANE: Requiring specialized delivery system  
20 could help get rid of that, too.

21 MR. HACKBARTH: I feel so much better that we  
22 don't have to resolve this today.

1 [Laughter.]

2 MR. HACKBARTH: I'm not depressed anymore.

3 [Laughter.]

4 DR. REISCHAUER: Then you can't join our  
5 depression SNP that we have.

6 MR. HACKBARTH: So we'll work on that language.  
7 Could I ask that we just go back through them in order, as  
8 opposed to jumping around? I think we'll be able to work  
9 more efficiently that way.

10 Let's focus on number one. In the interest of  
11 time -- I'm going to go want one, through the package. I  
12 started at four, and I apologize for that. But now I'm  
13 going to do it right and go through one by one.

14 What I'd ask is that if your comment is basically  
15 editorial in nature, I'd like to change the words a little  
16 bit, let's do that off-line through e-mail or something else  
17 and reserve this time to focus on major substantive problems  
18 that people have with the recommendations.

19 So draft recommendation one.

20 MR. DURENBERGER: This is a general comment but  
21 for the last 40 minutes I've been having a déjà vu moment  
22 which is, for 25 or 30 years now I've been listening to this

1 sort of discussion. And it's usually -- I could also call  
2 it a Republican moment where Henry Waxman is on the other  
3 side of the table and he's saying we've got to have a health  
4 and we've got to have this and he's reciting. That's the  
5 moment I've been having.

6           The concern that I have, I think, is that we're  
7 AFLAC-ing -- to use a common term -- quack, quack, quack.  
8 We are AFLAC-ing a very precise condition on the part of  
9 people. While we have a Medicare Advantage policy or  
10 program that we are not really confident has been  
11 prescriptive enough in the folks that generate it. It may  
12 be somewhat off-base and I'm glad, too, we have a month to  
13 think about it. Because before I vote for this, I'd really  
14 like to go back and focus on why we can't suggest that the  
15 Medicare, the general Medicare Advantage program consider a  
16 way in which benefits designed specifically to prevent  
17 institutionalization and prevent chronic illnesses and so  
18 forth. But when they do occur, and so forth, and we have  
19 disease management and we have other things.

20           And I don't know what I'm talking about, except I  
21 really think that going back and focusing on the basic  
22 Medicare Advantage program, what kind of benefits structure,

1 what should the performance expectations be? And within  
2 that, deal with dual eligibles and institutionalized and  
3 severe chronic illnesses, is better than opening up the gate  
4 again to AFLAC-ing 722 different versions of AFLAC and it  
5 will be 1,400 around the specific conditions.

6 I'm hope I'm wrong about that and I'm only sharing  
7 an instinct that's built up over a few years of watching  
8 this sort of thing at work. So I'll try to get over that in  
9 the next month, but it makes it difficult for me right now  
10 and I need to express it to vote for that recommendation.

11 DR. STUART: This is, in a sense, a technical  
12 issue but I think it has some potential impact in terms of  
13 the likelihood of these recommendations being adopted.  
14 That's the savings estimate. Because on the one hand I've  
15 heard that if the SNPs are not reauthorized, then the  
16 companies can simply fold these people into their regular MA  
17 plans. And if they fold them into their MA plans, there's  
18 no savings, there's no extra cost.

19 And so if this cost is specific to the SNP, then I  
20 think it overestimates the saving or the additional cost  
21 that would be associated with having the SNP provision.

22 DR. MILLER: Unless I'm missing something,

1 Jennifer, the estimate assumes how many people go back into  
2 plans and how many just drop back out into fee-for-service?

3 MS. PODULKA: [Nodding affirmatively.]

4 MR. HACKBARTH: And here we're working from the  
5 CBO estimate?

6 DR. MILLER: We've consulted with them on the  
7 magnitude here, right. The reason that it has a cost is  
8 because in current law there is a sunset to this. And so  
9 some people would drop back into fee-for-service and  
10 therefore their cost would go down in the baseline. But if  
11 you continue them, they won't drop back and that generates  
12 the cost.

13 If somebody could just nod, like a Scott or a  
14 Jennifer.

15 MS. PODULKA: [Nodding affirmatively.]

16 MR. HACKBARTH: At the end of the day what matters  
17 is what CBO thinks on these things and not what we think.

18 DR. MILLER: Right, there is that.

19 MR. HACKBARTH: So anything else on recommendation  
20 one?

21 MS. DePARLE: I said this earlier. I would  
22 support a longer timeframe of extension, like five years or

1 even four years, in part because I think the list -- you  
2 have to balance the urgency of doing something on this  
3 against the realities and the practicalities.

4           As my friend, Dr. Scanlon, often reminds us,  
5 trying to get all of this done and the amount that we're  
6 asking the secretary and CMS to get done. And also relating  
7 to comments I'll have on some of the other recommendations,  
8 given the discussion this morning about the relative lack of  
9 progress we seem to be making with quality and Medicare  
10 Advantage plans overall, I hope -- this should be the  
11 laboratory, to me. SNPs should be the laboratory for what  
12 can we really achieve with this population. I hope somebody  
13 of the performance measures would be outcome related, as my  
14 friend Arnie keeps saying, as opposed to just -- so that  
15 will take more time.

16           MR. HACKBARTH: Pardon me for being -- for  
17 truncating the discussion here. I think Nancy-Ann has  
18 raised a reasonable issue and clearly expressed. Rather  
19 than having a prolonged discussion about it, I'd just like  
20 to see a show of hands. Who would like to keep it shorter,  
21 let's say at three years and leave it as it is?

22           And then who would like to see a longer period?

1           So it's a significant division. So four years is  
2 obviously the right answer.

3           [Laughter.]

4           DR. REISCHAUER: There's no requirement that after  
5 three years you have to make them permanent or not, as  
6 opposed to say we had a lot of progress going on here, let's  
7 do it for another three years. It's unlikely that even  
8 within five years we're going to be completely comfortable  
9 with this organization's --

10          MS. DePARLE: But you want them to have the  
11 information upon which to make the decision about whether to  
12 extend or make it permanent. And I'm just expressing real  
13 skepticism about whether we can have that.

14          MR. HACKBARTH: We will resolve this someplace  
15 else.

16          MS. PODULKA: If we would like to discuss  
17 different time frames, I'm going to have to come back to the  
18 Commission with a new budget estimate. There will be a very  
19 real impact to any change in the number of years.

20          MR. HACKBARTH: Anything else on one?

21          MR. EBELER: I'm sorry. I'm just reflecting on  
22 this discussion. It seems to me the structure of one, as an



1 alternative, could be an extension but only for a narrower  
2 number of plans that are truly defined to meet special needs  
3 and a process of phasing a number of other plans into MA.

4           It strikes me that that's the policy objective  
5 we're talking about. We are really trying to divide this  
6 group a little bit. That's just a different structure.

7           MR. HACKBARTH: Let us play with these ideas on  
8 one.

9           Draft recommendation two.

10          MS. DePARLE: In the text, I would like  
11 performance measures to be defined as being not just beta-  
12 blockers after heart attack kind of stuff. Yes, that we get  
13 into some outcomes.

14          MR. HACKBARTH: That will be textual discussion.  
15 As Ron points out, obviously we'd have to make a conforming  
16 change to that duration on whatever we decide there.

17          Moving on, draft recommendation number three.

18          MS. HANSEN: This one would be as is is fine. But  
19 perhaps in the text that ties back to other ways to inform  
20 beneficiaries other than the website and kind of classic  
21 written materials. We talked about whether the SHIP other  
22 ways to make sure that again beneficiaries are going to be

1 informed with these kind of findings. So it just ties it  
2 back to yesterday's work.

3 MR. HACKBARTH: Okay, and I think we can maybe  
4 tinker with the wording of the recommendation but also  
5 emphasize that in the accompanying text.

6 Number four we talked about at length. Number  
7 five.

8 DR. STUART: I have a question in terms of why  
9 there are waivers at all. I understand that that some CMS  
10 demonstrations were given waiver status under this because  
11 they had -- their policies were such that they could enroll  
12 people other than meet these particular conditions. But I'm  
13 wondering why new SNPs would be given a waiver policy and  
14 whether, in fact CMS, is still doing that.

15 MS. PODULKA: CMS is continuing to grant  
16 disproportionate share waivers and that is a policy debate,  
17 to decide whether you want that to continue in the future.  
18 There are two options generally, if you want to continue it.  
19 One is to allow a certain percentage. The second is to have  
20 a list of specific exceptions, such as for spouses or for  
21 people who move in and out of Medicare eligibility. Doing a  
22 percentage is somewhat more of a catch-all than coming up

1 with a finite list.

2 DR. REISCHAUER: Jennifer, I don't know if I've  
3 misunderstood you, but I thought you said that  
4 disproportionate meant relative to that the general  
5 population. So if 8 percent were diabetics, you would  
6 qualify with 9 percent.

7 MR. HACKBARTH: That's the current definition.

8 MS. PODULKA: Absolutely correct. It's quite  
9 liberal, in some cases.

10 DR. REISCHAUER: Which is an interesting  
11 definition of disproportionate in the waiver. So it makes  
12 no sense at all.

13 DR. KANE: In a way, I don't like picking a number  
14 like 95 percent at this point, because I don't think we know  
15 what that means. I think we should say the waiver should  
16 only be granted under -- and maybe be specific about what  
17 qualifies for waivers. And then find out what that means.

18 But the 95 percent and looking at the -- I just  
19 feel like you're saying let's find out -- report annually on  
20 the number and circumstances of waivers. And by the way,  
21 the waivers cannot be used to get outside your target area,  
22 you have to have 95 percent targeted. Partly because I

1 don't know what it means and I don't think anybody does.

2 MR. HACKBARTH: So are you suggesting that we just  
3 go to more general language?

4 DR. KANE: I'm suggesting we say that they should  
5 report annually on the number and circumstances. And the  
6 waiver condition should be more specifically related to --  
7 and whatever those conditions might be, spouses, in and out  
8 of Medicaid, or use the -- or could benefit from the  
9 specialized delivery system targeted to that population but  
10 maybe not dually eligible yet, for instance. As opposed to  
11 saying 95 percent you've got to be on target. I don't know  
12 where the 95 percent comes from.

13 That doesn't mean we won't get there eventually  
14 but I just don't know that means at this point.

15 DR. STUART: I think the waiver really undoes a  
16 lot of what we're talking about in terms of having  
17 coordinated care. Even if you've got a spouse, if this SNP  
18 is directed toward care of diabetes and the spouse doesn't  
19 have diabetes, I don't see what the point is.

20 DR. KANE: To me it's more that the dual eligible  
21 population. Again, if you have a specialized delivery  
22 system for people who are Medicaid eligible and Medicare,

1 there are the people who might also use that specialized  
2 delivery system. And maybe what you're saying is make that  
3 a chronic disease SNP instead of a dual eligible.

4 MR. HACKBARTH: Let's not try to resolve the exact  
5 language right now. I think people are sympathetic with the  
6 goal that these plans ought to be targeted on people who  
7 will benefit from them. And maybe the best thing to do is  
8 avoid specific numbers or specific types of exceptions and  
9 stick with a broader statement that emphasizes that and then  
10 have some accompanying text that elaborates on our view.

11 DR. MILLER: I know you want to move on. There's  
12 not a way to be really dispositive on this, like these  
13 people. What I think we've done is we've talked to a lot of  
14 SNPs, people in the industry, the Agency. There's decidedly  
15 some interest in getting guidance out there on this, that  
16 this is a problem and wish that somebody would stand up and  
17 make a statement about it.

18 The 95 came from the line of thinking -- and this  
19 is not airtight logic. You kind of start with the 100  
20 percent, why are we making any exceptions? The cases that  
21 we run across seem pretty unique and unusual but not  
22 necessarily to say you can only do it in these circumstances

1 and then miss something. And I think that's what brought us  
2 to the -- give them some small degree of play, put a strong  
3 word out there we're -- really this is 100 percent, really.  
4 And that, I think, is the line of reasoning here. And then  
5 try and get behind what is going on.

6 I think if we end up with language, gosh we should  
7 do this, I think there won't be a lot of drive to kind of  
8 correct the current situation.

9 That's the only thing I would say.

10 MR. HACKBARTH: Well presented. What's the  
11 reaction to that? Stick with 95...

12 I'm seeing a number of nods. Who would like to  
13 stick with 95? I want to get done here.

14 Okay, we're done.

15 Number six.

16 MS. HANSEN: Just to Bruce's point, especially  
17 with a chronic disease one it's not about train wrecks, per  
18 se. But I think the intention has been accepted that we're  
19 talking about people who are not just a one disease type of  
20 condition. But it could be comorbidities and polypharmacy.  
21 That doesn't mean people are train wrecks necessarily. So  
22 some way of conveying some degree of complexity without

1 having to go that far.

2 MS. DePARLE: I think she's made the point and  
3 this harkens back to our hospice conversation yesterday.  
4 The word late stage, I don't want that to convey that  
5 they're on death's door before they can get into one of  
6 these.

7 MR. HACKBARTH: Number seven.

8 DR. MILSTEIN: Jay asked me to speak up.

9 But this one, I think, is good in the overall part  
10 of it. But to say that you've got to contract with the  
11 state agency could be problematic in places like California  
12 -- and I'm just repeating his comments. California has a  
13 per county two plan model. And so when you say contract  
14 with the state, you might be contracting with a whole bunch  
15 of entities. This one I would support, and I think Jay  
16 would, if we can have some flexibility about in terms of how  
17 that contract would be enforced.

18 MR. HACKBARTH: As I recall, Jay's proposal was  
19 contract or subcontract.

20 MR. BERTKO: Yes.

21 MR. HACKBARTH: Something along those lines.

22 MR. BERTKO: Right.

1 MS. DePARLE: I said yesterday, I work with a plan  
2 who's been trying to do this and even that isn't working.  
3 Kaiser might have the ability to subcontract. I'm not sure  
4 that every small special needs plan could.

5 So I'd just ask that we look at this more. It  
6 needs to be reciprocal. If the states aren't required to  
7 play ball here, I don't think it's fair to require the plans  
8 to.

9 DR. SCANLON: I think we need to be clear about  
10 what's at stake here, because the one problem with the dual  
11 eligible SNPs is that the dual eligible population is not  
12 homogeneous. The only thing they have in common is they're  
13 poor. We go from the very frail that are potentially  
14 nursing home users or nursing home eligible to relatively  
15 healthy people who just happen to be poor.

16 And so there's this question from the states'  
17 perspective what do they want to do about that population?  
18 In terms of contract with a plan, it makes a huge difference  
19 with they're contracting with an On Lok and they're trying  
20 to serve the population that they would be serving with  
21 long-term care versus the person that's healthy for whom  
22 there are very few Medicaid benefits they're going to be



1 getting anyway anymore because of Medicare covering drugs.

2 So the key part of this, it's almost like two  
3 recommendations here. The fact that we're going to limit  
4 enrollee cost-sharing is a critical part of this, which is  
5 independent of a state contract. Because for the healthy  
6 people, it's more the coordination of benefits in the  
7 insurance sense, who's going to pay, not the issue of  
8 coordination of care, who's going to manage these different  
9 services so that is to the benefit of the individual?

10 MR. HACKBARTH: [off microphone] What would you do  
11 with the recommendation?

12 DR. SCANLON: Potentially separate out the cost-  
13 sharing from the state contract or think about -- I'm  
14 comfortable with saying they should seek the state contract.  
15 But I'm not sure that it's necessarily something that should  
16 be an absolute requirement. That's kind of where I am on  
17 this.

18 MR. HACKBARTH: Others on this issue, very  
19 quickly.

20 DR. REISCHAUER: Yes, I think the dual eligible  
21 one, the logic behind it is very different from the others.  
22 As long as states are going to be responsible for ponying up

1 the money, I don't think we can impose on them a rule that  
2 they have to take all MA plans that are dual eligible SNPs  
3 if they have thought of a different way -- as California has  
4 -- to try and hold down its Medicaid exposure here. So it's  
5 not equal across the country, but that's the way our system  
6 works.

7           So I would stick with the contract or subcontract  
8 and realize that in some states it's not going to be  
9 possible. Until we take Bill's other recommendation about  
10 federalizing the low-income assistance, which is the right  
11 way to go, this is going to be a price we have to pay.

12           DR. CASTELLANOS: I think Karen mentioned this  
13 yesterday, too. It's really difficult to coordinate these  
14 plans from a provider viewpoint. If you think it's hard for  
15 the provider, what do you think it is to the patient?

16           So we need to try to attempt some form of  
17 coordination, not just for the provider, the physician, the  
18 hospital, but for the patient also.

19           MR. HACKBARTH: Last, recommendation eight.

20           Hearing none, we are finished.

21           Thank you Jennifer.

22           DR. REISCHAUER: The ninth inning closers are here

1     again.

2                   MR. HACKBARTH:  I must say your challenge today is  
3     greater than your challenge yesterday.

4                   MR. GLASS:  So let's move right along to hospital  
5     construction.

6                   In one word, yes, it's really going up.

7                   [Laughter.]

8                   MR. GLASS:  Even if you adjust for inflation, it's  
9     still doubled in the last five years.  So we looked at this  
10    little bit, took it apart a little bit to see if we could  
11    figure out anything else to say.

12                   If you look at it over the really long haul, we're  
13    still at a peak, a historical peak.  The only thing close to  
14    it was when Hill-Burton was in effect.  And that's also when  
15    Medicare start paying cost-based reimbursement, also when  
16    they started municipal bond market lending to hospitals.  So  
17    we've now achieved what was achieved with that triple threat  
18    back in the Hill-Burton age.

19                   MS. DePARLE:  You say this includes ASCs and  
20    imaging centers?

21                   MR. GLASS:  Yes.

22                   MS. DePARLE:  So when Hill-Burton -- for the

1 earlier data, did that include ASCs and imaging centers?

2 MR. GLASS: This data actually includes all of it,  
3 but of course there weren't very many at the time. That's  
4 really less than 10 percent. It's not what's driving this.

5 So are we done with it now? It doesn't look like  
6 it, according to this. If you look at that green line, the  
7 stuff in design is dwarfing the stuff that was actually  
8 broken ground on in 2006. So it looks like this may well be  
9 continuing for several more years.

10 One explanation could be well, maybe there's a lot  
11 more hospital use per capita. But in fact, it turns out  
12 that it's the other way around. So that's not a very good  
13 explanation for it.

14 MR. DURENBERGER: [off microphone] Is the  
15 definition of hospital the same throughout?

16 MR. GLASS: All of the ones that go back the long  
17 way are using this McGraw-Hill data, yes. That's the same.

18 MR. DURENBERGER: [off microphone] Became every  
19 time you use the word hospital does it include --

20 MR. GLASS: In most of these, yes.

21 DR. STENSLAND: Not for the hospital use figure.

22 DR. WOLTER: It's a little deceiving to say

1 hospital use, because that's really inpatient days.

2 MR. GLASS: No, actually it's not. I was trying  
3 to go fast. I'll slow down a bit.

4 The measure of hospital use is adjusted hospital  
5 days, which adjusts inpatient days to take into account  
6 outpatient care at the hospital.

7 DR. WOLTER: That did they adjusted inpatient  
8 days.

9 MR. GLASS: That's what adjusted means. It's  
10 shorthand for yes, this also includes outpatient. We tried  
11 that. We tried to deflate this by everything you can think  
12 of.

13 DR. REISCHAUER: But you shouldn't deflate this by  
14 per capita. It should be total number of whatever it is,  
15 patient days. You're talking about hospital construction.  
16 You aren't talking about hospital construction per capita.

17 MR. GLASS: This is hospital use per capita. The  
18 construction was per capita, also.

19 DR. REISCHAUER: It was per capita?

20 MR. GLASS: Yes. We've really tried to -- if you  
21 look at value of hospital construction permits per capita --  
22 the one up on the thing there.

1 DR. REISCHAUER: I was looking at the first one  
2 wasn't.

3 MR. GLASS: I'm trying to go fast.

4 No, we tried to do it per capita so that in case  
5 population was increased and that was the explanation and  
6 all that sort of thing. So we've tried to correct for that  
7 in the hospital use.

8 It turns out they're building a lot of new  
9 hospitals now, which is kind of interesting, if you look at  
10 this one. That's really at an all-time high. If you put it  
11 all together, it turns out new hospitals and additions  
12 really are predominating over renovations at this time.

13 So what is being billed, you asked us to look at  
14 that question. Here are data sources that are somewhat  
15 limited. But again facilities and expansion seem to be  
16 driving it. It's increased outpatient and inpatient  
17 capacity, though the number of inpatient beds is not going  
18 up in the nation as a whole. So some must be going away  
19 while they're doing the new construction. Either they're  
20 changing a room with two beds in it to a room with one bed  
21 in it or they're closing some old hospitals or old wings or  
22 something.

1           So one of the surveys looked at the question of  
2 what services are hospitals planning to add over the next  
3 few years? It turns out the top ones are radiation therapy,  
4 cath lab, and wound care.

5           What's interesting is cardiac care, which used to  
6 be at the very top of the list, is now less of a focus.  
7 Maybe everyone already has a cardiac wing or the change in  
8 Medicare payment maybe had an effect on that question.

9           One of the things going on is this evidence-based  
10 design. And the point of that is it actually increases  
11 costs by about 5 percent but by use of natural light,  
12 standardized patient rooms, larger single rooms for  
13 patients, and that sort of thing, it might have some effect  
14 on lowering length of stay and improving care. So it's hard  
15 to say. Maybe some of this will pay for itself in some  
16 sense.

17           Now Jeff is going to take apart some of this below  
18 the national level and see if we can see any factors that  
19 are driving it.

20           DR. STENSLAND: First, we looked at where is the  
21 construction occurring? The first thing we did is we looked  
22 at rural and urban. And we found even for the most rural

1 counties up to the biggest urban areas, they all are seeing  
2 a big growth in construction.

3           Then to look at whether there's a particular  
4 geographic area where it's all happening we drew this  
5 method. This map just has the urban areas. The reason we  
6 used just the urban areas is that many of the rural counties  
7 only have one hospital. So if you're looking at  
8 construction for a rural county, it's going to jump up and  
9 down to the idiosyncratic nature of that one hospital. But  
10 the urban areas tend to have enough hospitals that if you  
11 look at construction over a five-year period you can see the  
12 trends.

13           Basically the message here is that there's a high  
14 level of construction in some areas all across the country  
15 and it doesn't seem that there's any one particular  
16 geographic region that's driving this.

17           Maybe we can just skip through the next three  
18 slides and go to the summary slide, this one here.

19           We looked at the descriptive statistics on what  
20 factors might be driving this. We also did some  
21 regressions, various multivariate regressions, and we came  
22 to the same conclusions no matter how we looked at it. One



1 was that faster population growth tended to lead to a little  
2 more construction. This is things like Salt Lake City and  
3 Las Vegas tend to have a little more construction than other  
4 places. But also the interesting thing we found is that  
5 even in slow-growing places like Cleveland there's still a  
6 lot of construction growth.

7           We also looked at hospital margins. And we did  
8 find that in areas of higher hospital margins, they tended  
9 to have more construction growth. They have more money to  
10 spend, they tend to spend more money.

11           The interesting thing is that wasn't the only  
12 factor either. Even in areas with fairly low total hospital  
13 margins, they still saw an uptick in construction spending.

14           There was also some reports in the popular press  
15 that the hospitals were leaving the center city and going  
16 out to the suburbs. So we wanted to test whether really  
17 it's the counties with the low Medicaid shares that are  
18 getting the hospitals, and the places that have high  
19 Medicaid burdens are losing. We did see that places with  
20 high numbers of Medicaid patients have a little bit lower  
21 construction, but once again even places with high Medicaid  
22 burdens still had pretty strong growth in construction from

1 the 1990s period into 2000s.

2 We looked at certificate of need laws and we  
3 really didn't find a significant effect. But I want to put  
4 a little asterisk by that because when we talked to  
5 hospitals, what a certificate of need law is varies from  
6 state to state. And there may be some states where it's  
7 actually much more restrictive and actually functioning, and  
8 other states where it's very loose and it isn't functioning.  
9 But on average it really didn't have an effect.

10 Then we looked at age of facilities. Part of the  
11 problem here is we don't have something that tells us that  
12 the cornerstone of the building is 1956. The data we have  
13 is depreciation expense in the most recent year and  
14 accumulated depreciation expense. So you could say if  
15 somebody has \$1 million in depreciation expense in this year  
16 and they have accumulated depreciation expense of \$10  
17 million, you estimate that the life of the building is 10  
18 years.

19 The problem is that the Medicare cost report data  
20 on the depreciation, accumulated depreciation, is fairly  
21 poor. When we looked at it, we found very limited results,  
22 only that the counties with the very newest hospitals tended

1 to have a little less construction. But in general, I think  
2 I wouldn't put much stake in that, the quality of the data  
3 is poor.

4 Now stepping back and what do we get out of all of  
5 this is we could say that all of these factors that you  
6 would expect -- the main factors: population growth,  
7 Medicaid share, hospital profit margins -- they all have  
8 some effect but they're really only explaining a small  
9 portion of the variation from area to area.

10 So now we'll get to the summary. Every year we  
11 look at access to capital and we probably should go back to  
12 the main point of why we do this every year is to say is  
13 access to capital adequate?

14 In this case, we do see that access to capital is  
15 adequate, at least to fuel a building boom. This is the  
16 biggest building boom probably in the history of the  
17 country, looking at the data. But some may argue this  
18 shouldn't be a surprise. This maybe shouldn't be a surprise  
19 since we're wealthier than we ever have been in the history  
20 of the country and maybe we're at a point now where  
21 consumers are demanding single rooms, better technology,  
22 more outpatient space, private baths. If we want all of

1 that, all of that may cost money.

2           The other factor is that there wasn't a lot of the  
3 new hospital construction in the 1990s, as David showed you,  
4 so there might be some sort of cyclical effect.

5           But on the flipside, others may argue that really  
6 what we have here is a medical arms race that's going to end  
7 up driving up utilization. And of course, there is the  
8 potential that both these two sides could be somewhat right.  
9 For example, if somebody has an older building, they build a  
10 new building, it now has private rooms, private baths, new  
11 cardiac surgery center. The hospital across town might  
12 think to compete with them I need a new hospital with  
13 private rooms, private baths, a new cardiac surgery center.  
14 So both of those two rationales could be partially true.

15           The first question is whether Medicare policy, in  
16 some way, caused this building? Or somehow did Medicare  
17 policy contribute to the building boom? It doesn't appear  
18 that Medicare policy has been the major driver behind the  
19 construction. Medicare payment rates may have had some  
20 effect through the growth of cardiac surgery and imaging  
21 services. But nationwide it looks like there's other  
22 factors that are the main drivers, things such as that many

1 hospitals are getting old. But more importantly, interest  
2 rates are down and private payer margins are up and that  
3 could have a great effect on the construction.

4 Not that was looking backward. But looking  
5 forward, the next question for the Commission is whether the  
6 building boom what will drive Medicare policy? First of  
7 all, capital costs may arise. However, you should bear in  
8 mind that capital costs for a hospital are only about 10  
9 percent of the total hospital costs. So you would need a  
10 big increase in capital cost to get a big increase in  
11 overall cost. For example, a 20 percent increase in capital  
12 costs would cause Medicare margins to decline by about 2  
13 percent, just to keep it in perspective.

14 The other concern, of course is that additional  
15 capacity may drive up additional volume of the kind of  
16 things that Wennberg would call supply sensitive services.

17 That's the story. And then I guess the policy  
18 question that follows all of that is whether Medicare  
19 payments will end up rising up to these higher Medicare  
20 costs that will follow the building boom?

21 MR. HACKBARTH: Jeff, could you just go back to  
22 the implications for Medicare costs and just go through that

1 example again? So the capital costs are on average about 10  
2 percent of costs. And do the part after that.

3 DR. STENSLAND: So capital costs on average are  
4 about 10 percent of costs. So even if say construction  
5 spending grew by -- capital costs grew by 20 percent, then  
6 you would have 10 percent times 20 percent, which would  
7 equal a 2 percent increase in total costs.

8 And if costs went up by 2 percent in total due to  
9 additional construction, not due to some sort of increase in  
10 the market basket, then without a resulting increase in  
11 Medicare payment rates we would expect a 2 percent decline  
12 in margins.

13 Of course, this is all purely hypothetical.

14 MR. HACKBARTH: It is a hypothetical but that  
15 seems like a big number to me, not a small number. When you  
16 think of -- set aside the fact that we have minus five -- or  
17 whatever the number is now -- projected margins in Medicare  
18 but just look at the hospital industry long-term, 2 percent  
19 on the hospital margin is a big deal. It's not a big margin  
20 business.

21 And so what that example says to me is that this  
22 is a major financial implication for Medicare and other

1 payers, as well.

2 DR. STENSLAND: We could quantify it, too. We  
3 haven't quantified it. We could probably come back to you  
4 with some real rough ideas -- is 20 percent in the ballpark  
5 -- by looking at how much is built versus how much do we  
6 have. We haven't done that yet.

7 DR. WOLTER: Just on the issue I raised earlier,  
8 in our case when we do the adjusted patient days, we say  
9 adjusted patient days to make it clear that it's an  
10 adjustment for outpatient and inpatient. I don't know  
11 whether that's going to be important or not but it is a  
12 little confusing on that slide.

13 And then the other thing I would say is that  
14 captures outpatient hospital work and inpatient hospital  
15 work. It would not capture the myriad of other hospital  
16 building that goes on, whether that be clinics or other  
17 sorts of services that wouldn't be captured in the adjusted  
18 patient day figure. So I think we just need to be careful  
19 to understand that there would be other building going on  
20 that wouldn't be captured in adjusted patient days.

21 And then as I look on page three -- and by the  
22 way, I'll start by saying I'm concerned about medical arms

1 race and I'm concerned about fueling things that might drive  
2 utilization, no question about it. If we can tease some of  
3 that out of this, I'm 100 percent behind it.

4 But having said that, and I'm kind of going on my  
5 own experience, we are doing some building now because we're  
6 at an unprecedented 90 percent occupancy in the hospital.  
7 We are doing more diversion than we've ever done, and this  
8 is not in a rapid growth community.

9 We're remodeling over and over again a facility  
10 that was built in the 1920s, which by the way age of plant  
11 doesn't capture for some of the reason that you've said.

12 And so there are some real needs out there. And I  
13 was going to say, as I look at page three, I don't think we  
14 can say we're at an unprecedented building spurt yet because  
15 it looks to me like the volume is about what it was back in  
16 1970. And so that is about the life of plant, right?

17 So maybe this next few years, if your projections  
18 are accurate, we can get to the point where we say this is  
19 unprecedented. But there is some revitalization of very  
20 aged plant that's going on and I think we just need to be  
21 cognizant of that as we hopefully bring a balance to this  
22 conversation.



1           We are, for the first time in 15 years, going to  
2 the bond market. Really, the minority of our dollars are  
3 going for inpatient use. Some of the dollars are going to  
4 work with small rural communities to help them with critical  
5 access hospitals that were built in the 1940s.

6           And so I just hope we bring balance to the  
7 conversation but I'm all for trying to get a handle on maybe  
8 what's appropriate and what isn't.

9           DR. KANE: A couple of things. One is when I  
10 looked at states in the past 10 years or so and looked at  
11 their capital spending, the 1990s was really a repressed  
12 time, partly I think because we lost a lot of hospital beds  
13 in the 1980s and 1990s. So a lot of hospitals just  
14 conserved cash and didn't invest in the 1990s, partly  
15 because uncertainty, I think, about where the managed care  
16 market was going.

17           I think the other thing to keep in mind though, I  
18 think some of this is the repressed 1990s are coming out in  
19 the next millennium. But part of it is also did you age  
20 adjust the per capita? Because my understanding was we're  
21 kind of getting older. And if you look at the new services,  
22 it's cancer, heart disease, and diabetes are the three

1 places that will benefit from those new services. So that's  
2 kind of reflective of what I think the new population  
3 demographics are going to be in the next 20, 30, 40 years.  
4 This is the preparing for the baby boom to get old spending  
5 -- it could be. It looks like it might be to me.

6           And then finally, in thinking about the impact on  
7 cost, the hospitals that I'm familiar with in terms of what  
8 they're doing are often saying this will create operating  
9 efficiencies. The fact that we're now putting like services  
10 together and building information technology into them. So  
11 I think yes, it might well be a 2 percent capital cost  
12 increase. But we don't really know what the final operating  
13 cost implications are.

14           I guess it's hard to just take this out of context  
15 and say one line item is going up and we have to pull out  
16 all the -- not that we don't want to be sure it's for good  
17 things. But it doesn't surprise me that there's a lot of  
18 spending now. The demographic seem to me to require that.  
19 And I think there's a lot of potential for operating  
20 efficiencies to come out of better design.

21           MR. GLASS: That's part of the evidence-based  
22 design question.

1           MR. BERTKO: Can I just briefly added to Nancy's  
2 comment, not only is age adjustment there but there's also  
3 what I would describe as the actively at work part of it.  
4 So as people transition from work to retirement, their costs  
5 go up. A 57-year-old who's actively at work has about two-  
6 thirds the cost of the 57-year-old who is retired, for a  
7 whole variety of reasons.

8           DR. STENSLAND: We did look at age adjustment in  
9 the multivariate analysis. The descriptive statistics  
10 didn't have it in there and it didn't come out as a  
11 significant predictor of which counties had a lot of growth.  
12 The age adjustment was very blunt. It was only a share of  
13 the population over age 65 in the county.

14          DR. REISCHAUER: But what you want is the  
15 perspective, the next 20 years.

16          DR. CASTELLANOS: I'd like to give a perspective  
17 from the physician viewpoint. Can we go back to slide five  
18 for a second? It basically shows a hospital use lower than  
19 in the 1970s. This is exactly what we want.

20                 But today patient in the hospital is an entirely  
21 different individual that it was in the 1970s. They're much  
22 more complex. Their sicker. They require the ICUs.

1 There's a lot of new diagnoses that we're dealing with now.  
2 We didn't have AIDS at that time. We have a tremendous  
3 amount of that now. A lot of new treatments. This  
4 reflects, again on the wound care we talked about. We  
5 talked about cath labs, we talked about radiation therapy.  
6 And this all is reflected in the longer lifespan that we  
7 have and a decrease in our cancer incidents.

8 I think what you really need to look at is what we  
9 do in the physician community, we look at appropriateness.  
10 Is this appropriate? You talk about a building boom. I  
11 want to talk about baby booms. Thank god the hospitals are  
12 making money and reinvesting it in. We're going to need  
13 this over the next 20 years. We're going to have the baby  
14 boomers. Thank god the medical schools are increasing their  
15 population to deal with this group of patients and I'm glad  
16 that the hospitals are doing it, too.

17 I don't think everything is that bad. I think  
18 appropriately the hospital has expanded to deal with what  
19 we're dealing with today.

20 DR. MILSTEIN: As I listened to this presentation  
21 and some of the comments, you get a sense of there being two  
22 ways that money is being spent on hospital construction.

1 One, pro-social and very useful ways in terms of redesign of  
2 hospitals to be more efficient, to be more quality reliable.  
3 And then there's another category that I think is wasteful  
4 and potentially destructive. And that is building capacity  
5 in circumstances in which either A, there's a lot of  
6 evidence of excess supply sensitive services and/or B, in  
7 circumstances in which hospitals have not applied operations  
8 engineering 101 to optimize throughput of their existing  
9 capacity.

10 And based on what innovative hospitals have done  
11 over the last five years, I think the opportunity in that  
12 category is very large. I think you'd have to conclude  
13 based on the evidence available there's an opportunity for a  
14 30 percent at least improvement in number of patients  
15 treated per hospital bed if hospital operations were better  
16 engineered.

17 So I ask a question because I'm not sure -- I  
18 haven't been able to figure out the answer. Is there a way  
19 that we might change Medicare hospital reimbursement policy  
20 that might discourage capacity building in the second  
21 category and encourage it in the first category? If a  
22 hospital were to say well, I wanted more money, despite the

1 fact that the evidence is that my medical staff and the  
2 hospital together are off the charts on supply sensitive  
3 services, and we have not implemented operations engineering  
4 101 in terms of optimizing current hospital production  
5 capability, I would not want us to -- I would not want  
6 Medicare to aid and abet that.

7 On the other hand, some of the other applications  
8 that Nancy outlined and John mentioned are worthy  
9 investments.

10 MR. HACKBARTH: It would be great if we could do  
11 that and I agree with your point. I suppose, in theory,  
12 that's what a certificate of need program should be able to  
13 do. The evidence on their doing and is less than  
14 encouraging.

15 MS. HANSEN: Actually, it's building on what if  
16 type of scenarios. Looking at whether payment policy could  
17 -- going back to reinforce and pay for those most efficient  
18 and effective hospitals like some of the Plaintiff hospitals  
19 that have really started to change the throughput and the  
20 design.

21 And then secondly, this is more of a question that  
22 relates to whether or not there's any way to figure out if

1 fewer mistakes were made, the rehospitalization need issue  
2 is able to be somehow factored into that. Because it's  
3 based on kinds of utilization and the fact that many people  
4 get rehospitalized. So basically that's taking in capacity.  
5 If we're able to reduce using our other policy that only  
6 paying for so much, whether or not there's a way to factor  
7 in how much less hospital capacity bed days we would have to  
8 use so that you'd spread it over a larger population.

9           And then the final one is is there a way to also  
10 hypothesize -- there will be new ways to treat very acute  
11 people that have already occurred. Some people will have to  
12 be treated in this much more almost military intense way of  
13 the future. But more acute things are not only in the acute  
14 surgery centers but other types of places like hospital at  
15 home types of models.

16           So it's almost a disruptive technology approach  
17 consideration.

18           It's more of a context factor. I think the use of  
19 bricks and mortar to treat people could be thought of also  
20 differently.

21           MR. DURENBERGER: I love the work these two guys  
22 do and I just have to say one thing for Jeff. He came out

1 to Minnesota and we did one of these medical arms race  
2 things a couple of weeks ago and he made a marvelous  
3 contribution to the debate. And we had people from various  
4 states there as part of a discussion. And it was somewhat  
5 the specialty versus general and so forth. But he made a  
6 much broader contribution and I'm grateful to have had the  
7 opportunity to invite him out. And I just want everybody  
8 else to know the contribution that he made to the  
9 discussion.

10 Two quick thoughts on this. One is just on the  
11 subject of hospital construction and all that sort of thing.  
12 It might be interesting to know how much of that also comes  
13 from private philanthropy because we know that there's an  
14 increased number of people who like to see their names  
15 attached to somebody who saved their lives or their child's  
16 life and there's much more money to be had, and to the  
17 degree that that contributes.

18 The other one is the Federal research dollars.  
19 There's some interesting papers written recently about --  
20 there's one nice one about UPMC versus Penn and what they  
21 can do with \$500 million a year or something like that in  
22 grants, including some construction and so forth. And it's



1 not to condemn it. It's simply to better understand the  
2 problem.

3           Where I end up, my second observation I guess, is  
4 that this really belongs as much as possible, while it's  
5 appropriate to consider it in the context of payments and so  
6 forth, it really is a very, very important piece of work we  
7 need to do in the other project they talked to us on  
8 yesterday which is what role does financing reform play in  
9 delivery system reform? So just to endorse it as very, very  
10 valuable work, there are probably some other dimensions that  
11 we've all thought that they could add to it.

12           But that our greater contribution with this kind  
13 of information will be to deliver -- the issues around  
14 delivery system reform. Because people in Congress and so  
15 forth who are looking at the high cost of health care need  
16 to better understand what is contributing, I mean the a good  
17 things that are contributing to that, whether it's evidence-  
18 based design or whatever and then some other things, as  
19 well.

20           MR. HACKBARTH: This is a very complex phenomenon  
21 and there are good things happening and not so good things  
22 happening. In terms of the policy intervention, if any, I

1 think where Dave is, if you could quickly magically create  
2 incentives for efficiency and quality. Capital spending  
3 will take care of itself. People will direct the money  
4 towards those ends for which they are rewarded. This is a  
5 symptom, except that is a problem. I think everybody would  
6 agree some of it isn't. Some of it isn't. It is a problem.  
7 It's a symptom of a system that doesn't have proper  
8 incentives in it. And to try to fix it in isolation may  
9 lead to more frustration than positive results and you've  
10 got to change the underlying dynamics.

11 Good work. Thank you. I appreciate your patience  
12 with us.

13 Now a brief public comment period.

14 Please identify yourself and keep your comments to  
15 no more than a couple minutes. Thanks.

16 MS. SUBER: I'm Nora Suber with AARP and I wanted  
17 to thank you for your thoughtful recommendations on the  
18 special needs plans and say that we agree with the majority  
19 of your recommendations, especially as they were originally  
20 drafted. We do have some concerns with some of the changes  
21 that were suggested and I just wanted to touch on those.

22 On the first recommendation, we agree that the

1 SNPs should be extended for an additional three years. As  
2 of yet, we don't think they have proven why they are  
3 "special" and we believe that they should be reevaluated in  
4 three years. It doesn't make sense to us to extend them  
5 until and unless they prove themselves because they are  
6 quite costly to the program, as you know.

7           On the fourth recommendation, we believe strongly  
8 that MedPAC should recommend that Congress or HHS should  
9 require that each individual have a health care adviser. We  
10 think this shouldn't just be in the chapter text for fear  
11 that the point will be lost. It's not just to make sure  
12 that the individuals' care is coordinated, but in the case  
13 of dual eligibles in particular that they also have help  
14 having their benefits coordinated, especially between  
15 Medicare and Medicaid. This is especially important if you  
16 decide to not require a state contract. And also, if you  
17 decide to limit the monthly enrollment for dual eligibles.

18           On the issue of state contracts, we believe it  
19 would be helpful if you could note that CMS could assist  
20 states in establishing state contracts. We have heard that  
21 CMS can often be a barrier.

22           On recommendation number seven regarding dual

1 eligibles, we agree that they have been targets of abuse by  
2 private fee-for-service plans and SNPs. But again, we think  
3 it's extremely important that they have a health adviser to  
4 help them understand how to navigate the system, both their  
5 care and their benefits.

6 Thank you.

7 MR. HACKBARTH: Okay, we are adjourned.

8 Thank you.

9 [Whereupon, at 12:07 p.m., the meeting was  
10 adjourned.]

11

12

13

14

15

16

17

18

19

20

21

22