MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, March 8, 2007
9:53 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
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JOHN M. BERTKO
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WILLIAM J. SCANLON, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: I apologize for the late start.

Our first topic today is our mandated report on pay for performance for home health. Sharon, when you're ready.

MS. CHENG: Good morning. Today's session is going to be our final installment, as it were, on the work that we have done toward this mandated report in pieces. We've worked in small pieces up to this point.

This is probably going to be the greatest level of detail on the home health part of the mandate, and the next iteration that you are going to see of this work as it comes back to you to look at will be pulling back in focus, putting all of these pieces together, and also drawing out general principles. So this is about as tight as it's going to get. After this, we're going to back up and we're going to take a broader focus at addressing this mandated report.

At the last meeting some of the commissioners had concerns about home health as a setting, about the data from this setting, and the measures that we had. We are going to stress in this report that the Commission has stated that the measure set that we have is a starter set. We've been

characterizing it as such. It's an important principle to us that P4P as a system will evolve, not just here but in all the systems. This isn't a set piece that will change and respond to the environment.

In this particular setting then, you could imagine a measure set that would evolve to include process measures that relate to some of the outcomes that can measure. We could look at a structural measure like accreditation in this setting if that would be interesting. We could consider patient experience also as an important measure for this setting.

These measure sets are a starter set and they're going to evolve over time.

That said, we narrowed this down to about five pivotal decisions that in designing any pay for performance system you would have to address. The first question is where does the money come from? How do you fund that reward pool? The second then is how do you measure your providers? The third is once you've measured those providers, how do you set a benchmark? How do you determine their comparative performance? Then how do you balance awards for those who have attained high level of quality with those who might not

have attained those upper levels but they're making substantial improvements over time? And then finally, when you start writing checks, how do you calculate those rewards? And how does this system work on the implementation side of it? So let's go through each of these questions in turn.

The first question is how would you fund the reward pool? The Commission has stated in previous work, as a principle for pay for performance, that we'd like to see this system be budget neutral. It doesn't add, it doesn't subtract money from the pool. Its goal is to realign the incentives within the system and to make the system more responsive to our desire to get better value for our purchasing.

When we look at the private sector pools when they start funding a system like this there are quite a few examples. The range is broad. It goes from 2 percent to a 15 percent pool. Researchers from Harvard, from the Agency for health care Research and Quality, the folks at Leapfrog have done comprehensive surveys and there isn't a right level for the pool.

One of the things that we're going to use as a

tool to get us through considering these decisions is a model. This is just a model for illustrative purposes. This is definitely a tool for us to use so we can talk about the principles and the decisions. So I'm kind of just putting it out there.

For the purposes of our model, we considered a 5 percent withhold. That means that for the period of performance there would be 5 percent of the base payment that would be held back by the program throughout the year from all of the providers in the system. That revenue would be at risk. The risk of losing revenue again reinforces the idea that what we're after here, an important part of pay for performance, is changing the incentives of the payment system. We'd like a system that pays more for the best quality and pays a little less for quality that's low.

It also might serve as a motivation for part of the distribution of performers that's difficult to get to. What we're talking about here are the ones who are perhaps on the lower middle end of the distribution. They perceive themselves to be unlikely to win that attainment award. They might perceive themselves to be unlikely to show a lot of improvement. But they might be motivated to improve

their quality during our period of performance to avoid a penalty.

So that's part of our concept of trying to move the whole distribution to the right, not just to get at a tail.

Of course, on the other hand, a system that puts revenue at risk is not going to be as appealing to the providers that participate in the system. One study that looked at different incentive designs found that there might be a higher reaction by gaming to a system that included penalties, that people responded that they would be more likely to consider gaming a system like that.

In home health, if we considered a 5 percent withhold, in this sector for Medicare that generates $625 million for a total pool. So you can do some quick math if you were thinking of a smaller withhold or a larger withhold about what the total pool looks like. The median agency in Medicare had about $1 million in Medicare revenue. So the meeting withhold at the agency level would be about $50,000 for that period of performance.

Again, we have another principle to guide us when we're thinking about right levels here, and that's payment

adequacy. We want to make sure that if we're contemplating a withhold that we always have enough money in the system so that providers have the capability to provide access to care for beneficiaries.

Our second question then is how do we measure the attainment of high levels of quality? We have a principle to guide us here again. We stated that the measures should be well accepted by providers and the research community. To the extent possible, they shouldn't be a substantial new data burden to either the people that have to collect them or the people that have to analyze them, CMS or the providers. We should be trying to get at an aspect of quality that we believe is under the provider's control. This means this is something that they can have a direct influence on. And also it means that we're measuring something where there's room for improvement.

Finally, where it's appropriate, we want to make sure that these measures are adequately risk-adjusted. We want to make fair comparisons from provider to provider and we want to make sure that we don't develop an access problem for patients that might be a little bit more difficult to get those higher outcomes for.

So as an illustration of this second decision, we considered a measurement that has 20 indicators of the patient's level of function. We have two potentially avoidable adverse events. The way we put these measures together is that we take the average score on a scale from zero to two of the patient's functional improvement stabilization.

So after we've taken that average, let's say it's 1.8, then we would look to see whether that patient had experienced any adverse events during their home care stay. These are potentially avoidable adverse events, so the ones we were looking at was an unplanned hospitalization or the use of an ER that followed diabetes going out of control, injury from a fall at home, a wound that had a substantial infection, or hospital or ER use due to an improper medication, a dose or an interaction.

So if any one of those four potentially avoidable adverse events occur, then we subtract one point from that average. So we started off, with this hypothetical patient, with a 1.8 but they went to the hospital because their diabetes went out of control. So that score goes down to 0.8. That assigns higher weight then to the adverse events

than to our functional outcomes.

One of the reasons that we considered this as a design was another idea that's been important in our discussions is that we want to make sure that we are looking across settings when we can. So this is a measure that lets us look at the impact of home health on the use of hospitalization and the use of the ER.

It also starts to get at the efficient use of resources. To the extent that we can appropriately care for people in the home and prevent these potentially avoidable adverse events, then we're going to be using our hospital and our ER resources more efficiently because we're going to be avoiding harm to the beneficiary and something that didn't have to happen anyway.

To compare patients across agencies what we've done for our model is to group patients by their primary home health diagnosis. So in our model what we're doing is we're just looking at patients who have therapy, OT or rehab after care as their primary reason for being in home health. You can look at other primary diagnoses, CHF, COPD, pneumonia or other things and compare like patients to like patients across agencies using this system.

Finally, again for the purposes of our model, we only measured an agency's Medicare patients. Now many of these agencies are going to have Medicaid patients, they're going to have private pay patients. They're doing other lines of business. But we thought that by looking just at their Medicare patients we would be consistent again with our goal, our idea that what we're after here is aligning Medicare payments and we'd certainly be open to the idea that this would be a place where this system could evolve. It there was an opportunity for a partnership with a local quality initiative or something else that we could do, then we could certainly contemplate partnering with that and collaborating with that.

So our third pivotal decision then is how do you set the threshold for a reward and, in our system, for a penalty? Again, the Commission stated as a principle that P4P should be budget neutral at the end of the year. So to guarantee budget neutrality the program can hardwire one threshold before we've measured anything that's going on. We can either set the score that we are going to reward, we could predetermine the number of winners. We could say we're going to reward the top 10 percent of agencies. Or we

could determine the size of the reward.

But you can only do one of those beforehand to make sure that you don't spend out too much money because you have too many winners, or you don't spend out all of your money because you have too few.

So we were trying to think of which one are these are we going to use, again for our illustrative model. We looked at another Commission principle and that's that P4P, to the extent possible, should measure something that's under the provider's control. Well we hope, the philosophy of this system, is that providers can have a substantial impact on their quality score. It seems that providers would have less of an ability to affect the number of other winners or the size of other winners. And so picking the threshold as a score seemed to align with this principle.

We also acknowledge, when we contemplated the score as a threshold, whenever you're going to measure a provider's quality what you're doing is you're making the best estimate that you can of the true underlying quality of that provider. Anytime you make an estimate you're going to get some measurement noise. That noise is not going to be under the provider's control. A substantial source of

noise, for example, is if you have a small sample. That's not something that we're trying to solve here.

So by choosing the score and then by looking at that score and the confidence of that score as an estimate, then we're trying to get at something that we feel the provider can control and take out some of the things that seem extraneous to the things that they can control.

So in our model then we set a benchmark score. That's the threshold we decided to hardwire, before the period of performance. And we decided that we were only going to reward or penalize statistically significant differences from our benchmark. So high scores, large samples and consistency increase our certainty that what we're getting it is a good estimation of the true underlying quality of the agency and we're getting less of the effect of noise.

It also acknowledges, hopefully, in this distribution that most of our agencies are probably average. And so we're trying to identify the ones that are exceptionally good or the ones for a penalty that are exceptionally low quality.

The fourth decision is how to balance awards for

improvement and attainment. Again, we're going back to our principles on this one. We've stated that a P4P system should include both attainment and improvement awards. Again, this is consistent with our idea of moving the whole curve to the right. We want to make sure that we're acknowledging those agencies that have attained a really high level of quality, but we want to get at people who maybe are near the middle or near the top of the middle and we want to give them an incentive to do even better, to try to move that whole distribution to the right.

There are two large P4P projects out there in the environment already, the California Physician System and CMS Hospital System. They're both contemplating adding improvement awards to their system, which currently both of those run on attainment awards. That's an important part of our design.

So as an illustration then of how you could balance these two things together, we would test whether the year two performance was statistically significantly higher than year one. This is again the same kind of concept that we used when we were comparing agencies to the threshold. What we want to do is have a system that has a little less

of a tendency to reward noise and more of a tendency to reward what we think is a good estimate of a real improvement.

One of the upshots of this design is that it could end up rewarding a pretty small amount of improvement but that tests out to be statistically significant. So one of the things you could contemplate as a little tweak to this basic model would be not only this test of statistical significance, but you might also set a minimum amount of improvement. You wouldn't reward something under 5 percent or 4 percent or 10 percent, also.

So this gives us basically what we can contemplate as a matrix of possibilities. So in our system you can have three levels of attainment. You could be below our benchmark, you could be statistically similar to our benchmark, or you could be above it. When we look back from our period of performance to our previous year of measurement, you could either have shown improvement over that time or you could be not improving. And so this would be the opportunities for reward and penalty.

For example, if you were below our standard for performance and you were not showing improvement, then you

would be in our penalty pool. If you were average but you had shown an improvement, we could contemplate a reward that we would set to be half the size of the full reward. And then, if you were above our benchmark, you had attained that high level, then you would be eligible for a full reward.

So there are a couple of moving pieces here. What I'd like to do now in the next couple of minutes is look at a graphical representation to see how this would play out on an agency level.

What we've got, and this was in your mailing materials, we walked through with six agencies on this. These are based on our real dataset. These are six genuine agencies from our dataset. So what we can do is we can look at the national average score. We've measured that ahead of time to set our benchmark.

Then we look at the year two score. That's our period of performance. That's where we're focusing on, is year two. But we also look back to year one to see how they've changed over time.

So agency one, in this example, in both years their score was substantially below the national average and they weren't showing any improvement. So let's look at all

our agencies and we'll see how this plays out for six agencies in our system.

So you have agency one, two and three. What we're showing you is our point estimate and the confidence interval around those. In each of those three cases, the point estimate and the confidence interval around them are below our national benchmark. So those three agencies would be in the penalty pool.

The fourth agency has a point that's above our initial benchmark, but the confidence interval includes the national benchmark. So we would say statistically that's indistinguishable from the mean. So we would call that agency average. And then agencies five and six are both entirely above the national average, so they would be in our reward group.

Remember this is part of our matrix. Agency three is below the national score, but they showed significant improvement from year one to year two. So the effect of our model would be to lift that group of the penalty group and into the no change group. They're not eligible for a reward for improvement because they're still below the benchmark, but we lift them out of that penalty group.

That's how it plays out when you look at the whole system. The last step is how do you actually start moving money around? How do you calculate the rewards and the penalties?

To maintain budget neutrality then, we would suggest that the entire pool that we developed from that withhold would be spent, and no more than that pool would be spent. So average agencies would receive a refund at the end of the period of performance that was equal to the amount that was withheld from them. And then agencies with high attainment or improvement would receive a refund and then, on top of that, would receive a reward that was in proportion to their total Medicare revenue.

Here's kind of a complicated scorecard, and again this is just from our model so this is just one way of putting together, as we've talked about, a long series of decisions. But if you put it together in some of the steps that we've taken, we were able to measure the performance of 7,217 agencies. That's most of the 8,000 agencies that participate in Medicare and our measurement year.

You can see that we would assign them some to the penalty group, some in the no change, and then others in the

improvement and attainment. Each would have a different net financial impact. So the penalty group, at the end of the year, would have a negative 5 percent because their withhold would not be returned at the end. The no change group would have a zero percent net financial impact. Their withhold would be returned. And the improvement award is half the size of the attainment award.

The total impact of the system of the sector would be zero because we're spending out an amount that's equal to the amount that we withheld from the agencies that are in the penalty group.

As we've talked through this, one of the things that we've stressed is trying to get our estimate right, trying to make sure that we're matching an estimate of quality to an agency's true quality. That's going to have the effect of being able to assign any reward or a penalty to small agencies less frequency just because of their small sample size. We also contemplated two strategies to increase the small agency inclusion in the active ends of this system.

One way would be to allow voluntary quality associations. So small agencies could come together for the

purposes of measurement and have their patients pooled as if they were one larger agency. They could participate in the system.

Another way that we use consistently through our model, actually, was to pool data across two years. You get a lot more strength that way, and it also had the statistical properties of being more stable so you're not measuring shocks to the system like a change in ownership or other small things that have a little bit more of an impact on a one-year measure. We also have enough data in the system that we can use two years pooled to look at our agencies.

So our next steps are going to be to kind of take this on the road. We need to get input from you. We'd also like to talk to some measurement experts, some people that have worked on quality pay for performance systems and talk to the stakeholders in the system.

And then what we're going to try to do is integrate these pieces. So again this is sort of our lowest level of detail. So the next time we're going to come back, we're going to pull back. We're going to pull these pieces together. We're going to look at the theory of incentives,

the basis and the principles for pay for performance that apply across settings, some ideas about developing measures that we learned in developing this one and talk about P4P design.

So with that, I'd like to get your input on the plan.

MR. HACKBARTH: Nice job, Sharon. Questions? Comments?

DR. MILSTEIN: Very clear and helpful way of organizing our thinking about this.

My comment, specifically, was a suggestion with respect to the high end. Right now, under the current concept, there would be no differentiation between an organization that was in the top tier and was not improving and an organization that was in the top tier and was improving.

It seems to me if our vision for what we want from our health care system is a more rapid rate of evolution and discovering better ways of taking care of people, we might be well served to create a little bit more reward for those that were in the top tier and improving through innovating and discovering better ways of caring for people, in this

case in the home.

So I would want us to at least consider that higher reward for top tier organizations that were essentially breaking through and defining new benchmark performance.

MS. HANSEN: My comment also is that I thought the chapter was just really very clear and certainly made great sense. I appreciated the cross-setting approach because I think as we continue to move on this issue of looking, in some ways, the episode this is kind of implicit in that part of it. And the risk adjusting, I think, is absolutely important.

It's pointed out here that over time hopefully that the other populations, especially the dual eligibles -- and I know that that's definitely down the roadside. But I think so often that that complexity of population does merit that inclusion, since there's already data available in the OASIS database.

And then finally, the last one is looking at the different areas to look at. Therapy seemed like a really good functional way to look at this first cut. But when we start looking at the other ways to look at the data, I bring

this up kind of on a consistent basis, but just thinking as the population has comorbidities just how to take that comorbidity factor into play. And I don't have, by any stretch, any science on this. But rather than taking the singular diagnosis, so many people do have that comorbid issue that continually needs that kind of rigor of the lift of how to address that.

DR. KANE: I actually wanted to go a little further than the comorbidities and say that I'm a little concerned about socioeconomic differences that might not be captured. If you're in a low-income house and you have really poor housing set up, you might be more likely to fall. Or if you have nobody at home with you, you are more likely to have problems. So I just felt that the clinical groupings alone probably weren't a fair way to capture everything about why somebody might have problems.

Also, I didn't understand therapy being a clinical group. It's a treatment, not a diagnosis. I wasn't quite sure how that popped out as a clinical grouping as opposed to a treatment grouping. Certainly stroke patients often need therapy and I wasn't sure how they came out separately from therapy. So I guess I wasn't -- there must be some

rationale behind there but I didn't understand that.

The last thing, and I think for me was probably the most concern -- I don't know how you get around it unless you deweight it -- but the fact that the quality indices are measured, the functional improvements, are measured by the caregiver.

And that, as you explained to me, Sharon, is part of their care plan now. That's something you think about how am I going to get from A to B. But if it starts to be the reason that you paid or not, or a bonus or not, it's very subject to manipulation.

Whereas the bad things that could happen, like the hospital admission or the infection, those are all documentable separately. But these progressions on the care index are done by the caregiver. I don't know how you would audit that for consistency across agencies or even over time and within one agency as things started to heat up on the pay for performance measure.

So I guess those are my three things, the socioeconomic adjustment, therapy as a diagnosis, and then how do you adjust for these caregiver designations of quality improvement?

MS. CHENG: The socioeconomic has been something that as we've worked up to this point consistently have come up. It's a tough question because it's not tremendously appealing to develop a system that has, as an explicit statement, we are going to have a lower standard of quality if you serve patients in a lower SES.

And so trying to make sure that we adequately account for things that are outside of the provider's control and that we acknowledge that effort put into a difficult patient has been achieved, absolutely that's part of the system. But we also want to make sure that we don't accidentally set up lower standards. And so that's something that we'll keep thinking about and maybe we can have some discussions as we come back to you with how to account for socioeconomics in a system like this.

It's a tough question.

MR. BERTKO: Just a couple of questions that might be in your follow-up stuff. Going to a different version of actionable, it struck me to ask about how quickly this would be reported. Because would the first group of penalty people literally fall into a two-year penalty because they might not know the answer until mid to late in the first

year? And what would be the reaction there? Would there be consultants and such?

I don't know if you've talked about that at all?

MS. CHENG: We have. We don't have a real solid answer because we're using data that currently flows through the system, and all incredible credit to CMS on setting up this system. Right now agencies can get reports on their OBQI scores, which are the kinds of things that are going into our system. They can get those, I think quarterly. So CMS does really try to get this information back to agencies, not real-time but fairly quickly.

The level of complexity then is how much would that cycle change if they would go from computing the OBQIs, as they do now, to contemplating this measure that we've talked about. We've gotten a little bit of a reaction from them that this seems more complicated to them and might be slower. We can keep following up with that and see what kind of cycle would this information be able to flow on.

MR. BERTKO: A slightly related question which you'll just have to remind me is the penalty group here which would say get minus 5 percent, and this is kind of how do you set the threshold. If the 5 percent was taken out,

would they still be at least at break even status on average?

MS. CHENG: Break even now?

MR. BERTKO: In terms of cash flows, let's just say, to keep this as simple as possible. Margins. Would current margin less than 5 percent still be zero or above?

MS. CHENG: We can look at the margins of the agencies that are in our penalty group as it's currently constituted. The aggregate average margin for this sector is 16 percent.

MR. BERTKO: So it seems like yes.

MS. CHENG: But we could get at what the penalty group looks like specifically.

DR. REISCHAUER: I thought this was a really interesting presentation, and it brings to the fore the complexities one encounters trying to design a pay for performance system like this.

I think we would all feel that you get the most bang for your buck or the most responsive reaction from providers if the providers know if I can achieve X, I will get Y dollars. And I might have read this wrong, but it strikes me one can't do that with this system at all. In

fact, you've provided some examples here. But there is no behavioral response. And it's conceivable that if you put a system like this in place, you would get the British response to their pay for performance system, where everybody was above average. And so, in fact, there was no penalty at all. There was no money to hand out. Or the amount of money to hand out was infinitesimal.

I'm not saying I have a solution to this because if you change that aspect of it and guarantee a certain amount of money, then you lose some of the other advantages of this approach. But I think we should bring out sort of the complexities that can arise from a system like this.

You also sometimes create incentives that you wonder are they really the right ones. There's another chapter in here which I had the same reaction to, which is so let's say you aren't very good and you don't think you have much of a capacity to improve. Does that create an incentive to be small because your standard error is much larger? And while there might be efficiencies from larger scale organizations, what you build in over a long period of time is an incentive not to taking advantage of those because you might get dinged on this.

Or we've been through some discussions here about what is a home health agency? Is it a little outfit? Or is it 15 little outfits that are all together? I imagine that there is some corporate and organizational flexibility here where they can design themselves in such a way as to, in a sense, play off their standard error given their performance possibilities.

So those are just some of the complexities that arise.

But just to show you that I read this thing carefully, I think, I think there's a typo on page 13 where the pooled score data does not fall within -- for agency three -- between the first year or the second year score for agency three.

MS. CHENG: I'll chase that down.

DR. SCANLON: I feel less qualified to comment since I didn't catch that, Bob.

I wanted to step back a little bit and talk about the principles of pay for performance. I think that we should be thinking in terms of two business cases, one from the purchaser's perspective. And this reinforces what Arnie said, which is how do we get the most from our payments?

And that involves potentially both rewarding or creating bigger rewards for people that have achieved attainment and are improving. But it also goes to the issue of how we balance improvement rewards versus attainment rewards.

I think one of our equity instincts is to say we want to always reward the people that are at the top the most.

From a purchaser's perspective, that may not be the optimal thing to do because you're really concerned about what do you achieve in the aggregate. That's the principle we should be pursuing, is the business case from us as a purchaser.

There's a second business case that's involved, which is how we're going to get the provider to respond. You have to look at it from the provider's perspective. To me, we don't focus enough on what's the cost of achievement because it's not necessarily zero. People are not performing badly because they are just too lazy to do something different or they're too ignorant of it and we just have to point it out to them, immediately they're going to respond. They may have to make investments in order to improve their performance. And the issue is are they going

to make those kinds of investments.

I think it's particularly important in the area of home health when we look at the distribution of margins. We look at the average margin, we look at the distribution. There's a question of whether people at the upper end of the distribution of margins, whether the penalty is going to matter to them. If I'm going to lose 5 percent and reduce my margin from 35 to 30, am I going to make a 10 percent investment in order to avoid the 5 percent penalty? It's not going to be sufficient.

One of the things that we really need to be concerned about is the underlying payment system we have here and grafting the pay for performance on top of that because it's the underlying payment system and the pay for performance mechanism that the provider is going to consider in terms of their business cases and now they want respond with respect to what we're hoping to achieve.

Let me make a couple of comments about where I think we are in terms of the specifics of a pay for performance system. I agree with Nancy and Jennie in terms of the need for -- we really have to have incredibly good risk adjustment here. It's got to involve -- you've pointed

out the problems with the CMS risk adjusters. We need to improve on that and go a lot further.

I think it's maybe sort of misleading to talk about socioeconomic status as a thing we want to risk adjust for it. We're really trying to potentially adjust for informal care availability or informal supports. You could be very wealthy and have very poor informal care support.

We're not saying that poor people should get lesser care. We're saying that people whose circumstances are such, we may need to take that into account, that they lack the informal care.

In terms of measurement, while it's again sort of intuitively appealing to say we'd like to pay for improvements in terms of functioning, for this service I think we have to ask is that always the goal? It may be that it's incredibly good care that keeps somebody stabilized and even better care than for someone who improves. And so the idea that we would give two points for improvement and only one point for stabilization may not be the right metric.

The same thing is true with respect to deterioration. There are various paths for deterioration

and people could be deteriorating but getting very good care. And so the question is do we know enough to be able to come up with a metric that's zero, one, two? I think potentially we don't, that we really need to be considering how complex this service is. It's not something that's all focused on people that have the potential to get better and are going to get better with the right kinds of services.

That's it.

MR. MULLER: My comments are along those lines, too. We have evidence in, for example the last 10 to 15 years in public reporting, of cardiac cases that case selection sometimes gets driven by high report. We had that in specialty hospitals, where case selection had a lot of effect on margins. I think we have that in nursing homes. I would argue that, like Bill implicitly does, that a lot of the reasons for the different margins in home care and home health really have to do with case selection.

So I think the extent to which we have a reward system where the easier way to get the reward is case selection rather than better management of care, I think we have to be concerned about that, again with Bill.

In 5 percent, which is a bigger number than we've

discussed in other provider groupings in terms of putting into the pot, it may not matter as much to people making 60 percent on whole. But obviously if you think about 5 percent in another category, where the margins aren't 60 but maybe one or two or three or minus one or two or three, if we have a reward system with where easier way of getting there is to pick your cases.

I would go back to something that Carol Rafael used to point out to us all the time when she talked to us about this. There's very little margins in home care when you take incredibly complex patients. And there's big margins to be made when you take ones that are less difficult. In fact, we know from our previous work that by having gone more towards episode payments, you do have some tendency to go for the ones that are a little easier to take care of than when you've had per treatment kind of payment system.

So I, too, share the comments that were made earlier that I thought this was a very well principled look at how one thinks about a pay for performance system. But as long as we keep having an underlying system where there are great rewards for case selection, we may not want to

exacerbate that.

So I would you say we just need to say that a lot in terms of what we say here, that let's reward performance rather than case selection.

MR. HACKBARTH: Let me just ask about that. I agree with the basic point. We've got significant problems in the base payment system in home health. And from an incentive standpoint, I would agree that if you can make a 30 percent margin providing poor quality, you're probably not going to be all that concerned with a 5 percent penalty and going down to 25 percent.

DR. REISCHAUER: Remember, this is year after year after year. So your example of the investment of 10 percent really has to be looked at over a 10-year period because the investment doesn't necessarily have to be repeated every year.

DR. SCANLON: It's not clear. We're not talking about an investment in capital. We're talking about -- well, or labor. I mean, this is an issue, if you look at the distribution of margins, it's very correlated with the distribution of visits. So you're going to have to continue to provide more visits year after year. So you might not

get back. If it's going to reduce you from a 30 percent margin to a 20, and you can only get five back, you might only get that five back year after year.

MR. HACKBARTH: From my perspective, if we were to have a hierarchy of home health payment issues, clearly improving the base payment system would be number one on the list, if you have to choose.

The question then arises well, does it make sense to work on these concurrently, as opposed to sequentially? In other words, do we have to not do pay for performance for home health until we have a better base payment system? Or can we try to move forward on both fronts concurrently?

And that's less clear to me.

An argument that Sharon has made to us before is that when you have a payment system like home health it's sort of squishy and you don't know exactly what you're buying. In fact, pay for performance could be a useful complement if you can define objective things that you want to get. It can sort of help buttress what is an underlying weak payment system and direct some of the money towards things that you want.

That brings me to the concern that Nancy raised

about some of these functional status improvement measures being squishy. They're not an entirely objective assessment by people on the scene. You add payment rewards for higher numbers, I'm willing to be you're going to get higher numbers, even if the patients don't change.

But there are some measures that you've proposed that are more objective. Some of them raise questions about a risk adjustment. But I think that we may be able to work through some of those issues, get some objective measures that reward better performance, and do that concurrent with improvement of the base payment system.

I don't see it necessarily as sequential, oh, you can't do anything on pay for performance until you resolve the base payment system. There's a question at the end of that.

But as a policymaker, that's what you have to think through. None of these things is perfect, but can you move forward on multiple fronts at once?

MS. BURKE: I was going to simply reflect back, in the context of your question, to Bob's point that he made in passing. And that is one of the difficulties here is that we're not dealing with the things that occur in a building.

One of the difficulties here is the definition of what is, in fact, home health? What is, in fact, a home health agency? That's an issue that we raised in our previous conversation, that it can be a very small thing that cobbles together a variety of things rather than a broad array of things that we would, in fact, in the normal course, define as an appropriate home care agency with a variety of services.

So I don't disagree at all with what you're suggesting, Glenn, that one doesn't preclude the other and that is a conversation occurring on both. But I think there is a more fundamental challenge, which is the one Bob raises, which is what, in fact, is it that we think we are purchasing?

I do think that there is a value in looking at the more objective. Because I think Nancy's exactly right, there are a huge number of these things that could very quickly become very subjective and will, in fact, reflect either a decision on which cases you take, will reflect how one defines whether improvement has been made.

But all of that falls back to this fundamental question which is what is it? We have always had

difficulty, frankly, with things that don't occur in buildings because they're much more hard to define when you don't clearly articulate exactly what constitutes a home health agency and a home health benefit.

But I don't disagree at all that you ought to be able to at both but go to the objective to make progress, have that conversation. But I think we will be bedeviled continually by this fundamental question.

DR. HOLTZ-EAKIN: I think, having listened to all this, it's important to remember one thing. There are lots of dimensions here. There's the accuracy of the measurement. There's the scope of the entity that's going to provide the service that can be an influence. There's the level of the performance. There's improvement in performance.

And you've got one thing, which is the dollars you're handing out which you think are going to somehow get these all right simultaneously. That's a mistake. You have lots of other instruments available to affect some of these other things. You can report the scores and people know whether they're doing poorly or not. We talked about that in other context. You can provide transparency so that when

people are signing up they know something.

So let's not get fooled into thinking that the dollars that go out each year are the things that will get all of these stars to align. There are more ways to do it than one.

MR. DURENBERGER: My question has been asked several times and it largely goes around the issue of what are we purchasing? And what will it take to get it? And then reflecting that the answer to the second one will differ depending on size and a whole lot of other factors. So I would just reinforce the comments around those two sides of this because this applies them to a lot of the other things that we contemplate doing under pay for performance.

But if I may, I want to ask Bill one question because I didn't understand exactly what you meant by using the word equity when you were talking about from a purchaser's standpoint. How should a purchaser be thinking about equity?

DR. SCANLON: I'm not sure how they should be thinking about equity. But I do think that maybe it's our instincts that what's equitable is do we reward the best?

That they get rewarded for doing something that's better?

The reality is that if you're really trying to improve the average product that you're getting or the overall product that you're getting, maybe rewarding the weakest is your best strategy. That's what I was getting at. You're rewarding the improvement.

It runs against our instincts. The cynical side would be to say the top performers are going to be top performers anyway, and they're willing to do this for the money we're giving them. How often do you go off and buy something and say no, you're not asking enough for that, let me give you some more? It's not the thing we do normally as purchasers.

But I think, when we talk about pay for performance with respect to Medicare, and Medicare is this huge program and we should be concerned about equity, we often think about it that we need to reward the best. But from the overall program perspective I think, in terms of getting the most for our dollar, we need to be worried about how can we move -- as Sharon talks about -- moving the distribution to the right. Maybe we don't change the tail, we move the left-hand side of the distribution.

DR. REISCHAUER: This issue that you raised in your initial comment was one who struggled with on our Institute of Medicine panel, and there were many who said well, you have to reward the best. That's the American way. It's not right for somebody who is mediocre but improving to get more than the best.

My argument in that arena was if you set the system up with thresholds, achievement thresholds, as Sharon suggested, that you have to improve at least X percent to get an improvement award, this is all very temporary. You can only get them for two or three years without becoming the best or one of the better ones. And so we should view this as a transitional kind of situation.

I couldn't agree with you more, from the standpoint of Medicare as a purchaser what you are interested in doing is lifting all boats, particularly the boats that are lowest in the water right now.

MR. HACKBARTH: It was one of the things that I really appreciated about Sharon's work is her effort at balancing this improvement and attainment thing. I think maybe we can continue to tweak that some more, but clearly she's worked hard at that.

MS. BEHROOZI: Actually, I thought I had two comments but I think they've kind of merged in my mind listening to everyone speak.

Sharon, your work is great and really well self-contained. I'm tempted not to mess with it at all.

But as you say at the beginning that on the horizon there are other factors that probably ought to be incorporated. Listening to the conversation, it seems to me that process measures really ought to come in sooner rather than later. I think that would address Nancy's point about, I would call an auditability. You can actually measure whether somebody has got whatever, patient education going on, or worker education going on, or high worker turnover, all of those factors that would be measurable and would contribute to quality.

And it would also soften the blow, as you were saying, that improvement for those that are below mean but are improving, it would soften the blow of the penalty while certainly process measures being in place not only would soften the blow but actually provide a financial means maybe to help them get to the point of improvement if they thought they had to improve, if they had to show improvement before

they would either not suffer a penalty or be eligible for a reward. You know, throw up there hands and say how am I ever going to manage this? Especially of they're faced with challenges that are somewhat more out of their control like socioeconomic conditions or whatever.

It had struck me as I was reading the paper, when you were talking about the improvement and attainment reward columns being separate, but the penalty end, they overlap. They are contiguous, the not improving and below mean. You have to achieve both of those in order to suffer the penalty.

Well, to support Arnie's point and what I think people have been talking about, it seems that then symmetrically or whatever you should also have to be improving and above mean to get the full reward or the higher reward. And then if you're in that other box now, that says full reward which is above mean but not improving, if that's below the full reward, then that leaves more money available to put into the improvement pot, whether it's for the below mean or at mean or above mean, who are improving.

I guess in response a little bit to Doug's point that it's not all about the money, that is one case in which

it is about the money because you want people to have the money to be able to continue to make the investments. I don't know if it's 10 percent, but especially in process measures it might not be quite so expensive to put the measures in place that will eventually lead to the improvement.

DR. KANE: I just wanted to follow up on Doug's comment that there's more than payment here. And I wonder if there's a way to get a sense of the characteristics of those who fall into the penalty box now and see if there are process measures or measurable characteristics that differentiate them from those who hit improvement and attainment, or even case studies? Just some way to find what it is here that creates the differences that might not be accounted for by a clinical group or the things that we've got in the model now.

DR. MILLER: Just for at least Sarah and I and Sharon to track through some of this, and to give you a sense of how we'll deal with all this, as you know it's a mandated report. We'll be back in April to talk about it in its entirety.

Just a couple of things here. I'm going to

simplify this but don't think that we weren't listening.

There's three or four comments that need to be dealt with in a sense that let's just say at the front end of this report to kind of set the tone and say what the report does and doesn't do. To acknowledge again, as we have repeatedly, that it's very hard to define what this benefit is and what we're actually purchasing, which make this a challenge.

Secondly, walk through some of the issues with the measures, how robust the measures we are talking about here and the potential need for other kinds of measures, more outcome, more process, or some of the -- I'm not quite sure how to refer to it -- the circumstance of the beneficiary, and to have a robust discussion of that.

And then to acknowledge the payment system issues, the underlying payment system, and that those things need to be thought through and potentially thought of either simultaneously or to at least be aware that they need to be addressed.

To emphasize that there are other ways to get the facilities to do things than just moving money around, make that point.

And then to emphasize repeatedly throughout the report that we're talking about an illustration here. This is not us saying this is the particular way to do it.

The one thing I think I left out of that quick summary is there is this kind of discussion of rewarding attainment and improvement, the transitional nature of it, and how one thinks about those concepts.

I think if we can address that in the front end of this report to set the tone, I think we can capture, at least at some level, most of the comments that we've gone through here.

DR. SCANLON: I guess the issue is whether an illustration is taken as a recommendation. I think there needs to be some vigilance so that it's not. I think we have recent experience with a very good report that talks about pros and counts of different options. I think that at every step of our illustration there are pros and cons and that choices are not necessarily clear in most cases, or any case, in terms of what you want to do.

I think that's the kind of tone that we should be striving for. Because otherwise I think it becomes, this is the MedPAC model for pay for performance. And I don't think

we're there.

MS. HANSEN: The one question I have, Mark, and I know it's a twofold component. One is measuring the improvement of the organization, the entity. And then what happens to the individual.

I guess my only request to see how it could be highlighted that sometimes people will -- I just don't want the agencies to not take these complicated cases that sometimes don't improve a whole lot, which go back to a comment that Bill, you made, that I just don't want, again, to avoid bad cases. And some cases will not necessarily make these huge improvements.

So it's, on the one hand, very individualistic to the patient. But it does -- you want to have a school of gifted kids because you'll do well and move ahead. But what about these messy tough cases?

I just want to make sure that that is highlighted and protected.

MR. HACKBARTH: Okay, thank you, Sharon. Very good job.

Let's move on to our next topic, which is hospital readmissions, and Anne and Craig will do that.

MS. MUTTI: This presentation discusses a policy option to reduce Medicare payment for potentially avoidable readmissions. We presented this idea, as well as one on bundling Part A and B payment for inpatient stays at the last meeting.

Today we are focusing on readmissions only because of staff and time constraints. We plan to come back in the summer and fall and continue our work on this area and hope to generate more discussion next fall on that particular issue.

Our intent at the moment is to include an initial discussion of readmission payment policy and options in the June report. We would plan, again, to come back to you with further analysis in the summer and fall and give the Commission a chance to consider this issue further in time for the March report of next year.

Currently Medicare pays for readmissions that do not occur on the same day as discharge at the full DRG amount. This policy creates no incentive for providers to invest in the type of care that prevents costly readmissions. So a change to consider is to pay less for readmissions that may be potentially avoidable.

Pursuing this option provides an opportunity to address several of the major deficiencies in Medicare fee-for-service payment policy. First, it encourages providers to invest in patient care after discharge, creating a sorely lacking incentive for providers to coordinate care across settings.

Second, by holding one or more providers accountable for the collaborative performance of a team of providers, this policy would encourage providers to collaborate with one another.

Third, it would link payment to quality of care and to patient-centered care.

In a sense, it is a step toward broadening the bundle of services Medicare pays for. With DRGs, Medicare introduced an effective incentive to control the volume of hospital services during the stay. This option takes on the next challenge, how do we better align incentives for the volume of care once the stay has ended.

At the same time, it builds on an interest in having base payment rates reward better quality. In the DRA, Congress required that Medicare reduce payment for potentially avoidable complications that arise during the

hospitalization. More recently it required GAO to analyze how frequently and how much Medicare pays for never events, for which some have advocated that Medicare should not pay.

MR. LISK: I'm going to start of here showing you hospital readmission rates, which we define as the percent of cases discharged alive from the hospital that are readmitted within a specified time frame and they're not transfers. Here we show seven, 15 and 30-day readmission rates.

As you can see, the number of hospitalizations that result in readmissions is significant. In 2004, 6.2 percent of hospitalizations among beneficiaries resulted in a readmission within seven days, and 17.6 percent of hospitalizations resulted in a readmission within 30 days.

Readmission rates also vary by condition. The 30-day readmission rate for people with end stage renal disease, for example, is 31.6 percent.

Medicare spending on readmissions is substantial, $5 billion for cases readmitted within seven days, $15 billion for cases within 30 days.

In 2004, the average payment for readmission amounted to about $8,200, about the same as for an initial

admission.

This is what we currently spend on readmissions. The spending and readmission rates for what we might consider potentially avoidable readmissions would be less. We are working to identify potentially avoidable readmissions and will share this information with you in the future.

MS. MUTTI: Research suggests that hospitals and physicians can reduce the number of readmissions, often by improving the quality of care. AHRQ has found that by providing better safer care, hospitals can reduce the incidents of adverse patient safety events during hospitalization.

These adverse events, which include anesthesia complications, pulmonary embolisms, infections due to medical care, and hemorrhages, all can increase the chance that the patient will need to be readmitted. A study looking at California non-Medicare data found that the likelihood of readmission doubled, from 14 percent to 28 percent, if there was an adverse patient safety event in the initial hospitalization.

Second, by adopting best practice guidelines into

clinical care, providers can avoid complications that occur after discharge. For example, appropriate use of blood donors can reduce the risk of blood costs after discharge, early extubation can reduce post-discharge complications, as can better monitoring of medications at discharge. In fact, one study found that two-thirds of adverse events after discharge are due to medication errors.

Third, better communication at discharge is needed and is possible. Providers are able to reduce the likelihood of discharge if they fully and clearly explain how patient should care for themselves, how to take their medications, and what systems to look for. Nurse visits to at-risk elderly patients before and after discharge can also make a significant difference. A study in two Philadelphia hospitals found that such an approach reduced readmission rates 45 percent over the 24 weeks of the study.

Fourth, hospitals and physicians need to review their practice patterns. Some of the variation in readmission rates may reflect provider preferences. For example, some physicians may prefer to admit certain types of patients even though most of their peers successfully treat those patients on an outpatient basis. Some hospitals

may encourage early discharges when an extra day would have prevented the need for readmission. A reevaluation of some of these preferences may be warranted.

How systems' own actions validate the ability of these types of strategies to reduce costly readmissions. Many of the participants in CMS's physician group practice demonstration, who are at risk for the cost and quality of certain types of patients, see the opportunity to save money and improve quality by reducing readmissions. Indeed, they have employed just the kinds of strategies I've mentioned above. For example, one group was able to reduce readmission rates by simply arranging for follow-up outpatient appointments at the time of discharge.

How might payment policy encourage provider investment in processes of care that reduce the incidents of avoidable readmissions? Again, our focus is on making a change in payment rates. We offer one approach here, although certainly there are a number of ways you could do it. In fact, when we all sit down together we keep thinking of new ways you could do it. So we're just going to offer you an illustration. There are many ways to tweak this.

For example, the policy could focus on hospitals

with relatively high rates of potentially avoidable readmissions and reduce payment only for their readmissions. Top performers, that is those with relatively low risk-adjusted readmission rates, would not be penalized. This approach recognizes that some rate of readmission is to be expected. Even with the best care, some readmissions are going to occur, even those that are potentially preventable.

The focus, therefore, is on those with excessive readmission rates relative to their peers. To identify those with excessive rates, Medicare could first calculate each hospital's risk-adjusted readmission rate based on their prior year's performance and then select a benchmark readmission rate, perhaps based on the performances of those in the top performing quartile.

For the subsequent year, Medicare would reduce payment for each related readmission for only those hospitals with readmissions higher than the benchmark, as I mentioned earlier. Eligibility for the penalty could be reevaluated each year. The incentive to reduce readmissions is therefore twofold: first, by avoiding a readmission you get full payment for the services delivered. Second, if by avoiding readmissions you bring down your rate to be in the

range of the top performers, you would not be subject to the penalty in the following year.

This approach combines several attractive features. It does not penalize hospitals with lower rates of readmissions. The penalty can be applied as claims are paid, rather than assessed at the end of the year which may have a greater operational impact and create fewer cash flow problems. And it can be designed to reduce Medicare spending.

It does have the disadvantage of making the penalty in a given year dependent on performance in a previous year. We've toyed around with ideas of fixing that, but that could be another discussion.

So for those hospitals that have high enough readmission rates to qualify for the penalty, the next two slides explain how payment could be reduced for the potentially avoidable readmissions. This approach is designed to accommodate instances where the readmission is to a different hospital than the hospital with the initial stay. And this, from some preliminary analysis, is not that uncommon.

For this reason, the payment reduction applies to

the initial admission but is contingent on the occurrence of the readmission. So let me walk you through a couple of diagrams in an attempt to make that clear.

Under scenario A here the red and green bar reflects an initial hospital say for the beneficiary, both the duration of the stay and the payment for the say. The sum of the red and green is the DRG case payment for the hospital.

The red part of the bar is what with hospital would be paid as soon as Medicare receives the claim. The green portion is the withhold. The withhold is returned to the hospital if Medicare determines there was no potentially avoidable readmission within a specified time period. And for this example, we're using 20 days.

Because in this scenario the patient is not readmitted in the 20 days after discharge the withhold, which is the green part of the bar, is returned to the hospital.

In scenario B, again we have the same red/green line reflecting the initial hospitalization. The green portion of the first bar is the withhold amount. In this example, Medicare will see through claim review that the

beneficiary was readmitted about seven days after discharge from the initial say, and that's reflected by the yellow bar there. In this case, according to some set of decision rules, some clinical software that can be used, it was considered to be a potentially avoidable readmission. The readmission may be to the same hospital but it could also be to a different hospital.

Because this related readmission occurred within the 20-day window, Medicare would keep the withhold from the initial hospitalization.

The readmission is paid in full because it could be to a hospital that had not previously been involved with that patient's care. And in this way the withhold on the initial stay keeps the penalty on the hospital that had the greatest ability to prevent the readmission.

Applying a parallel incentive for physicians to avoid readmission should also be considered. It has the advantage of encouraging hospitals and physicians to collaborate in the effort to reduce unnecessarily high readmission rates. If either provider is not engaged in improving performance, improvement is obviously far more difficult.

One way to hold physicians accountable is to apply a withhold to physician claims for services delivered in a hospital that is subject to the penalty, that is those hospitals with the relatively high readmission rates. For surgical admissions, the withhold could apply to services delivered by the primary surgeon. For medical discharges, perhaps the withholds could apply to all E&M visits or other physician visits pertaining to discharge during the hospitalization.

As with the hospital, the withhold could be returned to the physician if no readmission occurs during the designated time period.

Among other design considerations are the need to define what potentially avoidable readmissions are. Software is being developed by at least one vendor and is expected to be available this summer. Providers and health plans have also developed their own clinical logic that incorporates those decision rules as to what's related and preventable.

Another issue is to consider that risk adjustment based on severity of illness may not fully account for all factors that influence the need for readmission. For

example, some people may lack the informal caregiver support needed to avoid falls or medication errors that necessitate readmission rates. If a hospital sees a disproportionate number of these patients, its performance may look worse than its peers and it may be motivated to avoid caring for those patients.

One response to the situation is to adjust the expected readmission rate by relevant factors, such as education level or home support to the extent that they are measurable. On the other hand, if you don't make such an adjustment you keep the pressure on the hospitals to affect the rate. And research has suggested that they can, indeed, affect the rate.

Another related issue concerns the potential for noncompliant patients to be unevenly distributed across providers. One response is to allow hospitals and physicians to indicate if a patient was noncompliant upon discharge or readmission. Readmissions for those patients would not be counted in the provider's overall rate.

To temper the incentive to declare a high proportion of patients as noncompliant, Medicare could publicly report the number of patients who are exempt from

the rate for each facility and require those providers who had excessive rates of noncompliant patients to have remediation plans in place, demonstrating how the provider planned to reduce the incidence of noncompliance, or at least was trying to.

This approach creates a large administrative investment, however, and may inappropriately reduce the provider's motivation to take the necessary steps to avert readmissions. For example, the line between a patient's noncompliance and a provider's ability to clearly convey discharge instructions is not always clear.

Our planned next steps on this issue are to further explore current readmissions patterns. For example, have their rates increased over time? What portion of all readmissions may be considered potentially preventable? What portion of readmissions are admitted to a hospital different than the one that had the initial admission? And what's the variation in readmission rates across hospitals?

We'd also like to further consider the design issues. How should chains of readmissions be handled? How should or could this be paired with a case management fee or some other positive reward for the investment in the systems

of care needed to reduce readmission rates? How do we avoid a time lag in establishing eligibility for the penalty?

So we have a lot of work that we plan to do. We look forward to your comments and reactions to our presentation.

MS. DePARLE: I continue to think this is very exciting work, and you've made more progress since the last time we talked about it and it gets even more exciting.

One question I have is going back to your slide about the percentages -- I think it was like number two or three, percent readmitted.

I was surprised at how much data we really have on this. You're saying that right now, by hospital, Medicare could say the percentage of patients readmitted to a particular hospital and it would be lagged only by one year; is that right? We could say how many were readmitted last year?

MR. LISK: We could, in terms of the data that's complete claims files, we could do 2005 now. When we started this analysis we had 2004 data available, and we could do 2005 now. So there is some lag.

In real time, conceivably you could do something

that is closer to real-time as claims come into CMS and not wait for the full year claims files, too.

MS. DePARLE: Because I'm not sure you'd even need that, not that it's necessary to...

MR. LISK: But for what we use, we use the real claims files for the completed year, so that's what we have. But theoretically you could do something a little bit quicker.

MS. DePARLE: You referenced the studies New York has done and, I guess, New Jersey. What do they do? Do they use this data and therefore use a full 18 month lag? Or do they do something that's more immediate?

MS. MUTTI: The New Jersey study was just at one year in time. It wasn't trying to implement anything on a real-time basis. So I think they just had whatever year that they had recently available. And New York, I would have to check and get back to you on that.

MS. DePARLE: Bill and I were chatting about how this, we believe, at least I believe, these percentages of readmissions there has to be a strong linkage between this and the care that people are receiving post-admission, our discussion right before this about home health and the

quality of home health care, for example, post-discharge, post-admission.

So is there a way to link up those percentages with what people were getting? So of the people who were readmitted in 30 days, the 17.6 percent, were they getting home health and SNF and by what percentages?

MR. LISK: If you go to your paper, actually, table two has the readmission rates by discharge destination. So that shows you differences by discharge destination.

What you'll see, and you can look at this at both and seven-day and 30-day rates. Let's say for home health, for instance, if you look at the seven-day readmission rate, it's actually a little bit lower than people who are discharged home without home health. But as you get up to a 15-day or 30-day readmission rate, it actually gets to be a little bit higher than the people who are discharged home without any post-acute care, for instance. Meaning that the home health care may have initially forestalled the readmission but eventually it was going to still occur, is one possibly.

But it could be also differences in the risk of

the patients, as well. So you have that here, as well, again with let's say the people who are going to skilled nursing facilities you should see higher 30-day readmission rates for those patients. then it could be some of the clinical aspects of those patients.

It could also be some of what happened in the hospital and why the ended up going to a SNF and why the end up needing to be readmitted later on, too.

MS. BURKE: Could it also be availability of beds? To where Nancy is going, inevitably one of the issues that always arises is the availability. The discharge planners will tell you our preference would of been X but there were no beds available. There were a number of things, as well as the condition, that is literally what was available in terms of the post-discharge. I don't know how easily you pick that up.

MS. DePARLE: They tell us that but then the aggregate data seems to indicate there is no shortage of these things. But I think you're right, on any one case you might find that.

And then I wondered, is it possible to match up the readmissions with a physician? Because a physician has

to be part of that. So is it the same physician who's doing the readmission?

Because your last point was about are there ways to create some incentives for case management or chronic care management or something? I think you were talking more about the hospital, but one wonders is it the same physician? Or have they somehow gotten to a different physician or a specialist who then is admitting them? So is it possible to link that up with the data?

MS. MUTTI: I don't know if this fully answers your question. In the example that we gave, we suggested maybe you could identify those hospitals that had higher than expected readmission rates. And for every patient that was admitted to that hospital, you could hold the physicians accountable for their readmission, also. So every claim will say what hospital the physician service was delivered at, so you would have that leverage.

MS. DePARLE: So you mean the original physician who admitted them the first time?

MS. MUTTI: We were suggesting that you could be a little bit more selective on that since it may not just be the admitting physician that had the total control over the

patient. But that in surgical cases it would be probably fairly safe to say that the primary surgeon had control. On medical cases that physicians that are delivering the E&M visits probably had more control than say a consulting physician. And we would be trying to get at those physicians that had the most influence over the possibility of a readmission.

MS. DePARLE: It does seem to me that's a big key to this and I'm not sure how you do it fairly. But it seems like that's a big key to understanding what's going on here.

DR. REISCHAUER: I'm on the other side of this. I think we can get too complex awful fast. You want the hospital accountable and it can deal with the physicians that you don't want to be, in a sense, penalizing let's say the sloppy physician in the bad hospital but not in the hospital where all of the colleagues are performing well. And you're getting to the small Ns here. There's just all sorts of complexities, I think, that you'd run into. I think is a case where you really want to make sure you know how to walk before you begin to trot.

MS. HANSEN: Actually, Nancy-Ann did cover several of the areas. And I guess I'm still on the other side of

you on this because I think I'm coming from the beneficiaries' side, is that if the endpoint for a Medicare beneficiary is to get the best care and have the best outcome, the ability to follow that continuity of -- you know, it's implicit care coordination to make sure that upon discharge, whether the physician writes the order to go to an available skilled bed or by default maybe not to a home health agency, there is a point of continuity and handoff there that makes a big difference sometimes in whether or not care will come back to a hospitalization with the risk adjusting for the complexity.

So I know that it's a question of being too detailed but it's almost a case scenario to really play out to see if there's a way to take a look at that so that the endpoint is minimizing avoidable hospitalizations.

DR. MILSTEIN: I think this is directionally very well aligned with the vision of almost every report and chapter of reports that we've written in the last couple of years. And I think, as you begin to drill into this, all of the usual cautions associated with the more performance-sensitive payment system would apply. You can just take almost everything we said in our discussion and it would

apply here.

That said, my intuition is there's a lot of opportunity to improve beneficiary quality of life and eliminate wasted spending in the segment of care between leaving a hospital and the next 30, 60 or 90 days.

I think most beneficiaries who I have a chance to talk to, to this day, don't really feel that there's someone watching out for them during that period. They sort of feel they're largely on their own.

My intuition would be that yes, some of the 16.8 percent readmissions within 30 days are not avoidable. But I've been very impressed with what's been accomplished over the last year when clinicians have really taken a hard look at things that were supposedly unavoidable and gone after them tooth and nail. I'm referring to, for example, the state of Michigan with respect to the central line infections that were just accepted as something that had to happened in American health care. There are quite a few hospitals in Michigan where it's been driven down to zero just because somebody said for the first time let's focus and let's not assume that these are inevitable.

I think a very substantial fraction of the 16.8

percent of readmission in 30 days, my intuition would be, would fall within that. So I think it's a really wonderful target.

In some ways, given our acknowledgment in the SGR report of how difficult it might be to achieve all of our vision right away, particularly in a way that would deliver results in the near-term, I wonder if we might conceptualize this as sort of a bridge toward this bigger vision. And should some of the solutions that we thought about in the SGR discussion be relevant here, such as should we allow, in addition to having a penalty provision, which certainly we need, should there also be an opportunity for a win by a hospital, in alliance with its physicians, forming at least an accountable care organization for the 90-day period post-hospitalization and there being a two-way opportunity not just to be penalized but also to win. Understanding it's far short of the vision that we would hope for, which would be accountability for a lot more things for a longer period of time. But is this a potential opportunity for an initial bridge or baby step?

MR. HACKBARTH: Arnie articulated better than I could some points that I agree with. But a key question, an

empirical question, is what percentage of these readmissions are potentially avoidable? Could you just talk a little bit about your plans to try to get a grip on what the size of the opportunity is?

MS. MUTTI: Sure.

There's a range of different rules that you could use. Some have decided just to use the initial admission and readmission counts as potentially preventable if it were all in the same MDC or the same organ problem.

The software that's being developed is a little bit more comprehensive than that, and it represents work over the course of the two-year period where they had a clinical panel reviewing specifically this type of initial readmission, this readmission, is it potentially preventable or not? And judgment being used here.

We are talking about trying to use that software with our data to give us a ballpark of what one approach cold come out as determining what percentage of claims are...

MR. HACKBARTH: Has anybody ever looked at or made a comparison of a system like Jay's where the incentives are right and properly aligned with performance and institutions

where the incentives are not properly aligned? Has that sort of comparison ever been done?

MS. MUTTI: We did speak to a medical director recently of a commercial health plan that had looked at California data and had done readmission rates by hospitals. I wonder if that might not be able to be teased out of that.

MS. HANSEN: I certainly would like to offer once more the national PACE data that goes across the country, since we have all of the incentives aligned plus the home factor considered. And whether the home assessment is done, the medications are there, the transportation is there, and if there was an infection it would be our responsibility. They do have that kind of data available nationally.

MR. MULLER: I think we all have to pay homage to the Goddess or God of continuity of care, but I think we're stepping into something here that's very much more complicated than this chapter indicates. The notion that of the these things are avoidable, I think, is way overstated. I think some are, obviously things like never events, if people have to come back in for retained foreign objects, I think we can all agree on that.

But asking hospitals to be responsible for what happens for 30 days afterwards, you're really going to have to put in a major cost structure to do that. And whether one wants to do that or not, and whether the best place to put that is in the hospitals, is another kind of policy matter.

But by and large, most of our cost structures are not geared towards that right now. They are geared somewhat towards discharge but not necessarily the management of care for the next 30 days.

As the table indicates, two-thirds of the patients go home. So if everybody's going to go home care and you can monitor it, it would be one thing. But many of them go home. And all of the kind of comments that were made earlier around the home care dialogue here, in terms of the differences in patient's homes, environment, and so forth, come into this consideration here.

Whether one wants to have -- if one had a major penalty for readmissions, then you have to start thinking to yourself how much assurance does a hospital want that people will never be readmitted? Do you keep patients an extra two days to make sure they never get readmitted, in terms of --

and therefore further exacerbating capacity problems in many of the urban hospitals which are running much fuller capacity.

We also work in a world, as we know from our January chapter, where hospitals on the average are making minus 2 percent or minus 3 percent on Medicare. So I think to add this capacity and to really monitor care and evaluate it for 30 days afterwards, my conjecture is that this would be an enormous increase in resources to be about to monitor that and so forth.

For example, just in my hospital alone in the last year we added 50 people just to help on discharge planning, mostly because we were so busy and we needed some help on that. Even simple things like saying let's get all the appointments made for the patient. Almost all patients now need some kind of physician appointment afterwards. That takes 10 or 20 people to do that, when you think about that, because it's not just making one call. You have to triangulate back and forth between what the family can do, what the physician can do, transportation, et cetera and so forth. Those are not easy steps. It just tells you how complicated this is.

I'd be more cautious about thinking there's a lot of easy findings here. I think -- I mean easy findings in terms of money. I think certainly on never events, I think most everybody can agree on that, that there should be some kind of penalty for that. And whether if there's an inappropriate management of things like surgical wounds or hospital-acquired pneumonia, one can think of some kind of penalties for that.

But an awful lot of what we're looking at here really requires a bigger commitment of resources. I think I'll build on one of the things that Arnie's said. This should not just be a penalty. This should be -- whether it's budget neutral or not -- there should be some kind of thinking about how many resources we want to put into this.

My sense is if we want a policy objective of better care for patients after discharge, whether we're willing to pay for that in some kind of modification system, I would say unlike Arnie's example of the kind of gains to be made in hospital where there's much more control, for example better management of central line placement. But I think the management of patients post-hospitalization, you're really asking hospitals to engage in something

they're not as geared up to do right now.

Again, whether one wants that to be done inside the hospital setting or some other kind of accountable care organization. You might say it's home care, but not all of these people go to home care. Whether all these people have primary care physicians, probably not.

So I could give you a whole list of things in terms of just even whether -- many of the patient that get readmitted come back to the emergency room. Whether they go to the same hospital as they were originally in because in an emergency by and large ambulances take you to the closest hospital and maybe not where you were treated and so forth.

So I could give you a whole list of things without going too far. My main point is this is an enormous difference in the cost structure. We may want to add this to the cost structure of hospitals but we may not. I would not assume that just the savings of avoiding some readmissions are going to pay for the difference in the cost structure.

MR. HACKBARTH: So what I hear you saying, Ralph, is that as opposed to looking at adjustments in the hospital payment policy, a better path from your perspective is to

look towards better integration and coordination of the post-acute care experience and setting up an infrastructure, whether it's housed in hospitals or someplace else, to better manage that as a way of affecting the readmission process, as opposed to trying to accomplish the goal through tweaking the hospital payment.

MR. MULLER: Yes, and also I would say -- I don't know whether the previous commissioners mentioned this -- the real-time problem here is considerable in terms of -- there's always some blatant ones that shouldn't be readmissions. But knowing within 20 days whether something has been inappropriately readmission or not is very hard to figure out and would require all kinds of processes for evaluation, audit, appeal and so forth. Which may take 60, 90, 120, 180 days to adjudicate.

So in many ways, if one takes off the payment for the readmission automatically, the notion that within 20 days we would figure out whether that's appropriate or not, I think is just not a realistic estimate. So it would take a long time.

So again, you'd have major squabbles in terms of what's an appropriate denial for a readmission and what is

not. I just don't see how this can be done very much in real time.

This is one in which I normally try not to get defensive about these things. I think it's so much more complicated than what we know right now. And I think almost everybody likes to think that readmissions are avoidable. I think most of them are not avoidable.

In fact, we have a payment system that, in fact, incents by having payments on a case payment does, at some level -- we're not going to the 95 percent confidence interval on when somebody should be discharged. We're making some judgments on average.

So obviously when you make some judgments on average as to when people should be discharged, to then say 100 percent of those should not have been discharged until everything appropriate was done would also have enormously to the underlying resources you would put in the payment system.

Whether, as a matter of public policy, you would want to put so many resources into a hospital system until you could reassure yourself that nobody ever got discharged until there was -- only about a 5 percent chance they would

come back, just strikes me as also not a wise -- because a lot of people just get better on t heir own afterwards.

So therefore, whether you'd want to put those resources in to make sure that almost 95 percent of those people could be assuredly said would have no risk of readmission, is probably also I think a big waste of resources.

DR. CROSSON: I actually have a point to make but I'll start out with my regular point, just so everybody is clear that I'll always make the same point. And that is that actually accountable care organizations appropriately paid to manage quality and resource use is the answer.

But on this specific question, actually as I looked at this and have listened to the discussion, I think this path is going to take us down one of the most complicated paths that we've ever taken. I'm not really convinced that trying to improve care through rewarding or penalizing readmissions is a sensible way to go for a lot of the reasons that have been stated.

There's the issue of risk adjustment. There's the question that we haven't even grappled yet with, which is how are we going to determine what's really preventable and

what's not preventable? And how individualistic, as Jennie said, to a patient is that really?

And then the whole issue of the post-hospital environment and what hospitals can or cannot do about that in the absence of some sort of integrated system.

I completely agree with Arnie here that there is something, though, to be gained here for patients. But the question is whether the lever is the readmission or whether the lever really isn't the fact that the science now, through Don Berwick and others, about what should go on and what shouldn't go on in the hospital and the relationship between that and adverse events and readmissions is getting better by the year.

And whether or not, if we were to simply deal with the hospital and physician payment for hospitalizations around the presence or absence of those events or processes or in some cases bad outcomes like a catheter-associated infection or whether, in fact, the patient had adequate protection for post-surgical blood clots or not. Whether or not going directly -- it's sort of like Mitra said earlier, this almost screams for process measures -- as opposed to trying to get into a system so complex and so subjective

that we'll essentially get lost and, as Ralph said, we'll add a lot of cost.

I think we're getting -- you know, process measures are not as good as outcome measures. But when the process measures very closely correlate with the outcome that you want, sometimes they are the right direction.

So I'm just wondering whether in the end this particular approach is going to be fruitful.

DR. KANE: The thought that came to mind here is end-of-life care and what proportion of readmissions are related to somebody dying within three or four months? Again, that might be related to what Jay is saying, that there's a process here around end-of-life care that maybe we need to identify. I don't know how many readmissions are related to end of life care, but I'm guessing there is some substantial proportion that are.

Just hearing about relatives, parents dying, going to the hospital on multiple times on their way down the tubes -- that's probably not the right way to say it -- but whether there can't be some -- I mean, that might be one of the kind of processes that we could identify and say do you have an appropriate way to intervene with families and

transition them into hospice or family counseling or some other way to avoid the need to keep hospitalizing people.

The first step is how many of these are end-of-life readmissions related to somebody in the last six months of life? And then, if that's true, what might there be in place, what kind of processes might there be in place to think about avoiding the admission and transitioning into hospice care?

DR. CASTELLANOS: I'd like to talk from a physician viewpoint. I agree, I think going down this road is going to be a bumpy, bumpy road. But I think we can learn a lot. I think there's no question that the physician community, in my opinion, can do a better job. And my opinion, I think the hospitals can do a better job.

I think what we need to learn from this is a lot of things. One is we need to look at it from a disease specific viewpoint. As Arnie mentioned, I think there's been a significant benefit from the central line improvements.

And we need to look at the top four or five disease processes that cause this readmission and then answer the question why is that doing? And more important,

what can we do similar to what was done with the central line to improve this? We're not going to cut it down to zero, but I think we can improve it.

As Ralph mentioned, it's very difficult to hold the hospital responsible for the care that the patient gets outside of that facility. And quite honestly, it's difficult to hold a physician responsible, especially when that patient gets transferred to a skilled nursing facility or a long-term care facility where that physician doesn't go and has no rights to dictate the care or help with the care. A lot of my patients go into a nursing home and I don't go to nursing homes. It's physically impossible to do that. So the care they get there, I have no responsibility for and, unfortunately, no direction.

The noncompliant patient, it's a difficult problem. I can tell you that 90 percent of my problems are caused by 5 or 6 percent of my patients. So how do I handle it? I don't see those patients. I ask them, I think we have a problem. I think you need to see another doctor. It's the easiest way to handle that. But it's not the best thing for the patient.

The other thing is the disease processes that I'm

dealing with. You can look, there are doctor and there are doctors, and there are hospitals and there are hospitals. What's happening in the community hospitals is that the high percentage of complication procedures are being -- excuse my language -- turfed to the tertiary center. I think Karen should talk on that.

Just because the hospital has a lot of complications or readmissions from say a very high surgical procedure and you see it not in a local hospital doesn't mean the tertiary hospital is doing a bad job. It means those patients are sick and those disease processes are difficult to deal with.

I think, in summary, I would like to say I think we can learn a lot by going down this path but I think the path is going to be very bumpy.

DR. WOLTER: Just to underscore a couple of things that have already been said, I think it would be useful if we could pull the data sort of by the disease state. If there's any a concentration of readmissions that would be interesting to see. End-of-life care.

And then I was going to mention that in the group practice demo, several of the organizations are focusing,

for example, on congestive heart failure admissions. Ralph, I think we believe actually there can be a significant reduction of readmissions related to something like congestive heart failure.

And that might be an interesting tack on this approach to start with one DRG or cluster of DRGs like congestive heart failure, rather than all readmission rates. Because we could maybe learn a little bit more about some of the issues we'd get into if we went to sort of all readmission rates.

It would really be nice to do it in the context of bundling that DRG, I think, because then you'd really start creating the incentives for people to work together.

But I do think there are probably a lot of devils in the details of trying to do this broadly right out of the gate.

And then also, to underscore something Jay said, there's probably a lot to gain in terms of reduction of readmission rates through things like medication reconciliation, reducing post-op infection rates. And that's kind of go where the money is, so to speak, would be really important to keep incenting hospitals to work on that

because they have more ability to influence those things.

So just a few thoughts.

DR. BORMAN: I have a question for you about table two in the mailing materials. The distribution of readmissions by discharge destination, and you've got that very nice share of the cases and share of 30-day readmissions.

My attention was kind of piqued by trying to look at this on a percentage change basis. Just as a down and dirty calculation, if you look at skilled nursing facility, their share is 16 percent, their share of 30-day readmits is 20. That's a 25 percent increase relative to their share.

If you look at the next line, inpatient rehab facility, their share is not quite 4 percent, their 30-day readmission is 33 percent. They probably have the biggest relative drop of the whole group.

I wonder, as you try to drill down here, whether those two groupings might, in fact, have some overlapping diagnoses that might go to some of those, that might offer you some of what we're talking about here in terms of not just globally going out after disease categories. But right here you may have identified where the biggest variations

are and yet may have some overlapping diagnoses. That might be a bigger payoff for the analytic time maybe to focus on those.

Just a thought, and there's probably some statistics here that this plain Jane general surgeon doesn't understand. But that did strike me.

In terms of a couple of things that have been said, I would absolutely support there is a facet here of patient accountability that's very difficult. It is a very fine line what a patient should be expected to be accountable for and what they are accountable for. But I think we cannot simply dismiss that, and we have to acknowledge that's an ongoing consideration. I have multiple examples that come to mind if anybody wants to talk to me privately that are rather hair-raising.

In terms of never events, I would just comment, I think we can all easily agree that never events are something that yes, we ought to be able to do with that and so forth. I would point out there's kind of a nice study that the ACS did relative to looking at closed claims over a recent two-year period, 2004 to 2006. It was an extremely small percentage of things that actually came to litigation.

So you would think it might amplify that group. It was a tiny percentage of the whole closed claims. And it was about 500 closed claims analyzed over two years. So I think we can all jump on the never events bandwagon and that's wonderful. It's a great place, something maybe we could do right off the bat, sort of like the outlier things we talked about in terms of the SGR. But I think we also have to realize that maybe the game will be relatively small on the surgical side of that, at least.

Then with regards to the point that Ron brought up, obviously we keep coming back to this issue of where's the robustness of our risk adjustment capability? And that will be a huge factor here. Even if one subtracts out academic centers, there are certainly in communities organizations that are clearly getting more complex patients than oftentimes are the kinds of things that Jay represents or Nick represents as places that are more capable to deal with sort of the patient that demands multidisciplinary care. It just begs for robust risk adjustment.

The last thing I would just like to mention is trying to think about this in terms of hospital and physician accountability and just remind ourselves that this

is one of those places where hospitals and physicians are fairly disparate. And that there is the opportunity for hospital payment pretty cleanly for the readmission. And for a surgeon, at least, when you're talking about a 90-day global procedure, unless you return the patient to the operating room you really don't get anything for that care.

And so within that context we are already not paying at least the provider for those events. And we should remember that and just be careful of having such a broad slash that we sort of double cut folks that are already facing or have a reporting mechanism and a penalty mechanism, using some of the terminology that we've had today.

For example, there's an easy identifier in the CMS system with regards to the dash 78 modifier, which is a return to the operating room, which you do get paid for. But it's discounted when it's done as a complication of the primary care.

So again surgeons in major globals already are being penalized for these events. So I would just caution on taking too broad a swipe at things here and recognizing that this is the place where physicians and hospitals

differ, and there are significant differences within the physician community related to things that are already bundled versus things that are not.

MS. BEHROOZI: Thanks, Jay, for trotting out my little red wagon, because I was going to try to hold back. But I really think that it's difficult to discuss this untethered from process measures because hospitals are already required now to report on process measures? Isn't that true? Under penalty of withhold? Some process measures.

So it's not like it doesn't exist all at yet. It's not like something that has to be built from scratch. And it's an effort that, I think, MedPAC ought to encourage be expanded.

And then not only will you get to some of those things that create the conditions for hospital readmission, but higher acuity of those people -- not necessarily the same people -- but people before they are released from the hospital, before they are discharged and admission for one thing becomes a discharge for another.

It's not just about -- it's often not about what the surgeons do or with the discharge planners do. It's

about whether people in the hospital are washing their hands. Those are the kinds of things that you might not be able to measure in the outcome of the patient, in particular, but that's really the kind of program that hospitals can report on.

MR. HACKBARTH: Okay, thank you very much for the thought-provoking discussion.

Next is our final session before lunch, and that is the 21st century Medicare beneficiary.

DR. ZABINSKI: Over the coming decades the population of Medicare beneficiaries is expected to change in some important ways. One change is the well-known increase in the number of beneficiaries as the baby boom generation becomes eligible for Medicare beginning in 2011.

A second change that has not been as widely studied is that the profile of beneficiaries' characteristics is likely to change in the coming decades. These changes will a affect program spending and beneficiaries' needs and their preferences for health care.

Today I will discuss our analysis of the changing profile of beneficiaries' characteristics. I want to emphasize though that this is our first crack at this

analysis and we would really like to encourage input from the commissioners on adding your thoughts on the characteristic changes that you view as important but that we've overlooked so far.

The purpose of this study is twofold. First, to start out by identifying changes in beneficiaries' characteristics that are likely to be the most important to the Medicare program. Then we want to move on to identify possible changes to Medicare so that the program could better serve beneficiaries in the future.

The method of our analysis was first to convene a panel of experts who have a variety of backgrounds and represent a variety of organizations. Then we supplemented the information from the panel by reviewing the literature. With this method, we identified first eight important changes to beneficiaries' characteristics that are likely to affect the Medicare program, and I will discuss those changes over the next few slides. Then after that I will present five possible changes to the Medicare program so that it could better serve future beneficiaries.

A first change in beneficiaries' characteristics is an increased prevalence of being treated for several

chronic conditions. For example, the proportion of beneficiaries treated for five or more chronic conditions increased from 31 percent in 1987 to 76 percent in 2002. The reasons underlying this change in the prevalence of chronic conditions are basically four. There's an increase in the obesity rate among the elderly; there's been advances in the technology for diagnosing chronic conditions; there's been advances in technologies for treating chronic conditions; and there's been some changes in disease definitions so that more beneficiaries are identified as having a chronic condition.

This increase in the prevalence of chronic conditions has some important implications for Medicare. First, it suggests the possible need for more care coordination where care coordination has been identified as being vital for effectively caring for beneficiaries who have several chronic conditions. Also, you want effective targeting of beneficiaries who will receive care coordination. In particular, you want to target those who would benefit the most and avoid those who would benefit only a little. This would help make care coordination more cost-effective.

A second key change in beneficiaries' characteristics is a decline in the proportion of beneficiaries who are disabled as measured by the presence of limitations in activities of daily living, or ADLs. For example, the number of limitations in ADLs per beneficiary declined from 0.68 in 1992 to 0.61 in the year 2000. However, this decline in disabilities has not appeared to have decreased the cost pressure on Medicare. That's occurred because the cost of those who are not disabled, that is beneficiaries who do not have any limitations in ADLs has risen in relation to those who are disabled. What this reflects is an increase in being treated for chronic conditions among those who are considered to be relatively healthy. It also suggests that the cost pressures from disabilities has declined over the last couple decades while cost pressures from chronic conditions have increased.

However, a recent study suggests that this decline in disabilities that we've seen may not continue well into the future. In particular, a cohort of baby boomers reported more difficulties in activities such as walking, climbing stairs, getting out of chairs, and kneeling or crouching than an older cohort that is in its first few

years of Medicare participation.

A third key change in beneficiaries' characteristics is that obesity rates have increased among the elderly and are likely to stay high in the coming decades. Obese beneficiaries are important because they're more likely to have conditions such as diabetes, heart disease, hypertension, and osteoarthritis. Also, they could have a greater need for dialysis.

The obese beneficiaries also have a relatively high annual cost and, surprisingly, several studies have shown that their life expectancy is not any shorter once they reach age 70. Consequently, obese beneficiaries tend to have very high cumulative cost to the Medicare program.

A fourth possible change in beneficiaries' characteristics is a decline in the proportion of the prevalence of employer-sponsored insurance, or ESI, to supplement traditional Medicare. For example, the percentage of beneficiaries who have ESI declined from 28 percent in 1999 to 25.5 percent in 2002. But this change is just the tip the iceberg. The decline is likely to accelerate because fewer employers have indicated that they will not cover future retirees.

For example, among large firms providing subsidized benefits for future retirees, 8 percent have decided to drop that coverage for future retirees in 2004 and 12 percent decided to do so in 2005. Also, the Employee Benefit Research Institute said these changes may not have a noticeable effect on the trends in insurance coverage until at least a few years after the baby boom generation begins to retire.

An issue in regard to this decline in the prevalence of ESI is that alternatives to ESI are likely to be viewed as inferior. For example, one alternative to ESI is Medigap coverage, but Medigap typically requires beneficiaries to have higher premium contributions for coverage that is often less comprehensive than ESI.

Another alternative to ESI is simply to go with traditional Medicare without any supplemental coverage. This option carries greater risk of catastrophic loss because Medicare does not limit beneficiaries' out-of-pocket liabilities.

A fifth change that we identified in beneficiaries' characteristics is a change in their racial and ethnic profile. In particular, the proportion of

beneficiaries who are of Hispanic origin is likely to increase. For example, right now we know that 6 percent of the 65 and older population is Hispanic but 14 percent of the entire U.S. population is Hispanic. This change in the racial and ethnic profile could present language issues for the program providers and for beneficiaries.

Also, Hispanic beneficiaries have some important clinical differences from the overall Medicare population in that they're more likely to be obese, diabetic or have limitations in three or more activities of daily living. They're also less likely to have cancer. Therefore, Hispanic beneficiaries may have different health care needs from the overall Medicare beneficiary population.

One interesting change that the expert panel discussed at length is that adult children may become a less reliable source of custodial care for their parents who are Medicare beneficiaries. The panel indicated that adult children often provide custodial care to their parents but they may become a less reliable source because people are having fewer children and adult children are starting to live greater distances from their parents. So in the future beneficiaries may have to rely more on paid sources of

custodial care than their children and these paid sources are generally not covered by Medicare so they can be quite costly to beneficiaries.

A seventh change in beneficiaries' characteristics is that future beneficiaries are likely to have more formal education than current beneficiaries. In particular, more beneficiaries will have college degrees and fewer will lack a high school diploma. Our expert panel suggested that this change in the education profile will result in beneficiaries becoming more involved in their health care decisions. For example, they may better understand their treatment options and they also may be more willing to ask questions of their providers.

In addition, future beneficiaries, being more indicated educated, may be more willing and adept at using information technology such as personal health records.

A final change in beneficiaries' characteristics discussed by the expert panel concerns income issues. First, income among the elderly has grown much more slowly than their health care costs. For example, during the 1993 to 2003 period annual real growth in income among the elderly was 1.3 percent. In contrast, annual real growth in

the Part B premium over the same time frame was about twice as high at 2.5 percent.

Also, the distribution of income among the elderly appears to be becoming less even, which mirrors the rest of the U.S. population. This may exacerbate differences in access to care between rich and poor beneficiaries which ultimately may lead to perceptions of inequity.

So after identifying changes in beneficiary characteristics that are likely to be important to the Medicare program, we moved on to identify possible changes to Medicare so that the program can better serve future beneficiaries. This part of our work relied on two sources. First, the expert panel. And secondly, previous work by MedPAC. In the end, we found that there was a lot of overlap between these two sources.

One change in the Medicare program that could result in better service to future beneficiaries in facilitation of care coordination. Care coordination has been identified as being especially beneficial to those who have several chronic conditions. This is important in light of the increase in the prevalence of chronic conditions that I discussed earlier. However, in past research the

Commission has indicated that the structure of traditional Medicare can make care coordination difficult.

So in the same previous work, the Commission also identified four keys to facilitating care coordination in traditional Medicare. First is the need for care managers, who are typically nurses, to act as the focal point for patients and their providers. Secondly, you need information systems that help identify patients who would benefit the most from care coordination, and this can help make care coordination more cost effective.

Third, you need incentives for physicians to be part of the care coordination team. And then finally, you need to find ways to get patients engaged in their treatment programs.

So in the June 2006 report the Commission discussed two models of care coordination that bring these four points together into a care coordination program. One of these models is similar to a pilot project and the other is similar to a demonstration project that CMS has launched in Medicare and are still ongoing.

A second possible change in Medicare is expanding the use of health care information technology. The benefits

of IT are that it can help improve quality, efficiency and care coordination. Recent analyses show that IT has been diffusing in the health care sector but its use is still not widespread. So in a previous report, the Commission considered several options for encouraging the use of IT. And in the end, the Commission recommended use of quality measures that are supported by IT in P4P initiatives.

A third possible change in Medicare is to use comparative effectiveness analyses. Comparative effectiveness allows one to compare the relative value of different services. It can help providers and beneficiaries make decisions about the most effective treatments for each health care dollar, which can help improve safety and quality.

In a session after lunch, Nancy Ray will lead a discussion of how comparative effectiveness analyses can be produced for use in the Medicare program and other parts of the health care sector.

A fourth possible change which was discussed at length by the expert panel is to promote lifestyle changes such as improving diet and exercise to help reduce obesity rates. Some programs like this already do exist, such as a

Silver Sneakers.

The panel stressed that these promotions should include the population that is nearing Medicare eligibility as well as actual Medicare beneficiaries because it is easier for younger people to make the necessary lifestyle changes. A point that I want to add to the panel's thoughts is that these programs do not have to be run through Medicare.

A fifth and final possible change that we identified is to restructure the benefits and cost sharing in traditional Medicare. To start, though, I want to acknowledge that Medicare is widely considered to have been quite successful in improving access to care among the elderly. However, the benefits and cost sharing in traditional Medicare are also considered to be unusual for an insurance plan.

For example, the deductible is higher for inpatient care, which is usually considered quite nondiscretionary, than it is for ambulatory care, which is typically considered more discretionary. An insurance theory says the opposition should be true and that nondiscretionary services should have lower cost sharing.

A second unusual feature of Medicare is it does not limit beneficiaries' financial obligations but most insurance in the private sector does so.

Possible modifications to cost sharing in traditional Medicare discussed by the expert panel include, first, having a single deductible for Part A and Part B. In addition, you may want no cost sharing beyond the deductible for inpatient services, but some additional cost sharing for most other more discretionary services. The idea is to have cost sharing that encourages the desired behavior by providers and beneficiaries.

And to allow this cost sharing to be effective, you may want to limit the extent to which supplemental insurance can cover that cost sharing.

A second possible change discussed by the expert panel is to include a limit on beneficiaries' financial obligations through a stop loss provision.

To conclude this discussion, we started by talking about eight changes to the beneficiary characteristics that could have substantial effects on the Medicare program in the future. Then we went on to identify possible changes so that Medicare could better serve beneficiaries in light of

those changes. The next step in this analysis include getting the commissioner's thoughts on items that should be added to the list of important changes to beneficiary characteristics or added to the list of possible policy changes. From there, we would update the analysis to reflect your input.

Then over the little longer term, likely in 2008, we would like to simulate the effects of important changes to the beneficiaries' characteristics and changes to the Medicare program so that the program can better serve beneficiaries.

Now I turn things over to the Commission.

MS. BEHROOZI: This was really interesting, Dan. Thank you. It's really comprehensive. And a lot of the things that people think they know are happening, but it's nice to see it all laid out here.

The one of particular interest to me is income among the elderly has grown much more slowly than health care costs and distribution of income appears to be less even. I think it's really significant and that has big implications for any recommendations with respect to cost sharing changes.

It seems logical that if someone makes less money, they can afford less of everything, including health care. But I don't think there are yet a whole lot of studies to support that. Just last month the Kaiser Family Foundation I guess extracted some data from its employer health benefits surveys and did a report on insurance premium cost sharing and coverage take up, which showed very significant differences in take-up of insurance coverage provided by employers given different levels of cost sharing. There was always a significant difference between higher wage workers and lower wage workers, no matter what the cost sharing level was of the premium.

So I think that that's the kind of thing, particularly if the income disparity is going to continue to grow, Medicare should pay close attention to that. We should not be discouraging people from taking Part B. The current difference between the premium for higher income and lower income beneficiaries maybe needs to be adjusted even so that it's lower for the lower income beneficiaries, not just about bringing more money into the system but about encouraging lower income people to get the coverage so that they can access primary and preventive care and end up not

having more acute conditions that land them in the hospital getting more expensive care.

And if there are ways to target copayments or deductibles or other kinds of cost sharing in ways that incent people to seek preventive care, I think that would also be a good avenue to pursue.

MR. MULLER: I too, Dan, think this is a very good chapter.

I have a question about how technology fits in and but it's not obviously a characteristic of a beneficiary. But as you think about the changes that are going on in terms of personalized medicine, in terms of more targeted therapies for neurodegenerative diseases, cancer, heart disease and so forth, when you think about the advances in imaging, when you think about the less invasive procedures for surgery and so forth, this could really change the kind of care that beneficiaries get.

So it's not a beneficiary characteristic but it could markedly change the kind of utilization patterns of beneficiaries and could also -- on the one hand, it could bring beneficiaries into the utilization cohort or it could take them out of that.

So I'm not sure how I would introduce this, but since we know from our previous work that the biggest driver of Medicare costs in general, in terms of the increment from year-to-year, are changes in technology I just want to have us think a little bit about how changes in technology that are forthcoming are likely to change the utilization of care by beneficiaries.

I do think, especially the movement toward what's called personalized medicine, much more individualized it's happened the most in the pharmaceutical area but it's going to happen in other diagnostic areas as well.

So again, if you could just think a little bit about how we would introduce that theme, because I do think it changes the beneficiary cohort of people who are utilizing services.

And especially a lot of the biologics and the pharma area are quantum levels of difference in terms of cost compared to what is right now. And we've also talked a lot about a lot about what's the threshold for acceptance of new therapeutics, again more developed in the drug area than it is in other areas. So I think those things could really change what I call the beneficiary cohort in terms of

utilization.

Again, I don't know exactly where to take it. I'll try to develop my thoughts, but certainly -- since you've done so well so far -- ask you to keep working on it.

DR. CROSSON: First, I just wanted to compliment Mitra for her thoughts about how to construct a better benefit structure that supports the care of the elderly with less income. I thought of a name for it. I don't know whether this would work or not. We could call it Medicare Advantage, just for the heck of it.

[Laughter.]

DR. CROSSON: I actually had a more technical question I wanted to ask Dan, and that is you mentioned early on that the cost of care for patients with disabilities has gone down while the cost of care for those with multiple chronic conditions has gone up. The question is has that changed over time, or do you know has that changed over time the relative cost by age cohort within Medicare or not?

DR. ZABINSKI: Are you saying has the costs of say the 65 to 69 changed relative to like the 85 and older?

DR. CROSSON: Correct.

DR. ZABINSKI: I don't know. That's a good question, though. I'm sure that's not difficult to find out.

DR. REISCHAUER: People with disabilities in those age groups? Is that what you're saying? Or just people?

DR. CROSSON: No, I was just mentioning that earlier on we had data that said that overall the cost of care for individuals identified as having disabilities has gone done. The cost of care for those identified as having multiple chronic conditions has gone up.

Part of the reason for that was described as the ability to diagnose chronic conditions. Quite frankly, I don't have any friends who don't have any chronic conditions at this particular point in life. So I was just wondering whether, in terms of -- I'm thinking of things like artificial knees and hips and other things of that nature. I wondered whether over time then that has changed the relative proportion of money that is going to, say the 80 to 85 year old cohort compared with the 65 to 75 year old cohort?

MR. HACKBARTH: Jay, on your first point, when Mitra was talking about that, it's funny, I had a different

reaction. I got QMB and SLIMB when she mentioned specific programs to support Medicare beneficiaries with low income. Funny how different people think differently about these.

DR. CROSSON: That's what makes the Commission so great.

DR. CASTELLANOS: With the conclusion, you asked us for some possible suggestions that Medicare could do that would serve the future beneficiary. There's no question that we need to, and I think we are going to, deal with the workforce problems and making sure there's access to care.

Another thing is we also know that the beneficiary is changing but the provider is changing, also. The new medical doctor profile of the person graduating -- and I think we had a little taste of that this morning when Ralph said the top 10 or 15 percent of the graduating class all picked dermatology or radiology or some procedure that was more important to their lifestyle.

I'm seeing it in my practice. We don't have a large practice, we have a group of 10 people. I see it from my age group all the way down to the young kid coming out. There's just no question that the younger doctor has different ideas of lifestyle. I don't think they want to

work as hard as Karen and I work.

I'm not saying they're not good doctors. I'm not saying they're not dedicated. But they certainly have a different profile of their lifestyle change.

The other thing we need to really strongly emphasize, again as we discussed with the SGR, is these educational programs in the medical school, teaching them about what we talked about, care coordination in this group, evidence-based medicine, cost-effectiveness. Again, we need to do that at an early age in their formal training periods.

MR. BERTKO: A quick comment. Dan, a good report and I'm going to follow Mitra and less to Jay on the cost sharing aspects of it, particularly supplemental coverage. There certainly is evidence -- that you've got one of reports there in the text about having zero cost sharing causing some amount of induced demand.

I would make the point that at least actuaries have seen, even a minimal amount of cost sharing that goes from zero cost sharing to something -- it doesn't have to be huge -- actually reaps much of the benefit. That might be used in the trade-off against the maximum out-of-pocket protection of some sort. So just to continue support for

your looks at this as you move forward.

The second one is a little bit more technical, and you talked about it on the last page, simulating some of these things in the future. I don't know whether you've thought about using agent-based models where you look at seniors' preferences. I think your good comment that I hadn't thought of earlier is the near seniors group, as well. And the agent-based modeling, in my experience, has done a little better job there than the microsimulation or actuarial models.

DR. KANE: I enjoyed it and it made me think a little bit about some of the changes that I think are important, one of which is the change in the site of care and, in particular, the housing environments of elders. A couple things are going on.

One is I think, at least in our marketplace in Boston, there's a lot less use of skilled nursing facilities for long-term care and much more use of senior care, assisted living, and independent living. And so there's much more of this congregate kind of long-term housing situations that aren't necessarily totally medical. They're much more housing and independent living with some support.

But the benefit package doesn't necessarily follow to these new sites of care. House calls is one of the things. Sometimes you can do house calls in a congregate facility whereas you wouldn't necessarily do it spread out geographically.

So the programs that encourage preventive services and care management in the home is a different kind of picture of where some of this might happen.

Telemonitoring in the home. I think there is an opportunity for a lot more home focused care that can be done because people are living in congregate facilities that have opportunities to put in infrastructure to take care of people and keep them healthy longer. And how can Medicare foster that? Does that result in better care than having the traditional silo-based care?

Group visits would be another thing, nurse practitioner teams. Medicare doesn't pay for this in that way yet, and I'm just wondering if we need to think more about the benefit of thinking about paying in different ways that foster more independent living.

MS. HANSEN: Actually Dan, I certainly had a chance to talk to you a few minutes before this and I really

appreciate the breadth of the report.

I'd like to build on one thing about describing the age cohort aspect and really teasing out these age categories coupled with comorbidities. Because I think one of the big factors, I remember years ago looking for were there any teased out data for the 85-plus population, which is actually the fastest growing cohort of older people. And that has a unique characteristic in that about 50 percent of that cohort will experience dementia, which is one of the more expensive aspects that isn't, by itself as a diagnosis, teased out as a payment category but affects all the other issues.

So I think the whole aspect of segmenting out the age categories would be great.

I'd like to pick up on the economic factor, even though this is about Medicare, is that certainly through our data with AARP we realize that baby boom as a growth group doesn't have very much in savings. On average, about 50 percent of the population has about $35,000 net savings right now. If that's the case, people are going to move into a dual eligible population in greater numbers than before. So we should start looking at that economic

modeling as to what's going to happen to the Medicare program because this will be a growing population.

The whole area of obesity as a major area is, I think, teased out with the impact of diabetes. I know Nancy will cover later about ESRD. But ESRD, which is one of our big cost programs under Medicare, will also be, I think, a program that will be affected.

Two points, one related to the whole area of diverse populations and disparities. Since, even in the current Medicare program, it is shown I think from the National Academy's reports that there are still access disparities or health disparities even with having a Medicare program. So that issue may get further compounded.

The final one has to do with the diversity. The Hispanic population was identified as the largest cohort group. But I wonder if we could do two things about that. One is kind of do a mapping of just some of the changes in the ethnic population changes in the country that are projected. Because that will have a large effect not only on the Hispanic population but a broader population.

With the Hispanic population even as the first lift, that language access is quite different. One of the

features is not just the way people utilize it but there are language elements that will make a difference as to how care and if care is received.

Thank you.

DR. BORMAN: One thing, Dan, on page three, and this was, I think, just a wonderful report. I think may be one of the most important things, sort of think tank ideas, that's going on in the background of the Commission. I just think this is wonderful work.

On page three you talk about increased use of cost-effectiveness analyses. I don't mean this as a wordsmithing comment, I mean it as a philosophical comment. If we're going to be thematically consistent, that should perhaps be comparative effectiveness because I think maybe we're starting to hear, particularly with your comments this morning about the reception of the SGR report, that that maybe is an area that we can more confidently go. As I recall, we struggled to define cost-effectiveness at last year's retreat. I think we ought to be thematically consistent here, in just the philosophic implications of that.

Relative to the data about obesity, I wonder --

and again, this is someone who's not primarily a giver of chronic care. But I would hypothesize that obesity in this is a harbinger of what we will see in other chronic conditions. That is, as we've gotten better at care and drugs and detection and surveillance, that we will allow people with multiple chronic conditions or even isolated ones -- hypertension or whatever -- to live longer. So I don't know that this is so much an effect of a single disease but the first effect that we will see, that you can live quite long periods of time with these chronic conditions.

So then you get into the issue of certainty we want to be interested in the preventive care. But there's a certain element of this that's genetic, that will get us down to a finite rate limiting place beyond which we probably cannot go unless we want to go to some perverse incentive of breeding programs or something that gets pretty crazy. As long as we can't pick take our parents.

As you model this through, that we're going to allow people to live to very expensive acute diseases. The potential implication there for end of life, I think, is huge. As end-of-life was brought up earlier, I think that

that has real implications here.

That leads me to the thought that we know that right now that the duals and end-of-life care are two areas that are huge cost to the program. To the extent that we can -- what data do we have about projecting that into the future as opposed to trying to project for a whole population that maybe we don't understand. Can we at least project for the groups that we know cost us a lot now?

I think that links up, if I understood Jay correctly, with the modeling for some younger cohort, not just the near-Medicare group, but potentially if you look at the 35 to 45 year old group now, our best bet about what they're going to look like as they are in the near-senior and senior group. It seems to me that that will have some benefit.

Finally just a comment about what beneficiary ideally serves the program financially versus societally or clinically. If you think about it, the 65.6 year old who dies of their lung cancer saves the program a huge amount of money. And so maybe that leads to this perverse incentive well, all this stuff we're doing to stop smoking -- it becomes crazy.

The reason I bring that up is to make a point about finding data and applying data. And the point, in part, is kind of timely in that the recent article about lung cancer screening -- and I don't want to get into the clinical validity or not of that -- but if you set that aside as a clinical piece, forget the implications about that on the cost piece are fairly extensive. And we need to be creative about learning to use clinical data for economic projection use, as well. That may speak to the comparative effectiveness discussion later.

DR. REISCHAUER: Comments on a couple of the dimensions that you talked about. One was employer-sponsored insurance and the decline of that.

I was wondering how far we go in ferreting out the implications of this? The first order implication, of course, is people won't have as generous a supplemental package as they had before. Therefore, Medicare basic service use will go down. In other words, it's a Medicare cost saving.

The second order would be that the fraction of folks in Medicare Advantage will probably go up, that being an efficient alternative if one doesn't have ESI.

Third is the number of people going bare will increase, therefore bankruptcies and dependence on Medicaid will rise.

We can go down a set of these things and you sort of stopped way, way up at the top on that. And I don't know how far we want to pursue these.

MR. BERTKO: I would only add one more. The Part D cost is higher in the stand-alone PDP than it is for the subsidy going into what's called the RDS, the Retiree Drug Subsidy.

DR. REISCHAUER: Then a bit on pulling out Hispanics and talking about them. I am very uneasy, and maybe our information base is a lot better than I think it is, but the issue here, to me, is are we saying something about genetics? Or are we saying something about income, culture, and the environment people grow up in when we are looking at their prevalence of disease or their use of services versus other groups? Are we talking about something that is shared by recent immigrants or Hispanics as such?

I want to dig a little deeper in this before I pull out Hispanics and say this is something that we should

focus on as important to Medicare in the future.

Finally, just a footnote on John's point and your discussion of copayments and how some services are less discretionary than others. We have the RAND study by Goldman, which shows pretty convincingly that very small changes in copayments or coinsurance for prescription drugs gets huge changes in compliance with drug regimens that could end up costing the system, in a sense, huge amounts of money over the long run.

So we want to be very careful about how we characterize these types of services.

DR. WOLTER: I wanted to comment, actually this slide kind of hits the things I wanted to emphasize. I heard Ken Thorpe speak recently and he's cited, Dan, in the references you provided on chronic disease. He is of the view that about 70 percent of increasing Medicare costs are related to the increasing incidence of people with multiple chronic conditions.

I don't know what database he's used to put that together, but it really strikes me that there is some urgency about how we shift some of the fragmentation in the Medicare system, some of the current incentives, and start

emphasizing that in fairly short order we better have better approaches to chronic disease management.

That, of course, would bring us back to the discussions we have been having about accountable care organizations, about caring for patients across sites, more investment in secondary prevention. And we have many more perverse incentives in place right now than we do have positive incentives to deal with this particular problem, whether it's physician self-referral or hospitals that do joint ventures with physicians. And all of the investment, really, is going into acute interventional care. And I feel some urgency about that.

I think maybe this type of report, which is really excellent, is another platform for us to talk about some of the changes that need to happen in fairly short order if we're going to be able to continue to afford to have the Medicare program and to take care of this increasing incidence of chronically ill people.

MS. BEHROOZI: Just briefly, I just want to make it clear that people with incomes low enough to make their decisions about whether to access health care based on whether they can afford it, not based on whether they need

it, is not limited to the dual eligible population, not limited to what I understand is the QMB/SLIMB population, and that is something I think we need to bear in mind and will get worse as we go forward.

MR. HACKBARTH: Okay. We'll now have a brief public comment period before lunch.

MS. FRIED: My name is Leslie Fried. I'm here on behalf of the Alzheimer's Association.

I just wanted to indicate that next week the Alzheimer's Association is releasing a report called Alzheimer's Facts and Figures, which will include updated information on prevalence of Alzheimer's disease -- which goes to the previous comments -- as well as some data that we had Hopkins do, Jerry Anderson, et cetera, on the significant increase in costs that people with dementia cost the Medicare program because they have multiple chronic condition.

It compares Medicare claims data of people with Alzheimer's disease that have certain multiple chronic conditions and those without dementia and have the same conditions. It's really incredible, the significant cost to the Medicare program.

So it's embargoed until next week but I will send a copy of the report to Dan and to anyone else who's interested because I think that it really spells out what the crisis for the Medicare program, especially given the boomer population and the increased prevalence.

MR. HACKBARTH: Thank you.

All right, we will adjourn for lunch and return at 1:15 p.m.

[Whereupon, at 12:25 p.m., the meeting was recessed, to reconvene at 1:15 p.m. this same day.]

AFTERNOON SESSION [1:20 p.m.]

MR. HACKBARTH: First up this afternoon is comparative effectiveness, and we have some now familiar, I guess, faces. Re-introductions may not be necessary but why don't you go ahead and do that anyhow, Nancy.

MS. RAY: I will. Thank you, Glenn.

Again for this year we have Peter Neumann and Josh Cohen to help us think through some of the issues of producing information that compares the clinical and cost effectiveness of alternative services.

The way we're going to proceed is I'm first going to give a brief presentation and then Josh will follow and then we'll finish with Peter.

Spending on health care is substantial and increasing rapidly. Public and private payers are looking for ways to improve the value of health care spending. This was one of the factors that motivated the Commission's recommendations on pay for performance.

Comparative effectiveness is another tool that has the potential to promote care that is more efficient and of higher quality in both the public and private sectors.

Comparative effectiveness offers us the potential

of understanding which services work and their value.

So first let me define some terms. When I say comparative effectiveness, I mean studies that compare the relative benefits, risks and costs of a service to its alternatives. By services I mean drugs, devices, diagnostic procedures, surgical procedures, and even no care. In comparative effectiveness studies, researchers can measure outcomes such as mortality, patient satisfaction, quality of life, symptom severity and costs.

I'd like to remind commissioners of our previous work. We have discussed clinical and cost-effectiveness analysis in our June 2005 and 2006 reports. We have not yet made any recommendations about it. In June 2005 we laid the groundwork, what it is, past history, and use by other organizations. In June 2006, we looked at methodological issues in conducting these studies and introduced some of the issues about setting up the infrastructure to conduct this type of research.

Comparative effectiveness can help fill in the gap between what providers know and do not know. Increased public and private spending does not seem to be producing uniformly better outcomes. Providers and patients have

little information that shows what treatment works best and for which population. Several recent examples that demonstrate this, for example the older drug class that is used to treat hypertension was subsequently found to work as well as a new class of drugs.

Comparative information, along with information of provider quality and cost, could promote greater transparency and value in health care.

There is no one public or private entity whose sole mission is to produce comparative effectiveness research. Among federal entities, conducting this research is fragmented. For example, and I'm just going to take you through one but I'd be happy to take questions, AHRQ looks at comparative clinical effectiveness under it's MMA mandate. AHRQ also looks at clinical effectiveness, cost, and cost-effectiveness in other work outside of its MMA mandate.

Comparative effectiveness is under produced by the private sector. Some researchers contend that it is a public good. A public good has two important properties. It is non-excludable and it is non-rival. Non-excludable means that it is difficult to prevent any person from using

the service free of charge. Once comparative information is publicly available it is difficult to stop other groups from using the information free of charge. Non-rival means that one person's use of the goods does not, in any way, detract from any other person's ability to use the same good in the same quantity. One group's use of the information does not detract from the use by other groups.

So private groups have less of an incentive to sponsor work. And when they do, some researchers have raised concerns that some studies are biased and that research with negative results is not always published.

Comparative effectiveness could be used by several audiences. Providers and patients could become more informed and value conscious. Private and public payers could use information to make better payment decisions. Josh is going to talk more about its potential uses. Ultimately, it could improve quality and safety. It may not necessarily reduce health care spending if it increases demand for services that are recommended but are under provided but it may improve the value of health care spending.

If commissioners want to move forward on this

issue, our contribution may be to give more insight into what an entity that produces comparative effectiveness would look like and the paper describes some alternatives. Here are five options. An entity could be contained within an existing federal agency, for example AHRQ. Or a new executive branch agency could be created within, for example, the Department of Health and Human Services.

Alternatively, a new independent agency that is not within any one department could be created. For example, like the SEC or the FTC or the FCC.

Another alternative is a public-private partnership. Your briefing materials outlines three different kinds of public-private partnerships that some researchers have looked into. These public-private entities can accept some private funding.

The one that some researchers have talked about is called a Federally Funded Research and Development Center or an FFRDC. FFRDCs are private not-for-profit organization and they are operated by universities and corporations but they are directly linked to a federal agency. For example, the National Cancer Institute in Frederick is an FFRDC and it is sponsored by NIH and it's administered by Science

Applications International Corporation and some other organizations. FFRDCs typically help their mother federal agency with scientific research and analysis.

The fifth option is to create one or more private-sector entities. Your briefing goes through some of the advantages and disadvantages of each of these five options. Some stakeholders want an entity that is close to or within the government, while others are concerned about too much government involvement. Some suggest that creating a commission along with the entity will provide for more objectivity.

The type of entity and its funding will affect the entity's level of independence from, on the one hand, the federal government and, on the other hand, the private sector. So you see how these are overlapping issues.

The paper also goes into options for financing a center, voluntary or mandatory, public versus private. One option is year-by-year federal appropriations. Another option is mandatory federal funding from either the general revenue or a trust fund derived from, for example, user fees. On the one hand, an entity would have more independence if it did not have to go through the annual

appropriations process. On the other hand, mandatory funding might make it less accountable to those who fund it.

This slide lists some of the other issues to consider if an entity were to be built. Peter will talk more about some of these, for example to ensure transparency of the process and that stakeholders understand how information is being produced.

Before handing the presentation to Josh, again commissioners, we are looking for your input. If you want to move forward, our contribution may be to give insight into the entity, the structure and its financing. We would like to get your input. If enough consensus exists to move forward with establishing an entity, we can discuss a draft recommendation to articulate the principle.

At this point, I would again like to just briefly introduce Peter Neumann and Josh Cohen. They are with the Center for the Evaluation of Value and Risk at the New England Medical Center. Both Peter and Josh have spent many, many years thinking about how to and the role of analyses that consider a service's value by weighing its benefits, risks, and costs.

Josh.

DR. COHEN: Thank you, Nancy.

I will be describing two case studies conducted for MedPAC by Tufts New England Medical Center illustrating the use of comparative effectiveness analysis.

The first case study investigated the use of erythropoietin or EPO to treat anemia and dialysis patients. The second case study investigated the use of screening to identify diabetes in asymptomatic individuals.

Turning first to the EPO case study, determining the appropriate treatment level for EPO involves balancing a series of often competing considerations. This slide lists three of the major issues.

First, EPO alleviates anemia in dialysis patients, improving quality of life. On the other hand, some studies have suggested that aggressive use of EPO to achieve higher hematocrit levels may increase mortality risk, as well as the risk for other possible adverse events. Finally, as with any pharmaceutical, greater use may involve greater cost. Any of these factors, along with others, might play a role in developing appropriate treatment guidelines for a population of patients.

Addressing these factors involves synthesizing the

available data on the outcomes of interest. I will be discussing two types of approaches: traditional evidence review and comparative effectiveness analysis. Although any particular review need not fit squarely into only one of these boxes, it is useful to compare these two types of approaches in terms of the types of information they produce and hence the types of questions they can answer.

A traditional evidence review of EPO has two key components. First, the review identifies the key outcomes. In the case of EPO, such outcomes could include the treatment's impact on quality of life and its impact on mortality risk. Other clinical outcomes, such as the risk of nonfatal cardiovascular events, might also be included.

For each outcome, a traditional evidence review provides an assessment to the strength of the supporting evidence. For example, a traditional evidence review of EPO might report that the evidence for improvement in quality of life is strongest at moderate increases in hematocrit but that evidence for additional quality of life improvements is less compelling as hematocrit levels are increased even further.

The review might also conclude that evidence for

mortality effect is strongest only when EPO is used to achieve relatively high hematocrit levels. The review might conclude that the most promising hematocrit target range is at an intermittent intermediate level where there is at least modest evidence of an improvement in quality of life and evidence of increased mortality risk remains limited.

While a systematic review provides a useful synthesis of the available evidence for the purpose of assessing which outcomes have been compellingly demonstrated, it does not provide all of the information needed by decision-makers. First, although decision makers must understand the scientific strength of the evidence for various effects, that information alone is insufficient to weigh risks and benefits. In particular, a typical decision maker also wants to understand both the probability and the severity of various outcomes.

Second, some decision makers will also be interested in the cost implications of the available options, including the cost of the treatment under consideration, as well as any downstream savings that the treatment might accrue.

The Tufts-NEMC EPO case study illustrates how

comparative effectiveness analysis extends beyond the questions typically asked in traditional evidence reviews. This slide describes our approach.

The analysis starts with an assumed population average EPO dose. We assume that a payer can craft policies that would achieve this average, for example through the use of appropriate guidelines or other levers that the payer can use.

Using data from the U.S. Renal Data System, we estimated the distribution of hematocrit levels associated with this average dose. By describing the distribution of hematocrit levels, we attempted to reflect the heterogeneity in patient response to EPO treatment. Based on the results of randomized clinical trials, we estimated the association between hematocrit level and both the quality of life and mortality.

Next, we expressed these clinical impacts in terms of changes in quality adjusted life years or QALYs. The QALY is a common metric used in hundreds of studies in the health economics literature. While it does not replace traditional impact measures such as mortality incidents, it does provide a framework to compare disparate outcomes.

Finally, we kept track of costs associated with procurement and administration of EPO. Note that we compared all of these outcomes, the benefits, risks and costs to a basic case comparator that assumes patients received 5,000 units of EPO per week corresponding to a population average hematocrit of 27 percent.

This slide shows our results. In each of the graphs I will show you, the horizontal axis is the population average EPO dose in thousands of units per week. The vertical axis is an outcome.

Our analysis indicates that quality of life increases gradually as average EPO dose increases, but that improvement slows at higher EPO doses. We also concluded that population average mortality risk climbs at an increasing rate as EPO dose climbs. Converting each of these effects to QALYs and netting them yields the result in this third graph.

Incremental costs can be estimated from this model, as well. Incremental costs and benefits can be compared by computing the cost effectiveness ratio, which is equal to the incremental cost divided by the incremental benefits measured in QALYs. A lower cost effectiveness

ratio is most favorable because it implies that the incremental benefits are achieved at a lower cost. For example, an intervention that costs $50,000 per QALY is better value than an intervention that costs $500,000 per QALY.

This graph shows our preliminary results on how the cost effectiveness ratio changes as the EPO dose increases. Note that at higher EPO doses, the cost per quality adjusted life year climbs quickly because quality of life benefits begin to decline and mortality risks begin to increase in our model. Keep in mind that we are still working on these results and that the case study is illustrative. Our report describes limitations to the analysis and identifies key research that should be conducted in order to develop a more useful policy model.

Importantly, the comparative effectiveness analysis methodology helps identify which assumptions should be further researched to reduce their uncertainty. Sensitivity analysis and uncertainty analysis tells us not only how uncertain each assumption is not also how much it influences conclusions regarding the benefits, risks, and costs of the interventions under considerations. We found

that assumptions regarding quality of life gains are critical in this particular case. We also noted that there is a need for development of a disease progression model that accounts for heterogeneity in patient response to EPO treatment.

The EPO case study shows how comparative effectiveness analysis can provide useful information to a range of decision makers. First, this type of analysis helps payers to review their policies to see if the interventions they are supporting are consistent with value.

Second, providers can use this type of analysis to evaluate the net impact of alternative interventions.

Third, the analysis helps to identify those sources of uncertainty that are important to resolve for the purpose of identifying optimal interventions.

Finally, comparative effectiveness analysis can take costs into account allowing estimation of cost effectiveness. Alternatively, depending on the needs of the user, costs can be omitted from the analysis and the analysis still facilitates comparison of risks and benefits.

That's all I have to say about the EPO case study. Now I'd like to turn to the diabetes screening case study.

Before describing the analysis available in the literature, I want to briefly point out what interventions are being used on the ground. The left column in this table lists the criteria CMS uses to identify asymptomatic adults for diabetes screening. The right column lists the types of treatments identified patients may receive.

A limitation to the existing literature is that the interventions they evaluate do not match up very well to the list on the proceeding slide. Perhaps the last study listed, conducted by Hoerger et al, comes closest in that it compares universal screening to targeted screening of hypertensive adults only. But even this study does not evaluate many of the risk factor combinations used by CMS. Nor do the treatments assumed by Hoerger et al match treatments used in real populations.

The next issue to keep in mind is how different studies model disease progression. The earliest analyses essentially assume that outcomes depend on glycemic level. These analyses assume glycemic levels influence the progression of microvascular disease, including the development of retinopathy, nephropathy and neuropathy. These conditions, in turn, give rise to clinical outcomes

including blindness, end stage renal disease, and lower extremity amputation. Finally, these conditions are assumed to be the means by which diabetes causes mortality.

The Hoerger et al analysis, which is newer, relied on more recently available data for its model. Hoerger et al retained the microvascular disease process but assigned it a lower level of importance than the previous analyses. They added to the diabetes model the idea that hypertension can give rise to morbidity and mortality by causing cardiovascular disease and potentially mortality.

The comparative analysis results highlight the importance of the modeling assumptions when estimating the benefit of screening different age segments of the population. This graph illustrates the relationship between age at screening and the cost per QALY gained. Note that the lower values are more favorable because they imply benefits are achieved at a lower cost. There are two upward sloping lines that suggest that young people are the most efficient to screen. Those results are based on the two earlier analyses conducted by CDC and Chen et al using the model that took into account only microvascular disease. The two downward sloping curves are based on results from

the Hoerger et al study. they imply it is most efficient to screen older individuals. That result reflects the inclusion of hypertension in the disease progression model.

The analyses we identified revealed the following: first, at least based on the most recent analysis it appears that screening more elderly populations for diabetes produces greater benefits per dollar invested than does screening of younger populations.

Second, this result depends strongly on what disease progression model is used.

The diabetes screening case study also demonstrates the importance of incorporating issues relevant to stakeholders. Even if the available comparative effectiveness analyses are technically sound, their value is limited if they do not ask the right questions. In the case of diabetes screening, it would be useful to evaluate the impact of incorporating additional screening criteria, of screening at a range of frequencies, and of using a range of treatments for identified patients.

Thank you and I will now turn this over to Peter Neumann.

DR. NEUMANN: Thank you, and good afternoon.

In my presentation I will briefly highlight the activities that an organization producing comparative effectiveness and cost effectiveness information for use by CMS and possibly other payers would pursue and key analytic and operational challenges it would likely face, expanding upon some of the issues raised earlier by Nancy Ray.

Presumably the organization would conduct its own comparative effectiveness research and/or award contracts and grants to academic and other organizations to carry out the research. Likely there be in-house staff expertise and activities but some, or even much of the work would be contracted out, as is the case with many existing federal agencies and at international agencies such as the National Institute for Health and Clinical Excellence, NICE, in the United Kingdom.

Typically, such research involves synthesizing existing data rather than conducting primary data collection. However, at times the organization might recommend and/or carry out primary data collection on a topic of sufficient importance where there is considerable uncertainty.

A central task for the agency would involve

setting research priorities and establishing criteria for priority setting. The organization could also sponsor conferences or scientific symposia on a host of issues surrounding the use of comparative and cost effectiveness analysis, including methodological questions as well as ethical, political, and legal issues.

Next we consider several placement options for the organization. First, within CMS. A greater role for CMS might seem natural and obvious, given CMS's need to determine what services to cover and pay for. However, as a matter of principle, and to ensure independence, it may be valuable to separate the function of the agency conducting comparative effectiveness analysis from the functions of the agency paying for health care. Notably, when CMS attempted in the past to use cost effectiveness analysis, it ran into stiff political opposition from many quarters.

Within AHRQ. As the lead federal agency for health services research, the Agency for Healthcare Research and Quality is a natural candidate to serve as the organization conducting comparative effectiveness research. Moreover, AHRQ has been overseeing comparative effectiveness research through authority stemming from the Medicare

Modernization Act. Some observers have argued that placing comparative effectiveness activities outside of AHRQ, and indeed perhaps outside of HHS, would have advantages in terms of institutional independence and insulation from the annual Congressional appropriations process.

Another option is placement within another existing agency such as the National Institute of Health, which has sponsored selected research in the area in the past.

Yet another consideration would be to add comparative effectiveness research to the FDA's mission. A potential downside is that comparative effectiveness research ideally should focus not simply on drug therapies and devices but instead cover a broad perspective outside of FDA's traditional mission, including medical procedures, diagnostics, care management, and public health programs.

Another option would involve creation of a new government agency along the lines of NICE in the UK with a dedicated mission to provide advice for Medicare and other payers on comparative effectiveness research.

A final series of options would be to establish some form of quasi-public agency. The agency could operate

as an independent single agency with support from various public and private sources. The information and advice from the entity or entities could be distributed as a public good to help target resources to improve health. Medicare and its private contractors could be free to use the recommendations as they see fit.

As Nancy Ray noted, variations on this theme are also possible, including an independent commission, Federally Funded Research and Development Centers, Congressionally chartered nonprofits or placement in the private sector.

Next, let me turn to some important issues of governance, oversight, and funding. Ensuring the independence of the organization will obviously be critical. One way to help insulate the organization is to separate analysts fro the decision makers. That is, maintaining institutional independence between those conducting research and those making reimbursement decisions. Various options are possible. For example, AHRQ could establish Federally Funded Research and Development Centers operated by a university or other nonprofit with guidance from an external board.

Maintaining independence for a quasi-public institution will present some unique challenges. The institution could, for example, have a board of directors composed of diverse stakeholders, including government officials, manufacturers, health care providers, academic researchers, and patient representatives. Although organizational separation of the decision maker and assessment functions has the advantage of better insulating the assessment process from political interests, it risks diminishing the relevance of the analytic process.

Finally, how the organization is funded, by whom and under what conditions, are questions of critical importance. Options include direct appropriations from Congress, mandatory federal funding, private sector either voluntary funds or user fees, or combinations of government and private funding.

Finally, let me mention a number of key analytic and process issues that an organization would confront. A central issue pertains to the rigor and validity of the methods used for comparative effectiveness research. The organization can play a constructive role in improving standards and consistency to the field.

A second issue pertains to the perspective assumed in an analysis. In terms of a cost effectiveness analysis, for example, an intervention may be cost effective from societal perspective but not from the perspective of any individual payer. An organization might recommend that analyses be conducted from both a societal perspective, for example because Medicare is a social program funded in part by general revenues, and from a Medicare perspective in order to inform questions about beneficiary health and program outlays.

Critics of comparative effectiveness analysis have sometimes worried that published analyses will reflect the hidden biases of investigators and their sponsors. Ensuring that analysts work independently and objectively will be critical issues. It will be important for the organization to have a transparent process. NICE in the UK, for example, has worked to publish its appraisals on its website. Moreover, meetings are held with various stakeholder groups.

Ensuring their legitimacy and successful functioning of the organization will also depend in part in having a process whereby decisions are subject to revision and appeal. Identifying research priorities is another

important area. Researchers have developed various methods for priority setting for a value to research over the years, including methods for explicitly quantifying the gains from research. Other researchers have attempted to explicitly quantify the impact of research itself.

Finally, it will be important for the organization not only to examine new services and technologies but to re-examine a services comparative and cost-effectiveness analysis over time.

Thank you very much, and we look forward to your questions.

DR. REISCHAUER: When Academy Health was doing a survey of this area, what should be done, they interviewed a number of the people around this table, including myself. One of the questions they asked was to do this right what kind of money are we talking about?

I had a flip answer to that, which I won't tell you what it was, but I'd be sort of interested -- admittedly, it takes some time to ramp up an effort like this. And presumably there is a stock of areas where we would want to learn more and whittle down that stock. But let's say five years out, what kind of resources would we be

talking about, just rough guesstimate?

DR. NEUMANN: Well, I knew the first question would be a hard one and you asked a question obviously of great importance. It's hard to know how to answer, frankly. People do talk about numbers in the tens of millions. Some people have thrown out numbers in the billions for this. I think people have thrown out even how do you get your head around this question. Even a very small percentage of total health care spending would still be a pretty big number. Some kind of reasonable fraction of NIH spending would still be a pretty big number.

I think if you look at what NICE spends in the UK as some kind of benchmark, for all of its challenges of doing benchmarks, it's probably 10 million pounds or somebody may have a better number than that, but I think it's in that range, rather than billions of pounds.

I would think a serious effort in this area should first require some analysis to try to figure out priorities. Are we talking about primary data collection or syntheses? I think syntheses, which is what AHRQ is doing now, is probably tens of millions. I think really doing primary data collection in terms of new trials, you're probably

talking hundreds of millions and higher.

DR. CROSSON: Essentially the same question but just another wrinkle on it because I've heard the same thing. I've heard numbers from $20 million or $30 million to focus on those key spending issues which seem to be most out-of-control to $2 billion in order to do something wildly comprehensive.

But one question I had was you mentioned early on that there could be two different models. One would be to build an entity that fundamentally did all of this itself, did all of the primary research and analysis, versus contracting out. Now it would seem to me that there are pros and cost to those two models I can think of.

The question is do you have an intuitive sense of which one of them would be the most efficient?

DR. REISCHAUER: Coming from an entity that might expect to get these contracts.

DR. NEUMANN: Putting aside any kind of self-interest, I think quickly you probably will start to think about contracting out to people who are experts in the field, in particular clinical areas and perhaps methodological areas, with some in-house expertise, as well.

My sense is that is the way NICE has done it in the UK and probably the way AHRQ and other federal agencies have done it that conduct research. There is certainly some intramural capabilities but a lot of it is contracted out.

DR. BORMAN: A couple of questions and thoughts. One would be -- and we've talked about it before here -- is the potential for tapping into existing databases. I think that links up to your point about synthesis versus primary data collection, and it also potentially speaks to the notion of maybe the first function is a clearinghouse function, just really to identify where things exist rather than necessarily go much further down that road in some very bureaucratic kind of fashion. Because certainly there are enormous databases out there, some public, some private, as the chapter and your report have pointed out. I would think that that would be much more effective.

Do you have any sense of whether there could be value in that sort of initial clearinghouse-ish kind of function that you could break this into some more digestible chunks by types of resources consumed or types of services delivered? Because certainly the kinds of measures you use, the modeling you use, and the volume of various services is

going to vary a whole bunch between certain kinds of very low volume but very complex procedure-based things and things that are very high volume but perhaps each individual item like -- just to pull one out of the air -- blood pressure check, is a much more finite, small kind of thing.

I ask that because it seems to me that, in addition to the independence that you identified as a key factor, that acceptance is another hugely key factor here. There will have to be some willing transfer of participation, trust, whatever, confidence in this. And the confidence could be in a process rather than an entity. I think that goes along with it not being one primary care source. But if you say okay, we need confidence in a process, certainly from the physician side I see that we use type of service in categorizing so many of our analyses. It just begs the question of would that be a way to break this into digestible chunks early on? Maybe later you'd come to combinations that you might have approach it in that way.

And then finally, just a comment about using QALYs and how you then operationalize from some of that. I would guess that part of the sensitivity analysis almost every time is going to have to get down to the actual assignment

by some test group of the value. Because when you just sort of survey people, well, is this is a good thing? Would you like to have this benefit, that benefit, subsidize this and not subsidize that, everybody wants everything. It's human nature. And particularly if it's technology driven, we really want it.

But when you say well, I'm willing to pay $10, $25, $50 or to have this instead of this, that kind of very soft sensitivity analysis starts to have a lot of real meaning in terms of what really is quality. And having valid quality of life scales for broad categories seems real difficult.

So if you could comment a little bit like say about the part about acceptance and clearinghouses and synthesis, and then a little bit about how you get to that end point of sensitivity. What are folks paying the bill really willing to trade? That may be different on the beneficiary side, the plan side, the physician side, whatever.

DR. NEUMANN: Many good questions. I guess I would start with research priorities. I do think there would be value in engaging in an analytic exercise to try to

figure out where to start. And exercises that do that tend to look at areas of big spending, areas of big health effects, areas where research can make a difference. And that often is areas of big clinical uncertainty. And wherever those analyses lead you, I think, would be good places to start.

I do think tapping into data bases, to get to your point, would be valuable. There are many now big comprehensive databases on the private side. And now with Medicare linking databases and outpatient and drug data linked with other traditional inpatient data, I think there's a lot of value to doing that and opportunities to do research where they didn't exist before.

Challenges to be sure analytically, and maybe in other ways.

I do agree with you that part of the challenge here is not simply one of methods and analysis but process and trust and political will. If you get a good process in place that people buy into, I agree with you that I think good things flow from that. And that's part of the real challenge here.

Finally, you mention QALYs, which is an area of

great activity in terms of research and great challenges and controversy. We know, for example, there's a lot of heterogeneity in the population about preferences for different things.

I think part of the answer is to force people to think about trade-offs and not just ask them, as you say, do you what these things? And how much do you want them? I think you need to ask people about trade-offs and really try to get people to think hard about what they're giving up and what they're getting.

But I think that would be an area that the Agency would have to think hard about and maybe it could sponsor some research and also serve as a forum to do good research.

DR. BORMAN: Just a quick comment. In my thinking about this, it seems to beg for a pilot, a trial, something we can all agree on that could potentially be an important question that we can, as crispy as any of these can be framed, frame it and go out there and see what are the extant databases that might help and look at a process and starting to outline what might be a process that is reproducible, test it to see if it has acceptance, and start and just see where the glitches are. Because just this very

broad brush of yes, let's hop into this area, it sounds great, it's motherhood, it's apple pie, it's the flag, sounds pretty expensive.

And so to me it just seems to beg for some kind of pilot.

MR. BERTKO: Karen has kind of asked at least got half of my question but I'll start by expressing certainly strong support from having MedPAC consider what, Peter, you and Josh have done. I think just the knowledge of this and the diabetes screening example is a great one. Whether or not the payment issue comes up, whether it should be encouraged, enforced, et cetera, seems important.

My question is back to priorities here. You guys have clearly worked in this area for a number of years, thought about it a lot. It's kind of a double question.

First of all, would you aim at future treatments, services, devices, drugs or current ones more or less? And then I'll put you on the spot and say since you've thought about it, what would be the top five areas you would start by looking at, if you were to throw your five into the hat with a number of other experts?

DR. NEUMANN: Again, I'll just quality it by

saying that would be a great piece of analysis to do for next year's meeting.

One thing I would say, I don't think this should just focus on drugs. I do think this is a broader question that should focus on services and treatments of conditions and diseases.

But if we're talking about Medicare, we might start with the biggest burden of disease, and we can look them up, but it's cardiovascular disease and cancer and diabetes maybe. It depends on how you define diseases. Mental health might fall in. There are probably some other ones that would be important.

Burden of disease certainly, I think, is a place to start. But just because something has a burden of disease doesn't mean that's where the money would be best spent. So I think then you have to move to analyses of treatments and where we could best spend research to reduce uncertainty and so forth.

There may be other areas, injury and falls and maybe other areas, that are not even traditional medicine that might be looked at, as well.

DR. MILSTEIN: Thinking about the range of what

this might cost, I think the high end, the annual budget, was in the billions. So as I run the math, a tenth of a percent of current U.S. spending would be about $2 billion a year. And that was about equal to the high end of the range.

One-tenth of 1 percent, some people might consider it expensive. I'd consider it a bargain. And particularly when viewed against the cost of current policy, which is completely uninformed by evidence, largely uninformed -- not completely -- largely uninformed by evidence of comparative effectiveness.

So I think $2 billion, and Medicare's prorated share would be about a third of that, would I think be a real bargain.

I'm going to, Peter if you don't mind, put you on the spot and ask you the following question. Because I realize that even though $2 billion is a very small percentage of current U.S. spending, it's still a lot of money. And where would it come from? So this is a variant of a question I asked you last year, but I'll ask it again.

I'm going to give you two different scenarios this time to make the question a little bit tougher. If tomorrow

we were to take available evidence on comparative effectiveness and change Medicare policy in ways that I won't -- we've talked about a number of pathways -- but change Medicare policy until such point that in any situation in which -- such that wherever we face treatment alternatives we always picked the most cost effective treatment alternative subject to the rule that we would never ask a patient to accept a lower quality of life. So subject to that.

If we were to do that tomorrow, just with the current available evidence, order of magnitude by what percent might American health care spending go down?

And then let me ask the hard question. Because I have to know what I'm getting for my $2 billion.

Now here's the hard question. Now imagine that we had the foresight to invest that $2 billion a year for the next 10 years. And then take a wild guess at the question, 10 years from now, after I've substantially built up by evidence, and let's say where I initially bet my money was exactly in the areas that you just suggested we invest.

Order of magnitude, a wild guesstimate, by what percentage might American health care spending be reduced?

Again, if we were to shift 90 percent of treatment share toward those treatments that were cost effective but we never, in any way, incentivized or asked a beneficiary or a provider to ever pick a treatment that involved lower predicted or likely quality of life for a beneficiary?

MR. HACKBARTH: We'll give you 30 seconds to do your calculations, 15 seconds per question.

DR. MILSTEIN: I want to say that, to be fair, I did give Peter fair warning at the lunch break.

DR. REISCHAUER: Can I just ask Arnie, to see if I understand what you're saying? What you appear to be saying is that you should never refuse somebody a benefit that increases, however marginally, quality of life no matter what the cost?

DR. MILSTEIN: Yes. I'm handicapping this.

DR. REISCHAUER: No, but then they're going to give you a positive number. They're not going to give you a negative number.

DR. MILSTEIN: Let's give him a chance to answer.

DR. NEUMANN: Last year I unsuccessfully tried to dance around this and I'll probably unsuccessfully try to do this again.

I said something like part of this is a political will question, of course, especially when you get into the things that are marginally better but more costly.

But if we were to try to take the other piece, if I understand you, which is just try to get out the waste, the ineffective portion with good comparative effectiveness research that sheds light on things are just not effective. And we would presume that spending $2 billion or some number would shed light on a lot of things that are just not effective and we're doing them now. And how much that would be, people have speculated. I've heard numbers, 10 percent, 25 percent of all of what we do now, and maybe even higher, is sort of waste if we define waste in that way. That there's no evidence that it really works.

So I really don't have any empirical number to give you, other than it's probably pretty big, maybe 10 percent or 25 percent is waste.

I do think it's very, very hard, even with good comparative effectiveness research, to define it well and say there it is and we're going to cut it out because medicine is often in the gray area and so forth.

So those numbers are out there. And I guess those

are the best numbers that I would just put out there, as well.

DR. MILSTEIN: Thank you. I would just say that even if it's half of the 20 percent, it's a massive multiple of the tenth of a percent we would spend.

MR. DURENBERGER: By my question I think one of the things I'm trying to get straight in my head is whether or not what we're up to here is promoting the creation of a new entity or we're trying to get it clear in our heads the role of comparative and cost effectiveness and how best to move that into some kind of a mainstream. And I'm hoping it's the latter rather than the former, that the issue of the entity -- regardless of what it might cost -- is a secondary issue to understanding what are the opportunities, what do we know currently about comparative effectiveness.

In order to get to that, let me also say that I know little about the subject. But I admire people who do. I think it was like six years ago, Peter wrote his first book on this subject as I recall and asked me to write a little blurb on the back. And I did, not knowing what I was doing, not going that I would be here talking to him here. But I just want to say how much I admire Peter. I don't

know Josh well. I just met him for the first time, I guess, today. So anything I may ask is a reflection of how much I know you already know.

But when I think about this, I'm thinking about it in the context of just the way Nancy expressed it. We're up to the business of value, the comparative effectiveness analysis compared to the value of drugs, devices, diagnostic, surgical procedures, medical services, and so forth and so on. It's a value question.

So when I start with that, I start with 35 years of experience reading Jack Wennberg's data about variation across the country. And I say there's no question about the fact that there are vast variations in value and how we match up health care against specific illnesses. We get a lot of that from that kind of research. So we know it exists. We know what the problem is. This committee has spoken to it many, many times.

Starting somewhere about 1987, I remember getting very interested in this subject. And by 1989 a group of us had created something called the AHCPR. And by 1995 or something like that, when some Republicans didn't think it was a good idea, tried to kill it.

The same group of people came to the support of then John Eisenberg and a lot of people to re-create what is now AHRQ. Even though I know some of the early examples of lower back pain and things like that, it's always been my expectation that having made the initial investment in that agency, because we couldn't make it in NIH. NIH was the logical place for it but they didn't want the job. So we made it in AHRQ.

AHRQ has been taking advantage, in one way or another, of the fact that across America there are places where you can go find value. And some of that will be in practice and some of the people are here in this room. Others will be in large databases maintained by some of those practices, maintained by UnitedHealth Group, which seems to do a lot of this kind of work.

In my own community the Institute for Clinical Systems Improvement has been doing something like this, below the radar, for 14 years. It's probably a model in the country. I'm only giving you that not to credential my minuscule knowledge, but to lay the groundwork for the question which relates to how best, in a country like this as opposed to Great Britain -- because we are not Great

Britain and we never will be -- how best in a country like this do we raise the value of comparative effectiveness and all of the related research activity that has to go into that?

Is there not a better way, whether it's the Medicare Advantage program or it's other programs that we currently are funding in this country, is there not a better way in which to develop the capacity for third-party payers, before we get the individual third-party payers, to help individuals make, and doctors and patients, make the decisions they need to make? And are there examples around this country where that does work?

I use the Institute for Clinical Systems Improvement as an example of it. For 14 years they've mainly been developing the guidelines, training the doctors into it, beginning the process of technology assessment, other things that they do. Now they're beginning to move into things like setting up criteria for the use of diagnostics.

And again, this may all be embryonic and so forth, but this sort of thing does happen and is more likely, it seems to me, to take place when it is in a community in

which there is a practice culture that already values value, if you follow me.

So again, I'm just trying to think about how do we get the job done. Coming to Washington, building a new building, blah, blah, blah, blah, blah, whatever billion dollars it is, is not a place I would start. I can tell you that.

In Washington we do have a place that is financing this kind of activity all around the country. It's called AHRQ. It doesn't have enough money. It's been barred by some of the language in the Medicare Modernization Act from spending more than X number of dollars. But it's there.

So I'm simply suggesting and trying to get your reaction to the fact that -- and it may be one of these options that's in here -- that a very important federal role -- maybe it's a near-term role rather than a long-term role -- is the kind of activity that an AHRQ, properly financed, has been asked to engage in. And to engage -- whether it's the Kaiser Permanentes or it's the Institute for Clinical Systems Improvement, wherever, to engage people who are already out there in the provider community or related to the provider community, to try to get this task of

comparative effectiveness accomplished.

Somewhere in there is a question.

DR. NEUMANN: First, thank you for your kind words and for writing a blurb for my book.

[Laughter.]

DR. NEUMANN: As I think about this, I would agree with you that I think part of this is a matter for regional and maybe local efforts. You mentioned some, the Institute for Clinical Improvement, and there's the Drug Effectiveness Review Project which is run out of Oregon but it is an alliance of many states and some nonprofits. There's Kaiser and the Blues and Aetna, each of which has their own technology assessment type capability. And I think it's probably very healthy for there to be these kinds of local efforts that are tapping into the community and value in the way they're thinking about it.

And perhaps even value in the sense that there's simply not one federal place where that's being done.

But I also think there probably is, at some point, a threshold where this becomes an enterprise that's larger than any one individual place can fund and handle. Certainly if we're talking about $2 billion or doing primary

data collection and clinical trials to try to figure out if one service is better than another, it probably exceeds the ability of a local effort to fund. And it's probably a public good in the way that Nancy Ray described that needs to come from the federal government.

I'm a huge fan of AHRQ and I think that what they do with the evidence-based practice centers and the local efforts is great. But it tends to be syntheses of existing information, which again is fine. But I think if we're really talking about an ambitious comparative effectiveness initiative, it may be a much bigger effort that needs to be thought about in a different way.

MR. HACKBARTH: Dave is, I think, addressing or raising a question that I wanted to get to. I do this little thought experiment in my head. We do have some good things happening in pockets across the country. I try to imagine the path by which, say over 10 years, those are going to grow to the scale that's appropriate for the problem that we're talking about.

And I just don't see how those little operations funded in various ways, sponsored by local groups or particular health plans, get to the scale that we're talking

about. I just don't see how it happens.

That's not to say that I think they ought to be wiped out and that they're bad. But I'm more inclined to approach the problem the way Arnie is framing it, which is there is an enormous need and an enormous economic problem that we face that we know is only going to get worse.

If you want different results than you're getting, you probably have to not just tinker with what's happening right now but have a fundamental change, a locus that can support a much larger scale of operation. But also add credibility to the process from a societal perspective that these more isolated local plan-sponsored entities can never bring. Whatever good they do, they're just not up to that task.

When you frame it the way you do, do we really need another building in Washington, I cringe. You're good at that. You've done this before; right?

MR. DURENBERGER: I've had a lot of practice.

MR. HACKBARTH: It's easy to make this sound like a really dangerous, threatening thing. I don't think anybody would seriously argue that overnight we ought to say we're going to spend $2 billion in the next year, and let's

start on the building right away. You're going to ramp up. And you need to think about how to ramp up in an intelligent way that continually adds credibility to the developing entity. You need a plan. You need a strategy to get there.

But I, for one, think the problem is huge and boldness is required, not timidity. At the same time, caution in how you ramp up and get there. I think this is a societal issue, a public good that deserve public funding, and a forum where we can have standardization of methods to give added credibility to the results, and a forum as in the case of NICE where people can come and take their best shots at it. We can have an organized public discussion about the quality of the analysis.

I just don't see how you get there with this fragmented approach that we currently have.

MR. DURENBERGER: Glenn, so I understand my own question and your reaction to it better then, let me ask you a question. Is it your notion, as you look at this, that somehow or other if we were to persuade the Congress to make the investment, that you start with the work, the research work and the development first before we go to the business of requiring that third-party payers must...

MR. HACKBARTH: Absolutely. I haven't thought through that strategic series of steps by which you get from where we are to where we need to be. So I don't pretend to have that plan. But I think you need to think that through. And I wouldn't start with the tacks as the first step. I would do some other things first.

DR. REISCHAUER: Can I just pile on? Having the group in Minneapolis, the Blues, Kaiser doing this has to be duplicative. There are certain things which maybe have a local component. But if we're dealing with human biology and the application of a piece of technology like a defibrillator that can't vary across the country or across the world really.

I would envision, in the long run, this really being something where the developed nations of the world coordinate their efforts and their data to try and inform mankind on what is most efficient way to produce good health.

MR. DURENBERGER: Whenever it's a defibrillator or whatever, the way in which it is deployed does vary across the country. Sometimes that variance is not good. Sometimes that variance is very good because it's in the

practice of medicine and it's in the way in which technology is deployed in medicine and decisions are made that you begin to create what you're looking for in terms of an advance in medical science.

Part of my problem with whatever I call it, the building in Washington, is that that advance does not get adapted very well. If it occurs in Montana or it occurs someplace else, it will take a long time for that sort of thing to get adapted. You just made the argument. If you have to run everything through our local NICE or our local whatever it is.

MR. HACKBARTH: You're touching on what I think is a critical point. I apologize for going on here, but these are big issues. I don't think of this as a payment entity. And Peter touched on this in his comments. This entity is not making payment decisions, either coverage-type decisions or how much to pay for individual units.

In our system, multi-payers, that would continue to be a decentralized process. This is an information agency to help guide rational decision making. Then payers go off and decide for themselves the pace at which they want to invite a new innovation into their program. Those

decisions would remain decentralized.

MS. HANSEN: Relative to looking at the process that I think Karen brought up, and one of the components I wondered if can be taken into account or addressed in some ways, just the impact to different economic categories of beneficiaries. And by that I mean more and more is also shifting over to the beneficiary to have some share of costs. I wonder if there is a way to say -- and this came out, I think, in some of the Oregon public meetings that came about -- to say that it's one thing to say this is the most effective or the best solution to what this clinical problem is. But perhaps it's a very expensive one.

On the other hand, there are other solutions, let's just take migraine medication. Medicaid policies in Oregon allows four pills a month. But this person may get seven migraines a month. And so he's looking for not just the past, which is the most expensive, but it could do I have a next level of this so that I can get eight pills a month for that amount of dollars, if that was the case?

So is there ever some thought about just the cost equation as to what your money can buy besides the pure rigor of the data in terms of the science?

DR. NEUMANN: I think typically you are separating the analysis from the decision maker in the sense of, as was earlier said, the analyst is putting the information out there. This is the consequences on cost and on health of using this drug or device or service. The decision maker is then making the decisions typically about whether it's four pills that they'll cover and pay for versus seven, or whether it's third tier versus second tier.

So typically those tough decisions certainly don't go away with this information. But it would not typically be the analyst who is making the decision about four versus seven pills or what the out-of-pocket spending should be, what the copay should be.

But I do think this information can help inform those type of decisions. If it seems that seven pills a month are reasonably cost effective, for example, a payer might say okay, we'll give you seven and not four and not have you walk around with another couple of migraines each month.

MS. HANSEN: I wasn't looking for the analyst to make that kind of local decision, but the ability to array the information for the degrees of effectiveness. So I'll

have at least a 70 percent chance that I'll get my migraine reasonably addressed, rather than having a real stomping one. Maybe I'd go for the one that's not going to best level but reasonably good so that I get some mitigation of the issue.

So you're saying that just whether or not the analyst will help provide that kind of information for the decision maker to make.

DR. NEUMANN: Right. And the analysis and analytic techniques are certainly flexible enough to accommodate lots of different ways to array the information. It will depend on how good the data are to inform certain types of questions. And ideally, the analyst is going to bring information that the decision maker really wants. So you can work together to figure out the kinds of information that's needed.

MS. RAY: I just want to add, I think it's important, when you think about moving forward with comparative effectiveness, that the information that is derived, that it can be translated so that patients can use it, that medical professionals can use it, as well as payers. I think, first and foremost, in your mailing

materials, is that it has the potential of informing patients and providers to understand better what works and what doesn't work.

MR. MULLER: Like Dave earlier, I've been following the work of Weinberg for over 20 years. You always see these estimates that 10 percent or 20 percent of American health care could be redirected. And then I see our struggles here to find a couple hundred million except by payment freezes and realize that some people feel this can all be done by Medicare Advantage. Some people feel it just needs some more accountable health groups with some maybe pre-payment factors. There's some evangelists out there who believe that information technology can solve it all. There's others who feel work redesign can do it all. I often feel we need more investigation of that great cartoon, and then a miracle appears, and figure out exactly how that all works.

But that being said, I want to speak a little bit to the constitutional structure of this because I do think, whether one calls it a new building in Washington and so forth, and I look at both examples of the NIH and the Howard Hughes where I think there's been major advances in American

medicine through some kind of combination of intramural and extramural expertise where we basically take advantage of all the knowledge around the country, oftentimes in universities but elsewhere, but also we have an intramural set of professionals who work on these things to kind of maintain it so you're not just contracting it all out.

I look at the kind of public goods which have ups and does in the last few years like the Census Bureau and the BLS and so forth, where you also try to maintain some kind of public database for the long-term public good.

I think somewhere in looking at those things I would say there may be a recommendation here where you create something like the Census that can be maintained in a longer term, but also take the advantage or the expertise there is around the country by funding in a combination of ways.

I think Nancy's paper and the comments of Josh and Peter get to that, as well, where we have an effort that has some permanency do it in terms of some cadre -- maybe not immediately reflected in a building in Washington so we don't get into those kind of concerns -- but obviously by the fact that both the NIH and the Hughes is here and the

BLS is here and Census, it tells you something about the centrality of where information is used for public purpose in this country.

So I think something along those lines, since I think one of the premises of what we talked about here today is not just whether we go forth with this but how do you constitute it.

I think one of the advantages it has is not just a permanency, but I think somebody spoke earlier to concerns that these things can get captured. I think one of the ways of making it less likely to be captured is, in fact, to kind of disaggregate it like that through a granting process the way NIH does. NIH has a number of other features, such as peer review and so forth, that allows for there to be less capture. But having processes of peer review for allocating these investigations, having extramural processes where you take advantage of what the Blues are doing and what the universities are doing and so forth, I think would be a good way to go as well.

So the parts of the recommendation that we're looking at, I like something like that that has permanency, that takes advantage of the good things that are going on

inside the country.

Like Bob I agree, this is something that does lend itself to science. And science, in some ways, unlike the classic stuff about states as laboratories for the nation, there's a right way to do things. You can basically say it doesn't have to be reinvented 30 or 40 times, so making the investments and getting it right.

I would also go back to the conversation we had last year with Peter, let's just not do drugs. Peter reiterated today, let's look at medical processes. But also, whether you follow some of the stuff that Berwick and others have done, I think we have to be looking at how one actually executes and implements these processes, not just the technology itself but basically understanding the work of medicine.

Arnie speaks a lot to this and we try to do it a lot through payment redesign.

But I still think one of the reasons we don't get Wennberg's 10 percent to 25 percent is we don't have enough understanding of how the work of medicine really goes forth. I do think investing in that, as well, is a critical part in this. There's a reason that doctors or nurses, et cetera,

don't implement the "right stuff." I think an awful lot of it has to do with we don't understand enough about how they really do their work. I do think we should do a lot more in understanding the mechanisms of our work in medicine as well as the technology.

So I think, again to reiterate, some kind of quasi-public agency, leave how it's funded to later discussions, that takes advantage of some of the learnings we have from NIH and Howard Hughes, but also some of the permanency that the Census has and relies on intramural as well as extramural expertise, and also looks at not just the technology of medicine but also looks at the work of medicine, I think would be a good way for us to proceed.

DR. KANE: Actually, I'm following a little bit on what Ralph was just saying at the end of his remarks, which was I went to two different lectures about decision analysis, one by Zeckhauser and one, I think, David Paltiel. The topic was why don't people take decision sciences seriously? Why don't they take rational thought and implement it into their decision making?

I think that goes to Ralph's comment that we don't really understand the process by which this kind of

information gets built in to medical decision making either at the payer level or the provider level or the beneficiary level.

I guess that's I think it would be really useful, and I think it has to be in the American context, not the British context, but it would be really useful to get a sense of when there is some -- I guess my other concern, before I get into what I think would be useful, is in public health we're always coming up with what you should and shouldn't do off these great cohort studies of longitudinal analysis of health, and there's a lot of analysis of what you should or shouldn't do. But it seems to change a lot over time, so that people kind of get a little burned out with what's the best thing to do for my diabetes today or my diet tomorrow.

I worry a little bit that this kind of analysis might be subject to some of the same problems that you are making some -- there is some estimating and probabilities and values and maybe even ethical assumptions made in coming up with your conclusions, even if they have a high point, an optimistic, and a base case and a pessimistic. And that those are subject to change and make the whole analysis

change. And people kind of burn out after a while with that and then turn off to all of that.

How do you make this stuff really useful, really effective at the levels that we're talking about? And enduring and not something that just sounds like a bunch of ivory tower academics coming up with how many angels dance on the head of a pin?

I don't think you are that, but I just have heard from your own colleagues that it's very hard to make your kind of results influence real decision making at the different levels that we care about.

DR. NEUMANN: You raise a great question. I think it's an ongoing challenge. Part of it, I think, is a methodological one that we need to be more transparent and clear and educate people about the value of the analyses.

I think there is a component here that maybe the expectations are too high in the sense that the analyses are thrown into the political arena and to systems with all kinds of funny incentives to do things. And why people are not rational, in part, is due to the nature of the way decisions get made, given those incentives and given other political challenges, ethical issues. You mentioned

behavioral realities. People don't stay on diets and exercise and do things that they should do rationally and all of that.

But I don't think that should cause us to stop the analyses. I think we need to do a better job at them and communicating them and making them more consistent and independent and rigorous and everything else.

But I do think they will be thrown into the system at the end of the day. And maybe part of it is getting the incentives in a better place and fixing the system, too.

DR. CROSSON: I completely support this direction.

I'd also like to thank Peter for laying out the issues so well. You probably don't know, but I did my residency training at NEMC and you were comparatively effective in producing me, so I'm willing to take what you say very seriously.

[Laughter.]

DR. CROSSON: I'm basically following what Ralph and Nancy have said, and that is that I could envision a role for an entity, probably quasi-governmental but I'll get back to that in a minute, that plays a role of first of all leadership, coordination of funding, standardization of

process, and verification probably of results without necessarily doing it all and without doing away with those processes, those places and processes and collaboratives and entities like we have in the Care Management Institute that are already doing this.

I think our entities -- and we have more than one -- do and would be very happy to collaborate in the process where this work was parceled out and for which there was more funding and complete transparency of results. And I could see that working very well and building on existing structures.

And I think the ramp up time in that kind of model could be a lot faster than starting something from scratch.

In addition to that then, I think we should look very hard again at AHRQ. AHRQ is not a quasi-governmental agency but AHRQ was created, like the Phoenix, out of the ashes of AHCPR because of the weaknesses of that model and the retaliation by a small group of individuals.

I could imagine that AHRQ could be re-chartered in a way, re-funded in a way, perhaps the base of funding broadened to be a combination of private and public funding, and made more secure than it is now, and act as that

coordinating entity.

I could imagine us coming out with some very specific recommendations to that end.

MS. BURKE: I wanted to go back to a comment that Dave made, but in part actually also support what Jay has said.

Nancy did really a very terrific job of laying out for us really two things in the paper as she describes it. That is one, the reasons that this kind of information might well be valuable to us and how it might be used; and then secondly, how one might create a structure that, in fact, would do it.

To Dave's point, however, I think perhaps the value added by the Commission might well be in the first case and less so in the second. And that is around the discussion of confirming the value of an organized effort to produce information like this, how it can contribute to a decision making process going forward that has an enormously positive impact on our delivery system and the need for consistency and quality in that kind of information and some of the issues that arise in the course of how one produces it and where it comes from.

I worry a little bit about to what extent we can, in fact, and I don't disagree with Jay's view in terms of AHRQ. I, in fact, cochaired the Academy work on this issue and the material that was ultimately, as a result of that, that Bob commented on in terms of the reviews and consultation that took place over a long period of time in completing that report.

But I worry a little bit about us trying to come up with a definitive answer on exactly what is the right structure. One of the things that we found in the course of the Academy's work was the complexity around that question and the politics around that question. Dave's point and Jay's point, as well, as to the reasons that we have AHRQ are evidence of exactly how complicated those politics get in terms of the financing, the structure, the authority, the competing demands among different factions.

Which is not to suggest that the Commission might not help contribute to that by raising some of the pros and cons, as Nancy has very nicely done in the course of this paper.

But I would caution, and it will be left to people other than Ralph and I who won't be here in the course of

your work over the next year or so, that having folks in from those agencies -- not that you both haven't done a great job in talking with us today, and Nancy hasn't in the course of doing her paper -- that there really are a lot of issues around how you structure it, what the financing might be, where the cooperation might come. Dave's point that NIH fundamentally didn't want to do this, AHRQ has stretched their necks in a variety of ways.

But again, it's not clear to me whether working towards a single answer by the Commission is necessarily the best value added by the Commission in the courts of its work. The reasons why, the value of the work, the issues that might be addressed in the course of how it's best produced.

But again, I simply reflect the complexity of the questions we engaged at the Academy level where we didn't have the same kind of responsibilities of the Commission in trying to sort that question out. So again, I don't disagree where Jay gut but query whether or not, in the course of the Commission's work, that's necessarily where you want to work towards a single answer, this is the right entity to do exactly this. But underscoring the reasons for

doing it and moving in that direction, I think might be perhaps better done here.

MR. HACKBARTH: So what I hear you saying, Sheila, is that you certainly think we're not ready to do that at this point. And you even question whether we can devote sufficient time and attention on an ongoing basis to come up with a definitive answer and it ought to be left to others to do so?

MS. BURKE: Simply in the following way: I mean, I think there are enormous skills around the table and people with lots of different expertise that could be brought to that question. But I think in the normal course it would involve bringing the NIH to talk with us about what their view is on this topic. What is AHRQ's view on this topic? What is the view of folks who would like to see an SEC created?

It would seem to me that the staff has done terrific work. But if, in fact, the Commission wanted to go in that direction I think it is a fairly complicated question. There are a lot of folks that can talk to us about how you structure governmental entities or not, and what the source of funding might be. There are a lot of

politics on the Hill because of the jurisdictional issues, whose authority does it fall within? Does it, in fact, come from appropriated funds? Does it come out of the entitlement programs?

There are all those sort of questions that arise in the course of creating federal entities that all of us have gone through. The Commission may choose to do that. But I think it would take more than simply a staff paper doing pros and cons. It's a much deeper question with lots of different issues that have to be addressed.

I do think there's an enormous amount to be done even improving the reasons. We all agree, I think, substantively on why you would want to have this kind of information produced and how it can, in fact, benefit us notwithstanding some of the issues that arise in terms of the questions about the information and how applicable it is and how practical it is that people put it into play on a daily basis.

That, in and of itself, is a huge question and one that I think we could easily address -- not easily address but we certainly can address.

But the second question, I think, is a complicated

one. The Commission may choose to take it on. But I think it is not something that, on the basis of a single staff paper doing pros and cons. I think there are just huge issues that have to be dealt with that you may choose to take on. But I simply say, having gone through it with the Academy, they are not simple questions and not easily dealt with in a short period of time, I think. Although I think Nancy did a terrific job of summarizing a lot of those critical questions.

But I simply reflect it was a complicated issue and not one where people came easily to an answer.

MR. HACKBARTH: Let me use Sheila's comment to frame the question. We have before us a draft recommendation. In fact, would you put that up, Nancy, so everybody can see it.

I don't want to go through and modify language, but I think we could all quickly identify phrases here that we might want to modify based on the discussion, whether we add modifiers to entity, whether it's produce comparative information or sponsor and produce, whether the charge includes -- as Ralph suggested, research as to how and why information is applied. There are a lot of potential

modifications.

So I'm going to try to strip it down to a more basic question, and that is how many commissioners would like to see us attempt to craft a bold-faced recommendation in this spirit if not with this exact language? As opposed to how many would prefer Sheila's recommended course, which is to talk about these issues, help frame the question, but stop short of trying to make a bold-faced recommendation?

MS. BURKE: May I alter that just slightly in the following way, Glenn? I do think it makes sense, my own personal view, for the Commission to, in fact, come to a recommendation that relates to the value and importance of the development of this kind of information and its application.

My hesitancy is around a recommendation specific to the creation of an entity to do it.

So I would not at all oppose moving to a recommendation around the subject matter. It is really this that says establish an entity, which I could read in 20 different ways, including doing something different than AHRQ.

So my concern is moving towards a recommendation

specifically related to the creation of an entity, not towards underscoring the value and importance of the development of this material and its application.

MR. HACKBARTH: That's helpful. So to coin a phrase, there are two paths here.

[Laughter.]

MR. HACKBARTH: So let's focus on the concept, if not the exact word of create an entity, a capability, as one potential focus of a recommendation, develop a capability.

And then the other would be a recommendation that doesn't focus on entities or capabilities so much as the importance of this area. It might be more broadly stated as the importance of investing in the development of comparative effectiveness information for the future.

I may be trying to make a false distinction here but there's a group of people who want something concrete and there are a group of people who think the topic is important but I want to stop short of concrete.

DR. REISCHAUER: But not a building.

MR. HACKBARTH: But not a building, right.

So what I'm trying to do is get a sense of the

proportions on each side of that. Bill, do you have a way to help me make the question clearer?

DR. SCANLON: I think part of the problem, and maybe Sheila can correct me if I'm misinterpreting you, but part of the problem is where we are in terms of something concrete is not very concrete. And I worry about the idea of, in some respects, passing the ball to the Congress with telling them you go specify this.

The reality would be that they may come back the way they did with pay for performance, and say now what do you guys actually mean by this?

We should be endorsing the concept, which I think is your second alternative, is something that I'm comfortable with. And then the issue is should we be willing to take on some of the kind of work that Sheila's talking about over the next few years to be able to give the Congress some more really concrete ideas, something that they can then put their arms around.

I think right now we don't have that. As you said, entity here can be interpreted many, many ways.

MR. HACKBARTH: Did you have a favored noun for describing this, if it's not entity? Maybe capability is

sufficiently broad and generic.

MS. DePARLE: I feel like we've said that before. I think we said something almost like that, or should invest. My concern is, I've listened carefully to what Sheila said and I'm sympathetic to it. But I think we run the risk of being too subtle here. I don't think there's any way to avoid the food fight that will have to occur.

MS. BURKE: That may be that case.

MS. DePARLE: So I'm ready to just go ahead and plan a flag and say we should establish an entity.

MS. BURKE: So if you're asked the question, the natural question that the Congress could well ask, is do you mean AHRQ? Do you mean -- to Glenn's point, I don't disagree with you that we've said there is value in this information. I agree and I certainly support going beyond that.

My question is are you prepared today to say what the entity is? Because that's next question. The next question is well, do you mean we need to do something other than AHRQ? Do you mean you want to give this to NIH? Do you mean that you want to create a separate freestanding federal entity? Do you mean you want to support --

MS. DePARLE: I could answer that because I think we've gotten the data.

MS. BURKE: My only point is is the Commission prepared to answer that?

MS. DePARLE: I don't know about other people.

MS. BURKE: That's my question.

MS. DePARLE: I think we have today the most comprehensive survey of the landscape that I've seen.

MS. BURKE: So what's the answer?

MS. DePARLE: I would say AHRQ, based on Peter's analysis and everybody else's. That may not be where my colleagues are but I think I could -- and I think we should set forth all of the pros and cons.

MS. BURKE: I would say AHRQ, too. It wasn't clear to me that that's where we had come in the course of the discussion.

MR. HACKBARTH: A potential course is to have a recommendation that's broad and say refers to an entity. To some people, I think entity is important in terms of going a step further than we've been before. But frankly acknowledge in the text that we are not prepared to say a particular entity. We can go through some of the obvious

candidates, including AHRQ, and lay out the pros and cons of those. Which would be a little less presumptuous than to say we know the right entity based on what we've done thus far. But use of a term like entity would be, I think, an important step forward from the general discussion we've had to this point.

We need to move on. Obviously, this isn't a final vote. I'm just trying to figure out what we need to do for our next meeting and where we are, how divided we are on this.

So let me, at the risk of gross oversimplification, ask people who would like a recommendation that calls for an entity with appropriate modifying language? Could I just see those hands? If somebody would take a note on this, it would be helpful for me in following up with commissioners.

DR. KANE: Can you also say that it would focus on Medicare program priorities as opposed to the general -- since it's MedPAC, should we sort of bring just the priorities to be Medicare?

MR. HACKBARTH: Actually, that would not be my preference but we can talk some more about that.

MR. HACKBARTH: Okay, the hands of people who think we ought to stop short of that are Bill, Nick...

DR. WOLTER: I'm contemplating.

MR. HACKBARTH: Karen, Sheila.

MS. BURKE: Again, I don't want to prolong this, but my only concern is if you say that, then the question would be why didn't you say AHRQ? I worry that saying that in a vague way will undercut those of us who arguably think it ought to be AHRQ if you're going to specify. I worry in the absence of a specificity, someone will presume that that is what you didn't do. That concerns me.

DR. REISCHAUER: Wouldn't the text in all of this describe the pros and cons?

I actually am not an AHRQ fan. I'm a public-private entity. And I don't think there's any way a government agency can do what I think has to be done.

MS. BURKE: But just to complicate it further, in the course of talking about AHRQ, one of the questions was whether AHRQ took responsibility of creating an opportunity for a public-private partnership outside of AHRQ, that they were the place to essentially do one of these FFRDCs.

That, in fact, the thought of many of us, in the

course of the earlier conversation, was to do exactly that for that exact reason, that it ought not happen in AHRQ, can't happen in AHRQ as it's currently constructed, but AHRQ ought to be the place were it, in fact, occurs.

I don't disagree with you at all.

MR. HACKBARTH: There are lots of further important issues on this, and we need to cut it off right now.

I'd just like to address a comment to the audience. I want to make clear the purpose of this show of hands was not to take a definitive vote on the question. It was really to help guide me and the staff on what to do between this meeting and the next meeting.

So I would urge that people not run off and report this as MedPAC voted to do such and such. That's not what it was. We're short of that. But with this guidance, this information, we can now go back to commissioners between meetings and try and flesh out these ideas and find a way to common ground, I hope.

Thank you, Josh and Peter. As always, excellent work. We may be seeing you again at some point in the not-too-distant future.

Good work, Nancy. Thank you for your help on this.

We are going to dramatically switch gears here and move from grand questions of the broad health care system and its future to talking about physician practice expense.

We are running behind, and I apologize for that. I didn't want to cut that last discussion short.

Next up is practice expense, and I'm hoping that I will be a better leader and lead us through this more efficiently. So with that inspirational comment to start you off, you're up.

MS. RAY: Last fall CMS proposed major changes to its method for calculating practice expense payments. In its final rule, CMS adopted these changes. I'm going to take you through the impact of these changes and Ariel will talk to you about one of our concerns.

Just a little background to frame this topic. This work fits into our broad agenda to examine physician payment issues. In particular, the accuracy of payments. Recall that in our March 2006 report we made a series of recommendations to improve CMS's process for reviewing work RVUs. These recommendations address the concern about the

mispricing of services in the physician fee schedule. The Commission and others have argued that accurate pricing may be leading to increased volume for certain types of services.

Inaccurate pricing is also an issue on the practice expense side. In our June 2006 report, we raised concerns about the age of the data CMS uses to calculate practice expense payments and some of the assumptions CMS uses to estimate the practice costs of imaging services.

So what are practice expenses? Just a brief reminder, practice expense payments pay for the expense of operating a practice. Direct practice expense payments cover the cost of non-physician clinical labor, medical equipment, and medical supplies. Indirect practice expense payments cover administrative labor, rent, utilities, and other expenses. Practice expense payments are important. They account for about half of the payments to physicians.

So CMS implemented, in January 2007, six major changes to how it calculates practice expense payments, how it calculates the method and the data it uses. So just real briefly, CMS now calculates direct practice expense costs by summing the nursing costs, medical equipment costs, and

supply costs for each service, holding everything else constant. This change benefits office-based services that use high cost equipment and supplies. CMS also changed how it allocates indirect costs to each service. Ariel is going to talk to you more about this.

But indirect costs are important because they account for, on average, two-thirds of a specialty's total practice expense costs.

CMS accepted and used more current practice cost data from eight specialty groups. Under a BBRA provision, specialty groups could choose to submit more current practice cost data. CMS used the new practice cost data from the eight groups and older data for most of the other groups to calculate indirect practice expense RVUs. So doing so favors those services primarily performed by these eight specialty groups: cardiology, radiology, radiation oncology, dermatology, urology, gastroenterology, independent diagnostic testing facilities, and allergy.

Another change CMS made is that they are now using the same method to calculate practice expense RVUs to services involving physician work and services not involving physician work. This refers to the so called non-physician

work pool. Before 2007, practice expense RVUs that did not involve physician work were based primarily on charges.

CMS is also using more current volume data. Again, this change will benefit faster growing services like imaging, holding everything else constant.

Finally, CMS is using the 2007 work RVUs that include the budget neutrality adjustment to allocate indirect costs to specific services. Recall CMS just completed its third five year review of the work RVUs and this resulted in increasing work RVUs for some E&M services and major procedures. To implement this change budget neutral, CMS decreased all services work RVUs by 10.1 percent.

So you can see that once CMS implements all of these changes in 2010 practice expense RVUs, on average, will increase for E&M services, other procedures and tests, and decrease, on average, for imaging and major procedures.

There are a lot of moving parts here. As I took you through, there are six new moving parts to the method and the data. So to better understand these changes, we isolated the effect of first changing the methods and then using new data.

So the blue bar here shows the impact of using the new methods and the new volume data. The green bar adds to that the impact of using the new practice cost data for eight specialties and the older practice cost data for most other groups. The yellow bar shows the impact of all the changes including using the 2007 work RVUs.

First, the change in the methods, the blue bar. You can see it had a positive effect for E&M and other procedures and tests and a negative effect on imaging and major procedures.

Next, let's look at the impact of using the new practice cost data for some specialties and old data for other specialties. When the green bar is higher than the blue bar, then the newer cost data had a positive effect, which it did for imaging services, other procedures, and tests. By contrast, it had a negative affect on E&M, services, and major procedures.

Finally, we move to the yellow bar and that includes the effect of all of the method changes and data changes that CMS will make in 2010. So you'll see that for E&M and major procedures, using the 2007 work RVUs offset some of the losses from using the newer practice cost data.

By contrast, for imaging, other procedures, and tests, using the 2007 work RVUs offset some of the gains from using this practice cost data.

Now the effects on individual services, however, can sometimes differ from the service category. And I just want to highlight two examples for you here, but I'd be happy to answer any other questions you have.

First, looking at E&M services. In 2010, on average, practice expense RVUs will rise by an average of 7 percent. But for nursing home visits, however, practice expense RVUs will fall by 5 percent. This is because the five-year review did not increase the value of its work RVUs. And remember, the work RVUs have this sort of indirect effect on practice expense because work RVUs are used to calculate indirect practice expense values.

The second example I'd like to highlight here is with major procedures. Here is where you can see the effect of using more current practice cost data for some groups and not for other groups. On average, across all major procedures practice expense RVUs fell by 8 percent. However, practice expense RVUs increased by 37 percent for coronary angioplasty. That is because it is a procedure

primarily performed by cardiology and this specialty was one of the eight groups that submitted the newer practice cost data, and this specialty accounts for about 94 percent of the total volume of these procedures.

So at this point I'm now going to turn -- Ariel will discuss some issues we have.

MR. WINTER: Now we'll focus on how CMS calculates indirect practice expense, which includes administrative staff, office space and utilities, and other expenses.

Because indirect costs cannot generally be traced to specific services, CMS has had to develop a method for allocating these costs to individual codes. It's important to keep in mind that this process is not an exact science and there is no single best method for allocating indirect costs.

Nevertheless, we'd like to propose four broad principles that we think should guide any indirect allocation method. First, the method should be based on factors that actually drive indirect practice costs. For example, they should probably include non-physician clinical labor because indirect costs are probably related to the amounts of clinical labor that's required for a service.

Second, it should avoid creating incentives that favor certain services or sites of care over others.

It should limit the administrative burden on CMS and providers.

Finally, it should be reasonably understandable.

This slide addresses an issue that Nancy Kane raised at our September meeting. Practice expenses include costs that are fixed in the short run, such as rents and utilities, and variable costs such as clinical labor and supplies. Most of these fixed costs can be classified as indirect costs. Some researchers have proposed that Medicare should only pay for a practice's fixed costs until those costs are covered, perhaps by making a periodic lump sum payment that varies based on the practice's characteristics. Medicare would pay for the variable costs of the service on a per service basis.

Although this idea is conceptually appealing, it would be quite difficult to implement in practice. To estimated a practice's fixed costs, CMS would need to collect extensive data on practice characteristics such as their size, the number of offices they have, their service mix, and Medicare share of volume.

CMS would also need to develop a manageable number of homogeneous payment classes, which would be difficult given the wide variety of practices.

Finally, there could be opportunities for physicians to increase their payments by changing their practice characteristics, for example by increasing their number of offices.

Given these difficulties, it appears to be more feasible to pay for indirect costs on a per service basis, which is what CMS currently does.

CMS follows a two-step process to calculate indirect RVUs per service. First, they create pools of indirect costs for each specialty, which is the top box on the slide. One of the key data sources used to create these cost pools is physician survey data on practice costs, including the more recent cost data for some specialties that Nancy discussed. One point to remember is that the size of a specialties' indirect cost pool influences how many indirect RVUs their services receive.

Once CMS creates a cost pool for each specialty, they allocate the cost pool to the services the specialty performs. In general terms, this allocation is based on

each service's physician work RVU and direct cost RVU, which includes non-physician clinical labor, medical equipment, and supplies. Services with the highest work values and direct costs receive the most indirect expenses.

CMS chose to use both physician work and direct costs in the allocator to balance services performed by office-based and hospital-based specialties. Hospital-based specialties perform services with low direct cost but higher work values. Thus, if the allocator was only based on direct costs, it would be difficult to allocate indirect expenses for these specialties.

On the other hand, office-based specialties generally perform services with lower work values but higher direct costs.

This chart assumes that all services are provided by only one specialty. But in reality, most services are provided by multiple specialties. In these cases, the indirect cost is a weighted average of each specialty's indirect costs for that service.

Here we have the full formula for allocating indirect costs. First, CMS multiplies the direct cost of the service, that is its clinical labor, equipment, and

supplies by an adjustment factor. This factor is the ratio of the indirect cost to direct cost for the specialty or specialties that perform the service. Because this ratio is greater than one for most specialties, this adjustment increases the overall importance of direct costs in the allocator. As a result, direct costs account for about one-third of the allocator, on average, instead of one-quarter. Finally, the adjusted direct cost is added to the physician RVU, which accounts for about two-thirds of the total allocator on average.

If the service has a low work RVU, than the non-physician clinical labor cost is used instead. This is done to accommodate services that have no work RVUs such as the technical component of imaging studies. For these services, the non-physician clinical labor is counted twice because it's also included in the direct cost portion of the allocator.

We have several concerns with CMS's indirect allocation method. First, it's complex and difficult to understand. Second, it includes medical supplies and equipment even though the relationship between equipment or supply costs and indirect costs may not be linear. For

example, a $1,000 supply probably does not require 10 times as much office space and utilities as a $100 supply. Thus, allocating more indirect costs to services that use expensive supplies and equipment may overvalue those services.

A third concern is that the current allocator counts clinical labor twice for services like imaging that have no work RVUs. It's unclear why these services should be treated differently. Physician work and non-physician clinical labor are, to some degree, substitutable. If the service involves no physician work, then its clinical staff costs should be higher, so there's little justification to count the clinical staff cost twice.

This adjustment increases indirect RVUs for services with no physician work, which increases the incentive to perform them.

Finally, the use of specialty-specific cost pools makes the method more complex and may also create distortions in the RVUs. As Nancy noted, CMS uses more recent practice cost data for some, but not all, specialties in creating these cost pools.

The eight specialties that recently submitted data

tend to have larger cost pools than other specialties, which increases the amount of indirect RVUs assigned to their services.

On the other hand, some stakeholders believe that the use of specialty cost pools based on physician survey data makes the method more resource based. We designed two alternative allocation methods that illustrate ways of addressing these concerns, both of which would use existing data. In doing so, we are mindful of the four broad principles that we outlined on slide eight.

In developing the two alternatives, we played around with lots of different permutations with different trade-offs. But we settled on two specific approaches or alternatives in order to be able to model impacts. You can certainly make a case for other iterations.

This table summarizes the two alternative methods that we chose to model. Our first alternative does not use equipment or supplies and does not double count clinical labor if the service has no physician work. Thus, it limits the financial incentive to perform services that use costly equipment and supplies or have no physician work. This allocator is based on the non-physician clinical labor and

physician work for the service. The underlying concept is that indirect costs are related to the amount of labor involved in a service, whether provided by a physician or non-physician clinical staff.

This option does use the ratio of indirect to direct costs for the specialties that perform a service, which is applied to the non-physician clinical labor part of the allocator. It also uses specialty specific cost pools, which offset some of the effect of dropping equipment and supplies from the formula. This is because specialties such as radiology that use expensive equipment and supplies should have larger indirect cost pools, which means their services will receive more indirect RVUs, other factors being equal.

Now we'll describe option two. This option uses all the direct costs -- the clinical labor, equipment, and supplies -- in addition to physician work. Like option one, it does not double count clinical labor for services with no physician work. Unlike option one and the current method, it is not use specialty-specific indirect cost pools. Instead it uses a single cost pool across all specialties which equals the total amount of indirect RVUs in the

current payment system. This change makes the method less complex and reduces distortions created by using more recent cost data for some but not all specialties to construct the cost pools.

Although it does not use specialty cost pools, option two does use each specialty's ratio of indirect to direct costs as derived from survey data. So the survey data continues to play a role but it's much more limited.

This chart shows the impact of options one and two on the new fully implemented practice expense RVUs. The title says 2007 but it would actually be 2010 because the changes will not be fully implemented until then. And the modeling was done by our contractor, NORC.

Both the baseline and the two alternatives include the new methods and new data that CMS began implementing in 2007.

Under option one, which is the yellow bar, PE RVUs would shift from imaging, tests, and other procedures to E&M services and major procedures. RVUs would be lower for imaging and tests because these services are more likely to use expensive equipment and supplies or to have no work RVUs.

RVUs would be higher for E&M and major procedures because these services are relatively small equipment and supply costs. Major procedures would also increase because they have higher work RVUs and work RVUs account for a larger portion of the allocator under option one, compared to the current method.

Under option two, which is the green bar, PE RVUs would increase for E&M services by 7 percent while the other categories would decline by between 3 and 7 percent. These effects occur primarily because specialty-specific cost pools are not used in this option, whereas they are used in the current method. Services performed by specialties with larger indirect cost pools, such as radiology, cardiology, dermatology, and orthopedic surgery, would decline. That's why we see an overall decline for imaging, major procedures, other procedures, and tests.

Conversely, services performed by specialties with smaller indirect cost pools would have higher RVUs under this option. These specialties include physical therapy, emergency medicine, and family and general practice. And this accounts for the increase in E&M RVUs.

Option two would have an indirect effect on

spending in other parts of Medicare. This is because option two would physician fee schedule rates for outpatient therapy services, which is not shown on the slide, and these rates apply to therapy services provided in other settings such as hospital outpatient departments. So if therapy rates under the physician fee schedule increase, this would increase spending at the hospital outpatient setting.

The issue is that under current law this additional spending could not be offset by budget neutrality adjustment in either the physician fee schedule or the outpatient PPS, so there would be a net increase in Part B spending.

To summarize our presentation, for 2007 CMS used new method and new data to calculate the PE RVUs. On net, these changes resulted in higher PE RVUs for E&M services, other procedures, and tests and lower RVUs for imaging and major procedures.

The use of new practice cost data for eight specialties may distort the RVUs for practice expenses because cost data for other specialties are based an older survey. This factor has a large impact on PE RVUs.

In our June 2006 report, we said that CMS should

regularly collect practice cost data from all specialties and use this data in calculating RVUs. This would create a level playing field for all specialties.

Finally, we have some concerns about CMS's method for allocating indirect costs. We've developed two alternative methods to illustrate approaches that would be less complex and minimize financial incentives to perform certain services over others. Both methods would significantly redistribute PE RVUs among services. So we'd like to get your feedback on these alternative allocation approaches and anything else we've presented today.

Thank you.

DR. BORMAN: I think you all have done a really nice job of laying out the issues and modeling some of the many permutations. As you two know better than I do, if you took all the six changes and all the various ways you could put it together, you could have a sea of modeling out there that just confuses the issue further. So I applaud you for picking a couple and using them illustratively.

I come away from the analysis not ready to go to the point of advising you about these models or taking that forward. What I take forward from some of this, and it may

be a very jaundiced view, is that number one, this is a very complex system. And it is one, frankly, that many of us struggle to understand and retain the understanding. Almost every time I look at this I have to go back and look at some of the primary definitions. And yet I think I go to enough forums about this that I may be a little more knowledgeable than some. So number one, it says it's a very complex system.

Having said that, to me that raises the corollary question does this start to take us down a road of saying that the RBRVS has become so complicated, where does it fit in in meeting our needs? And I think it's a big philosophic question, one that you weren't trying to answer here. But I think it is a national follow-on of some of the arcanery of this, is that first point.

I think another thing that I come away with is, as you've nicely summarized, there are a lot of moving parts here and they're moving over a relatively short interval. There's the work RVU shift, there's the PE RVU shift. there's the DRA provisions. There's a lot of moving parts here. And each of them was changed in a different way.

The work RVU part was the separate work adjuster.

The PE thing was the whole deal. It's a transition thing. This is a very complex thing.

I think we would take a huge chance at making something worse or finding ourselves saying something that a year down the road we'd have to walk away from and feel pretty foolish about if we don't let this play out just a little bit. Physicians are very creative people about learning how to work within these systems. Some might say manipulate, but I'm going to say work within.

There could be all kinds of permutations of these changes that we can't even imagine right now. And I would argue for a little bit of a stopped clock here a little bit to know where we're going to end up before we start looking at alternatives and potentially making recommendations about alternatives, and going down different roads at least within the context of an RBRVS system as it's currently designed.

Because I think there is great danger in that. We don't know where we are now, frankly, and particularly because of the data lag relative to -- it doesn't reflect the changes that we've already made.

So I think there's a huge issue here. I think it's wonderful to examine and I think it's very important,

number one, to educate people on what the system is, remind us all of the factors that are in it, remind us all how complex it is, that we do need to keep our finger on the pulse of this, that there are some -- hopefully there will be better data out within a year with regards to better SMS-like data. And now matter how you slice it, some of that information is important.

But for example, there are even little pieces of this that become hugely important like the practice expense per hour. If you have a specialty that works 60 hours a week on average versus 45 hours a week, you indirectly advantage the people who work less because your PE per hour is, by definition, higher.

There's all kinds of little pieces of this that I think we need to have uniformly collected data by specialties, have a sense of what those data are before we say specialty specific data don't play a role here, give it a little time to let the permutations or the ways to move within it become more obvious, and remind ourselves that this raises a bigger issue of the whole complexity of this system.

The other thing that I do think is an important

point that I would ask everybody to remember is this shows you how much the work values also play into the PE values, and they're a huge piece of this. And so every time you do something to the work values you also, by definition, change the PE values.

The flip is not true. And that brings arguments for how you handle changes to those. So a word of caution about that.

MR. HACKBARTH: Let me ask you this, Karen. I hear you say no recommendation. But I thought I also heard you say that you think that the illustrative examples are a reasonable way of showing the implications of some of these assumptions. And so you're not objecting to including the illustrative examples?

DR. BORMAN: I absolutely support showing some illustrative examples. And I also think they implied that in the background some of what's gone on, and maybe why it seems illogical, is someone out there is looking at the endpoint. And how much we can afford to move some of these things around.

MR. HACKBARTH: Just one other question. In talking about the examples, the presentation in the paper

lay out some guiding principles, one of which is that we are to collect uniform data across specialties, as opposed to depend on specially-developed and submitted data.

But I thought I heard you maybe question that, as well.

DR. BORMAN: I agree with the point of uniformly collected data. The point about making this specialty specific adjuster go away, I'm not so sure about.

MR. HACKBARTH: So to sum up, what I hear you say is no recommendation but you don't have any major objection to any the component parts of the analysis or presentation. Okay.

MS. RAY: I just want to mention that the AMA is currently fielding a multispecialty practice cost survey and they're going to be collecting -- the plan is to collect data through the end of this year. And the goal would be for CMS to use the data in calculating the rates for the 2009 fee schedule.

MR. HACKBARTH: Other comments?

DR. CASTELLANOS: I'm going to be a little bit more practical. There's no question we want accuracy of payments. We want to make sure that Medicare is paying for

the service they get. On the other hand, it's important that the physician gets paid for his services, too. So it's a two-way street. We all agree that accuracy of payment is very, very, very important.

I guess the problem I have here is some of the issues, without being redundant and commenting on Karen's comments, is I'm not quite sure why we're doing this at this point. As we just heard, the data that has been collected is from the eight specialty groups. But every specialty, every person, every medical society had the opportunity and was invited to provide the data. It was their choice not to provide the data. It was these eight specialties that went out and spent the money to collect the data and then give it to CMS.

You can't say it was just the specialties that were interested in doing it. Obviously, they had an interest in doing it or they wouldn't have done it. But every specialty and every society had that opportunity.

As you found out, we are collecting new data. The AMA is sponsoring it and it is being financed by CMS. That's starting this spring, is my understanding, and it will be available hopefully later on in the year and

hopefully can be implemented in the 2009 program.

What I'm concerned about is a comment that was made by Jay Crosson about two months ago when he was talking about hospitals and capital expenses. If you remember at that time, he was talking about California and how they changed some of their rules and regulations. They had to improve the hospitals because of the earthquakes and building new, and he was talking about capital improvements and funding. It's hard for somebody in his situation, spending billions of dollars, to not have some predictability of reimbursement.

Well, it kind of comes down to me. I'm a small businessman. I run a practice. I have costs. I have employees. I have to buy equipment. And I buy equipment on a good business decision. I look at the cost of the equipment and I look at my reimbursement and whether I can afford it, and whether it's the best thing for my patient. And then I make these decisions based on these criteria.

What I have a real concern, especially with the option number one, is that I think the rug is going to be pulled away from a lot of the specialties that use high cost equipment and supplies. First of all, you're limiting the

financial incentive to perform these services using this costly equipment. Second of all, I think you're going to be asking me or forcing me to use less sophisticated equipment. When something new comes out and it's been shown to be evidenced-based and accurate, I'm going to consider purchasing that so I can provide a better service for my patient. If I don't have that opportunity, I'm going to have to send that person to another site, probably the hospital setting, which we all know is going to be more expensive. So I don't really know what we're accomplishing by doing that.

The third issue is an issue of, as Karen said, we have a lot of moving parts right now. The changes made by CMS have been implemented January 1, 2007. We have two months of an experience to date. We don't have a dataset that's accurate. We're going to get it. We hope we're going to get it, I should say.

We've made some changes specifically against the imaging equipment because there's no question, we want to make accuracy of payments correct. But we don't know what the effect of the DRA is going to do on equipment yet. We just don't know that. So I guess it goes back to my first

point. I don't see the rush of doing anything here today.

To answer your question, Glenn, I think it's great to have these examples. I think option one is going to hurt the high equipment specialty field. I think it may impart a significant problem of safety to the patients, especially in some of the procedures like radiation therapy not using the best, latest equipment.

Thank you.

MR. HACKBARTH: Let me ask Mark a question. What is the plan for using this material? Is it planned for inclusion in the June report? Or is this just to further an ongoing discussion in the Commission? How do you see it being used?

DR. MILLER: A couple of ways and reasons that we got into this. Once again, there were a couple of commissioners who, when this was in progress and being discussed by CMS, decidedly had interest in kind of knowing better what was going on because it's so complex.

Two, we also have a responsibility as a Commission to respond on federal regulations. This was a regulation. We needed to comment on it. Part of the exercise was also to make sure we understood what was going on.

I think the third reason that we did it is people don't understand this, and we have people on the Hill -- part of our mission as a Commission, I think, is also to educate even when we don't make a recommendation. So I think part of the exercise was to go through and take this beast apart and try and figure out what was driving what.

As you can tell, and I know it's very hard to follow. I've been through it with these guys a couple of times and I barely hang on each time that they take me through it.

I didn't anticipate necessarily sets of recommendations out of this. I did anticipate publishing it in the June report as an exercise and as kind of disentangling this to make people understand it as a service to -- hopefully as a service to the Hill, so that they understood. Because I believe that people go to the Hill staff and talk to them about the implications of this. And I think they often don't understand what's going on behind it.

So I really saw it as a chapter in June to make sure that people understood what had happened, basically.

MR. HACKBARTH: Thanks, Mark.

I agree that this is an important element of our mission, just education, help people understand the sensitivity of this to different types of assumptions and how money is redistributed. I agree with Karen that we should stop well short of a recommendation at this point.

I would also have no objection myself to adding some language about your stability in payment point. I think that's a legitimate policy concern, that you don't want to keep yanking on these things, especially things that shift around a significant amount of money. There are consequences of that, and they are not generally good consequences. So I think that that would be an important addition to the discussion

A couple more comments and then I'd like to move ahead to try to keep us reasonably close to on time.

DR. MILSTEIN: These refinements that have been laid out for us are primarily aimed at the objective of better assuring equity or fairness across specialties. Every time we see one of these analyses, I keep going back to the MMA language about CMS beginning also to refinance payment systems to pay what an efficient provider requires to deliver a service. I've realized that there are a lot of

ways of defining efficiency, but one of them is what we call production efficiency meaning what kind of practice expense resources are required to produce a unit of billable service.

Have there been any analyses within specialty on degree of variation in practice expense per unit of service? As long as we're talking about refinements, we might think about are there ways in which CMS might better address the MMA directive from Congress to begin to better gear its payment system to what an efficient provider might require?

MR. WINTER: I'm not aware of any such studies offhand, but it could be something that the MGMA has worked on because they do survey practices about their practice costs, and they may make some adjustments based on type of service. So we can look into that.

DR. KANE: Years ago I got involved with trying to help figure out physician practice expenses. I can tell you that all efforts to microcost this rationally are impossible. So forget about that. I just point out that they are fixed and we're paying on a variable cost basis. But I know already we can't come up with a way to incorporate that.

I think as a Commission, perhaps what would be useful is to say what should be the goals of this payment system? And then are we getting there? I think we have, at times, said we don't think we are meeting the goals. And the goals seem to be things like appropriate use of service and ability to attract in residents into this field.

If we really want to go down that path of ability to track residents into this field, we have to bring in what's the physician income by specialty? Is it a reasonable income? And if it's not -- and I know that's an ugly subject and a lot of people just don't want to go there, and I don't blame them.

Given that we can't do this microcosting remotely accurately and just forget, that's a silly idea to even think you're going to get there, how can you most reasonably allocate in a politically defensible way is really the question? It's all buried in all these details.

So what I see really are three questions that this paper raises that we could discuss if we really wanted to and make a comment on. One is is it reasonable to do bottom up allocation of the direct costs? I think so, as opposed to the alternative way, which I think was pretty random, top

down and even more diffuse than the bottom up.

Two is is it reasonable to include equipment and supplies, which are in the direct costs already. So you're getting the direct costs built in. What's happening is the indirect costs are being allocated on the basis of your direct costs. Do you want to include the added costs of equipment and supplies to the overhead allocation? I agree that I don't see that there's any direct relationship between the equipment and supplies and overhead costs. They certainly add to your direct costs, and that should be recognized. But there's no study that says that makes your rent higher.

The third question is should Congress -- this relates to your studying of your cost pools and your specialty costs. Should Congress mandate that CMS or someone other than AMA -- but maybe it's AMA -- collect this specialty cost data on a regular basis so that it can be updated routinely and put in here so that it's equitable and it's done all at the same time, all for everybody, instead of eight specialties do it and the others don't and so we end up having this unevenness?

Those are the three questions I see that have to

do with whether we think it's a reasonable arbitrary exercise or not. And everything else, we're just guessing at what we're trying to do here.

DR. BORMAN: Just the piece, because I purposely stayed away from it, about whether your directs influence your indirects. I would agree with you they don't necessarily one-to-one track. But I would just offer the example, if you have an expensive piece of equipment that requires structural stability, you have to have a bigger space for it, you have to have different air-conditioning for it, you have to have lead shielding.

There are some things for which there will be a relationship. And I think we just don't know that well. And I would be a little bit hesitant about saying X, there's no relationship, or Y, there's a one-to-one.

DR. KANE: And that's the problem. We don't know. But then you put it all in there and you're saying that everything that's more expensive gets a higher overhead allocation. And I don't think that's justified either.

So maybe we have to get a more deeper study on what types of equipment require more space. But other than that -- and that's another -- we could recommend that if we

think that's a really, really important piece of it.

MR. HACKBARTH: Ariel, you look like you have a --

MR. WINTER: One quick comment. Option one recognizes, to some extent, there's a relationship between a practice having equipment and higher overhead because you're still using the specialty-specific cost pool. So a specialty like radiology has a higher cost pool. That's still going to be reflected.

What's changing is how that cost pool is distributed among their services. So more of it will go to services with higher clinical labor and higher work and less of it to services with higher equipment and supplies. But it's still in the cost pool in option one.

DR. CASTELLANOS: Not to this point, but one other comment. I think it was brought up at the public testimony this fall that CMS cuts back on the direct costs because of budget neutrality by a third. But they also cut back on the indirect costs by two-thirds. And if you look at the Federal Register, it's step 25. And you'll see that. If you don't have it, I'll be glad to show it to you.

MR. HACKBARTH: Okay, we need to leave this for now.

When I think of physician payment, as I see what we're doing, we have two decidedly different tracks. As part of our ongoing educational informational role for the Congress, I think it's useful for us periodically to look behind the curtain at the very technical, even arcane work that needs to be done to make this system work and try to refine it over time.

The other track, which to me is the more fundamental one for the Commission, is that several commissioners, Bill and Arnie and Karen and others at different times, have raised the question whether physician payment policy ought to be guided solely by an increasingly complex effort to identify the resources and professional knowledge and skill that go into individual services. Or whether physician payment policy ought to be guided by other considerations such as value of services rendered or even our need to have an adequate supply of different types of physicians.

That latter track, to me, is a very important one that we need to come back. I love this stuff. I love the practice expense stuff, but there's life after practice expense.

Thank you very much.

Next is Medicare Advantage. Who in this illustrious cast is the -- Jennifer.

MS. PODULKA: If you don't mind bearing with me, we're going to start in the middle a little bit since we are having technical difficulties with our slides.

Imagine a slide up here that talks about Medicare Advantage which Carlos and Scott will be doing after a brief interlude to update you on special needs plans, which are one type of Medicare Advantage plan.

As you may recall from the last season of this, SNPs were created by the MMA to serve three distinct types of Medicare beneficiaries: those are dually eligible for Medicare and Medicaid, those who reside in an institution or in a community with a similar level of need, or those who are chronically ill or disabled.

SNPs function like and are paid like other MA plans. The key difference is that they must include the Part D drug benefit and, in exchange, they are allowed to limit their enrollment to those targeted populations I just described.

Since SNPs were first introduced, they've grown

quickly. In 2005 there are 125 SNPs available. Last year that more than doubled to 276 and it continues to grow for 2007, although the information I'm going to present today is a bit dated in that we focus on 2006.

If you note in the bar on the left, in 2006 of the 276 total SNPs available, more than 80 percent were for dual eligible beneficiaries. The bar on the right shows that in July of that year there were more than half a million beneficiaries involved in SNPs with most enrolled in the dual eligible plans.

We further examined the SNPs available in 2006 and found that only 13 percent of them were offered by parent organizations that focused exclusively on providing SNPs. That's shown by the red pie slice there. The other 87 percent of SNPs were offered by parent organizations that also offered regular MA plans, which suggests to us that these organizations offer SNPs as one of a menu of options.

Breaking out the pie a little bit more, the next few slices, green and lavender, show that about 60 percent of SNPs were, in fact, offered alongside other MA plans in the same exact service area.

As I mentioned, I'll be coming back next month

with some updated information about SNPs in 2007, but I wanted to leave you with some questions to keep in mind. First, SNPs offer the opportunity to improve the coordination of care for special needs beneficiaries, but we question what their exact role should be.

Two, should Congress and CMS expect SNPs to behave differently or be special, going beyond what regular MA plans offer?

Three, to what extent does SNPs ability to limit their enrollment matter to their mission? And can this mission be achieved by regular MA plans?

Finally, the MMA authority that created SNPs scheduled them to expire after five years so they'll be going away after 2008 if Congress does not act. So we questioned, should they be extended in their current form, extended with structural changes, or allowed to expire?

Leaving you with those questions in mind, Carlos will now begin describing MA findings.

MR. ZARABOZO: First, we'll start with a look at the enrollment numbers for 2007. Enrollment in Medicare Advantage plans grew by 700,000 between August 2006 and February 2007 primarily coming from growth in private fee-

for-service plans. Those plans grew by 66 percent in this six month period. So now about 70 percent of enrollees in Medicare Advantage are enrolled in private fee-for-service plans.

The enrollment patterns in private fee-for-service in 2007 are similar to what they were 2006. Over three-quarters of the enrollment comes from counties that were historically paid at floor rates, that is counties with a minimum Medicare Advantage payment rate established by statute.

Private fee-for-service continues to draw significant enrollment from rural areas. About 41 percent of the enrollment is from rural counties, about the same percentage as last year. So currently, about 5 percent of the total Medicare population in rural areas are enrollees of private fee-for-service plans.

Just as a reminder of how these plans are different from other plans, they are not coordinated care plans and do not have networks of providers. Generally, enrollees can use any Medicare provider. Thus in rural areas, for example, these kinds of plans do not have the kinds of costs that HMOs and PPOs incur in forming and

administering networks. Private fee-for-service plans also are treated differently in that they do not have to meet the quality standard requirements that apply to network plans.

As you'll see in the next slide, the program payments made to private fee-for-service plans and the benchmarks for such plans are substantially higher than Medicare fee-for-service expenditure levels and higher than program payments made to other plan types.

Here are some numbers from a table that is familiar to you from the March report to the Congress and from past presentations. Scott has analyzed the payments and benchmarks in Medicare Advantage and found that overall in 2006 benchmarks for MA plans exceeded Medicare fee-for-service expenditures by 16 percent and Medicare Advantage program payments exceeded fee-for-service expenditure levels by 12 percent.

On this slide we've added an additional row that shows the level of rebates in each plan type expressed as a percentage of fee-for-service expenditures across the enrollment, across the counties where they are enrolled. This again is as of July 2006. The rebate dollars are the funds that are used to provide enrollees of MA plans with

extra benefits.

The availability of extra benefits financed by rebate dollars is what has generally driven the growth in Medicare private plans. The extra benefits are benefits that plans offer that are not covered by Medicare or enhancements of the Medicare benefit package through reductions in out-of-pocket expenditures including reductions in premiums for Part B and Part D.

The extra benefits have been Medicare private plans attractive to beneficiaries and, in particular, attractive to lower income beneficiaries who are not eligible for Medicaid or other supplemental coverage such as employer-sponsored retiree coverage and who find Medigap premiums too expensive as a supplement coverage.

The argument has been made that the program payments in excess of fee-for-service expenditure levels in Medicare Advantage are worthwhile expenditures because they provide extra benefits to enrollees. The Commission has expressed this concern about the effect on beneficiaries who currently get these extra benefits if Medicare Advantage benchmarks were to be reduced. However there's some equity and efficiency issues that need to be considered.

Among the equity issues is the overall point that the Commission has raised frequently, which is that the Medicare program should be financially neutral between fee-for-service Medicare and the option of private plans. There are also equity concerns affecting beneficiaries in terms of access to plans. For example, in 2007 fewer than 40 percent of rural beneficiaries have access to an HMO plan which is the plan type that offers the highest level of extra benefits in Medicare Advantage. In addition, there continues to be significant geographic variation in the level of benefits that beneficiaries have access to in different types of plans across country.

Beneficiaries must also elect to be in a private plan. In some cases, this involves restricting a person's choice of providers. We know that, for example, that disabled Medicare beneficiaries, those under 65, are much less likely to enroll in private plans.

We'd also point out another equity issue here which is that when rebate dollars are financed by program payments that are higher than Medicare fee-for-service expenditure levels, then the extra benefits are being funded through taxes in Medicare Part B premiums from all Medicare

beneficiaries, not just those enrolled in these plans. Only some Medicare beneficiaries, therefore, derive a benefit from the way in which the MA program is financed while the majority of Medicare beneficiaries are paying for the benefits that only some beneficiaries receive.

On the question of whether the MA program is an efficient means of providing extra benefits to enrollees, here is the table that you've seen before, with one row ended. The last row shows where plan bids are in relation to fee-for-service Medicare expenditure levels. That is, how much does it cost different plan types, on average, to provide the Medicare Part A and Part B benefit package compared to fee-for-service expenditure levels? As you can see, on average it is only HMOs that are providing the Medicare Part A and Part B benefit at less than Medicare fee-for-service expenditure levels. Their bids for A and B services come in at 97 percent of fee-for-service.

At the other end of the scale from HMOs are private fee-for-service plans. Although the value of the rebates they provide to enrollees is about 10 percent of Medicare fee-for-service expenditure levels, the program payments to these kinds of plans are 19 percent above fee-

for-service expenditure levels and, thus, only about half of the amount is used to finance extra benefits for enrollees in these plans.

For HMOs what the 97 percent means is that, on average across HMO plans, some of the extra benefits are financed by rebate dollars that are generated because these plans can provide the Medicare benefit package at a cost that is lower than the level of Medicare fee-for-service expenditures.

Another way of looking at the 97 percent figure is that if benchmarks are reduced there could still be extra benefits provided to enrollees in the Medicare Advantage program.

Given that some plans are able to have low bids and can generate rebate dollars with bids below fee-for-service, this slide shows that about half of enrollees in MA in 2006 would have been able to receive extra benefits if benchmarks had been at 100 percent of fee-for-service expenditures. About half of enrollees would have had no extra benefits and these enrollees would have been disproportionately enrollees of PPOs and private fee-for-service plans.

These figures show what would have happened had plans bid exactly as they did in 2006 and it assumes that beneficiary enrollment would have been exactly the same as it was in 2006. This, of course, is an unlikely set of assumptions. We know from the history of private plans in Medicare that a reduction in plan payments would likely lead to a reduction in plan participation in Medicare, a reduction of the level of benefits and plans, and reduced beneficiary enrollment in plans because of the reduced benefits and access. This is what happened beginning in the year 2000 after the Balanced Budget Act of 1997 introduced payment changes in Medicare just as the managed care industry was facing a restructuring resulting from what was known as the managed-care backlash.

We'll now turn to Scott, who will discuss possible ways of implementing the Commission's past recommendations dealing with benchmarks in MA.

DR. HARRISON: As I'm sure you remember, the benchmark is a bidding target under the bidding system for MA plans that began last year. The local MA benchmarks are based on the county level payment rates that were used to pay MA plans before 2006. Those payment rates were at least

as high as per capita fee-for-service Medicare spending in each county, with some counties having rates significantly higher than fee-for-service as a result primarily of minimum or floor rates.

In the past, the Commission has recommended moving benchmarks to 100 percent of fee-for-service spending. However, as Carlos has illustrated, such a move would immediately reduce benefits that plans offer, which may cause many plan enrollees to leave their plans and even cause plans to leave the MA program. Thus, the Congress may wish to protect current plan enrollees from large shocks to their plans.

At the same time, however, leaving benchmarks well above fee-for-service levels encourages the growth of inefficient plans and enrollment in such plans makes future reductions more difficult.

In this section, we will discuss specific approaches to a transition to move benchmarks gradually toward 100 percent of fee-for-service expenditure levels and we will look for your suggestions on the pros and cons of these different options.

The first three approaches I'm going to describe

are all glide paths to get the rates back toward 100 percent of fee-for-service spending. First, the Congress could freeze benchmarks or perhaps instead limit growth to a minimum update until fee-for-service catches up to the benchmark. This policy would begin to address all areas with benchmarks above fee-for-service immediately, but it would take years and maybe even decades for fee-for-service levels to catch up in some areas. Under this approach, beneficiaries might not see big changes in their benefits for a few years, perhaps giving plans a chance to increase efficiency to maintain or grow enrollment.

Or Congress could set a maximum for the benchmark at some percentage of fee-for-service and gradually reduce that percentage until it reached 100. For example, assume the cap was set at 140 percent and reduced by 10 percentage points each year until all benchmarks were set at local fee-for-service spending in year five. So in year one all benchmarks higher than 140 percent would be reduced to 140 percent. In year two all benchmarks would be limited to 130 percent of fee-for-service, and so on.

This policy would first address areas with the largest discrepancies between benchmarks and fee-for-service

costs and would bring all benchmarks down to fee-for-service within five years. While the reduction in benefits would not be immediate, there would be significant reductions annually. Enrollees in areas where plans are not competitive with fee-for-service Medicare are likely to see rapid reductions in their plan benefits.

Under another approach we could blend an area's fee-for-service rate with its historical benchmark and the historical benchmark could be weighted lower each year until it was eliminated. For example, in the first year the blend could be 80 percent historical and 20 percent fee-for-service. In year two, the weighting could be changed to 60/40 until we reach year five in an example and then it would be at fee-for-service.

Advantages to this policy include that reductions would begin immediately would be proportionate to the discrepancies between benchmarks and fee-for-service costs. For areas where the benchmarks were not relatively high the annual reductions would not be large. All benchmarks would be reduced to fee-for-service in five years and therefore those areas with relatively high benchmarks would see large reductions each year. As with other transitions, the budget

savings would build gradually in these.

Now I want to talk about two other types of approaches. The Commission has already recommended to address double payment for indirect medical education costs, the double payment for those, immediately. Under this approach the effects, however, would be concentrated in a few areas. other areas with benchmarks well above fee-for-service would not face any reductions. This option by itself would not move benchmarks much of the distance toward 100 percent of fee-for-service. However, the IME could be removed to calculate the proper fee-for-service spending in an area and one of the approaches that I discussed on the less slide could be used to actually do the moving of the benchmarks towards fee-for-service.

The final approach I will discuss today is to use plan bids to help determine the benchmarks. There are several versions of this option. We focus here on the approach that would operate like the bidding system that is used to set the regional benchmarks. Plan bids in an area would be averaged and blended with the area's fee-for-service spending to calculate a benchmark. Part D bidding works similarly except there's no fee-for-service component.

Under this type of policy, Medicare would continue to use local competition to influence plan payments which are thus more likely to reflect the costs of efficient providers. Average bids for the Medicare Part A and B benefit package are currently well below the benchmarks and are often below fee-for-service costs. Therefore, the resulting benchmarks may approach fee-for-service spending, although it is likely that program costs would end up getting to 100 percent.

The MA demonstration scheduled to begin in 2010 uses a variation of this approach where the fee-for-service premium would be affected, in a limited manner, by plan bids. If the Medicare fee-for-service program became a full participant in the bidding, we would arrive at a premium support system where beneficiaries in some areas would have to pay additional premiums to stay in fee-for-service. Under that scenario MA spending would equal 100 percent of fee-for-service spending.

Now let's move away from the benchmark discussion briefly. We would like your input on one more issue.

For the first time, insurers are offering high deductible health plans linked with a Medicare Medical

Savings Account or MSA. As of February 1st, there are more than 2,000 beneficiaries enrolled in MSA plans under Medicare.

In our March report, we noted our concern that MSA plans enjoy an advantage over other MA plan in the bidding process. When an MSA plan bids below the benchmark, the full difference between the bid and the benchmark is deposited in each enrollee's MSA account. Other MA plans receive 75 percent of the difference between their bid and the benchmark as a rebate to provide extra benefits to attract enrollees. So we believe that this policy provides MSA plans with an unfair advantage over other types of MA plans in attracting enrollees.

Now we'd like to hear your views on all of the subjects we've discussed thus far.

MR. HACKBARTH: Can I just ask a question? Earlier in the presentation Carlos was talking about how the added benefits are financed. And some of it comes from taxpayers, either through the payroll tax, the funds, the Part A Trust Fund or general revenue taxes that fund Part B. But the other part of the funding comes from beneficiary premiums for Part B.

I was wondering if you can give at least a rough estimate of the portion of the Part B premium that is attributable to payments above 100 percent?

DR. HARRISON: We figure that about $2, give or take a little bit, would be actual Part B premium payments all beneficiaries would pay for the fact that the Medicare Advantage program is getting paid more than the fee-for-service sector.

DR. REISCHAUER: That's a month?

DR. HARRISON: That's a month.

MR. HACKBARTH: To the extent that the program grows and to the extent that the program grows, in particular in plans that are receiving the largest subsidy, if you will, that number also will grow.

DR. HARRISON: That number would also grow, yes.

MR. BERTKO: Not unexpectedly, I've got a few comments.

First off, is no question about any of the numbers presented here. But it's also useful to think about what the numbers look about in 2007. The 2006 numbers are higher for a couple of reasons. One, they include a technical error that CMS made that was corrected on the budget neutral

risk adjustment factor, and it was substantial.

Plus, the effect of the phase-out goes from 100 percent of a 75 percent number -- and you don't want to know all the prongs on that. Let's just say the difference in those two combined factors -- and Scott and I haven't discussed this but I think if I say 4 to 5 percent reduction I'm hoping you will nod or at least not complain.

So the comment that that is that while all the numbers in here are appropriate for 2006, the 2007 and the differences are all smaller. So he's almost nodding.

DR. REISCHAUER: So the implication of that is then moving that 100 percent and a level playing field won't be such a big adjustment?

MR. BERTKO: It will be a smaller adjustment, Bob, yes. But it also should be a smaller number towards, among other things, the number Glenn just referenced.

DR. HARRISON: I wish that were true, but I don't want to put out a new number now because we don't have the enrollment yet, and we probably will by April. But there are a couple of factors that drove the number back up a little bit this year.

One is that last year what we had was a 75/25

blend of demographic risk. The risk ratio was larger than the demographic ratio by a decent amount. And so that's going to affect the numbers.

And then the other thing we need to sort through is the normalization of 2.9. We'll get back to you in April with what the 2007 numbers show.

DR. MILLER: Scott, one other thing. Doesn't it also depend on where the enrollment ends up?

DR. HARRISON: Yes, it does. In fact, even between the end of 2005 and the middle of 2006, just from the enrollment shift we added a point.

MR. HACKBARTH: Just to make sure that people are following that, so when we present statistics, as Carlo did, that the average payment is 112 percent of fee-for-service, the average benchmark is 116, that calculation is a reflection of where the beneficiaries are enrolling and in what types of plans. So the extent that the high payment levels encourage people to go into private fee-for-service, the plans that are receiving the largest subsidy, even though John is correct that there may be some other factors tending to push down the payment rate, those references to fee-for-service are driven up by the composition of the

enrollment.

MR. BERTKO: Can I go on to my next points now? We could do this probably all afternoon, but we won't.

The next is just a modest comment, I think, and I'll put this more a question on the 112 percent page and the efficiency page. I believe that those are claim benchmarks that you're referring to with that relatively small marginal cost that CMS pays to actually pay the claims through its fiscal intermediaries?

DR. HARRISON: Are you talking about the fee-for-service numbers?

MR. BERTKO: Yes.

DR. HARRISON: I've been assured a couple times, because I've heard this before, by the actuaries that they have included all appropriate admin costs and payment adjustments that happen after the fact.

MR. BERTKO: That's the one that's back and forth is, I believe, the marginal cost as opposed to allocating any other parts of CMS towards it.

DR. HARRISON: That's probably right. I don't know that, but that's probably right.

MR. BERTKO: There's a building in Baltimore,

among other things.

And lastly on just that adjustment, there also is the still missing VA/DOD costs, which are appropriate and we think we will know what that number is next year but not this year. We definitely won't know it this year.

Having said that, a couple of other comments here. This is a bit towards people moving to private fee-for-service. Our company in particular, and several others, offers regional PPOs, coordinated care plans in the nomenclature of the MMA, and private fee-for-service. What I would call the value to beneficiaries, what they pay versus what they get, is actually in almost all cases bigger, better in the PPO plans and the preference of seniors is for choice of providers.

Somewhere down the road I think they will age into this. They will find that the preference is better and they will move that way. So far this really reflects what seniors appear to want.

Another comment along the way is just that the current payment system, including the floors -- at least to my reading -- reflects the intent of Congress to spread the alternatives to traditional Medicare to rural areas among

others and to exurban areas. It's been successful at that.

As we think through this, my comment is -- kind of addressing Scott's part in what we do, if anything, and when -- we are serving rural and underserved areas. We are serving low-income people who otherwise couldn't afford Medigap plans or don't have ESI-type of plans and anything we would do, I would hope, would minimize disruption. This is a year in which payment levels were low, I think, across the industry. The revenue increase in Medicare Advantage averaged about 1 percent. And for the most part plans stayed where they were. A few more came in and there were relatively few withdrawals, even in a 1 percent era being a relatively tight type of thing to do.

The last one -- and now I sound like Jay here -- in spite of the formal name called care coordination and private fee-for-service being out of it, the big players in this game -- and it's ourselves and a couple of others -- have put together fairly good infrastructure that, in the absence of networks -- although you can have private fee-for-service network-type things, they're not today -- but they do do a fair amount of care coordination. The whole discussion we had this morning on readmission rates, we're

showing success in reducing readmission rates by the ones by doing near real-time calls. We get an admission. It shows up in our claims system. We ask but can't tell doctors, hospitals, and patients to call. But they do 90 percent of the time. And we talk to them.

We had a comment here earlier about the 30 discharge letters you hired. We're spread out. We have -- I don't know the exact number -- between 50 and 100 nurses working telephonically to call people up and help them with their discharge. The stuff works. It's not technically a coordinated care plan but there's a bunch of stuff we're doing and we're on the way to doing more of it.

So this is a little bit of the old chicken and egg. We're trying to do benefits for people that are spread out across the country, save money, offer care coordination. I would agree it's not perfect in a lot of ways yet, but we're achieving some amount of success along the way.

MR. DURENBERGER: I just want to follow on John's comments, and I think they're appropriate even though they're not well known, which is one of the problems with not having had any congressional oversight on anything including this issue.

My comments are, and I don't want whatever I say to be misconstrued because I have been in favor of privatizing Medicare since 1981. I've been engaged in the original HMO demonstrations, the cost demonstrations, and the risk demonstrations in the mid-80s, all the way up through various kinds of specialty efforts including Medicare+Choice. I guess John and I met on the competitive bidding demonstration in 1998.

So I have no doubt in my mind but what there is an appropriate role for private health plans in the Medicare program and any comments that I make are related to that and I think that any comments that many commissioners make relative to 100 percent of traditional Medicare are meant the same way.

But the key question is what's relationship between what we ask of the health insurance plan and what we're willing to pay them. I doubt if that question has ever been asked. It was asked in the old days because we thought we knew what we were doing and we had evidence of it, and we knew when we were getting our money's worth and when we weren't getting our money's worth, and we didn't always react in quite the same way or appropriate ways to

reward it. But we did. And there was a lot of oversight over that whole process. But that's still the critical question.

The first one of those has always been improved service, care coordination, quality, whatever you want to call it. The assumption has been that -- however you might look at them, the HMOs, or the health insurance plans as they've become -- that you were buying something for the beneficiaries that they couldn't necessarily get out of the current medical care delivery system.

And the evidence was they were getting it at 95 percent of the average cost.

The second thing was that to deal with the average community cost of delivering Medicare services. This is a debate we had in the competitive bidding commission. The idea of a competitive bid was to find out in competition between health plans what is the real cost of delivering a basic set of Medicare services in Kansas City or Phoenix or Minneapolis or wherever it may be. That was the idea of it.

That is a policy point that probably only the private sector can help you get at.

The third one is to lower beneficiary cost. The

evidence is where it works it lowers beneficiary costs. The evidence in this one is it lowers beneficiary cost if you give them more money and then they use it sort of like a Medigap plan or something like that. But the question is always which is the best way to lower beneficiary costs?

If you would lower beneficiary class with subsidy, a $65 billion subsidy, you might say there's a better way to do it.

The fourth one is improved benefit structure. I think there's evidence that in this current approach there's improved benefit structures. But I remember about the original benefit structures of the original demonstrations was people in my community could buy one health plan with added benefits for $14.95 a month and no paperwork. They flocked to it. That is a benefit structure that appeals to the Medicare eligible.

But that appeal then means that something else has to change in order to make it work. That's physician behavior, admission practices and hospitals, a lot of things like that.

So if you put all those four things together, and in the old days you could do that in some parts of the

country for 95 percent of traditional Medicare, I have to ask myself the question why can't you do it for 100 percent? The evidence came, and I can't say that this is the case now but it's at least worth some congressional oversight. The evidence came to us when we were doing the competitive bidding demonstration that the kind of health plans that were doing private Medicare in the 1980s are not the same health plans today. That's part of the program that everybody is going to have to deal with.

In this case, there was no question that the predecessor to the lobbying organization was out to kill the competitive bidding demonstration. They followed us. Whatever community we selected they found a Republican senator. In Missouri, Kansas City, it was Kit Bond. In Arizona it was John Kyl. They found somebody to sponsor a resolution of some kind to kill all of this sort of thing.

I only say that to reflect my own set of experiences over time which lead me to the conclusion only that it really is imperative that we, the Congress in particular, ask the question about what are we getting for our money? And then from that you can get a specific policy goal. We may want to say all we want is extra benefits.

And we may want to say all we want is extra cost-sharing or maybe we want...

But the evidence is most people need some kind of coordinated care, improved health care. The HMO, by the data here, gives it to them at a cost lower than traditional Medicare still does. I don't know where those HMOs are located. It still does.

John, certainly with all due respect to you, the idea that this is what beneficiaries want when they choose a PPO or they chose something else and so forth is not the measure by which I would be able to make a recommendation in this commission or if I were still in the United States Senate or something like that. Because it is unlikely that a lot of beneficiaries are aware of the fact of what they're getting for their money, even though it's taxpayer subsidized money or whatever you might call it.

And it is the responsibility of policymakers to deal with what's behind those expenditures. And I think that is a responsibility that at least has not been well discharged since 2003.

MR. HACKBARTH: Nancy,-Ann, I know you need to leave. Why don't you go.

MS. DePARLE: Thanks, and actually I want to build on what some of what Dave just said.

I think he's asking the right question, which is are we getting our money's worth? I agree there hasn't been enough oversight of this program in the last few years since it's been implemented.

But as I look at the data that we do have, I would say that for me the answer is yes, for many of the local coordinated care plans or CCPs, what you and I would think of as the traditional HMOs. The reason I say that is because I think, from what I've seen, they are providing coordination of care, hospitalists, preventive care, a much more intensive package of benefits and clinical coordination -- Jay's plan is one of them -- than you can get in the traditional Medicare program.

We spend 90 percent of our time in this commission talking about the ways in which the traditional fee-for-service Medicare program doesn't do these things and what can we do to make them happen.

It may just be, and I'm preaching to the converted here, but it may just be, I think we would all agree, that that costs a little more money. That may be part of why it

costs a little bit more money for these coordinated care plans to provide those things.

On the question of some of the other types of plans, some of the newer types of plans, we haven't seen the data. What I have seen so far doesn't convince me, at least, that private fee-for-service offers those same benefits. I'm intrigued with -- John and I have talked about this over the past few months -- I'm intrigued with some of the things he's seen that they've been able to do without much real authority, as you say, to help drive down inappropriate utilization, which is bad for beneficiaries and bad for the Medicare program.

So maybe I'm making a judgment too early there, but at least with respect to the traditional coordinated care plans, I think they have shown their value. And you've heard me say many times that one reason I'm a fan of them is because they can do things that traditional Medicare has not been able to do, either because it hasn't had the administrative wherewithal or the political support or whatever to do.

So for all those reasons, that's where I would come out on that question. But I do think it's the right

question to ask.

I would just say I hope we continue to focus on that question. You hearken back to 1997 and our competitive pricing demonstration, and I think there are three members of this commission who were nice enough to take my phone call and agree to serve on that, and spent hundreds of hours in something that turned out perhaps not to be -- well, certainly not to be much fun, and perhaps not to be so useful.

But it also reminds him of what we went through during that period. I would just say, if you'll recall, as I remember it, the goal in the BBA with respect to HMOs was really to expand them, in part because they offered benefits such as prescription drugs that were not available in all areas of the country.

To be sure, there was a lot of discussion of why did they get paid more in Miami than Minneapolis? Or why are payments so different. But there was overall a desire to expand the availability of that care in 1997.

And what happened was exactly the opposite. I don't think anyone anticipated this, but it was a very disruptive, wrenching experience for the Agency, for

Congress, for beneficiaries to go through. Millions of beneficiaries lost their care plan or were disrupted in some way. Many of them lost faith in the Medicare Advantage program, the Medicare+Choice program as it was then called. And I'm sure the plans that participated in and had to withdraw from some areas lost some of their brand with those beneficiaries.

No one intended that. So I just would say here it seems like there is a very deliberate approach to let's reduce down to 100 percent of fee-for-service. And while philosophically certainly I can support that idea, I just hope that -- as I think is on the table -- that if we go in that direction that we do it very mindfully of all of the unanticipated consequences that can flow from even what was 10 years ago a well intentioned proposal to do something very different that ended up having that consequence.

DR. REISCHAUER: I guess as the third veteran of that commission, I have to add my two cents worth here.

As Dave said, the original intent of the private plans was to offer Americans a different delivery system, one that was thought to be more efficient, provide higher quality care, that possibly could generate some savings that

could be redirected towards added benefits or lower cost sharing.

And with respect to the coordinated care plans, one can make that argument no matter where you set the benchmark. It's much harder to make that argument with respect to fee-for-service, private fee-for-service, because it's offering, in a sense, the exact same product. And unlike the coordinated care plans, really nothing is being asked of it and, in fact, it's getting a huge advantage relative to them in that it can use the administrative market power of Medicare in its pricing with providers. Unlike the other Medicare Advantage plans, it isn't asked to submit the same sort of quality data.

I was interested, John, in what you said because you implied that, notwithstanding no requirement for you to provide services that might improve quality, might in a virtual way coordinate care, you're doing that.

So my question would be well that's great and shouldn't we begin asking you for the quality data?

DR. MILSTEIN: Okay.

DR. REISCHAUER: Okay.

DR. CROSSON: I have to say I wasn't particularly

looking forward to this report. I was actually hoping it would be scheduled at the May meeting. Oh that's right, there's no May meeting.

[Laughter.]

DR. CROSSON: But having read it, I thought it did a very good job of touching on a set of key issues here and we've already started talking about them.

One is, of course, the question of equity between Medicare Advantage and fee-for-service and what we really mean by that and how fast that equity should be achieved.

The second thing that's treated, I think, well in the paper is the fact that doing it and certainly doing it too quickly creates the risk of disrupting the relationship between the plans, including mine, and the beneficiaries. And also it well raises the concern about the potentially differential impact on certain vulnerable populations, including low-income beneficiaries.

But it also raises the fourth consideration, which I think Bob just brought up, and that's an issue of equity among MA plan types. I think those are the four issues that we have to deal with.

I have my own thoughts about which of these

options make the most sense but I'm not sure this is necessarily the time to do that. What I hope that we do is that we develop more information for the Commission on each one of those four issues and then we work our way through them and decide along the way whether we think we can or should come up with a point recommendation, getting back to this same issue again, on these four points or whether our job is to create a set of pros and cons in very clear language for the Congress to make the determination.

It will be interesting to see which way we go. My guess is that in the end we're going to end up with issues that are so value laden on at least three of these that we may end up presenting, and hopefully very clearly, the pros and cons for the policymakers to decide.

MS. HANSEN: Actually, I think especially Bob and Jay have covered what I was interested in, in the area of the equitable accountability for plans that get the private fee-for-service element.

The other point I wanted to underscore, Glenn, that you brought up was the premium support aspect of it relative to the beneficiary, their paying on top of and not all getting the benefit from it. If we're going to have to

have them make up, it's the beneficiary that has to pay some more.

I know implied in that that some of perhaps the tools of coordination that are being developed that will eventually benefit everybody. But right now I think the beneficiary might be placed in a position to do some added premium support.

But I also know that I come through to say that I do believe in the equity side, but I do want to agree that there are many benefits right now that here go to the people who are the lower income, that they do get some benefit from it. So the graduation of this and the intentionality of how we do this will be real important.

And finally, I just would like to say that if, in fact, the care coordination stuff does come out of the private fee-for-service, then I think that stands to get elevated and looked at because that is, at the end of it, what is really crucial on the chronic disease management side.

DR. WOLTER: The thing that concerned me about this last time we discussed it was the issue of trying to create equity with a fee-for-service plan that, in other

context, we all agree is very inequitable in terms of the large amount of payment variation around the country in that system. And so I really worry that we're kind of getting back to that again and we may end up with a situation, if we follow this path, where we, in essence, allow the plans to play in the areas where the utilization and the payment rates are already higher than we wish they were. And that's great, because maybe they will have some impact in those areas.

But it wouldn't be the same as saying let's have a strategy where taken in aggregate we would like these plans all together to deliver care at lower than the average fee-for-service cost across the country. And let's do what Bob was implying. Let's really start strengthening what we're requiring back in terms of information about congestive heart failure admission rates or other things that could very likely be linked to lower annual expenditures. And that would be something I could get very excited about.

But to link this back to county level fee-for-service rates when that is currently such an irrational situation, just doesn't feel very good.

DR. SCANLON: Given all that we've heard about the

equity across plans, I think this is almost a footnote.

But I believe our recommendations would be strengthened if we thought about -- if we stopped considering Medicare Advantage as a single homogeneous entity, and to make potentially differential recommendations. The glide path to equity doesn't have to be the same for all the plan types.

In doing that, you might create an option for plans to be able to convert to a different type if they want to be on a slower glide path.

But consistent with all we've said about value purchasing, if we're not getting anything additional why do we want to prop something up longer at some kind of higher level?

The second kind of differentiation I think we would consider is how much above fee-for-service are we willing to tolerate before we want to move quickly? These options here, they're not all equal in terms of how they're going to impact different areas. You might want to consider combining these options and having a cap on how much above fee-for-service that one is willing to go, which will affect some areas. But then other areas you might want to do up

blend and move from a blended position.

I think working through some of these options would be an important thing to do.

MR. MULLER: Along the theme of the last few comments, and going back to Bob's recitation of some of the intent of this 10 years ago, it almost struck me that in managed care you were, as a beneficiary, putting yourself into a coordinated care plan. You would do that maybe for lower copayments, maybe increasing at that time for better benefits. That was a fair trade to go into.

I do have a concern of when I see the 66 percent growth in private fee-for-service and 2 percent in coordinated care, in some ways if you can get that kind of random walk down medicine street and get extra benefits, I'm surprised that everybody didn't convert to private fee-for-service. If you can get extra benefits, any rational person would say I want that. It doesn't cost me anything, so everybody in the Medicare plan should go to private fee-for-service and get the extra benefits. In some ways you could keep going in that direction.

My concern is that if we're going to offer extra benefits to people, why don't we just offer them here? What

says this population should get them? If we want extra benefits, we should think about how we want to target them.

If we want to target them towards people who get coordination, then we should give more encouragement to the coordination plans. They're obviously coming in at an economic level that we find attractive by being less than fee-for-service, whereas others are coming in at 120 percent.

If we're really concerned about offering incentives to coordination, why just do it through private fee-for-service? Why don't we offer it to primary care physicians? We've discussed that at other times. We've had some discussion about how one actually puts coordination payments into an E&M schedule and whether the ACP has been recommending medical homes and forth.

Without going through all that again, there are other ways of getting coordinated benefits in the fee-for-service plans through primary care and even specialty physicians. You don't have to go to a 22 percent premium.

This strikes me that we're paying an awful lot for the same system and the argument that people benefit from it, there are other ways to target benefits more selectively

towards people who want to benefit.

So I'm with Bill, in a sense borrowing from him. I think we have different recommendations around the different plans. If the care coordination plans are meeting what we want them to do, I'm very distressed the growth is 2 percent and 66 percent in an area that basically mimics a system that we spend, somebody said, 95 percent of our time criticizing.

So I'm very concerned that we're willing to pay 20 percent extra for a system that we don't like and we don't have enough movement towards a system we do like with only 2 percent growth.

MR. HACKBARTH: Let me just pick up on Ralph's comment.

Our immediate impulse, I think almost across the board, is well on timing you want to do gradual because we don't want to hurt the beneficiaries. And that was the gist of what we said a couple of years ago when we talked about getting to 100 percent over time.

But I've had, personally, second thoughts about that with regard to private fee-for-service. In fact, I think time may make things worse. Indeed, in time it may

become politically impossible to deal with the issue.

As the number of people enrolled in private fee-for-service grows, drawn in by free benefits, financed not through the efficiency of the plans but through the generosity of the taxpayers and other Medicare beneficiaries, it becomes every day more difficult for members of Congress to say I'm going to take this away.

So the idea of a glide path down may just be wishful ivory tower thinking about at least this particular sector of the Medicare Advantage program.

With regard to the targeting issue, I basically agree with Ralph. If Congress wants to provide more benefits to low income beneficiaries, we know how to do that. We know how to do it at a lower cost.

So why, when Medicare faces long-run sustainability issues, should we be choosing to use vehicles that are known to be more expensive? Let's connect the dots here in the various statements that we make and not just talk in chapter one about long-run sustainability and then go on and accept policies that threaten to make that much worse.

Again over time, if we allow this to continue and

hundreds of thousands of new people go into that open door, drawn by free stuff, we're in the process of taking areas that have been lower cost for Medicare and pulling them up.

I'm very sympathetic with the geographic equity issues but to be real blunt about it, for our long-term sustainability problem, we've got to take the high areas and level down. It is not a strategy to take the low areas and level up. And yet, I think that's what we're doing through the back door with Medicare Advantage right now.

DR. WOLTER: I think, Glenn, the question I'm throwing out is the strategy just to return to current county level fee-for-service going to get us some attention to the high geographic areas where the payment is out of whack? I'm worried that we are creating strategies to do that. That's all.

MR. HACKBARTH: And you're absolutely right, Medicare Advantage won't do that. And that's why I personally thought that the discussion in the SGR report about geographically-based limits that press down on the high-cost areas and put the greatest pressure on those that contribute most of the problem, that's how you deal with that geographic inequity. You can't resolve it through

Medicare Advantage. You've got to do it through traditional fee-for-service.

It's a choice. We agree on the goal but we've got to use a tool that's appropriate to the task.

MR. MULLER: You don't get there by making the floors higher than the system you don't like. It's totally perverse.

MR. HACKBARTH: We're behind. Any other comments? Thank you.

Next is SNF refinement.

DR. MILLER: Just before we get started, I want to make sure a couple of things. The public should know that Carol Carter was slated to make this presentation and she has had some family emergency. And so Sarah Thomas, who's the Deputy Director here, has agreed to step in and take the presentation. I'd like to thank Sarah for that.

And for the commissioners, it may mean we might have to follow up on a couple of your questions. And please take care of Sarah, because I need Sarah.

[Laughter.]

MR. HACKBARTH: This is a rare opportunity to heckle Sarah. We don't get this.

MS. THOMAS: Do you want me to go ahead and start, since we're behind?

We have talked for maybe two or three years about some of the problems in the SNF prospective payment system. I think the two key issues that I just want to remind everybody about before we get into the meat of the conversation is that even though the cost for these services called non-therapy ancillaries, which are respiratory therapy, drugs and IV drugs, and I'm sure there's a longer list of things? Even though the costs were built into the PPS, the case-mix system doesn't pay more when a patient needs more of these services.

So what we've heard from a series of reports that were done by the OIG and from our own site visits is that there's really a disincentive for SNFs to take patients who are expected to use a lot of these non-therapy ancillary services. In fact, we've heard about over time some of the SNFs getting out of the business in furnishing it, not taking patients, and then they end up back in the hospital.

The other theme that we've earned over the years is that there is an incentive in the system, sort of the opposite from the non-therapy ancillaries, that you get paid

more, the SNF gets paid more to do more therapy. This would be occupational therapy, physical therapy, and speech language pathology. So it's the opposite problem as the non-therapy ancillary problem.

What I'm going to do is I'm going to talk about some work that CMS recently put out in a report to talk about possible reform options which would deal with both of those two issues I just mentioned, and also take into consideration an outlier policy for this payment system. And then what I'm going to do is shift the focus of the presentation to Dr. Korbin Liu from the Urban Institute, and he's going to talk about work that he's going to do for us in the coming set of months. This is intended for publication in the June report, although we think that we're going to be actually driving recommendations in a longer-term time frame.

And when we come to the end of the presentation I'm going to ask you to help give us some feedback on how to narrow the scope or broaden the scope to include some broader issues about the payment system. So that's what I'm going to turn to you guys for at the end.

CMS funded extensive research to explore

alternative ways to more accurately pay for SNF care. Urban Institute actually did much of that work. Although CMS made some refinements to the PPS in 2006, we've stated that these changes did not go far enough in revising the payment system.

Just to remind everybody about how this payment system works, SNFs are paid a daily rate which is adjusted for case-mix using the Resource Utilization Group classification system. This is a patient assessment tool that comes off of something called the Minimum Data Set or the MDS. Payments go up or down depending on patient characteristics and their use of services such as therapy. Information is gathered from that MDS.

In order to qualify for a SNF stay, patients must have had a prior hospital stay.

This summarizes work that is published in the CMS paper on what they did to look at options to improve the payment for non-therapy ancillary services. CMS has actually acknowledged that the RUG-based system is only a modest predictor of the variation in non-therapy ancillary use and actually spent a lot of time in its report and outside to developing a refinement.

These are basically the summary of two models that were promising. One would start with the current RUG system and it's a system that would be called the RUG 58 + Service Index Model. The other model that they looked at was called the New Profiles Non-Therapy Ancillary model. Under either of these options a new component would be added to the PPS that would calculate a separate payment for non-therapy ancillary services. So there would be then instead of three parts of the payment system, there would be four.

The RUG 58 + Service Index Model starts with RUGs and adds other variables that come from the existing patient assessment tool, the MDS. The New Profiles model, by contrast, actually starts with a classification system that was developed by the University of Colorado Health Sciences Center and it actually adds information from the previous hospital stay. So everybody's had one of those, so you can pull some information from that, as well.

The current payment system explains about 10 percent of the variation in non-therapy ancillary services. If you look at that row with the amount of variation and cost explains, you can see that both of these models do two times better than the current system at explaining the

variation in non-therapy ancillary costs. The last line summarizes the data collection. For the RUG 58 + SIM model, you actually would just use additional variables from the MDS. And then from the New Profiles model, you pull some information from the hospital stay. In neither case would you need to create a new data stream. You may need to pull some data from some existing places.

The second chart here is the summary of the different models that CMS looked at to deal with this therapy issue. Right now the payment system basically is like a fee schedule. It pays more the more therapy is provided. Both of these models would, instead of being based on that sort of a system, they would build a prediction of the amount of therapy that a patient would be expected to use and pay that amount prospectively. The two models, first is the New Profiles, and it actually pulls data from the prior hospital stay like the New Profiles for Non-Therapy Ancillaries model. And then the DRG model actually just uses the DRG from the prior hospital stay.

The current system, which matches pretty well to service use, has performance -- I think the explanation is in the 30 percent range, 39 percent of the variation. You

can see that for these two models they don't explain costs as well. And actually I believe the DRG model -- both of these models actually did a better job at explaining the variation in speech language pathology costs.

In terms of data required, again these would draw from the prior hospital stay. It would not require new data collection. It might require existing data to be rerouted to be added into the classification system.

These are some questions I'm going to return to you guys at the end, but let me just give you a sort of a heads-up on one of the things that we'd like you to give us some feedback on.

Before we even start delving into the system one thing we might want to ask is whether we're comfortable with the current system being based around a per day payment or whether we might want to consider a per stay kind of model. The advantages to a per stay model is it's a larger bundle of services. On the other hand, the disadvantage is that there's maybe a risk that SNFs might start shortening stays inappropriately.

The other issue we're going to tee up at the end is the extent to which you would want us to explore these

predictive-type therapy models or whether you'd want us to focus on some other issues.

Let me also take you through some of the outlier policy issues. These are basically to encourage providers to -- it protects them against spending extraordinarily high amounts on particular patients. It may protect some SNFs from taking on certain cases that they might worry might end up as being high cost.

Generally outlier policies look at the total cost of patients, not a particular category of costs. But because non-therapy ancillary services are a specific concern in the PPS, CMS's researchers actually looked at creating an outlier policy particularly for non-therapy ancillary service costs.

What they found is that total cost and non-therapy ancillary cost outlier policies would actually help the financial condition of particular groups of SNFs. That is hospital-based facilities, government-owned facilities, small facilities, and facilities with high Medicare shares. On average, the financial condition of freestanding facilities was pretty much unaffected by a non-therapy ancillary cost policy but would be lower under a total cost

outlier policy

Here's some data on the distribution of costs in these two types of facilities, freestanding and hospital-based. I'm using this to illustrate why hospital-based facilities would benefit more from outlier policies than freestanding SNFs.

If you look at the median costs, the differences aren't particularly dramatic, particularly for non-therapy ancillary costs. What you can see is that at the extremes there really is a quite substantial difference in the cost for these two types of facilities. Of course, an outlier policy which is targeted towards paying for these extremely costly case would help. You can see why it would help the hospital-based facilities.

One question to think about is if you see that there's something that needs to be fixed in the payment system, perhaps an outlier policy isn't the best way to do it. Ideally if you see that there's something systematically wrong, you might want to fix that with a systematic adjustment to the payment. But it is something that you might even want to consider as a short-term adjustment while that fix is being created and implemented.

So that's something we'll return to at the end.

Now I'm going to turn it over to Dr. Liu to talk about work he has planned to do for us.

DR. LIU: Thanks, Sarah.

One of the first things we did in the past year was actually help MedPAC develop a new analysis file. A lot of our research that was done for CMS was based on a 2001 file. So we created a brand new 2003 file of SNF stays.

The data that went into this particular analysis file included the Minimum Data Set information on individual assessments for the SNF patients, claims from the SNF stays themselves, and claims from the prior hospital stay. So you've got three major sources of information on patients.

So being good researchers with a brand new file, we felt as a first step it would be important to reexamine some of the predictors and models that we had found to be very interesting and to be associated with various cost centers. So that would be one of the logical first things for us to be doing.

The second bullet under the new file says IV therapy and respiratory therapy. I wanted to highlight those two variables because in our prior research we found

those two to be particularly good predictors of non-therapy ancillary costs. We did, between the University of Colorado and the Urban Institute, we did quite a bit of data mining which is to look at all available information that we had on patients. These two really popped up.

The way that's phrased, it's IV therapy/respiratory therapy based on both claims and MDS interaction. One of the things we discovered in our prior research was that when you only pulled out IV therapy or respiratory therapy indicators from the MDS, they didn't turn out to be as powerful predictors of non-therapy ancillary costs as one might expect. One would expect that primarily because of a lot of anecdotal information we had, and I'll get back to that in a second.

It turns out the way the question is phrased in the assessment, it's phrased something along the lines of in the past 14 days did you receive IV therapy? Now a lot of these assessments are based on the first five days in a skilled nursing facility. So that 14 days actually covers a lot of use in a prior hospital stay. So between the two, it's confounded in terms of how powerful that variable might be for a SNF stay.

That's why, as a way to get around that, we interacted the MDS indicator of IV therapy or respiratory therapy with the actual SNF claims, which indicates that it be done at the SNF level. So once we did that interaction, those two variables just popped up as incredibly powerful.

Anecdotally, I had done a study on post-acute care -- this is in 2000 before a lot of the post-acute care PPSs were implemented. And we talked to stakeholders, including associations and the nursing home industry and so forth. And everybody said boy, IV medication and other IV therapy are extremely expensive these days and they're not built into the payment system. Respiratory therapy the same way.

We also found, looking at cost report revenue centers, that after the PPS was implemented a lot of the freestanding skilled nursing facilities stopped billing for respiratory therapy and it was not reflecting in the cost reports themselves.

So again apparently because the respiratory therapy and IV therapy are very expensive services, or could be, they are very good predictors of costs. And we will come back to that.

After looking at the database and re-examining the

predictors and models that we had developed, there are various new avenues actually that I think that we want to explode that we didn't really spend a lot of time on in the past few years. In our initial conversations with MedPAC staff, we came up with a nice list of new things to explore. I wanted just to highlight a few of them.

One is this question of per diem versus per stay. Most of our prior research focused on per diem as the dependent variable. We did examine per stay on a very cursory basis but I think there's a lot more that could be done there.

Length of stay adjustment. We did not use length of stay during a SNF stay as a possible factor in predicting costs. I think the notion is that in the early parts of the stay your costs are likely to be higher than the latter parts of the stay.

So we do have this variable. This is a variable we plan to take a look at and see how that does in connection with predicting various types of costs in the SNF.

Another impetus for looking at this is we discovered that the inpatient psychiatric hospital PPS now

does include a length of stay adjustment. So this provides a sort of a precedent, in a sense, for looking at it.

Another new avenue that we were thinking about exploring was simply looking at those high cost cases themselves and finding out, rather than trying to use a lot of variables to predict costs, but just to actually look at the ones with high cost and see who they are.

I think a good example of this particular exercise would be like HIV patients. We sort of know intuitively they're going to be expensive, they're going to have high NTA costs, and they do.

Another factor when you're considering whether to include HIV in any kind of classification model is that there's only 1,000 cases nationally. So that goes against the likelihood of trying to incorporate that particular cell in a classification system. But again this is more of a data analysis exercise.

A fourth one I'd just like to mention is that we thought it might be productive to look at nursing costs and facility level case-mix. It's facility level because the nursing cost variables are available only on a facility basis from routinely collected administrative information.

Unlike the non-therapy ancillary, the rehab therapy variables, which are available on a per person basis through the claims, the nursing cost variable has to be teased out of the cost report which, by definition, makes it a facility level dependent variable.

We'd would like to explore how Medicare case-mix might be related to nursing costs on a facility level.

After exploring these new avenues, we'd would like to return again to creating or examining the building blocks that can be combined perhaps in various combinations in new SNF PPS options. We had developed some building blocks. They were very preliminary and I think we're at the point now where we might be able to refine a lot of these.

Number one listed there is non-therapy ancillary. It's perceived to be the most important service component by a lot of folks. So we will examine the building blocks we have and see if we can modify them with perhaps length of stay adjusters and things of that sort.

The predictive therapy models, we have a predictive therapy model. The New Profiles is a good example there. In the New Profiles model we had actually two components. One was PT/OT combined and one was speech

by itself. One of the things we plan to do going forward is to combine all three of those therapies into a single model. They were also created using a lot of variables and we want to slim down the number of variables there.

The third one is DRGs. We've developed some models using DRGs and these are DRGs based on the hospital DRG. In one of Sarah's earlier tables, the R-squares were not particularly high for the DRG models. But I've got to tell you that in the DRG models we used only two sets of variables. We used only the DRG and then we used functional status variables from the SNF say.

We wanted to keep this one as clinical as possible so those variables in the DRG models we used are not very gameable.

MR. HACKBARTH: Korbin, we're running behind schedule. So if you could take it up a couple of levels in terms of specificity and not go into as much detail, that would help.

DR. LIU: Will do.

We developed some outlier payment options and they were for NTA and also for total cost and we'll revisit some of those primarily in combination, I think, with some of the

classification models.

Then as we begin putting some of these building blocks together, there are a lot of things we want to consider. The sources of data, because of the complexity and perhaps burden of pulling data from too many different sources, the number of variables that go into creation of these classification models, and we want to keep the payment cells as small as possible for simplicity purposes.

There's going to be a trade-off in any of these combinations. One is the statistical variance explanation power, and that trade-off may be at the expense of burden for both providers and for CMS to administer these programs.

And then we'll look at the incentives.

I think the last thing I want to do today is to show you an example of -- this is an NTA model. It's based on three variables. It's based on that IV/med variable that I had mentioned earlier, it's based on the respiratory therapy variable that I mentioned earlier, and the third is the RUG classification. This is an NTA model that has an R-square of about 20 percent. It uses three variables. The reference here is that the NTA average cost is $63. So what you end up with in this model is six cells, six payment

cells.

The first one is a case where there is no IV and there's no respiratory, and the person is classified in one of the rehab classification groups. That payment is $39 relative to the $63 average. That's because you don't have either IV, you don't have respiratory, and these are primary therapy patients.

So at the other extreme, number six, are people, cases with both IV meds and respiratory therapy. And they have an average cost of $247. So you've got both extremes.

The last point on this chart is that if you look at the cases with neither IV nor respiratory, like cell number one, cell number three, that's almost 90 percent of your cases. So about 90 percent of your cases are below or at the average.

I think I'll stop right there.

MS. THOMAS: We're going to wind up. These are some suggestions of things you might want to talk about, whether you want us to go beyond thinking about ways to refine the per day system and even think about per stay. Think about this question of predictive therapy model versus one that pays more the more you do. And about an outlier

policy.

You're also, of course, free to ask questions about anything that Korbin or I presented.

MR. HACKBARTH: Sarah, could I asked about the history a little bit? We have a per day system now. In general, we seem to prefer bigger bundles rather than smaller. Could you just describe why, when the current system was put in place, the decision was made to go with per day versus per stay? Was it because of the weakness of the case-mix adjustment?

MS. THOMAS: I guess what I remember, and maybe Bill has the answer. I think it's because the MDS is oriented towards per day, right, from the long-term care side?

DR. SCANLON: Actually I was at GAO and we were advocating the per day system. I think the primary system is because in a SNF your Medicare stay does not mean that you leave the SNF. You can be staying in the same bed and continue on as either a private pay or a Medicaid patient.

And that, in some respects, created a great deal of uncertainty about the amount of under provision of Medicare covered days that might occur under a per stay

model.

I don't how much that has changed. We certainly have had changes in the nursing home sector in terms of a lot more use of assisted living facilities. But we still may have a lot of people that are continuing on as nursing home residents, being paid from other sources. That was the primary thing, I think, that was driving it.

MS. THOMAS: One of the things that Dana points out to me was that there was a desire back at the time to develop a system that would be able to work with both Medicaid and Medicare. So I was kind of on the right track with that answer, that it be compatible with the MDS system.

MR. HACKBARTH: Questions? Comments?

DR. SCANLON: Two quick comments. One, I think the problem we have is we're working with bad data. When you had your lower R-square on your therapy models, I think we have to remember that the therapy use that we're looking at is therapy use that's been distorted by the incentives created by a system that maybe encourages over provision. I don't think we have a gold standard in terms of what are the therapy levels that we should be targeting and therefore can predict.

The fact that the existing system predicted more is not a surprise. It's not clear how bad your model was.

The other thing I would say is that the outlier policy, with respect to total cost that you describe, sounds like a reward for inefficiency more than anything else.

With respect to non-therapy ancillary though, an outlier policy which in some ways could be considered a carve-out policy, might be a way of dealing with the fact that in a number of instances we're talking about things are done relatively rarely and that we're not going to ever be able to predict them for the small caseloads that many skilled nursing facilities have. And the best way to deal with them is on an outlier basis.

At the same time, we want to be very sure that we're picking things that aren't gameable so that we know that there is a real medical need for these kinds of services.

MR. HACKBARTH: Explain, Bill, why you said that the outlier policy sounded like a payment for inefficiency? Why is this different than the hospital outlier policy?

DR. SCANLON: For one, we're paying on a per day basis here. It's going to drive the differences in terms of

the costs. We don't have a sense of how the nursing costs vary because we don't measure that. If that's not captured in the rate already. we don't have a measure of that. The things that are going to vary are the non-therapy ancillaries or the length of stay.

Sarah, in talking about which facilities would be affected most by an outlier policy for high cost, it was hospital-based, governmental, and I would think that maybe the ones that are --

MS. THOMAS: High Medicare share and small.

DR. SCANLON: Right. So it's ones where you can think of it more from an efficiency level than sort of the patients or the residents need as driving those higher costs.

MS. HANSEN: Just a comment. Korbin, you're familiar with all of the PACE sites. I just wonder whether again, because they haven't had the incentive to do any gaming as such, the ability just to look at their utilization patterns. It's not going to be the big dataset but it does give you some patterns of utilization for therapy.

DR. LIU: Glad to.

DR. KANE: Weren't we talking, when we were talking about hospital readmission rates, that there may be things that go on in the hospital stay that create problems in the post-acute setting? I don't know if this is just a wild goose chase but would that predict -- would it be possible to look at, I guess 16 percent of hospital discharges are two SNFs. Would it be possible to sort out -- are there things that happen in that stay that predict the greater needs of a visit in the SNF?

At some point, I'd like to see the SNF and the hospital bundled but I don't know if that make sense. But meanwhile, what does the hospital stay tell us besides just the DRG that might help predict what goes on in the SNF?

DR. LIU: I guess one of the things -- the hospital -- the information about the hospital stay really is intriguing, conceptually intriguing, because it really is what kicks off the SNF stay. And so when we were looking at the data from the hospital stay, we were very intrigued about what was taking place in the hospital that might be associated with SNF costs, for example. It gets a little bit fuzzy because you can't tell, on the one hand you think more therapy done in a hospital, there might be more therapy

done in the SNF. On the other hand, maybe there's an offset instead. So if there was more done in the hospital there would be less needed in the SNF. So it's very complicated but I think it's a very interesting relationship.

We could look at the hospital stay, spend a little more time looking at those characteristics.

DR. KANE: Some of the things we were talking about was things like adverse events in the hospital having a post-acute effect. So some of the untoward things. So I don't know if that's possible to dig up but I think that would help us think more about how linked those two should be and whether the SNF is actually getting penalized if it's only paid X when it received a patient from a hospital that had been damaged more than they should have been.

MR. HACKBARTH: Any others? Okay, thank you very much. Thank you. Korbin.

And last for today is findings on hospital-based SNF.

Craig got the seat of honor.

MR. LISK: I am going today present results of an analysis that we conducted to take a closer look at hospital-based SNFs. To remind you, hospital-based SNFs, as

you know, have very low margins, as reported in our March report, minus 85 percent in 2005 compared to freestanding SNFs who had a margin of 13 percent. We want to understand better the financial situation of hospital-based SNFs and how they may differ from freestanding SNFs.

We also wanted to see if we could classify hospital-based SNFs into different SNFs models. Are they homogeneous or not? We plan to include this analysis in this year's June report along with some of the stuff in the previous discussion, as well.

The basic outline today, I'm going to briefly review our case study, results that we had. That is actually now available on our website, on hospital-based SNFs. We're going to look at a comparison of freestanding SNFs and how they compare, hospital-based SNFs compare with freestanding SNFs, and look at the different models of SNFs. These later two analyses are new analyses.

On the case study, this past year we conducted a site visit of several different markets with hospital-based SNFs, and we found that hospitals closed their SNFs because of financial losses, a more profitable or better use of the space such as a need for more acute care beds, the

difficulty in staffing particularly with RNs, and some point also to some regulatory issues, state regulatory certificate of need issues.

Hospitals retained SNFs because of savings on acute care from shorter inpatient stays, easier or quicker access to post-acute care and, in particular in some rural areas, for access to SNF services in the community, and continuity of care particularly for physicians to have easier access to their patients.

We heard and saw about three different models of hospital-based SNFs, and I'm going to go back into these when we get to the table on that so I can save a bit of time here.

I want to first describe some basic characteristics of Medicare patients who use post-acute care services, this isn't just those who use SNF services, but these are some basic characteristics of patients who use post-acute care. What we find is within and across DRGs that patients who use post-acute care services tend to have longer acute-care inpatient hospital stays, they have higher severity of illness scores measured by the APR-DRGs. In turn, because they have these characteristics, they also

have what we would say on a case level lower inpatient margins compared to cases that don't use SNFs within DRGs.

So how do hospital-based SNFs fit into marketplace? Well, they represent a small share of the facilities, just 8 percent, and they account for 17 percent of the SNF cases and 9 percent of patient days.

As this is a per diem payment system, payments track pretty close to patient days. Payments account for about 10 percent in hospital-based SNFs.

Hospital-based SNFs differ from freestanding SNFs in a number of ways. They are smaller, 26 beds on average compared to 98 for freestanding. Hospital-based SNFs have a higher proportion of Medicare patients. They also have shorter stays on average compared to freestanding SNFs, half of what they are in freestanding SNFs. Staffing is also higher in hospital-based SNFs, and from research that Korbin Liu had done in a previous study, also found that skill mix of the staff was higher in the hospital-based compared to freestanding. Higher as they had more RNs and LPNs than others.

Of course, as I mentioned at the beginning, the Medicare's SNF margins are very different between the

hospital-based and the freestanding facilities.

So how do the patients differ? This table shows differences in patient characteristics of patients in hospital-based and freestanding SNFs. Beneficiaries in hospital-based SNFs are slightly younger. Their severity of illness as measured by the APR-DRGs for the inpatient stay is also lower. But their share of hospital days that are spent in an ICU is greater, 27 percent of their inpatient days compared to 23 percent of the patients who were admitted to a freestanding SNF.

A higher proportion of hospital-based cases also come from MDC8, which is for musculoskeletal conditions such as major joint replacements. This MDC has a lot of rehab patients and that's why we looked at that. So that's a very big difference.

Hospital-based SNFs are also less likely to take patients who come to the hospital from a nursing home. You see 2.4 percent of those patients came from the nursing home into the hospital then to the SNF, compared to 5 percent for freestanding facilities.

If we look within and across DRGs, we find in general that hospital inpatient stays are slightly shorter

for patients discharged to hospital-based SNFs compared to patients discharged to freestanding SNFs. For major joint procedures, strokes and major small and large bowel procedures the difference though is a little bit greater, a day or more.

We find the inpatient case level hospital margins to be similar for these two cases and the severity of illness scores for APR-DRGs to be slightly lower for the hospital-based SNF patients, although there are some DRGs where it is higher.

This next slide shows the percent of cases that are discharged to different post-acute care settings from hospitals with SNFs and hospitals without SNFs. Hospitals with SNFs tend to use SNFs more and other post-acute settings less. Hospitals with SNFs discharge 17 percent of their patients to a skilled nursing facility compared to 14 percent of hospitals that did not have a skilled nursing facility.

Interestingly, hospitals use their own SNF for only about a third of the patients using these services, on average.

While SNF use is higher, use of home health,

inpatient rehabilitation and long-term care hospitals is slightly lower. And overall a slightly larger proportion of patients in hospitals with SNFs use post-acute care services compared to hospitals that don't have a SNF.

Beneficiaries discharged from hospital-based SNFs use a second post-acute care provider more often than beneficiaries that are discharged to a freestanding SNF. In your handouts it should say freestanding SNFs in that third column.

This slide shows what percent of SNF patients use a second post-acute care provider immediately after leaving the skilled nursing facility. What we find is that 9 percent of the patients are discharged from the hospital-based SNF to another SNF, compared to freestanding SNFs where it's 1.7 percent.

And 25 percent are discharged using home health care compared to 12 percent of patients discharged from freestanding SNFs. And 2 percent use inpatient rehabilitation facilities versus a very small percent from freestanding facilities.

Freestanding facilities do have a larger proportion of their cases that go back to the hospital

compared to hospital-based SNFs and some of that could be due to patient characteristics and other capabilities of the hospital-based SNF and the closeness to the hospital in the hospital-based SNF.

But overall, a higher proportion of freestanding SNF patients are discharged home directly from the SNF stay as compared with hospital-based SNF patients.

So in looking at resource use of hospital-based SNFs, we cannot consider just what happens during their SNF stay, but we also need to consider what happens after. And that has implications for a case level payment system versus a per diem payment system in our considerations.

Looking at financial performance of hospitals with and without SNFs, we see lower overall Medicare margins in hospitals with SNFs compared to hospitals without. But this 0.9 difference in 2005 is the smallest we have observed since the SNF PPS went into effect.

We also see the inpatient margin for hospital-based SNFs is slightly higher, a possible indication that the hospitals are benefitting on the inpatient costs from having the skilled nursing facility.

So let's look at how costs differ between

hospital-based SNFs and freestanding SNFs. This table shows average per diem routine and the different types of ancillary costs for hospital-based and freestanding SNFs. Routine costs reflect room, board, and nursing costs. As you can see, routine costs are much higher in hospital-based SNFs as compared to freestanding SNFs.

If we look at ancillary costs, therapy costs are similar but the other ancillary services, often referred to as the non-therapy ancillaries, we see much larger differences in the costs between the two types of facilities. For example, in supplies it's $18 compared to $5 on average per day.

The higher cost may be the result of easier access to ancillary services in hospital-based facilities or it could be due to differences in patient characteristics. But we heard from our site visit there is a desire from doctors who treat people in hospital-based SNFs to treat patients as if they are in the hospital.

MR. HACKBARTH: Craig, can I ask you about this one before you leave?

Take supplies and it says $18 for hospital-based versus $5 for freestanding. In that $18, does that include

overhead allocations?

MR. LISK: Yes. These, in both cases, reflective overhead allocations in here. Yes. I should have mentioned that.

So what do we find when we look at direct costs? We covered this a little bit at the January meeting. Hospital payments don't cover post-acute patient's IPPS costs, including overhead. The average payment-to-cost ration was 0.82 for patients discharged to hospital-based SNFs for inpatient acute care. But on average, hospitals cover their direct IPPS costs, that is costs excluding capital and overhead, of the patients discharged to the SNF.

As might be suggested from the extremely negative hospital-based margin, hospital-based SNF payments don't cover either the fully allocated costs of SNF care or even the direct cost of the SNF care. But if we consider total payments, hospital plus hospital-based SNF, they come very close to covering total direct costs. That's the cost excluding the overhead or what we think of as a variable cost of care of the patient stay in the hospital. The payment to direct cost ratio is 0.99 for these cases.

One point I want to add to this is, in how we're calculating our variable costs, we're calculating on an average cost basis. So on a true marginal cost basis, we are overestimating probably the true variable cost here.

I want to now move on and briefly discuss how the hospital-based SNFs fit into the different models that we saw on our site visits. There's the long-term care model, which these patients look very much like the people going to freestanding facilities on average. There's the rehabilitation model, which concentrates their patients on joints and other types of cases requiring large amounts of therapy. And there's a complex model which focuses on medically complex patients, and these are sometimes referred to as transitional care units. These patients often look like hospital patients just continuing their stays.

About 15 percent of facilities fit into the long-term care model, 47 percent into the rehab model, and 17 percent into the complex care model. About 20 percent don't cleanly fit into either of these different models. I can get into that a little bit more if you want.

This next slide gives us a comparison of how these different facilities compare across these different models

on characteristics, facility inpatient characteristics. As you can see, most of the characteristics, freestanding SNFs and long-term care model, the hospital-based SNFs look very similar across the different characteristics. The rehabilitation model has a large share of cases in musculoskeletal conditions, which we would expect. And it has shorter stays and higher staffing than the long-term care model.

The complex care model has the shortest SNF stays, the highest staffing, and the highest share of Medicare patients, and a very high share of patient days that were spent in the acute care site in the ICU, 32 percent. they also have the largest proportion of patients continuing SNF care to another facility, 14 percent. And 27 percent continue care in home health.

This use of SNFs in home health is actually similar to what we see for patients who were discharged from hospitals that don't have a SNF that are discharged from the hospital without a SNF.

The rehab also, if we look at severity of illness -- that's not on the table -- the rehab group has the lowest severity of illness on average.

This next slide shows how costs differ for these three different models of hospital-based SNFs. As you can see, costs per day are lowest in the long-term care model and they're highest in facilities we identified as the complex care model.

The same is true for direct costs, which we also have on this slide. The last line shows the ratio of payments to direct costs for hospital and hospital-based SNF services combined. We see here that hospitals with a long-term care model SNF more than cover the direct costs of care. The ratio for the traditional model and the complex medical model are below one but not too far below.

Given our method of calculating direct costs where we have routine an ancillary services on an average cost basement basis less overhead, this estimate of direct costs is likely overstated and thus the ratios are likely higher than what are shown below, shown on the slide.

There have been significant concerns raised by you and the industry about hospital-based SNFs. This analysis was meant to explore more in depth the differences and similarities between these facilities. On the one hand, we find that hospitals with the SNF discharge patients more

often to skilled nursing facilities than hospitals without them and that their SNF care is more frequently followed by care in a second post-acute care setting compared with freestanding SNFs. We therefore need to consider this when we compare episode costs for patients using different types of skilled nursing facilities. Post-acute care for many patients, therefore, does not end with discharge from the skilled nursing facility.

We also find that on average hospital-based SNFs have much higher routine and non-therapy ancillary costs per day than freestanding facilities. Some of this may be due to easier access of ancillary services in the hospital setting or a hospitalcentric approach to providing care, but some may be due to differences in the complexity of patients not measured by the current payment system.

MS. BURKE: Craig, could you go back two steps and just remind me. Do I recall that in the paper earlier you noted that a larger majority of non-hospital-based SNF patients came out of nursing homes?

MR. LISK: Yes.

MS. BURKE: So the fact that -- presumably, they would go back to a nursing home?

MR. LISK: Yes. About 7 percent of patients discharged from a freestanding nursing home go to being a long-term care resident and 5 percent from hospital-based.

MS. BURKE: I'm just trying to sort out among these issues which you could anticipate or not. The fact that hospital-based discharges would go to a facility wouldn't be terribly surprising by comparison because, in fact, in many cases the non-hospital-based, in fact, are discharged back to nursing homes?

MR. LISK: Yes, but basically what I was trying to say is that about 47 percent of patients from a freestanding nursing home go home directly from the nursing home, whereas 40 percent after their hospital-based stay go home without any post-acute care. So there's a difference of more post-acute care use with even the patients who are using the hospital-based SNF. There's more use of a second post-acute care provider after, even accounting for the fact that some of those people are going back to a nursing home.

MS. BURKE: Thank you.

MR. LISK: Hospital-based SNFs also have higher staffing and provide easier access to beneficiaries physicians to see and monitor the patients in the post-acute

care setting, promoting continuity of care. But we don't know whether we really have quality of care differences here or not that we find worth the difference in the cost.

We also find that hospital-based facilities are not homogeneous. There are different models of care and their role in providing post-acute care services appears to potentially differ. The long-term care model looks very much like the freestanding SNFs with long days. And the patients in the complex care model look very much like the extended stay patients that, in other hospitals that don't have SNFs, may very well be staying as longer stay patients in the hospital.

Finally, we also find that hospitals come close to covering the direct costs of hospital and SNF services combined. At a minimum, this is what we need to do is at least be covering their variable costs if we're wanting to make sure that they have adequate payments for covering that.

Adjusting for severity --

MR. MULLER: That's inpatient costs only; right?

MR. LISK: No, that's inpatient and SNF costs.

MR. MULLER: But not outpatient and all that other

stuff?

MR. LISK: No.

Adjusting for severity should improve the inpatient profitability of patients and reforms in the SNF PPS may also improve the financial situation for this portion of care, as well.

So some of the things the Commission has on the table in terms of what we're considering may improve the financial situation here that we see here and improve these numbers on the bottom line there.

I'd be happy to answer any questions you have. I know it's late and we can continue this discussion another time, too.

MR. HACKBARTH: Do you plan to look at Medicare case costs, and so look at the total cost inpatient hospital, hospital-base SNF, plus whatever follows that versus models that don't have the hospital-based SNF in the middle and went straight to freestanding?

MR. LISK: We theoretically could do that if there's desire to do that.

MR. HACKBARTH: Do you think it would be worthwhile looking at that?

MR. LISK: It gets more complex when we're trying to get the costs of all of the different settings together but I think it could be worth doing if we were trying to consider bundled payments.

MS. THOMAS: Glenn, did you mean payments or costs?

MR. HACKBARTH: Obviously, there are two different ways you can look at it. What combination costs Medicare the most, and then you could look at it from an efficiency standpoint which combination has the lowest cost of care. I don't know if the stories would be the same or different.

DR. MILLER: I think one of the issues is that you still have this problem of not being able -- we do think that different types of patients go to these different -- have the hospital-based SNF in the middle of their episode and still don't have a particularly good way of adjusting for the differences in the characteristics.

Part of this effort was to talk about the hospital and the hospital-based SNF because that's been an issue that has come up each time we've done payment adequacy and people have gone back and forth on it, to at least try and isolate -- let me put it this way.

If you look at the data just in a margin sense, it's like why is anyone doing this? I think what Craig is getting at is if you look behind it and on a patient care basis and the different models they're using, there may be an argument from a financial perspective for the hospital to keep these around.

You could assemble the data that you've asked for, Glenn. I would be a little concerned though that we know that there's some sorting going on in those two different episodes and how we can actually adjust. Because we all think that the SNF RUG adjuster is not a good enough case-mix adjuster.

MS. BURKE: And we really can't, or can we, judge whether there are qualitative issues? For example, you note specifically, Craig, that there is a higher ratio of RNs and LPNs in the service mix in terms of the facilities that are hospital-based.

Query whether -- I think Jennie and I would argue at least historically we've always believed that RNs, in fact, have a qualitative impact in terms of the nature of the service. Query whether, in fact, we know that on more than sort of our own instinctive reactions.

MR. MULLER: There are studies of that in hospitals.

MS. BURKE: I know there is on the hospitals. But the question is here it has a demonstrable impact in terms of the cost. Query whether we think it has any qualitative impact.

MR. LISK: It may have an effect on hospital readmissions, for instance, whereas certain nursing homes, they don't necessarily have to have an RN 24 hours I don't think. That might have an impact where someone could -- somebody was a problem in the middle of the night and they send to the ER instead of someone there might be able to manage it, an RN might be able to manage it in some nursing homes. I don't know how often that's the case.

I think part of the ratio issue on the nursing home staffing is possibly just due to the differences in size, too, is the hospital-based units are smaller and if each one has one RN in each shift, by definition they're going to have a higher staffing ratio.

Also on the hospital-based SNFs, they may be able to float someone over if they don't even have an RN in the middle of the night, they may be able to float someone over

from the hospital to take care of that situation, in that situation.

MS. HANSEN: Just as artifact I don't know whether the California experience is somewhat different because there are actually registered nurse staffing ratios, as well, that are built-in to the hospital that have gone on now for at least two-and-a-half years. And so the hospital nursing homes there will be staffed differently. So that will be another thing to take a look at.

MS. THOMAS: You remember we had Andy Kramer from the University of Colorado come in. We actually have some contract work going in the background where he's looking at his two quality measures, readmissions and whether people go home to the community, and trying to look at those patterns of differences between those two.

It's always going to be somewhat confounded by differences in cases and convenience, too. If you're in the hospital maybe you don't need to be admitted to the hospital, if you know what I'm saying.

But we're going to take a look at his draft report and hope to bring it to you even as soon as next month.

MR. MULLER: Craig, I'm a little puzzled by pages

seven and eight where the severity -- obviously it's a crude measure on page eight of level three or four is roughly the same yet the length of stay is half.

Is that just a function you think of their being more rehab patients?

MR. LISK: This is, of course, -- the severity --

MR. MULLER: Slide eight. They're roughly the same.

MR. LISK: Right. This is for the hospital side of the patient. And so the severity is lower but the ICU days is higher. So you kind of have that -- one is lower and one is higher, if you think about the ICU as another measure of severity of the patient.

DR. MILLER: Ralph, you said something about rehab?

MR. MULLER: On a later slide. But I'm saying that -- I would say that if you take that as a measure of the severity of the patient coming in, 42 versus 46 on this slide and 27 -- I'd say they're roughly the same measure of severity. Yet the length of stay is half.

That just puzzles me. I don't know the answer to that. You generally think if the severity is the same that

you think the length of stay --

MR. LISK: I think the length of stay is half is partly reflected that many of these patients are going on to use other post-acute care afterwards whereas in the freestanding SNF they're not.

And then some of the ones who were longer stay in the freestanding SNF may be continuing on and more likely to be nursing home patients. So it's kind of that combination of things that are going on.

DR. MILLER: The reason that I was asking is because I thought you were also picking up on the fact that they are MDC8, which we haven't drilled down far enough but that could be rehab.

MR. MULLER: That was the second part of that.

MR. HACKBARTH: Others? Okay, thank you, Craig.

We will now have a brief public comment period.

The ground rules are...

MR. PRECHT: I'll identify myself and be quick.

I'm Paul Precht. I'm the Policy Coordinator for the Medicare Rights Center.

over the last years, we've been dealing a lot with the fallout of very aggressive and sometimes deceptive

marketing of private fee-for-service plans. And in particular, dual eligibles who are able to change each month have been targeted by some very aggressive brokers.

So what we're hoping is that in the course of your work on Medicare Advantage that you look at a couple of questions. One, whether private fee-for-service plans, which provide very little if any coordinated care, are an appropriate home for dual eligibles, many of whom have multiple chronic conditions. And also whether the private fee-for-service model, whose chief benefit is to provide reduced cost sharing, is of benefit to a dual eligible who already has zero cost sharing by virtue of being in Medicaid.

I'll call your attention to a plan that's now being marketed by WellCare. It's the Duet Plan. It provides -- the cost sharing structure is virtually identical to original Medicare, $10 off the inpatient deductible but other than that it's 20 percent for the doctor, et cetera.

It's targeted to dual eligibles and it's marketed as a zero copay plan. But the zero copayment is entirely due to the fact that the target market has Medicaid.

So the question is what value does this provide to the Medicare program?

And that raises the second point, which is private fee-for-service plans are exempt from the kind of bid review that other Medicare Advantage plans. CMS is barred by law from looking at the supplemental benefits and that's why we have things like the Duet Plan. We also have plans like Sterling Option II that charges 20 percent for Part B drugs and there's no out-of-pocket limit.

So what are our counselors supposed to say to somebody that's locked into a plan like that except don't get cancer?

So we're hoping as you look at private fee-for-service plans that one of your recommendations might be that they not be exempt from this type of bid review, and that you look also at whether it's feasible to have a mandate for an out-of-pocket limit.

Thanks very much.

MS. WILBUR: I'm Valerie Wilbur with the National Health Policy Group, and my organization represents the Special Needs Plans Alliance. And I wanted to make two comments on the section of the report dealing with SNPs.

The first section had to do with the questions that your staff for asking. The two questions that I wanted to address were should Congress and CMS expect more of SNPs?

I think if you look at what they've said already that the answer is yes. If you look at the legislation for SNPs, one of the primary reasons for establishing them was to provide a platform for all these specialty demonstrations that were going to be expiring soon to have a home to transition into MA plans. If you look at the report language, it talks about encouraging replication of those models for people with comorbid conditions, frail elderly, other Medicare beneficiaries that have special needs.

If you talk to staff on the hill, they're all asking are the, in fact, meeting the intent of Congress by doing something special?

If you look at CMS's expectations and their SNP applications for 2008, they're much more detailed in their requirements for documentation about what SNPs are going to do to take care of frail elderly, adult disabled, people with multiple comorbidities and people at the end of life. They're asking are the duals having Medicaid contracts so that there's an opportunity for coordination? And if

they're doing Medicaid contracts are they, in fact, capitated?

I would suggest that the additional detail in the CMS application would suggest that CMS does expect something different.

The second issue I wanted to address was the point about whether they should be extended. I would suggest it's premature to make a decision that they shouldn't be extended because of the 470 SNPs online this year, 200 are new this year. So it's a little bit soon to decide whether they worked or whether they didn't work.

If you look at the experience of what I would call the legacy demos that many of the SNPs are coming from transitions, like Minnesota, Wisconsin and Texas, there's very good evidence of reduced emergency room use, nursing home days, inpatient hospital use. So they look promising. We don't have the data available yet.

Even the report that comes to Congress at the end of the year is going to be more about profiles -- what do they look like, what are they doing -- not outcomes because the HOS, HEDIS and CAHPS data aren't available to CMS for the report that will come up in December.

The second point I wanted to make is I was really happy that people were talking about relative payment equity across the different MA plans. I would encourage MedPAC to look at relative payment equity in relation to SNPs, but SNPS that are serving the high-risk population. I know that all SNPs aren't targeting the highest of the high-risk population. But the most recent research we have that looks at payment equity across the different plans that was done in 2003 or 2004 for CMS that Greg Pope did, showed that for the highest cost 20 percent high-cost population for Medicare, that the HCC methodology they put in place was going to continue to underpay by about 14 percent.

Even CMS acknowledges the HCC does way better than the old AAPCC model in the middle. They say it's perfect in the middle. But even CMS acknowledges that on the low end and the high end there continues to be payment inequity relative to fee-for-service.

So when we submitted our comments to CMS, we asked them to look at a couple of things. The top 20 percent, what's the relationship between that population and people with frailty, disability, comorbidities, late stage conditions? Because nobody's ever really reported on that.

And the second thing we asked them to look at is please look at the relative payment equity of the HCC adjuster, the pharmacy adjuster, and the dual adjuster relative to various stages of frailty, disability, comorbidity and condition.

I think if we look at those things, we're going to get a sense that the SNPs that are really targeting the high risk aren't overpaid by 10 percent, as your report indicated for CCPs in general, but in fact they're underpaid relative to fee-for-service.

I think at this point in time we see great promise for these plans. It's too late to pull the plug on them, but we know for sure that they need to be paid equitably if they're going to meet the promise that some of the demos have. So it would be great if MedPAC could look at some of those issues.

Thank you very much.

MR. HACKBARTH: Okay, we are adjourned until 9:00 a.m. tomorrow.

[Whereupon, at 5:52 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, March 9, 2007.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, March 9, 2007
9:00 a.m.

COMMISSIONERS PRESENT:

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

P R O C E E D I N G S

MR. HACKBARTH: Today we begin with a mandated report on the wage index reform. As I recall, this is due in June.

MR. GLASS: Glenn, if you like practice expense, you're going to love the wage index. It's another one of those technical factors that moves a lot of money around the system. In fact, a recent article was called the Wage Index Factor: Your Medicare Reimbursement Driver. In fact, it can change hospital base payments from $4,100 to $6800.

So it's not only of interest to providers, it's of interest to Congress. And as you said, the Congress has mandated that we report on the wage index by the end of June this year. What that means to us is we only have today's meeting and the April meeting to discuss possible recommendations.

If you choose to make recommendation, CMS has to take them into consideration as it prepares the FY 2009 proposed rule for the inpatient prospective payment system for hospitals and that should come out in April of 2008, which is about a year from now.

When CMS puts out that rule, it's supposed to consider that list of things you see up on the slide there, many of which we've discussed in the past and they're in the paper handed out to you before the meeting.

Today I'm going to briefly review the current method and its limitations. Jeff will then explain the new approach and its characteristics, and I will then compare the CMS Index to our new index and present some possible directions for recommendations.

Just briefly, the current approach uses data from hospital cost reports, uses wage and benefit data in particular. It then uses those data to calculate an average wage for the market area. The market area are metropolitan statistical areas, which are usually a central city and surrounding counties, and the statewide rural area, which is all counties in a state which are not in an MSA.

That area's average wage is then compared to a national average wage and that gives you the wage index. There's a separate adjustment along the way for occupational mix, and reclassifications and other exceptions to the wage index change the calculated index for about a third of the hospitals.

Some of the limitations in the current approach is data are from hospital cost reports, not all employee areas in the market. And that can be idiosyncratic to the hospitals that are reporting, particularly if there are very few hospitals in the market. We'll give some examples of how that works out later.

Also, the concept should be to estimate input prices to modified PPS payments. Instead, this using hospital data is conceptually a back door to cost reimbursement system. Hospitals that control costs get paid less. Those that increase costs get paid more by the wage index calculation. And that creates an incentive to report higher costs.

Another objection is that the market areas may be too large. The central county in an MSA may be a somewhat different labor market than the outlying counties and large changes in the index values between labor areas could be an indicator that the market area itself is too large.

The adjustment for the occupational mix is difficult to make. It was discussed for years and finally a court case forced them to adjust for so-called 100 percent occupational mix, but it requires a separate survey and the

somewhat elaborate methodology and not everyone is very satisfied with that.

If you look at the result, the resulting wage index is fairly volatile from year to year and it has many exceptions that have accreted over the years into the system. And they're probably all symptoms of underlying issues that people weren't happy with so they created an exception.

Let's take an example of what results from the current system. The state of Connecticut, this is the pre-reclassification hospital wage index. The state of Connecticut has four MSAs, and that green area up in the corner is in the state-wide rural area. The green area is the statewide rural area. Note it does not have the most wage index. The lowest wage index is that blue area in the middle, which is the Hartford MSA. The orange MSA over there, Bridgeport-Stamford-Norwalk, is the highest. You'll note that all of these are above one, which is rare. Most areas of the country are not above one.

You'll note the red colored there, the highest wage index bucket, isn't there yet.

This is just the pre-reclassification hospital

wage index. What did they actually end up with?

If we look at the wage index that hospitals actually received, it turns out that most hospitals in Connecticut are exceptions. Each dot here is a hospital and the color of the dot shows its actual post-reclassification wage index. Only five of the 32 hospitals stayed with their original wage index. The two rurals up in the corner, the two yellow in New London MSA, and there's one in New Haven that stays the same color. All the rest are reclassified. That is they get a wage index that is higher than their own area's wage index.

The 12 hospitals in the blue area are lifted up by the rural value and become green dots. This is the so-called rural floor provision. 15 get some other exception, including some getting reclassified to the New York City MSA, which accounts for the red dots over in the lower left-hand corner.

We should note that for budget neutral reclassifications, which are most of them, other hospitals have to pay. For a hospital here to go from 1.1 to 1.2, every other hospital in the nation has to go down a bit, including those where the wage index as well below one.

In this state, the exception is the rule, which is one of the reasons we think the new approach may be warranted.

In a somewhat related issue, if you're a SNF or another provider, you're probably paid under the pre-reclassification wage index. So if you're in that blue area you'd get that pre-reclassification wage index even the hospital next to you, or even possible the same hospital if you're a hospital-based provider, is getting a different wage index, a higher wage index. So people have raised that as something that they don't think is very fair.

Also, the data that these are coming from are somewhat limited. We looked at a number of MSAs. And a large MSA, such as the New York City MSA, average hospital wages vary from $27 to $57 but all these hospitals get the same wage index. It could be that the market is just too large and that we're really looking at different labor markets. Or it could be that there are large areas in the reported data or in the occupational mix adjustment. We really can't tell which.

In a medium MSA like York, Pennsylvania there are only three data points and there's not much confidence in

the mean value. If you look at a confidence interval, it goes from $19 to $30, which is about the range of data points that are reported. About half of the MSAs have three or fewer reporting hospitals.

In the York MSA one of the hospitals reclassifies out because it has a higher average wage. What that means is the two hospitals that are left have to compete with it for workers and they have a lower wage index than the one that reclassifies out. So the question is is that fair to the other two hospitals? And by the way, it once again rewards hospitals for reporting higher costs.

Finally in a one hospital MSA, there's really not any assurance that what gets reported is that the underlying labor costs. Or it could be very idiosyncratic to that particular hospital.

MR. HACKBARTH: How many one hospital MSAs are there?

MR. GLASS: We actually have that number.

DR. STENSLAND: 58 MSAs have one hospital. That's about 2 percent of the hospitals.

MR. GLASS: So if there's a new labor agreement or they start contracting out some workers, that number could

change very rapidly and without any change to the underlying labor cost.

Because of these limitations, the large number of exceptions, and other issues we've discussed in the past, we've explored whether there was a better way to determine wage indexes. And Jeff will now describe our new approach.

DR. STENSLAND: Before I start describing the approach, I want to thank BLS for assisting us with obtaining the data needed for these computations. They've been very helpful as we work our way through the difficult task of accurately reflecting an area's input prices.

The new approach has two key factors. First, the new wage index is designed to reflect input prices in the market, not necessarily each individual hospital's costs.

Second, the new methodology limits errors that can because caused by imperfect data. We know that both the current CMS cost report data and the BLS data are not perfect. The current CMS system gathers data on the average compensation paid at a hospital. This is simply total compensation over total hours. The BLS gathers more refined data. It gathers data on each occupation and each wage of each individual employee. The BLS unit of analysis is each

nurse, each LPN, et cetera.

In addition, the BLS collects data from all employers of health care-type workers, not just hospital employees. So the average RN salary reported by the BLS would be a blend of the salaries of individual RNs at the hospital, the SNF, and doctors practices. But having a larger sample of respondents in the survey, the BLS data will be less affected by one errant value.

One limitation in the BLS data is it only includes wages. It ignores benefits. To correct for that we obtained data on the ratio of wages to benefit from hospital cost reports. We then created a wage index that reflects the relative costs of total compensation, BLS less wages plus estimated benefits in each MSA and each statewide rural area.

A large MSA or statewide rural area may be too big to be considered a single labor market area. On the other hand, each county may be considered too small to be a self-contained labor market. Therefore, we created a blended wage index that is based at least 50 percent on MSA level data from the BLS with the remaining weight being county level data. The MSA level data comes from the BLS and the

county level data comes from the Census. Because we blend MSA level data with county level data, each county ends up having its own wage index under the new system. The wage indexes within an MSA or within a statewide rural area are all within 5 percent of the mean. We limit how much the county data can move the average wage.

We also acknowledge that the county borders are not the same thing as labor market borders. Hence, the data are imperfect. To prevent a hospital on one side of a county border from having a significantly lower wage index from its competitor across the border, we smooth the wage indexes. In the end, every hospital wage index is at least 90 percent of its highest neighbor's wage index.

Visually we can look at the impact of smoothing as follows: this is the pre-reclassification wage index for Minneapolis MSA in Minnesota, and the Rochester MSA in Minnesota, and the rural areas of Minnesota. Red represents the highest wage index, white is a medium wage index. If there's any blue-gray areas, that's the lowest wage index.

You'll notice that there's a sharp drop-off as you move outside that Minneapolis MSA and outside the Rochester MSA.

The new system will remove these county level cliffs, as we can see on the next slide.

Now we note that there's always a pink county between a high wage red counties and the low wage white counties. We also notice that the center of the Minneapolis MSA is paid a higher wage. From a practical standpoint what that means is it says the data is telling us that the center city hospitals have to pay their workers an extra $5 dollars, $10, $15 a day to compensate them in for the commute into the center of the city. That's a difference between this system and the other system, which ignores those commuting costs and assumes that the wage is the same throughout the MSA.

As I mentioned before, we smooth the wage index because we acknowledge the data are not perfect and we want to make sure that no hospital has a wage index that's significantly lower than its competitors.

Now let's look at how the system smooths differences across the borders of two rural states.

This is the CMS pre-reclassification wage index for the Dakotas. Having driven, on one of our site visits, from a hospital in South Dakota to Bismarck, North Dakota, I

found it odd that the wage index for rural North Dakota and for Bismarck were both more than 10 percent below the wage index for rural South Dakota.

It's important to note that the Bismarck wage index is determined by only two hospitals and the rural North Dakota wage index was determined with information from only seven PPS hospitals. The small sample of observations could affect how accurately the CMS wage indexes for the Dakotas reflect differences in underlying input costs. There could be some other factors also.

Now let's look at the new system. Under the proposed or alternative system, we see that the rural North Dakota and rural South Dakota now have very similar wage indexes. The cliff along the border is gone. In addition, we see that Bismarck's wage index has risen up almost to the level of Fargo. There's also a smoothing along the border between Minnesota and the Dakotas.

One benefit of the BLS data is it's based on a larger sample of employers. It includes not only PPS hospitals but also critical access hospitals, SNFs, doctors' offices. By having a larger sample of data we reduce the effect that low wages from one or two hospitals will have on

the wage index. The wage index is determined more by the conditions of the market and less by the behavior of individual hospitals.

One goal of the wage index is stability. We don't want a hospital's wage index bouncing up one year only to bounce down the next. Our primary results suggest that the BLS-based approach is more stable. This could be due to having a larger sample frame, all employers not just hospitals, and due to having the survey based on a blend of different surveys taken over a three-year period.

We will be investigating this issue further and we'll report more on the details of volatility at the next month's meeting.

One additional issue is which wage index will result in Medicare payments more closely matching Medicare costs? To test this we use a multivariate regression model. The result is that the CMS wage index fits costs slightly better than the new wage index. The model explains 84 percent of the variation in hospital costs using the CMS wage index and 82 percent using that new wage index.

This small difference should not be surprising. Under the current system hospitals that can afford to

increase their wages get paid a higher wage index and in some cases can even reclassify into higher wage index areas. Currently, high wage hospitals can often reclassify. Low wage hospitals in the same county or even the same city often cannot reclassify.

In contrast, under the new system, all hospitals in the same town would receive the same wage index and all hospitals in the same county would receive the same wage index.

Recall that CMS starts with the average wage paid by a hospital. CMS does not know the degree to which those wages are based on say technicians in the cath lab or to what extent those hourly wages are based on housekeeping salaries. To approximate and partially correct for this lack of detailed data, CMS uses a separate occupational mix survey to address that wage index for differences in the type of nurses employed by the hospital but the adjustment is only for nurse wages.

The new approach, using BLS data, does not need an occupational mix adjustment because it starts with more refined data. The BLS collects data on each individual employee. To compute the wage index we then weight the

relative wages of each type of employed by that occupation's share of overall hospital payrolls. Because we use a fixed national weight and occupation-specific wages there is no need for an occupational mix adjustment.

Currently the other PPS providers, such as SNFs, home health, they use the pre-reclassification version of the hospital wage index. They don't have their own wage indexes. Under the BLS/Census approach, we could readily tailor separate wage indexes for each sector. The sector's wage indexes would be computed using the same underlying BLS and Census data. The only difference would be how we weight the various occupations that make up the index. For example, SNFs would receive a higher weight on LPNs and a lower weight on RNs while hospitals would receive a higher weight on RNs and a lower weight on LPNs to reflect their mix of employees.

Over the next two weeks, we will be investigating whether there would be enough difference in the SNF, home health, and hospital wage index to justify these three different wage indexes.

Now David will discuss who would win and who would lose under the transition to a new wage index system.

MR. GLASS: The basic result of this is that more hospitals would gain than lose moving to the new wage index from the CMS hospital wage index. The CMS wage index we're using is the post-reclassification index not including the 508 adjustments that are not budget neutral and expire at the end of 2007.

You can see that about 860 hospitals gain from 1 to 5 percent while about 800 lose that much. Over 500 hospitals gain from 5 to 10 percent and slightly over 400 lose that amount. And finally, over 200 gain over 10 percent while under 200 lose.

Because a fair number of hospitals would see fairly major shifts in the index values, we might want to phase in this kind of change. Many of the hospitals that lose are those that have reclassified and the gainers are ones that could not reclassify.

Another way to look at the result is what does the resulting distribution look like? Here we're looking at the distribution where red is the CMS Index and yellow the BLS/Census index. You can see that the new approach has fewer hospitals in the lowest two bars and in the very highest bar. So it has fewer extreme wage index values.

More hospitals end up in the central part of the distribution and it smooths out, which makes it more analytically attractive -- to us, at least. Under both systems the average wage index is just below one, hospital weighted.

Even though we see these differences you have to remember that these indexes are still highly correlated. The correlation is over 90 percent.

In summary, the advantages of the new approaches: the data represents the entire market, as Jeff has said, it has a better chance of telling us what the underlying labor input costs really are. It's less volatile over time, automatically adjusts for occupational mix. There are smaller differences across borders, which should reduce the need for exceptions and hopefully reduce it to zero. It can be tailored to other types of providers and give them each their own wage index instead of using the pre-reclassification index. Less data burden on hospitals and less sensitive to imprecision in reported wages. The disadvantages explain slightly less of the variation in hospital costs, as Jeff said, and some phase-in period would probably be needed when transitioning.

Because the Congress asked for the report by the end of June, we've included two draft recommendation this month for your consideration. The first reads as follows the Congress should direct the Secretary to compute a hospital wage index that uses wage data from all employers and industry-specific occupational weights.

We want to make the point that it should be a broad survey of underlying wage levels rather than hospital specific, more of an input price and less of a cost reimbursement system, more appropriate for a prospective payment system to use, and the fixed weight specified to eliminate the occupational mix problem. This would get rid of reclassifications, simplify life and hopefully make things more predictable for the providers.

The rest of this should presumably be in the text rather than in the recommendation.

We've addressed this recommendation to the Congress because we think that a change in law is needed rather than CMS accomplishing this through regulation alone. The law now says that the Secretary should update the factor on the basis of a survey conducted by the Secretary of the wages and wage related costs of hospitals in the United

States. So it was pretty prescriptive.

Another approach could be just to make the language less prescriptive and leave it up to the Secretary how to do the wage index and then we can make our recommendation directly to the Secretary, saying do this sort of thing.

If you make any recommendation, CMS has to consider it when they're developing their proposed rule for FY 2009.

DR. MILLER: David, another thing to think about, particularly in this one, just before we go to the next recommendation which is a little bit more mechanical, is whether you would want to include a strong statement with the recommendation that to end the exceptions process. I mean, part of the objective here is through all of the new data methods and then the smoothing is to get rid of that process. So it's something that you should be thinking about when we discuss this recommendation.

MR. GLASS: Thank you, that's a good point.

The second one is really just we don't want to create any bad incentives so the recommendation is as a condition of participation in Medicare, the Secretary should

require that hospitals and other providers submitting cost reports participated in any BLS-sponsored wage survey when requested to by BLS.

Again, we just don't want to create an incentive for people not to answer the survey if they have low wages.

We'd be happy to answer any questions you have and look forward to your discussion of the recommendations.

MR. HACKBARTH: Can I just ask one question? This is very good work and it has a lot of appealing characteristics. It makes sense. The barriers here, I fear, are not analytic but rather political because of the redistribution of payments involved.

Just a question about the concept of calculating the index based on broader employment and not just employment by hospitals. That's very appealing to me. But I wonder in the case of RNs, in particular, whether the job is really quite different between being an RN in a medical practice or a skilled nursing facility or home health agency, as opposed to in an inner-city teaching hospital or public hospital, and whether that's really combining jobs that are quite different and appropriately paid for on different pay scales.

Is that something that you've thought about?

DR. STENSLAND: That is a limitation of this system and it's a limitation to the extent that the relative share of the nurses in each market differ. So for example, maybe the nurses in a physician office get paid a little less than the nurse in the hospital. But as long as there's that same proportion of physician office nurses and hospital nurses in each market it's okay, it will work out. But there would be a little distortion if, for example, you have a county and all the nurses work in physician offices and there's a lot of physicians offices and SNFs, for some reason, in that county and not hospital. But I think that's a fairly rare occurrences.

MR. HACKBARTH: Is there a way to test the validity of that assumption, that it sort of works out because the proportions are fairly constant? To me that's one job category that sort of leaps out where you might be blending things that are dissimilar.

DR. STENSLAND: We can work on that.

MR. HACKBARTH: We don't need to dwell on it right now.

DR. CROSSON: I had somewhat a similar question

and it has to do with the fact that the new system, which I agree seems very elegant, takes out the occupational mix adjustment.

So the question is, getting to winners and losers, is there a classification or type of hospital that we know has a much higher mix adjustment that would then end up generically being in the loser category? Or is the occupational mix adjustment sort of just a random phenomenon?

MR. GLASS: Actually, I think what some people have objected to with the occupational mix adjustment they're using is it that if you have, say you're in California and you have to have a certain ratio of nurses to patients, I guess. And they therefore employ more RNs and fewer LPNs, for example, than hospitals in other places. The occupational mix adjustment actually penalizes that hospital, the one they have in the current system. So California hospitals actually get taken down by the current occupational mix adjustment. Ours would not do that.

DR. CROSSON: I wasn't being a regionalist particularly in asking the question.

MR. GLASS: I just thought it might be of

interest.

DR. CROSSON: Actually it is, and thank you. It's helping me think about this issue more acutely.

I was wondering beyond that, beyond geography, want do we know about the occupational mix in various types of hospitals? For example, is there a different occupational mix in academic medical centers than in community hospitals?

MR. GLASS: There may well be. What the proposed system says is we don't need to worry about that because we're trying to understand what are the underlying labor costs, what are the labor input costs in each market? So we don't have to worry about that so much.

DR. STENSLAND: For example, we're taking a weighted average. So we're taking 43 percent of the RN wage in each market, plus 2 percent of pharmacist wage in each market, plus such and such. So the occupational mix we're holding constant across all the markets. So the only thing that moves it up and down is whether the RN wage varies up or down in the different market, whether the pharmacist wage varies up and down in the different markets.

Under the current system they say oh, you have a

wage of $35 an hour on average. That's partially because you have a lot more RNs and LPNs than is average. So we think it's not that the underlying wages are so much higher in your area. We think it's just that you have a lot of RNs. So we're going to adjust that $35 downward to account for that occupational mix.

MR. HACKBARTH: Me try to help here. I think I understand what Jay's coming from. He's sort of coming at it from the other direction. That in fact, we ought to be paying more to institutions that have more complicated high level mix of occupations. The way we want to do that is through the case-mix adjustment, as opposed to through the wage index. We want the wage index to be neutral on occupational mix. And then if an institution has a lot of complicated cases, that number is multiplied, if you will, by the case-mix adjustment to increase payment.

Right now we have it double counted. We have an occupational mix factor in the wage index, which means that potentially we're distorting that.

I'll just stop there.

DR. KANE: [off mike] There are more experienced nurses in the ICU. If you have to attract more experienced

nurses that would --

DR. REISCHAUER: The case-mix, there are two elements to it. You might have to do more stuff and you might have to have a different mix of labor. I think you're catching half of it but not the other half.

DR. SCANLON: Why aren't you catching both parts, because you take out the wage portion before you calculate the case-mix adjustment?

DR. REISCHAUER: But if you do ---

DR. SCANLON: That's what you're supposed to do. That's what they do. They standardize costs and then they calculate that DRG weight. And so if you do that, you should be reflecting both a different mix of labor that's required for a particular case, as well as the stuff that goes with different cases.

MR. MULLER: [inaudible.]

DR. SCANLON: I don't understand the difference between the occupational adjustment in the current method and this one, because both of them are basically weighting by occupation. So to me they're equivalent. It's not that one is -- and California loses in both. Sorry, Jay.

DR. MILLER: That was the way I was going to try

and come at this. Under the current system you can get rewarded, or at least your wage index value will be higher just because you're employing a higher skill mix, even though the wages are not necessarily different from area to area. The recent requirement that they have to adjust for occupational mix is trying to take that phenomenon out.

The proposal that we have here, in a sense, already does that. It's not so much that it's -- it already accomplishes what the survey and what the changes that they're required now to make in the wage index is supposed to accomplish.

MR. GLASS: It is actually a good thing, if you start with the current system, to try to occupationally mix adjust it. That would be a good thing to do. What we're saying is that it's a very difficult thing to do and the charm of this approach is that you avoid that whole question by starting with a fixed weighting across the nation.

DR. STENSLAND: The same thing with the ICU days. In theory, as Glenn was saying, if somebody has the kind of -- maybe they're on a ventilator and they have that kind of DRG, then that DRG weight should reflect the fact that they have more ICU days.

[Simultaneous discussion.]

DR. KANE: I know there's a differential for working -- there's a differential. You have to pay a nurse a higher amount to work in a highly critical care environment than you do to work in a nursing home. So the RN wage is differential based on where they work. And I think it might also reflect their level of experience of the RN. So when you're doing the wage survey, are there differentials for the nurse's wage based on the site of care?

DR. STENSLAND: It's not for the nurse's wage, but that should be reflected in the costs of the ICU and then reflected in the cost-to-charge ratio of ICU, and then reflected in the weight for the DRG.

MR. MULLER: That weight is calculated nationally; right? It's not a hospital-specific weight.

So with our recommendations and CMS's implementation of it, we do have the cost-to-charge weighting of the DRG. But it's not as if the California hospital gets their weight different than a New York hospital. That calculates a hence national weight for cancer or heart disease and so forth; right?

MR. HACKBARTH: And you wouldn't want a hospital-specific weight.

MR. MULLER: I understand that. I'm just making the point that the weighting does not capture the kind of occupational mix dialogue we're having here.

Now we may decide we're indifferent to occupational mix, but I'm just trying to tease out whether, in fact, the argument both in the paper and the way you stated it, that the case-mix index captures the differences by having let's say either more RNs because California and some states require staffing ratios. Or the common one is by and large cancer nurses have to be paid more than OB nurses because it's harder work, et cetera, and so forth. Does it capture that or not?

MR. HACKBARTH: The weights are national and so it doesn't reflect the difference in California's regulatory requirements that might affect the cost structure in California versus another state for the same patient. No question about that.

MS. THOMAS: There's also the IME adjustment which, to the extent some of these hospitals have higher cost structures to reflect, more complicated stuff they do,

we're capturing that and more in the adjustment. It's not perfect. These are not always teaching hospitals, but many of them are.

MR. HACKBARTH: So it doesn't capture state-by-state variation in regulatory requirements or institution by institution differences. But I'd argue that you wouldn't want a system that would do that. And so you want a wage index that is neutral to occupational mix, as opposed to going through the current process of trying to take it out once it's in. This is a more elegant approach that avoids it at the front end and you adjust for differences in the intensity of resources required for different types of cases through the case-mix adjustment, not through the wage index system.

MS. BEHROOZI: Just on this point, but also in terms of leading into the question. First of all, thanks. This explained a lot of stuff that I think I wasn't the only one who had a little trouble with a while ago.

But in terms of all of these individual questions that people are asking about what the impact is of any one of the pieces, what I had wanted to ask was is there a way to create a profile of the winners and losers by the nature

of the institution they are? We're sort presuming this could have an impact on teaching hospitals or this can have an impact on community hospitals or hospitals in a certain geographic area or state. Can you sort of plot that out?

I realize that there are more winners than losers, but can we get what the characteristics are of the winners and the losers?

DR. STENSLAND: There's no exact pools. We can say in general the places that tend to win under this were places that weren't benefitting under reclass and maybe had a fairly low wage index, they tend to be winners here. People that benefitted a lot under reclass, maybe you were say on the border of an MSA, you were just outside of there, and then you were able to reclass into this MSA, and you didn't just get the wages for around this part, you got the same wages as the people in the center of the MSA. So sometimes you got a big bump-up, 15 percent or more through your reclass. They tend to lose under this scenario.

MS. BEHROOZI: Right. It sounds like the ones who figured out how to play the game better under the old roles won't be as favored under the new rules, just by what you've described now. But I think if we could go down, drill down

a level in terms of the characteristics.

Let me just ask a question that I don't know if it was answered somewhere already. Is physician employment counted in the occupational data?

DR. STENSLAND: No. And that's, I think, one advantage. In the current system, physicians can be counted in the wage index to the extent of their time that is not involved in teaching or patient care. But they're supposed to set up a contract with the physician and say how much of your time is, just in general, hospital administration? How much is in teaching? How much is in patient care? I think that's often been a hassle and a problem in terms of accuracy of the data.

MS. BEHROOZI: That also could go to some of those characteristics of institutions. Poorer community hospitals tend to employ physicians more than teaching hospitals or whatever, I think. That's my impression. So if that's not a factor, then that wouldn't have a disproportionate effect on poorer community hospitals. But I think that's the kind of characteristics that maybe people are concerned about, whether there's a certain type of hospital that's impacted more.

DR. STENSLAND: I think there's a lot of hospitals that don't reported any physician wages on the current cost report system. Because again if the doctor is maybe employed by the hospital but they're spending all their time on patient care or patient care and teaching, then they're not supposed to include any of those wages in the current wage index anyways.

So doctors are pretty much almost out of both the wage index. 90 percent of the hospitals report less than 1 percent of their salaries going to physicians. I think most present zero because their doctors aren't in administration, they're just patient care or teaching.

MR. GLASS: I think we can prepare a kind of impact chart, urban and rural and how many go up and how many go down sort of thing.

DR. STENSLAND: The suburbs will generally lose. Just because I talked about the commuting affect, the current system doesn't account for any commuting costs. So Manhattan gets paid the same as New Jersey suburbs. In this system, New Jersey suburbs would get paid less than Manhattan because the data indicates to us that the hospitals are having to pay a little more to get people to

commute into Manhattan than to stay in Jersey and work.

MS. BEHROOZI: Also, thank you very much for including the benefit data, which I had raised in an earlier meeting, because that's such an important component, particularly in some MSAs or counties or whatever, relative to others.

I had a question about whether that needed to be specifically noted in the recommendation with respect to the legislation that we'd be recommending, because it doesn't appear there specifically. Since it would come from a different source, the hospital cost data, I think it probably ought to be noted in particular that, in addition to the BLS data and the Census wage data, that the cost report data on benefits ought to be in there.

I don't know how hard this is to do and I don't mean to torture you with this, but again just going to al the different question that people have about impacts of things, even starting with Glenn's question about how much using BLS data ignores the differences in different settings, RNs in hospitals versus other settings. I wondered if you could --

MR. GLASS: I don't think you want to say it

ignores the differences. It simply averages the wages from all the different --

MS. BEHROOZI: Smooths the difference.

Whether you could break out the impact of each of the different facets of the analysis because there are different ways of achieving the same goals in terms of, for example minimizing volatility. BLS data is collected over a longer period time. You could look at hospital cost data over a longer period of time. You could do a rolling three-year average or that kind of thing.

So if there's a way to break out each of the steps that you take essentially, to see what the impact is, to see again if that has a specific impact that we might want to consider, if it raises issues that we might want to address.

MR. GLASS: We can try.

DR. STENSLAND: Maybe if you have any specific ones maybe you could communicate with us or Mark, just because there's kind of an endless number of permutations we could do in this. And so we'll try to focus on some of the few ones that people are most concerned about.

DR. SCANLON: I think we're dealing with a very

important problem with the PPS design. The labor market definitions were, in essence, too crude. And you've really made significant progress there in terms of improving things.

I guess I'm concerned because -- and some of our earlier discussion illustrates this -- the reclassification history is a tortured one, to say the least. We didn't get to all the reclassification options in one fell swoop. We got there through a series of a plaintive cries of we're different and we need to be treated differently.

Probably the most memorable hearing I ever attended was where the first panel of witnesses was 17 members of Congress explaining why their hospitals needed to be treated differently. So I think we need to be concerned about that we're different aspect again, because we can have a rational system, and this certainly improves greatly on the old system, but we're going to hear -- as we've heard today -- isn't this different? Isn't that different? That kind of thing.

A concern I have is moving completely to the BLS data and giving the hospital's information a much smaller role here. I'm wondering if -- I guess I might prefer using

your methods of calculation but actually collecting the data from hospitals. If the BLS survey is simple enough for employers to fill out for free who are being paid nothing by the federal government, isn't it something that hospitals could provide you comparable information as a condition of Medicare participation? Since they're actually being rewarded for their Medicare participation?

That still leaves us with the problem of the small number of hospitals in certain areas, and I think we need to think of a way to deal with that.

In terms of some of the other problems, the volatility, the BLS data is dealing with volatility both by the large sample and by smoothing over several years. We could think about something like that for hospitals, as well.

It would remove one of the arguments about how we are different because I think we could anticipate not too far down the road was wait a minute, these are data for all employers, hospitals are different, we're particularly different in our community. Those things, unfortunately, resonate and we do get reclassification options built into law that change things.

Again, if this survey is simple enough, it's not beyond the pale to say SNFs and home health agencies should also fill it out so that we could have data that are specific to them as well to make the adjustments in the index for their area. That seems appropriate.

DR. MILLER: Can I ask one thing? Isn't that what goes on in the BLS data? They go out and they survey the hospital, home health agencies, and ask them what their paying their labor. It's just not every --

DR. KANE: What's the response rate?

DR. MILLER: Under recommendation two, they would.

MR. GLASS: It was over 70-some, 76 percent, or something.

DR. MILLER: Bill, I'm trying to get to the implications of your question. I may have missed it but I thought you were saying shouldn't we ask the hospitals to fill out the BLS --

DR. SCANLON: The difference, as I understand it from the paper, in the BLS what we're talking about is a sample of employers. So we don't have the universe of hospitals, we wouldn't have the universe of home health agencies or SNFs. And on top of it, it's voluntary, you

don't have to fill it out. I don't know what the selection bias is, if there is any, but there may be some.

You raised in the paper the issue that the IG has looked at the data that is being supplied by hospitals currently to CMS and fond some deficiencies. I guess I would hypothesize that if you look at the BLS data with the same type of audit approach, you would find problems that were as significant if not greater because there's more of an obligation with Medicare. The whole concern about when you send something into CMS, are you liable in any way for providing false information?

Given all of these things, I'm thinking that if CMS is sponsoring the data collection, we may have better compliance both in terms of participation as well as the quality of the data.

We don't have the physician office, necessarily, or other employers of nurses or other types of personnel to match in here. But again, I think that actually could end up being a handicap as much as an asset in terms of the arguments down the road of why we need to do something different. That's what's worrying me, since we've had this history of making all these exceptions.

DR. HOLTZ-EAKIN: I have lots of comments but I think that's exactly the wrong thing to do. Point number one is that the BLS data are, in fact, very high-quality data. They're not perfect but these are the data that are underneath things like the Consumer Price Index. The Jobs Report came out today that's going to have average hourly earnings. This is what these data are. They are vetted for their quality on a regular basis. I don't think we should be suspect about that. Like all data, they could be better.

The second is that the goal is to isolate that part of the cost of doing business that comes with a piece of geography. Like my life is harder because I'm in here.

And so you want to take and find all the employers in a labor market because they're all participating in that piece of geography. You want all of the ages of workers. You want all their education and training. You want all of their occupations that experience and take out all of that stuff that you can and find out what's just left because you've got to drive into New York City. That's an expensive place to do business.

So you don't want to just do hospitals or SNFs or anybody. You want everything that you can. So I would

argue that this is a dramatic step in the right direction because it expands greatly the amount of information that comes into identifying the cost of doing business in a location.

It's not a reimbursement model. It's just trying to identify costs of doing business due to geography. This is much better at doing that than the predecessor. There's no question.

My question is twofold. Number one, could you go over why it has to be a statutory change again? To be blunt about the politics, we know that there are these winners and losers. The exceptions didn't come out of nowhere and the reclassifications didn't either. So if you put this thing back into the Congressional field, you're going to open it up to that. So why can't CMS simply say here's a better wage index.

MR. GLASS: Let me just read you this. This is from Section 1395(w)(w)(d)(3)(e) of the --

DR. HOLTZ-EAKIN: I read it but I forgot it.

MR. GLASS: Basically it says the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary and updated as

appropriate of the wages and wage related cost of subsection D hospitals in the United States.

And then not less than once every three years the Secretary, through such survey or otherwise, shall measure the earnings and paid hours of employment by occupational category and shall exclude data with respect to the wage and wage-related cost incurred in furnishing skilled nursing facility services.

So it's just really proscriptive.

DR. HOLTZ-EAKIN: It sounds like it to me.

My last question is is there a precedent outside of this group anywhere of requiring someone to participate in the BLS survey? There's a long history of making sure these surveys are of high enough quality but I'm unaware of anything like this anywhere else.

DR. STENSLAND: I think that that isn't, and the people we've talked to at the BLS aren't completely against it but they're not completely comfortable with it either. You can talk about whether you want is, but maybe before you actually vote we could get some specific statement from the BLS and their opinion of this.

DR. REISCHAUER: I'm with Doug on the first issue

about what's appropriate. Could you tell us just a little bit about the BLS versus the Census information? Where is the Census information from? Which survey are we talking about?

MR. GLASS: The Census information that we were using is from the decennial long form census.

DR. REISCHAUER: That's what I thought.

MR. GLASS: The American Community Survey is taking the place of the long form and so instead of being done every 10 years it's done continuously and would provide data, at least for large conglomerations, fairly regularly. In other words, I think if it's a large county we'd get numbers from the American Community Survey every year or two and the smaller counties would be less.

DR. REISCHAUER: And again, you're merging several years together to get -- but we have some areas more contemporaneous than others.

MR. GLASS: Right, under the American Community Survey process, yes. But all of it would be more current than once every 10 years.

DR. REISCHAUER: And the BLS? Is it continuous?

MR. GLASS: Every six months they do a survey of

200,000 establishments. And they put together three years of data or 1.2 million establishments.

DR. REISCHAUER: Thank you.

On Mitra's point, we always a show winners and losers, numbers of hospitals. And that can mean 50 beds or 600 beds. You really don't get much of a feel for what we're talking about here. It would be nice to see that chart weighted by beds or something, and you'd have more of a feel. The break that I'd like to see would be reclassified versus non-reclassified. Because if what we're doing is whacking most of the people who are hurt are the reclassifieds, I'd have less sympathy for whatever anguish they might express.

MR. GLASS: Because our wage index is budget neutral by design to the current wage index, if you weight it by discharges it will essentially be no effect over all. If you weight by discharges the effect overall will be zero because it's budget neutral to the current wage index.

DR. MILLER: What you're driving at is that, if I understand it, is that you may have people who are large winners or large losers. And you want to know not just the number of hospitals but the numbers of either beds,

admissions, dollars involved in it. And I think we can work to that.

MR. MULLER: The high number of reclassifications, especially you show this in the Connecticut example -- I don't know what the number is nationally, but it tells you there's a lot of incentive to reclass.

So I'm trying to differentiate in the recommendation here how much of the winners and losers of the redistribution comes from presumptively the reclassification process versus the smoothing process.

Right now I think one of the reasons people try to reclass obviously, if there's such a cliff between what you get on this side of the border and that side of the border, you try to figure out how to be part of that.

So the way I understood your Minnesota and Dakotas examples is we're going to have some smoothing in regions so that there's more than a flow of labor markets -- I don't know if that's the right phrase -- as opposed to kind of a cliff.

So how much of the change they we're proposing here comes from the ending of reclasses is versus the smoothing of labor markets? I have three or four questions

but can you give me a sense of that? Is it largely from the ending of the reclasses or more from the smoothing process?

DR. STENSLAND: I think it's probably larger from ending the reclasses. The smoothing only moves around half of 1 percent of the money because we get to the county level and then we just smooth a little bit. So there's some counties in California where it has a fair amount of effect because you have some high wages in the Bay Area and the neighboring counties have to get up to -- so there's not a cliff.

MR. MULLER: So the assumption is, in a sense, as Doug and others have said, if there's strong gains to be made from reclassing, human nature will demand reclassification. So you're assuming that by having more smoothing there's less incentive to reclass?

DR. STENSLAND: To think of it like in the D.C. area, right now if you're in rural Virginia, if you reclass, you reclass into the same thing as Washington D.C. Central. But under this new system, even if you recommended that reclasses end and then maybe if Congress didn't exactly follow the recommendation and there continued to be reclasses, I think it would be easier for them to argue that

the reclass shouldn't be to the D.C. MSA but it should be the county that's adjacent to you that has just a little bit higher wage index.

MR. MULLER: So it's also having a tighter specification of the labor market. For example, in the New York example you gave where hospitals paying $27 or $57 were in the same wage classification. So you're saying we would have that kind of gradation, like I think you said anybody in your Minneapolis example, where you wouldn't take the $27 hospital and the $57 hospital and put them into the same grouping.

DR. STENSLAND: They may be in the same grouping. Now that $27/$57 part of that could that the market area is wrong. But I think a lot of that could be just the reported wages are wrong or the occupational mix isn't getting everything straightened out. Because it adjusts for nurses but it doesn't adjust for your cath lab employees versus your housekeeping. It doesn't know what that is. So there's a lot of room for error in the CMS data.

MR. MULLER: So we just have smaller labor pools in this recommendation, which helps to add -- it allows for more gradation rather than having the kind of lumpiness of

the gradation.

MR. GLASS: Right, the county level would essentially smooth it out all by itself.

MR. MULLER: I assume that the -- are we assuming that the critical access and other hospitals are outside the system in that recommendation? Is there a cost-base?

MR. GLASS: Their wage data would be in the system because the BLS collects it.

MR. MULLER: The payment level --

MR. GLASS: Their payments are cost-based.

DR. STENSLAND: Except for we have a home health agency or a SNF. If they have a home health agency or a SNF, their home health and SNF payments would still be affected by changes in the wage index, because those are not cost-based.

MR. MULLER: Let's go back to the question that was raised by Mitra and Bill and others, which is how appropriately the DRG case weightings captured the differences. I always defer to our economists here to our right, in terms of labor theory about how to think about these things.

So what we're saying is we don't want to really

correct for occupational mix within this system. We want to do that within the DRG system. That's what we're saying; right?

But to go back to the question of whether it's the California nursing ratios or intensive care units have more nurses than OB units and so forth, we think that is adequately captured by the DRG case-mix system? The fat that there's a different occupational mix in different medical errors should be captured, we think, fairly well by the DRG system?

DR. STENSLAND: I think maybe CABG person in the ICU versus the uncomplicated pneumonia person in the regular bed, that will be captured in the DRG case weight. But I don't think the California effect is captured.

MR. MULLER: That one we know is not captured well, so let's use another example. Please go ahead.

DR. STENSLAND: I just think the California, if you require by law that they have higher number of RNs and they have a higher number of RNs say for that cancer patient with the same condition as the number of RNs in New York City for a cancer patient with that same condition, this wouldn't account for that. We wouldn't give California a

higher wage because the state legislature has decided to mandate higher staffing ratios.

MR. MULLER: In a sense, in that kind of example where it's a geographic requirement, in a sense all of the labor market in California are under the same requirement so there's not a differential advantage or a differential disadvantage.

MR. HACKBARTH: Before we leave that point, it does not address the California situation. And I would argue that you don't want to address the California situation. That if you go down the path of saying we are going to adjust the Medicare payment levels for regulatory policies, differences in regulatory policies in every state, you've got to do the minimum wage, you've got to do probably a very long list. You've gone from a national payment system to a state payment system or even maybe a substate payment system.

MR. MULLER: I understand, but the one I'm concerned about, and I think some of the other commissioners are concerned about, and I think we're answering that we capture it through the case-mix index, is in the hospital-based reporting if routinely around the country it is much

more difficult to attract nurses to cancer units because it's hard work, people burn out, et cetera, and so forth, compared to -- not that anything is easy but just for the sake of argument less difficult areas of the hospital, this does not capture that in that sense because it basically says a nurse is a nurse is a nurse. And the fact that you may have to pay 10 percent or 20 percent more for cancer.

MR. HACKBARTH: The current system doesn't address that either.

MR. MULLER: I thought it does by being hospital-based. So if the hospital reports, by having big cancer programs, routinely higher average wages am I wrong in saying therefore we would have --

DR. MILLER: Can I say this just a little bit differently? Let me try it this way. Jeff, just make sure that this is right.

This is one thing that the current system does without the occupational mix adjustment if you don't adjust. What it means is if Jeff and I are running two different hospitals and we are paying the same wages for any given employee and he chooses, for whatever reason, chooses a higher occupational mix, his wages go up and mine go down

even though, in this very stylized example, we're paying the same wage rates for each type of employee, he chose more of these employees, his wage goes up, nine goes down.

MR. HACKBARTH: Take it one step further in the hypothetical example. Assume they have the same case-mix, they're treating the same type of patients and they're paying the same wages per employee. The current system rewards the hospital that chooses the higher cost mix of labor.

Well, it doesn't quite do that. It gets factored into the overall calculation of the wage index. So it's not even that targeted. The current system is not getting the money to the right places.

MR. MULLER: Let me summarize where we are. We're saying that, hopefully, by having more smaller labor markets and more of a blend from the very high cost labor markets there would be less temptation to reclass. And even if there is, there isn't as big a drop from one to the next, not as much of a cliff between one labor market and the next. Therefore, that would also hopefully be an incentive to have fewer reclassifications.

Now I think most people are concerned, when you

see that kind of Connecticut map where the exception is the rule. You say to yourself what kind of system, in fact, is being conducted?

Is Connecticut an outlier in the sense that such a high proportion of hospitals reclass? Or is that the norm?

MR. GLASS: Over a third of the hospitals either reclass or have some other exception nationwide. So Connecticut is an extreme example.

MR. MULLER: Thank you.

MS. HANSEN: I think we've covered a number of them but I do want to -- in capturing the complexity of the roles that are played in different settings. But I'd like to kind of extend that a little further to describe whatever is available for both the skilled and home health agencies a little bit more.

And part of it is right now I think of the 2.9 million nurses, which is the largest health care workforce relative to this hospitals and health care, just over 60 percent right now are in acute settings. But with the other 40 percent are in other settings that are not as easily captured, especially in home care.

But I just wonder if we could kind of start

tracking that a little bit because I think there will be some shifting that's trending and planning to occur. And maybe a source of some of this might come from the American Nurses Association, just because this is such a large body of the wage factor for health care.

So I really would appreciate that.

Thank you.

DR. KANE: I think this is a huge improvement over the existing system, and I think the wage information should come from outside the industry itself or it is basically cost-based reimbursement. And that system wasn't perfect. It didn't recognize a lot of the things we have concerns about then. So we're just saying let's perfect the part of it that we can.

So I'm very supportive of the general trend towards using data external to the industry you're trying to set a wage index for to get the wage index going.

I guess my only question, sort of two. Does the BLS data let you see what the reported wage data is by the hospital sector versus the skilled nursing? Can it break it out by the type of employer? So that you see that it looks like the hospitals do have to pay, on average, a 10 percent

premium relative to the others that you could build that if you had to?

DR. STENSLAND: We can see that at the national level but we can't see it on an MSA by MSA level. They keep that confidential so that we can't figure exactly who is reporting what.

DR. KANE: But maybe that's one way to deal with the fact that the concern that maybe hospitals have to pay more because the work is more intense than the home health agency. If at the national level it's consistently 10 percent more or something that you just bump up the -- I don't know if that makes any difference or not.

MR. GLASS: If you do that nationwide --

DR. KANE: Then it comes out the same anyway. Right. I just figured that out. So you can't adjust it down at the MSA.

On the occupational mix, trying to get at it the same way. On the occupational mix, is there just one classification for nurses? Or are there multiple? Like critical care nurse.

DR. STENSLAND: It's just RNs, LPNs, nurses aides, and then there's some various technician categories. But it

doesn't get into the RN differences.

The stuff that Ralph was talking about other people have brought up as a DRG refinement issue. On top of the DRG refinement we did, they said maybe there should be some DRG refinement for nursing intensity of different DRGs, rather than just the same room and board rate across all of these different DRGs. So I think that problem might really belong in a different discussion, maybe in further DRG refinement.

DR. KANE: Overall I think it's a great advance over what is.

DR. SCANLON: On the recommendation, I think that it's important to incorporate the methodology change, as well as the data issue. Because the methodology change is a very important part of fixing what was a bad definition of labor markets.

MR. HACKBARTH: Any reaction to that?

DR. STENSLAND: We can do that. Just note that the counties -- the labor markets will be subdivided into counties or something of that nature.

MR. MULLER: [off mike] In some sense you want smoothing rather than the cliff.

MR. GLASS: It's there in the smaller print. I guess we can just elevate the size.

DR. SCANLON: In a recommendation we may not have a specific parameter like 10 percent, but the idea of smoothing is, I think, the important concept.

DR. MILLER: Just to be clear for all of you and anyone in the public, the 10 percent is -- there's no magic to that number. It's just sort of how much tolerance and room you want between two settings. We did this for purposes of an exercise to go through and show you how it works. But we're not saying that's the parameter.

MR. MULLER: Just in the Connecticut map, because we have it up there, we were showing 30 percent differences in terms of the existing definition, the existing state?

MR. GLASS: The highest being 1.3 and the lowest being 1.0, yes.

MR. MULLER: Which in part tells me there are kind of intrastate variations that are probably as great as the interregional variations. And therefore there will still be some temptation to go for exceptions based on local conditions. Maybe this smoothing will take care of it.

MR. GLASS: If you remember on this map, the state

problem tends to get blended away, also.

DR. REISCHAUER: North Dakota is in the United States but South Dakota is not?

MR. GLASS: But just barely.

DR. MILLER: That's one of the impacts of this. We forgot to mention that.

[Laughter.]

MS. DePARLE: That might help the Trust Fund, too.

On this smooth process and the questions that Ralph raised and others have raised about the counties around the higher counties, I do think one great advantage of the direction we're moving is it just seems fairer to have it be smoother and less of a cliff. And having faced many -- having been responsible for many of these exceptions up here, or faced them down, I met with so many members of Congress who really just had a hard time explaining to their constituents why it was fair, when they were so close.

So I think if it's smoother or a more gradual slope, it will be easier for them to withstand those complaints. That's a word that hasn't been used today, I think. But I do think it just strikes one as fairer.

MR. HACKBARTH: Any others? Bill, do you want to

correct my misstatement about who wins under the occupational mix thing?

DR. SCANLON: Because this is on an average basis, it's the low-cost hospital, the low-wage hospital that actually gains because it's the average that's used to do this.

Again, this is all a relative index. It's not absolute wages. So even if hospitals are paying more than others, it's a question of comparing one market to another that's the critical thing in terms of the payment system.

MR. HACKBARTH: So the reason I think it's worth closing with that, the ideal situation is to be a low cost hospital that is in with hospitals that have a high occupational mix before adjustment. And that's one of the reclassification incentives. If you can get into that area where --

MR. MULLER: Can we charge for that halo effect?

MR. HACKBARTH: Good work. Thank you very much.

Our next topic is interaction between Part B and Part D.

DR. SOKOLOVSKY: Good morning.

Medicare prescription drug benefit is administered

through pharmacy benefit managers and health plans in a manner similar to drug benefits available in the commercial market. Most outpatient drugs are provided through retail or mail order pharmacies.

When drugs are provided in settings or under conditions that do not fix this model, patients, physicians, plans, and pharmacies can all experience difficulties navigating the system. Today I'm going to report on one such situation, the situation of overlapping coverage of drugs under Part B and Part D.

Stakeholders have repeatedly told us that determining whether a given drug should be covered by one or the other part of the program has been a headache for them. Commissioners may want to consider some recommendations to resolve some of the issues caused by the issue of overlapped drug coverage.

When Medicare was implemented, the Congress designed Part B to resemble typical ambulatory medical benefits provided by private insurers at the time. Physicians provided most drugs covered under Part B in their offices as part of a medical service. The Congress gradually expanded the type of drugs eligible for Part B

coverage. For example, as some older chemotherapy drugs became available in oral form the Congress decided to cover oral chemotherapy and anti-emetic drugs that were exact replacements for covered infusible drugs under Part B. The Congress also extended coverage to some vaccines, immunosuppressive drugs used following a Medicare covered organ transplant, blood products, and drugs used with durable medical equipment. Retail and mail order pharmacies dispense some of these drugs but physicians continue to provide most Part B drugs.

With the addition of Part D, Medicare beneficiaries now have access to coverage for most outpatient drugs dispensed by pharmacies. In the course of research for our report to the Congress on the effect of Medicare payment changes for Part B drugs interviewees reported instances where overlap in drug coverage caused many problems for them.

To examine this issue, we've been working with NORC and Georgetown University researchers to interview representatives of drug plans, pharmacists, and beneficiary advocates. Since plans are not allowed by law to cover drugs under Part D that should be covered under Part B,

decisions about overlap drugs can delay beneficiary access and increase costs and administrative burdens for plans and pharmacies.

In this presentation I will talk about the conditions under which the same drug can be covered by both parts of the program and possible solutions to the problems.

Most drugs are clearly covered by one or the other program, but in some instances pharmacies find that additional information is needed to determine which programs should cover a particular drug. Let me give you just two examples.

First, drug coverage can depend upon patient diagnosis. As you all know, drugs can be used to treat many different conditions. For example, physicians use immunosuppressive drugs like prednisone and methotrexate to treat many conditions. If a physician prescribed them following a Medicare covered organ transplant, the drugs are covered under Part B. These same drugs are covered under Part D for all other indications.

The second example, drug coverage can depend upon when a patient had a particular medical procedure or treatment that required additional medication. This issue

is similar to the first one, but applies to drugs that are covered for the same indication. For example, most oral anti-emetics that are dispensed within 48 hours of a chemotherapy session are covered under Part B. After that time period, they would be covered under Part D by PDPs even though they're still being used to treat nausea caused by chemotherapy. I'd be happy to address any of the other issues or conditions under question.

As many as 6,000 individual drug products can be covered by either one of the programs, depending upon circumstances. By law again, PDPs cannot cover a drug under Part D if it should be covered under another part of the program.

In 2005, before the drug benefit was implemented, CMS advised plans to place drugs that might be covered under either program on a prior authorization list. This means that the plans have to gather additional information about why the drug is being prescribed or where the beneficiary lives before they can approve the drug. When this happens, the prescription just can't be dispensed immediately at the pharmacy. The pharmacy must contact the plan, frequently the physician must provide information to the plan, and the

beneficiary cannot get their medication until the prior authorization is resolved. This also results in increased costs for pharmacists, physicians, and the plans.

I should note that in a study we did in 2005 about how prior authorization works in commercial plans, many plan representatives told us that they were very careful about what drugs they put on a prior authorization list because sometimes the cost of staffing a call center to resolve prior authorizations could be more expensive than any money they might save by not dispensing drugs that didn't meet their requirements.

In 2006 CMS made some decisions that allowed plans to make quicker coverage determinations. The Agency said that plans could accept physician diagnosis codes on prescriptions as enough information to determine which program should cover a drug. They also decided that no drug that was dispensed at a pharmacy could be considered a physician administered drug. So if a prescription appeared at the pharmacy the plans could assume that such drugs would be covered under Part D.

In addition, many plans began to use information collected from an initial prescription to automate the

process for refills. For example, if a PDP learned that a patient was taking immunosuppressive drugs because they had a Medicare covered organ transplant, the plan would know that future prescriptions for immunosuppressants were covered under Part B. Plans also include codes in their information systems to track if a beneficiary is living in a long-term care facility.

However, problems remain. Pharmacists note that plan processes for determining whether a drug should be Part B or Part D are quite variable. Plans are most likely to ask physicians for diagnosis information but some plans also request information on the indications for a drug, they want a faxed statement from the physician, or proof of denial from Part B. Some plans allow pharmacists to ask physicians about their patient's diagnosis. Others require that physicians complete written authorization forms.

If a physician writes the needed information on the prescription, plans can provide immediate authorization. However, to date few physicians have begun to do this. Physicians that prescribe a high-volume of drugs that could be covered under one or the other program, for example rheumatologists, are most likely to include diagnosis on the

prescription but other doctors are much less likely to do it. In addition, some physicians are very reluctant to include diagnosis on a prescription because of their concerns about patient privacy.

Although the use of codes to determine whether the beneficiaries live in long-term care facilities has helped, stakeholders told us that the use and accuracy of codes to indicate that a patient lives in a facility vary considerably. However, let me come back again to the fact that the problem we heard most about was the situation where it's just not possible to tell at the pharmacy why an overlap drug is being prescribed.

This leads to the following draft recommendation: the Congress should direct CMS to identify certain overlap drugs and direct plans to always cover them under Part D. These identified drugs should be low-cost and covered under Part D most of the time.

As I said earlier, inexpensive drugs, like prednisone and methotrexate, are prescribed for many conditions. They are covered by Part B only for the one situation where they are used following a Medicare covered transplant. The cost of these drugs is well below $2 and it

is estimated that PDPs end up covering them more than 90 percent of the time. Plans, pharmacists, and physicians will spend much more money and use more time and resources meeting prior authorization requirements to determine why the drug is being prescribed than it would cost plans to cover the drugs routinely.

And if the drug is held up at the pharmacy while plans collect more information, beneficiaries can be delayed getting access to their drugs.

Some plans told us that they have directed pharmacies to override the prior authorization and just cover them routinely but they are also concerned about their liability under any future audit. Fundamentally, what we want with this draft recommendation would be for CMS to draft a regulation about which drugs should be covered under Part D using these criteria. In order for CMS to do this, Congress has to change the law to modify the sections that say that Part B can't ever cover a drug that might be covered under another part of the program.

Stakeholder groups for both plans and pharmacists support this solution to the problem.

This recommendation is based on a year's

experience with Part D which suggests that some drugs should always be covered under one program. Similarly, many experts agree that vaccines fit much better under Part B, since they are typically given by physicians and physicians have no direct relationship with PDPs. If you like, I could come back to you in April with a modification to this recommendation that would place all covered vaccines under Part B.

Another problem that we heard about is that claims are processed very differently under both programs. Pharmacists told us that claim adjudication under Part D is much simpler for them. Plan decisions are generally made instantly. Under Part B pharmacists must dispense the drug, submit a claim, and then wait to see if it will be covered. Carriers may take a couple of weeks to make a determination. If the claim is denied, the pharmacist must then submit the claim to the beneficiary's PDP, if they have one.

In addition, pharmacists report problems coordinating with both programs. A PDP may produce an online message as a denial of a claim while the carrier wants a written form, a paper denial, before they will process the claim under Part B. In all these cases, while

coverage under Part B or Part D is being determined, plans are not allowed, again under law, to approve transition drug supplies. That is, the plan can't pay for a small supply of the drug under Part D until a prior authorization is resolved. In some cases, beneficiaries may have to wait until coverage is decided before they can get their drugs.

Again, the law doesn't allow plans to approve transition supplies for overlap drugs while the prior authorization is ongoing. One beneficiary advocate pointed out to us that prior authorization processes are not bound by the same timetables that apply to appeals. So beneficiaries can wait some time before they get their drugs. We were told by many pharmacists that they are providing emergency supplies but sometimes they have to absorb the cost of coverage if coverage is denied and the beneficiary cannot pay out of pocket.

So draft recommendation two says that Congress should allow plans to cover a transitional supply of overlap drugs under Part D, with certain limitations, until a coverage determination is made. The limitations would be that the transition supply should be time-limited and it should not override the plan's formulary.

This recommendation would improve access for beneficiaries and reduce risks for pharmacists.

Pharmacy and PBM trade associations again both support this approach. Again the law would have to be amended in order for plans to be able to provide coverage for a drug that might be covered under Part B.

I wanted to bring to your attention one other issue, and that's brown-bagging. Although we were told by some physicians that they are sending patients to pharmacies to purchase drugs under Part D in order to administer them in the physician's office, which is something called brown-bagging, interviewees did not describe this as a widespread practice. Some specialty groups reported that their members were engaging in brown-bagging for a few drugs that they couldn't purchase at the Medicare payment rate. A number of pharmacists reported that they knew about the practice and had asked physicians who were doing it to order the drugs in advance because they were not medications that they routinely stocked. And also, they tried to arrange for patients to pick up the drugs on their way to the physician's office so that the drug wouldn't be improperly stored.

No plan representative that we spoke to reported brown-bagging as a problem, although plans may not have any way of knowing whether the patients are going to self-administer a drug or take it to their doctor's office.

While some physicians were experimenting with this practice, others raised several concerns. Doctors did not want to put the patient in charge of maintaining the proper storage requirements for a particular drug that had to be kept at a certain temperature or have other specific storage requirements. In addition, many pharmacists, as I said, don't regularly stocked these drugs and so waiting for them to get the drug could create problems with a patient's medical treatment schedule. Part D claims data, when it's available, could help us to understand more about how widespread this practice is.

Just to sum up, overlap drugs can delay beneficiary access to medication and increase costs and administrative burden for physicians, plans, and pharmacies. CMS and plans have taken actions to ease the problems but some issues remain. The most common problem, again, remains determining coverage for drugs that are used to treat multiple conditions.

So we would like Commission feedback on this topic, and also especially to discuss the draft recommendations.

DR. CASTELLANOS: Joan, I think that you dealt with a difficult problem very nicely.

I guess one of the concerns I have, I think it's just an omission on your part. You mentioned in the report that you interviewed health plans, pharmacists and beneficiaries. I don't see where you interviewed physicians. I think physicians are a very important part.

The second point is I'm not sure if you're aware but the AMA has established a group specifically looking at this.

And the third issue, you may want to contact CMS. There are two people in CMS that deal with this almost exclusively, a fellow named Bill Rogers, Dr. Rogers, who is head of PRIT. He's probably the most experienced person dealing with this.

This problem has been in existence now for about two years. Fortunately, most of the problems have been "worked out" as you would expect. I think you may want to look at getting some physician input and the AMA input and

CMS input.

DR. SOKOLOVSKY: I just want to say that, although for this particular project we didn't interviewed physicians, it was the interviews with physicians for the last report that brought up this problem.

DR. CASTELLANOS: Those are the last two reports.

DR. SOKOLOVSKY: They are the ones that brought it to our attention.

DR. CASTELLANOS: I fully recognize that, that you did a great job with those two previous reports. But I'm not sure if you asked physicians in the context of the problems they're having between these two programs.

DR. MILLER: Joan, you did do your consultation with CMS? I guess I want to reinforce, I think it was some of the problems raised by the physicians that brought this to the table. And then we're going through the rest of the actors in a process to try and isolate what each of their views are.

DR. CASTELLANOS: Mark, I'm not getting argumentative, but Bill Rogers is a personal friend of mine. And he's the one that's the key person on this in CMS. When I spoke to him this week, he said he hadn't been contacted.

DR. SOKOLOVSKY: That's true and I will certainly reach out to him. I had informal conversations with other people at CMS but not him.

MR. HACKBARTH: The other thing is that I thought what I heard you say is that the origin of this was actually physicians. And the other people that you've talked to in CMS and plan representatives and beneficiary representatives, this is an area where there's agreement.

DR. SOKOLOVSKY: Strangely enough.

MR. HACKBARTH: One of those happy occasions. I think that's worth underlining.

MR. BERTKO: Joan, just a couple of places where you may have be intending to add this but I'll mention it. There is a connection here just into the administrative mechanics of bids and formulary approval and everything. Number one, we've had several instances of changes being made after the bids are in. So the timing on this -- there might be some cost impact. I can see from your responses that you reported from plans the administrative savings might, in fact, offset some of these lower cost things. But it would be nice to know that.

I know the formulary approval process is really

important to us and to CMS. And again, having that done kind of in a normal fashion as opposed to late in the year would be pretty useful.

MS. HANSEN: Joan, this is really eye-opening to see the whole range of issues, so I really appreciate your doing the report. I have a question and then I have a comment.

The question was about the vaccines possibly going into Part B. Are we talking about all vaccines, including flu vaccines?

DR. SOKOLOVSKY: Medicare right now covers flu vaccine and a number of other preventive vaccines, but it doesn't cover other vaccines just for prevention and new vaccines coming along. So this would be a process of -- right now if it's just for prevention the previous process has been that the law actually has to change to get to be covered under Part B.

We could, and I have not had time to fully work this out, I was trying to get your reaction first, but there is an advisory group that advises CDC about preventive vaccines. And they divide not only the new vaccines as they come along, not just in general, but by age of the people

who should get it, by their risk group, by gender, by a bunch of other things. We could have a process where if a new preventive vaccine -- and the one that people are talking about is for shingles -- comes along and they believe it should be covered for the Medicare population, then it could be covered without needing a change in law for it to be covered.

MS. HANSEN: This is probably really a specific one just so that I can understand. Let's say a flu vaccine that right now is generic, let alone the shingles vaccine in the future. Many of these are given in supermarkets. So does this change effect that at all?

DR. SOKOLOVSKY: No, generally speaking, the entities that provide these vaccines at supermarkets or drugstores have a Medicare billing number and are able to and do bill through Part B.

MS. HANSEN: Thank you.

And then the comment that I have is this is just fascinating. I was just looking at a report from OECD and when we compare our administrative costs relative to all these other countries, ours is like 85 percent higher than others. And so when I hear all of this going on relative to

kind of the synchronization of B and D, it's so clear the issues that have to get done in order to make this happen.

But then I bring it back to the beneficiary and the impact on the beneficiary, in many cases waiting a little bit, some of these things are not as vital. But some of these cancer drugs. If this gets addressed in some of the recommendation, that's great.

But I just wonder if -- I don't know that this is almost too operational -- but to be able to ask in this effort that some kind of synchrony occur with much more real-time data. And this underscores the need for a health information infrastructure.

But this whole approval process type of thing, diagnosis/no diagnosis, is just such a painful process to hear about that is pretty straightforward despite the HIPAA issues of privacy. But to be able for a beneficiary to get a medication, whether it's an urgent for certain medications or a reasonable time for others, I just wonder if we can build in, either to the chapter in terms of the context or anything that would be appropriate -- and I'm not sure that is appropriate -- in the recommendation itself to just underscore that this affects quality and access ultimately

here.

I know, and it makes sense that the pharma and the plans are happier because there's greater synchrony. I really would like to make sure that the beneficiary impact looms large in the course of it, because the administrative structures are better. But how does that really affect the whole purpose of this ability to get medications?

Thank you.

DR. SCANLON: Certainly, it seems that central to all of this is the need to determine whether it's going to be B or D that's going to cover this, and the prior authorization processes are critical to that. And while I guess you could think of issues that apply to all plans, it sounded like from your presentation that there's also variability in terms of how well this is working.

I think from that perspective, concerns about prior authorization have extended beyond the drugs that might be covered under B, as well as D. The two different thoughts: one is how is CMS monitoring the prior authorization experience in terms of getting information? And then, even a further step would be to share that information so that people understand how well plans perform

in this area?

The second, you mentioned that there are no standards for prior authorization in terms of a timetable. The question would be whether or not there should be standards for prior authorization, that we should have some kind of an expectation that the process will be completed within a particular time frame.

I know that there's been some voluntary efforts in terms of trying to standardize this, and the question is whether there should be more direction from CMS in terms of trying to standardize this to make it easier for physicians and beneficiaries and pharmacists to be able to deal with it.

DR. CASTELLANOS: Just a point of information. Jennie, you asked about which vaccines are covered under Part B and D. Under Part B, the influenza, pneumonia and hepatitis B are covered. All other vaccines are under Part D.

DR. KANE: Following up a little on what Bill just said. On the database that the consumers use, the Medicare.gov, where you pick your drug plan, are there required elements or can there be required elements that

they have to fill out around how fast it takes them to do a prior authorization? In terms of informing the beneficiary at the time they make the choice of plan, can we make a recommendation that this kind of information has to be disclosed?

DR. SCANLON: I actually think that would be ideal, that there were standards of performance of plans that you shared this information, just as in Home Health all Compare or Nursing Home Compare, or Hospital Compare we have found measures to say this is how well this provider is performing. We would potentially want to do the same thing with Part D plans.

But right now it's just basically the description of the benefit, the formulary, et cetera.

DR. MILLER: Sounds like you have an interest in us trying to work something up like that for the next meeting.

DR. KANE: Say what we think should be on that website that the consumers use to choose the plan, beyond just the formulary. There should be more service attribute type information.

DR. SOKOLOVSKY: It will say on the formulary

whether a particular drug requires prior authorization. You do get that.

DR. KANE: But we don't know how fast the prior authorization takes. We don't know frustrating it is, how many forms. I think there needs to be some sort of beneficiary input or survey required that shows up on satisfaction with the administrative processes.

DR. REISCHAUER: I think that might be very complicated and not tell you very much because you're going to have an average with a distribution around it and it might differ geographically and everything else.

DR. KANE: Isn't that true of all consumer --

DR. REISCHAUER: I think setting a regulation about a maximum time is really a much better way to go.

DR. SCANLON: But I think we should be moving in the direction that Nancy is talking about, which is what are meaningful measures of plan performance that we can put on to the website to share with consumers.

DR. REISCHAUER: That's a bigger topic which we don't want to just add on to this.

MR. HACKBARTH: I agree with the direction as being potentially important. But what I would urge is that

we not just focus on one thing and say this ought to be included, that we step back and look at this more systematically. In particular, after we have some experience with the program and we've got a sense now, here are some really big items that we ought to set about to advise beneficiaries on.

MR. BERTKO: Glenn, let me only add at this point, J.D. Powers has surveyed PDPs in a number of states and some of this may already be available. So why redo it if it's out there?

MS. THOMAS: A couple of years ago we actually did a chapter that even included a table describing dimensions of performance measures for plans. We can certainly, in the chapter, reference that and bring it back to you guys to refresh your memories on what we said there.

MR. HACKBARTH: In fact, that's the framework that I was thinking of. And our hope is that over time we will start to get some data that would allow us to look at various dimensions of performance, as I recall. And then we could really think systematically about what sort of information you may want to provide.

DR. MILSTEIN: One of the reasons that American

administrative costs are as high as they are, not just for this program but for all programs, is because all these programs often engage in what I'll call the false economy of reducing information requirements associated with payment with the idea that that is somehow less of a burden. But the consequences of that are to generate more burden downstream.

I would hope that one of the things we might want to consider, though maybe not resolve today, is whether or not this is a moment in the evolution of the Medicare program where we might want to consider recommending a policy that no prescription is coverable under any program within Medicare unless it's paired with the diagnosis for which that prescription is written.

It requires more deliberation but I just think we're far past the time. There are disadvantages, but the disadvantages of not doing it, I think, are greater.

MR. HACKBARTH: Okay. Any other comments before we move on?

Thank you, Joan.

Our last session for this meeting is on Part D and long-term care pharmacies.

DR. SCHMIDT: We're also going to touch on a set of issues related to Part D that policymakers perhaps didn't anticipate as much when they were putting the drug benefit into law. Specifically, right now I'm talking about how Part D is affecting the way drugs are delivered to beneficiaries in long-term care settings.

Residents of long-term care facilities are typically frail. They often have multiple comorbidities, and often cognitive difficulties as well. Naturally an important policy goal is that the changes brought about by Part D not adversely affect their care.

Today I'm happy to have with us David Stevenson and Haiden Huskamp. Joe Newhouse is also part of this project team but is not able to be here today.

MedPAC contracted with them, the Harvard Medical School Department of Health Care Policy, to interview stakeholders to get their take on how Part D's introduction is affecting things.

I want to start out by laying out what we think are some key issues with respect to delivering drugs in the long-term care setting. We're going to go through more detailed slides and then come back to this later and I

wanted to give you a sense ahead of time of what we think are some key issues.

Nursing facilities are highly regulated and much of that regulation focuses on getting the right medications to the right patient in a timely manner. In part, because these are medically complex patients, resident of nursing facilities take many drugs. And as a result they're also at higher risk for adverse drug events. There are lots of adverse drug events in long-term care settings. But there are also some questions about the quality and appropriateness of drug use in nursing facilities that predate Part D. For example dosing levels for certain psychoactive medicines or questions about the management of patients on anticoagulants.

Within this context, as we move into Part D we need to monitor whether the new program is affecting the care of these patients.

CMS's marketing guidelines for Part D prohibit providers, including nursing facilities, from steering patients toward specific plans because of potentials for conflict of interest. For example, a nursing facility might find it more convenient to have every resident in one

particular specific Part D plan, but that might not necessarily be in the best interest of each of those patients. At the same time stakeholders are telling us that there's considerable administrative burden from having to interact with multiple Part D plans.

One interesting aspect of delivering Part D in a long-term care setting is that there are two sets of formularies and two sets of rebates involved, one for the Part D plan itself and one for long-term care pharmacies. Historically, long-term care pharmacies have used revenues from rebates to provides certain required services to nursing facilities without charging much more than the cost of the drug ingredients and dispensing. CMS is concerned that long-term care pharmacies -- they're concerned about them receiving these separate rebates from drug manufacturers and the Agency thinks this could raise Medicare program spending. We'll tell you why in a few slides.

If those rebates go away, it could have implications for both the long-term care pharmacy industry as well as other payers, potentially even Medicaid.

An overarching issue throughout all of this is

that some stakeholders believe that Part D's approach of using competing private plans isn't a good fit for the long-term care sector. CMS and some other stakeholders believe that Part D's approach can work and, in their view, past ways of doing business weren't necessarily the best.

I want to emphasize from the start that we are not talking about patients who have a SNF stay who are covered under Part A. We're talking about people who have a longer-term stay and often require personal care, custodial care, that sort of thing.

There are on the order of 2 million Medicare beneficiaries in long-term care facilities according to survey data. I'm not going to go over the stats that are in your mailing materials about their demographics other than to say these are medically complex patients oftentimes. They're fragile because they have multiple comorbidities.

There may be, as a result, less consensus among providers on how exactly to treat these patients. They're disproportionately among the oldest old. A few of them still have spouses alive. There's often high levels of difficulty with activities of daily living, obviously which is why there's a loss of independence. And there's often

high of cognitive impairment. Many of these individuals are very low income and, as a result, more than half of them are dually eligible for Medicaid. They also use a lot more prescription drugs than beneficiaries who live in the community, on the average six to 10 prescriptions per month compared to about two to four.

They also use some categories of medicines more frequently in this setting. Some of these are identified as being particularly high risk for adverse drug events related to medication errors. I'm thinking of things like antipsychotics, anticoagulants, diuretics and anti-epileptics.

There is a very different distribution system for nursing facility residents for the distribution of their drugs than for beneficiaries who fill scripts at retail and mail order pharmacies. The long-term care facilities can use retail pharmacies, but instead most of them use very specialized long-term care pharmacies. These long-term care pharmacies dispense to the nursing homes and then to residents in a very highly specific and regulated way. These regulations are a result of laws that were passed primarily in the late 1980s and early 1990s that came about

over concerns about medication errors, quality of care, and safety.

Long-term care pharmacies use their own formularies. They have to dispense in a different way from retail pharmacies because of state laws and regulations. For example, they have to repackage drugs into unit doses, these little blister packs. They often have to do compounding in preparation of IV drugs. They have to be available to deliver drugs 24 hours a day. They also have to provide the services of consultant pharmacists who keep electronic dispensing histories of each patient and conduct monthly drug regimen reviews that are required of nursing homes under conditions of participation for Medicaid.

Now we're going to walk through how this distribution system worked prior to Part D and then, in the following slide I'll show you how it's changed.

We're using an example of a dual eligible but keep in mind that there are other types of residents at nursing facilities who either had retiree drug coverage or paid out of pocket.

We start out in the same sort of manner as for the retail distribution system. Manufacturers and wholesalers

deliver drugs to pharmacies. But again, instead of retail pharmacies, most long-term care facilities use these long-term care pharmacies. Long-term care pharmacies dispense to nursing homes and then to residents.

The physicians who write prescriptions for nursing home residents can be either a facility's physician, such as its medical director, or doctors who are in the community. Nursing facility staff and the consulting pharmacist check to see if the drug is on the long-term care formulary and they shepherd the process with their prescriber for documenting medical necessity and so on. Under current regulations if a consultant pharmacist makes a recommendation for a therapeutic substitution, the attending physician has to consider that and respond to that.

Like PBMs long-term care pharmacies negotiate with manufacturers for rebates. If a long-term care pharmacy is able to move drug utilization of the nursing facility residents towards a manufacturer's specific drug, then the manufacturer typically pays a rebate. Given how care is delivered in nursing facilities and the role of these consulting pharmacists, long-term care pharmacies are likely to have a higher rate of formulary compliance than PBMs that

are operating in a more retail setting.

Prior to Part D, Medicaid paid nursing homes for the room, board, and personal care services of dually eligible residents plus a separate fee-for-service payment to the long-term care pharmacy. But the fees paid to the long-term care pharmacies largely were just for covering the drug ingredient and the dispensing services. Much of the costs of the other services, such as those for the consultant pharmacist, were thought to have been financed through the rebates from drug manufacturers.

As of January 1, 2006 Medicaid no longer was the primary payer for drug coverage for duals.

Now we have the world after Part D. Instead now Medicare is paying monthly payments to a private plan that provides Part D coverage to the beneficiary. Since we're talking about a dual eligible in this case, Medicare is also paying their monthly premium and cost sharing.

Just like with retail pharmacies, from this monthly payment that Medicare is making to the plan, the plan in turn must make a payment to the long-term care pharmacy for the prescriptions it fills, subject to the contract terms between them.

As we've talked about before, Part D plans use formularies to manage the drug benefit and to encourage their members to use certain brand-name drugs rather than others by putting them on preferred tiers. In return, the drug manufacturers typically pay a rebate.

So a situation that is unique to delivering drugs in the long-term care sector is that there are two different entities, both covering the same enrollee, that have separate formularies and are each receiving separate rebates from drug manufacturers, again the Part D plan and the long-term care pharmacy.

Remember that CMS auto-assigns duals, including those who are in long-term care settings, into plans that qualify. That is, they have premiums that are at or below certain regional premium thresholds that differ around the country. Each region has a dozen or more plans with premiums that are low enough to qualify for these auto-enrollees. So CMS is randomly assigning duals to them, no matter whether the plan's formulary covers the mix of drugs that resident is taking currently.

Other nursing facility residents who aren't duals decide whether or not they want to enroll. The end result

of that is that any given nursing facility has residents enrolled among several different plans.

CMS's marketing guidelines prohibit providers, including nursing facilities, doctors, and long-term care pharmacies, from steering to particular plans out of concern of conflicts of interest. However, nursing facilities must have to educate residents or their family members about the different plan choices available. Residents can switch plans up to once per month and there's no cost sharing for residents of nursing facilities after 30 days.

So now let's reflect the fact that there are lots of beneficiaries at each nursing facility, shown here in blue. Since there are many plan choices available to residents, each facility has residents scattered among different Part D plans. Medicare is making a monthly payment to each of those plans on behalf of those residents.

Meanwhile, most nursing facilities have kept a relationship with a single long-term care pharmacy to provide all the pharmacy services. CMS's network access requirements for long-term care have meant that all the major long-term care pharmacies have had to negotiate contracts to be within the networks of all Part D plans. So

this has allowed nursing facilities to continue using this approach of a single long-term care pharmacy.

Part D has radically changed the sources of financing for long-term care pharmacies, as you might imagine. Since a majority of nursing facility residents are duals, the long-term care pharmacies used to be able to look to a single state Medicaid program for the bulk of their financing. Now they have to negotiate with each of the Part D plans.

Each plan has its own formulary, its own requirements for prior authorization, its own processes for grievance and appeals, and its own set of rebates from drug manufacturers. The nursing facilities and long-term care pharmacies now have to help residents navigate different plans and formularies and coordinate documentation for prior authorizations.

Now David is going to provide more detail on what he and his team have found from interviewing many of the key stakeholders.

DR. STEVENSON: Thanks, Rachel.

To assess the impact of Part D on the nursing home and long-term care pharmacy sectors, we conducted 31

telephone interviews between November 2006 and January 2007. We interviewed a wide range of stakeholders including nursing homes, long-term care pharmacies, group purchasing organizations, Part D plans, clinicians, and others. We sampled systematically to maximize representation of Medicare beneficiaries, meaning simply that we interviewed the larger or tried to interview the larger nursing home chains, long-term care pharmacies, and Part D plans.

The key areas of focus that I'll talk about today are five: first, Part D enrollment and plan selection; second, dealing with multiple PDPs at the nursing home level; third, the clinical impact on nursing home residents; fourth, the financial and administrative impacts on nursing homes and long-term care pharmacies; and then finally, the competitive impact of Part D in the long-term care pharmacy sector.

As Rachel mentioned, duals are randomly assigned to plans with premiums at or below the regional benchmarks. Even though nursing home residents can switch PDPs at any time -- and that includes duals and non-duals -- there is some concern the prevalence of cognitive impairment in the nursing home setting could impede the consumer choice model,

could impede consumers' ability to choose among plans. Not all residents have access to family members or legal guardians who can help them navigate Part D plans and choose the one that's best for their needs.

Importantly, as Rachel also mentioned, nursing homes are prohibited from steering residents to particular plans.

In our stakeholder interviews, several nursing home providers with whom we spoke expressed a great deal of frustration at these limits, particularly on their ability to direct residents to a particular plan. Some nursing homes, however, it should be noted, do not want to assume this role. So there's a tension between directing residents based on what they may want to particular plans and then not taking on a potential conflict of interest.

The practice with respect to these marketing guidelines, importantly, varies across the nursing home providers. Some are much more cautious than others about overstepping CMS's guidelines. I should say there's also a little bit of confusion about interpreting those guidelines.

Data are not yet available to track plan switching at the facility level. Anecdotal accounts about the extent

to which this is happening seem to vary. The locus of enforcement of these non-steerage clauses seems like it will happen largely at the state survey agency level, although several chain providers mentioned the OIG, as well.

Dealing with multiple PDPs at the nursing home level. As discussed above, Part D introduced a lot more variation to the nursing home clinical and administrative environments. For duals, nursing homes now have to work across multiple PDPs, as opposed to just a single Medicaid program. And the six to 10 plans are fairly typical for a facility of 100 residents or so. Plans can differ, as Rachel said, in coverage, use of utilization management, and also administrative processes.

We heard about wide variation in how "friendly" PDPs were perceived to be to long-term care. This fell on several dimensions. Formulary characteristics, both coverage and utilization management processes. Ease of administrative processes, getting claims paid, for instance. And also accommodating long-term care specific needs such as emergency medicine supplies and also certain formulations of drugs such as solutions that nursing home residents use more often than other beneficiaries.

I'd like to note a particular role that nursing home physicians play in Part D prescribing, both in the initial prescribing and also in navigating the utilization management requirements across plans. They expressed a great deal of frustration with the administrative burden despite steps by CMS to make this easier. CMS, for instance, has instituted a standardized appeals and exemption form but some stakeholders indicated that this form was not always honored. Or if it was accepted, that the PDP-specific form was required in addition to it.

Typical practice characteristics of nursing home physicians, at least attending physicians, can make some of these Part D challenges more difficult. Many nursing home physicians practice offsite and work across several nursing homes, so dealing with prior authorization or step therapy requirements they might not have access to the resident's medical records at hand.

In terms of the clinical impact of Part D on nursing home residents, it's really difficult to assess without quantitative data on drug utilization and also other aspects of nursing home care and quality. With that said, stakeholders report within class utilization shifts but they

don't report a broader shift in total drug use. Advocates and long-term care providers also don't report more generally negative health outcomes that they think are attributable to Part D/

They did mention safeguards such as the protected classes under Part D, where all or substantially all drugs within a class have to be covered by PDP, and also nursing home requirements under the Nursing Home Reform Act or OBRA, where nursing homes are required to adhere to a clinical plan, regardless of an individual's ability to pay or have coverage for those clinical plans.

Although medication access generally seems sufficient among stakeholders, specific areas of concern were identified. These included Alzheimer's drugs, EPO drugs, selected antibiotics, and the antidepressant Lexapro, among others. For these and also for other drugs the clinical impact of this limited access depends on multiple factors including the prevalence of use, the availability of therapeutic equivalence, the efficacy of particular drugs in question. Importantly, some limits could be appropriate clinically, especially in the context of what Rachel talked about, concerns about overuse and utilization.

Financial and administrative impact on nursing homes and long-term care pharmacies. Part D changes the relationship between nursing homes and their long-term care pharmacies. Prior to Part D, timely delivery of drugs, clinical predictability, and compliance with regulatory standards were really cited as the most important things for nursing homes in their long-term care pharmacies' performance.

Part D introduces a new tension. It's a tension between nursing homes need for timely dispensing of drugs and long-term care pharmacies' assuring coverage for these drugs. Both parties have an incentive to minimize prescriptions for non-covered medications but neither wants to be on the hook financially.

As I mentioned before, per OBRA '87, nursing homes are the ones that are legally responsible for following care plans administrating and dispensing the drugs.

I should also note that there's variation in the timing and the extent to which long-term care pharmacies are pursuing payment of these non-covered drugs from nursing homes. Rejected claims that we'll talk about in the next few slides are a visible sign of this tension. There's

variation in these rejected claims across drugs and classes and also there's variation across PDPs.

So this slide uses data from one long-term care pharmacy from 2006. Just to orient you to the table, on the left-most column are the top 20 drugs in terms of rejected claims and in the top row are the reasons for the rejected claims. They're mostly self-explanatory, a drug not being covered, no history record on file which can include not only step therapy requirements but also certain diagnostic tests that must be performed before allowing coverage for a drug. Refill too soon, prior authorization requirements, and then also other administrative reasons.

The main point of this slide that I want you to take away from it is that there's variation across drugs and also drug classes in the reasons why drug claims can be rejected. For instance, the top row, Lexapro. It's in the protected class of antidepressants but plans can cover either Lexapro or Celexa. They don't necessarily have to cover both. So the main reason here that claims were rejected for Lexapro is that the NDC is not covered.

A little further down the table you'll see Aricept and Namenda, which are two Alzheimer's drugs. The main

reasons that those claims are being rejected is in prior authorization requirements. Similarly, below Namenda is Procrit, an EPO drug. And the main reason it's getting rejected is for prior authorization requirements. But again, the key point is that limited access can be because of different reasons. It might be because of drugs not covered. It might also be because prior authorization requirements aren't met.

This next slide uses data from the same long-term care pharmacy from 2006. to orient you again to the slide, the left column is 16 of the Part D plans this long-term care pharmacy works with. The right column is a plan rejection rate relative to the average plan's rejection rate. So for this one long-term care pharmacy, if you have a rate of one that means you're on par with the average in terms of the percent rejected claims versus the percent claims you have filled.

You can see, and my main point is, that this varies quite a lot of across the 16 PDPs on this slide, from 0.23 to 3.54.

If you assume a reject rate of around 4 percent, which is what we heard from some long-term care pharmacies,

the implication of that is that the rejection rate varies from around 1 percent to around 14 percent across PDPs.

Before talking about the impact of Part D on the competitiveness of the long-term care pharmacy sector, it's useful to have a slide that shows the share of nursing home beds by long-term care pharmacy firms. As you can see from the slide, Omnicare covers a large portion of the nursing home beds in this country, around 50 percent. PharMerica and Kindred cover the next largest shares at 13 percent and 6 percent respectively. Then smaller, local, regional and also retail pharmacies cover the remaining third of nursing home beds in the country. So it's a rather concentrated market.

The competitive impact of Part D on the long-term care pharmacy sectors really is still evolving. We heard little about market entry or exit thus far, although there is some consolidation in the sector. Importantly from the previous slide, PharMerica and Kindred are set to merge in the second quarter of this year, and we've heard about other consolidations within this sector, as well.

Group purchasing organizations and also long-term care pharmacy network organizations are playing an important

role in this field, in this sector, to help level the playing field. Group purchasing organizations have been around a while, but the long-term care pharmacy network organizations are more Part D specific and they negotiate on their members behalf collectively with Part D plans.

Also, we should note that economies of scale are still important. Despite the role that group purchasing organizations and these network associations can play, larger long-term care pharmacies still can have advantages in terms of warehousing and packaging. But then on the other hand, local relationships and services are important as well, and the smaller long-term care pharmacies might be better able to deliver some of those.

Continuing the competitive impact, information on the importance of rebates, past, present and future, was difficult to obtain in the interviews. The larger long-term care pharmacies have likely benefitted more from these rebates in the past. Prior to Part D, these rebate revenues reportedly subsidized services to nursing homes, for example consultant pharmacist services might be bundled in with other services at low or no cost to the nursing home.

In the context of Part D, CMS hasn't disallowed

these rebates but they have expressed strong reservations about them. They cite potential incentives for inappropriate prescribing, overutilization, and also higher Medicare costs.

The consensus among stakeholders was that long-term care pharmacy rebates continued in 2006 but would likely decline in future years. If they do decline, if this does indeed happen, it could lead to greater transparency of pricing and increased price competition if services are indeed unbundled. It could also help level the long-term care pharmacy playing field between the larger pharmacies and the smaller pharmacies. But it also could lead to higher prices for nursing homes.

Just to sum up some key findings from our work. Some nursing home providers expressed a desire for greater flexibility in directing residents to a smaller number of long-term care friendly plans. There's a tension here. Steering could help match residents to plans based on their needs or it could be driven by financial considerations that aren't necessarily in residents' best interest.

Second, Part D introduced greater clinical and administrative variation into the nursing home prescribing

environment. There's a tension now between utilization management strategies used by the PDPs and then the burden of these strategies on nursing home, clinical, and also pharmacy staff. As I noted above, there were some access challenges that stakeholders cited in particular drugs and classes.

Finally, although stakeholders do not report major problems for beneficiaries to date, the clinical impact really needs further study. Most people were speaking anecdotally. They weren't really based firmly in data.

There is a changed nature that Part D brings about between the nursing home and long-term care pharmacy relationship. There's a tension between the nursing homes' need to dispense drugs quickly and long-term care pharmacies assuring coverage for these drugs. There's also variation across this contracting in terms of how rejected claims are handled.

Finally, the competitive impact of Part D on the long-term care pharmacy sector is currently unclear, with the potential impact of changing rebate structures being particular important. There's a potential for increased cost being passed down to nursing homes.

DR. SCHMIDT: We wanted to finish up by returning to this slide of key issues. With this presentation, we wanted to talk through how pharmacy benefits are delivered in this long-term care setting and how Part D is changing things. But at this point, we're not bringing any recommendations to you to consider. We simply wanted to start a conversation about this topic and address any of your questions and get your feedback on it.

As you can see, it's a very complicated topic and the changes underway are going to have important implications for the beneficiaries who reside in long-term care settings, other stakeholders in the Medicare program, and potentially even other payers such as Medicaid.

In the future, as things evolve further, we may come back to you with potential recommendations based on your feedback but we see this as just the start of a longer-term conversation about this topic.

MR. HACKBARTH: Thank you. Well done.

Here's the question that leaps out at me. Could you go back to one of the initial slides where you went through the series that showed the layers of complexity that are added by this?

We've introduced new complexity into this situation and we've done that as a result of an effort to offer a choice to Medicare beneficiaries in their prescription drug coverage. There's often a trade-off to be made between choice and competition and administrative complexity. So here we've introduced complexity in the name of choice for a population, a significant percentage of whom are auto-assigned to plans and another increment are cognitively impaired.

I wonder whether the complexity/choice balance is being well struck here. I guess that's the basic question that leaps out at me.

DR. KANE: Isn't competition also supposed to lower costs? So besides choice, shouldn't that be another one of the questions?

MR. BERTKO: I was going to add just what you said, Nancy, in a different way. That's that one of the things that drives down costs is the competition for the auto-assigned members which, of course, cross much broader than just the nursing home folks.

The flip side of that, also, though is that nursing home folks, as Rachel mentioned, are very expensive.

The risk adjuster works pretty well. But the random assignment of these to plans bidding for these things actually helps smooth out the worries of how you bid and then to make sure that you don't either get the wrong kinds of incentives present.

MR. HACKBARTH: You can have competition of different types. You can also have wholesale competition through the long-term care pharmacies driving down drug prices as well. Individual patient choice, especially by cognitively impaired people, may not be the most efficient way to get price competition in the drug marketplace.

DR. SCHMIDT: Also though, some of these people do have legal guardians who can help in the decision making. I don't think that the entire nursing home community necessarily wants to play a part in narrowing down the choice. I think there was a variety of responses among them on that.

DR. MILSTEIN: In ancient times I used to be the medical director of a skilled nursing facility. And I think one of the points on the slide, I think, bears further emphasis. It's this notion of impact on better clinical management of people in these facilities. By and large, I

think it's a fair statement to say that most people in these facilities do not have great access to sophisticated thinking about how to optimize therapy as the course of their care changes or even in relation to unsatisfactory baselines that are unappreciated.

I think in weighing these two primary choices, I think it's very important to realize that it's a huge advantage both to the physicians who are writing these orders in the nursing homes and to the beneficiaries in the nursing homes, to have one clinical pharmacist who is on the beat and closely tied in with the pharmacy.

Once you begin to dilute that you not only get people from far away at a much greater disadvantage in deciding what might work best in waiving or not waiving based on prior authorization, but you also lose the access to a concentrated important sophisticated asset to both the doctors and the charge nurses in these facilities, which is a dedicated pharmacist who is trying to make this work.

I think the question that John and Nancy raised is an important for us to answer which is the question of can we come up with some kind of estimate of the incremental economic value of introducing all these additional spaghetti

lines in the equation. And then we can weigh that against the likely significant loss of clinical resources that occurs when you no longer have the concentrated force of a single pharmacist whose job it is to help a facility succeed in managing very, very difficult to treat patients.

DR. SCHMIDT: I just want to clarify that, as is shown in this slide, there's still a single long-term-care pharmacy involved in the situation. But yes, there's the complexity introduced by all of the plans and all of the prior auth, et cetera.

DR. MILLER: On this point, the thing that also jumps out at me, and we want to return to the beneficiary perspective immediately. But just to stay off it for a second, that long-term care pharmacy's separate incentives and separate relationship with the drug manufacturer, I mean there may be a great clinical advantage there. But then there's also this other kind of question in the middle of the nursing home.

MS. HANSEN: This is also, in terms of long time ago, I spent 25 years actually with this population and with many in the nursing home. So I just want to concur on the beneficiary side of what Arnie brought up. I think one of

the things that, relative to the newness of this and the clinical relationship, is two things with the new system. One is the loss of the consultancy possibilities at this point if the rebates are going to be in question, because the complexity of meds and those kinds of things are really important to have that kind of consultancy.

The second point that I have some concern about is perhaps some greater detail at some point of the impact to the administrative complexity or kind of the operational aspect of the drug delivery mechanisms. I think it goes without saying it's tough enough already to get people to want to work in long-term care facilities. Turnover rates already are about 100 percent a year. This is something that if you add greater burden, which is one of the commentary I heard you make to this, the whole issue of quality of care and this population -- I think a colleague of mine has said there's nothing so unequal as equal treatment of unequal people. The ability to have people, two-thirds of whom are cognitively impaired, and even if they have patient representatives it's not an easy area to deal with.

So I just want to proceed cautiously on the

different matrices of judgment, whether it's cost and competition in that aspect. I think at the end of it what happens to the ability to get the safe drugs in a cost competitive way with full transparency but with the kind of consultancy that is involved when people take, on average, whether it's six to 10, my experience is eight to 10 medications, on a daily basis.

So it is one of the things that I just want to drive back to, looking at the complexity of operationalizing this. And then also thinking about the importance of having competency advice by clinical pharmacists with oftentimes not just the medical director but the host of physicians that oftentimes consult with a given nursing home.

DR. CROSSON: Assuming that one way out of this which you implied a bit might be to provide, allow, nursing homes to play some role, some agency role, some responsibility, some coordinating role or the like, you noted that that idea received mixed support from the nursing homes.

So the question is among the ones who said gee, we don't think we really want to do this, is that an issue of administrative burden, concerns about liability, concerns

about accusations of conflict of interest?

And then the second part of that is could you imagine that some of those things could be managed or an environment created in which those concerns might be minimized?

DR. STEVENSON: In terms of the concerns we heard about from the providers who don't want to take on this role, it was really the last two that you mentioned, the concerns about liability. And also what they expressed is a belief that it was in potential conflict of interest for their facilities to advise residents.

Nursing homes often get, under Part D, information from their long-term care pharmacies about which Part D plan cover their residents' drugs better and worse than others. So the nursing homes have a sense of that. But as I said, from some nursing homes, they don't want to take on this added role.

In terms of whether things can be put into place to mitigate those concerns, I'm not quite so sure. I would leave that to others to chime in.

I just want to add a couple of things based on the previous discussion, as well. That is in terms of the role

of the consultant pharmacist, I think it's important also to remember the consultant pharmacist typically works for the long-term care pharmacy. Some of the stakeholders with whom we spoke expressed some concern about this and talked about the previous pre-Part D system didn't necessarily work as well for beneficiaries as it could, especially citing overutilization as one of the potential outcomes of that. So I just wanted to raise that, as well.

MR. HACKBARTH: Could I just ask a follow-up question on that? I understand the potential difficulty and risk involved in a nursing home advising or choosing on behalf of a patient a private plan. But aren't many of the same issues involved in their selection of the long-term care pharmacy under the old system? Conflicts of interest, you're choosing them because you get a better rebate, as opposed to for clinical reasons.

It seems like in the role there's an inherent potential conflicts and risks and liability and it's just one versus another type.

DR. SCANLON: I agree with you. And on top of that we've got another chart we could draw for the Medicare Part A patient where the nursing home is supplying the drug

as part of the payment and has this relationship with the long-term care pharmacy that they've chosen.

DR. STEVENSON: The residents going into a nursing home for a Part A stay obviously don't have a choice of PDP. It's bundled into the nursing home rate.

MR. HACKBARTH: But they're making choices, which has important implications for patients.

DR. HOLTZ-EAKIN: I basically want to echo that and say that I come to this blessed with complete ignorance of how this all works. If you look at that chart you can tell a lot of stories.

I guess my question was is there, out there in the future, the prospect of better systemic data that would tell us something about cost savings of this versus the old system and appropriateness of dosing and prescription?

I want to thank you for the evidence you've brought. Is that really the best we're going to see?

DR. SCHMIDT: We're hopeful at some point in time we're able to look at the prescription drug event data from plans and identify people who are in a long-term care stay and take a look at some measures of appropriateness from the literature and try to get a sense on how actual use compares

with suggested use.

DR. REISCHAUER: But will we have any baseline data to compare it to? When David was talking about clinical impacts, I'm thinking what are we going to compare this to?

DR. HUSKAMP: For the dual eligibles, you could link the Medicaid data. For the non-duals, it's a problem. You wouldn't be able to compare but for the duals you could compare to the former system by linking the Medicare and Medicaid data. And then you could also add in data from the Minimum Data Set of quality of adverse drug events, other outcomes, and things like that to look at as well. But none of that data is available yet.

DR. MILSTEIN: Does anybody know whether in the legislative deliberations associated with MMA consideration was given to allowing the long-term care pharmacies to select a Part D insurance company partner and be able to essentially offer a limited Part D plan that would only apply to patients in facilities in which they offered long-term care pharmacy services?

DR. SCHMIDT: I don't know the exact answer to that question. I think that a lot of these concerns about

this particular setting were brought up at the last minute in the whole debate about the MMA. So I suspect not but I do not know that for sure.

DR. KANE: It would be helpful, I think, in talking about this to know what the policy options might be. I'm kind of lost because it's not clear that we can go back to the old system in any meaningful way. And we don't know if the old system was particularly better, although it's clearly administratively simpler, the old system.

But what do you see as the options? Because there is no perfect out there and this looks pretty administratively complex and has dubious impact on clinical quality. But what are the options? It's hard for us, not knowing the environment, to get a sense of the options.

DR. SCHMIDT: Again, we don't know the exact clinical outcomes and we weren't, we felt, quite prepared to come to you with recommendations or options. But just in thinking these things through, it could range from the status quo, living as things are with Part D, to kind of delivering this in an entirely different way where you have -- I think Joe has thought through some ideas for having some regionally-based contracts to particular providers to

provide to individuals living in a long-term care setting.

Or something in between might be doing things like beefing up quality reporting for this population while Part D continues or looking to the medication therapy management programs that Part D plans now have and seeing if there's some way to accommodate this population a little more fully in those.

MR. DURENBERGER: Nancy's mention of the policy options brings me probably more to a comment or an observation than anything else.

First, let me express my gratitude to the staff for introducing this, and you, Mr. Chairman, for introducing this issue. I've been here five years now trying to get dual eligibles and things like that on this agenda, as you know, and it's very hard to do. I think in the last couple of days, this in particular puts it in perspective, I think we've come to realize how important thinking about the policy of Medicare, Medicaid, a lot of other things is.

Like many people here, I have been a proxy for parents, in my case maybe 12 years. For some of you it may have been a longer period of time. And the "policy issue" that's difficult for me as I address the specifics, whether

it's the quality of care issues or service issues or this issue, or IT, comparative effectiveness, take all of the things we've been talking about. But bringing it to a population that has to have a proxy of some kind, whether it's by choice or it's by incapacity or disability, they have to have a proxy.

The question that's raised in so many ways by the research here is if you're a public policymaker and you're going to decide, try to decide, what's best for the beneficiary, where do you invest accountability for that?

It's easy to say family and things like that and I'm illustrating the difficulty of a family member. But Arnie's mention of his past experience leads me to observe that the persons in the system that we value the least but depend on the most are the medical directors, the physician's assistant, the same people we rely on for our aches and pains for our kids and ourselves and the rest of the system. But we've never valued these people.

I don't know why you're no longer a medical director in something else, but it's attribute to those who will stay --

MR. HACKBARTH: I've got an idea.

MR. DURENBERGER: For those who will stay in this field, given the fact that we have not, as a society, vested that particular part of the profession with the kind of accountability, responsibility and then rewards that we do in every other part of the medical profession.

And so as we go through this I'm hoping that we will also deal with that kind of proxy issue and try to focus Congressional thinking on the importance of elevating certain people -- particularly, I think, the professional side -- of focusing them on how do you best do the accountability not just for the dollars but for the beneficiary?

MR. HACKBARTH: Other questions or comments?

Thank you. That was thought-provoking.

We'll now have a brief public comment period and I'd ask you, as always, to identify yourself and please keep your comments brief. Thank you.

MS. LLOYD: Good afternoon, Danielle Lloyd with the American Hospital Association, getting back to the discussion earlier today on the wage index.

First of all, I wanted to commend the staff on the creation or development of a very complex wage index

proposal. We appreciate all their work on that.

The AHA has our own workgroup that we've convened of state, regional and metropolitan association executives that's also been looking at this issue. We did send you a letter last week that detailed some of the questions really. It was mostly questions that the group wanted to bring to your attention about the proposal. But let me make a couple of quick comments related to that.

Firstly, three of the big issues, or if we rank the issues among this workgroup that are most important, three of the top ones are the volatility issues, the unrealistic labor market definitions, and then also the cliffs when neighbors have very different wage indices.

The group is very intrigued by a couple of aspects of the proposal in particular. The idea of a three-year rolling average for the data, county by county variation within the MSAs and then also for the rest of the state, and then also this smoothing idea.

But one thing we thought would be helpful is if the Commission could look into these three ideas on the existing CMS data as opposed to on the BLS data for a couple of reasons. First of all, as outlined in the letter, this

group and the AHA has some major concerns and reservations about the BLS data. I won't go into those because I think we gave 10 examples in the letter that you all, I'm sure, don't want to hear.

The other thing is that, as was pointed out by the staff, these three things could potentially be done by CMS without changes to legislation, unlike the data source because the use of BLS itself would need a change to legislation. So these are things that might be able to move forward without that change.

A couple of other things is we were very happy to see that you guys are going to be looking into or running more data on volatility. We're very interested to see that. Hopefully you'll share that in April.

Also, as Mark Miller pointed out, the 10 percent number on the smoothing, as an example, we don't know if that's a magic number or that's the right number. There are some areas of the proposal that it might be helpful if you guys did some sort of analyses on that 10 percent, for instance, also maybe on the 5 percent difference from the mean on the county by county variation to see can you get a sense of what might be the right number for these types of

proposals. That would be helpful.

The last thing I want to just say is we're very appreciative that you all have put some more effort into the benefits issue that Mitra brought up last year, since then, and have worked on that adjustment. It would be helpful for us to have a little bit more detail on exactly that was developed and a little bit more specifics on that adjustment because it was really sort of just set out there as a new adjustment for benefits. So at least for the public audience. So that will be helpful.

Thanks very much.

MR. BAKER: My name is Dale Baker and my company is Baker Health Care consulting out of Indianapolis. I work with hospitals on Medicare geographic reclassification matters, and I work with hospitals and hospital associations on wage index matters. I'm going to give you kind of a view from the trenches on some of the issues that I think might require just a little bit further refinement on some of the premises that have been made.

First of all, how accurate is the data that hospitals are turning in today? I would to you it's very accurate. There's a 100 percent audit rate by the fiscal

intermediaries and the hospitals have a period of time when they "scrub" the data. Let me tell you, they take it very seriously.

Here's our book that we use with hospital associations and we update every year in terms of showing them what they need to do and all the regulations going back to 1994 so that they can get their data right. The vast majority of hospitals in the industry are doing what I would consider to be a very good job of scrubbing the data, and then it gets audited subsequently by the fiscal intermediaries. At the time it's prepared, it can be pretty crude.

That gets back to one of the premises that the OIG came up with, and that is that there's a whole lot of errors that are embedded in this data. I think the use of the OIG reports have to be put into a little bit different context. OIG had a structural problem. They started this in February of 2005, their audits of the 14 hospitals. They found out from CMS that they had two weeks to complete the audits to give them the data if they were going to use the data in the 2006 cycle.

They immediately concluded they could not do that.

So instead of using the data that had been scrubbed and audited, they studied the data from the raw cost reports. And so they made their adjustments from the raw cost reporting data that had not yet been scrubbed by the hospitals in the normal process that CMS has put out.

At the time, with the Massachusetts Hospital Association, I met with the lead OIG person in the Boston office and we asked them if they would segregate their findings between the adjustments that would be made in the normal scrubbing process by the hospitals and the intermediaries from their true audit findings. And at the time they told us they would do that, but in the final reports they did not.

So when you look at the results of that OIG audit, there's nothing wrong with what OIG did. It's just the use of that data, if you don't understand that you can get a misleading result.

The other thing that OIG did is they challenged CMS on the policy of how they record pension and post-retirement benefits. They actually wrote CMS a letter saying that these should be funded, not recognized under generally accepted accounting principles. Some of the

biggest adjustments that they put in their report are related to this change in interpretation, which the hospitals had no clue of and were actually using in accordance with generally accepted accounting principles.

So the OIG report, I think, is not a very good indicator of the accuracy of the data. I would tell you that when the scrubbing process is through, this data is very good, very, very good.

Secondly, an issue is do the hospitals manipulate the data? Some of the questions is well what about a single hospital MSA? Are they manipulating data? I would tell you, in my judgment, no. I get the phone calls from CEOs all the time saying wait a minute, if I give my employees an increase won't that give me a better wage index and won't that allow me to be reclassified? And the answer is yes, but there's a four-year lag between the time you change your data and when it would be reflected in your wage index.

If you’re talking about geographic classification, you're using three year's data so it can take you up to seven years before any kind of adjustment you might make in your data is going to help you in a geographic reclassification process. So I would tell you that

manipulation of data in today's system is really not an issue, even in single hospital MSAs.

Another statistic that I'd like to just clarify is only about -- it's 20.7 percent of the hospitals in the country are geographically reclassifed, 14.4 percent of the urban hospitals and 40.1 percent of the rural hospitals. The number that has been tossed around is one-third. The different from that is the out-migration adjustment, which was brought in I believe a couple of years ago in the Medicare Prescription Drug Bill and it affects about 600 hospitals. It does exactly what you're talking about, it smooths, it's a smoothing type of a process. I think those two adjustments need to be considered separately.

Another item is wage related costs. According to this year's data files, wage related costs vary from 5.11 percent of salaries to 47.77 percent of salaries. So there are some very, very big variation in terms of wage related costs, and I think that's something that's important for your staff to consider.

Also, there was discussion about the impact of geographic reclassification. I think it's around $750 million a year now, is what the impact of that is. I do

have the number, I just don't have it with me today.

But the real shift in these monies coming out actually occurred on October 1st, 1991 when geographic reclassification was first implemented. The impact today is merely the difference between the 2007 reclassifications and the 2006 reclassifications, and I would tell you it's a very, very small number.

Two other things. On the volatility issue, the Connecticut Hospital Association just asked us to do a study that said what if you limited the volatility of wage indexes to 1.5 percentage points? What would it cost? Our number that we came up with is about $287 million. So that's another approach to one of the issues that you guys are taking a look at.

Lastly, in the Dakotas, if you include those critical access hospitals in the database I think you'd get better data to take care of the Dakotas.

Thank you very much and I salute you for what you do for our country.

MR. TUTEN: That's a tough act to follow. On behalf of the Long-Term Care Pharmacy Alliance I'm Todd Tuten from Patton Boggs. I just wanted to address a point

that came up in a question to Commission staff about the legislative history from our perspective.

Really, the outcome placing the duals drug coverage under Part D, as we saw it, was driven by competing philosophies and cost considerations. Initially, there was a move and the Senate approved a proposal to keep the duals under Medicaid. The issue then in the House became do these individuals get the same benefit as all other beneficiaries? And what would the cost of creating a special benefit for them or keeping them in Medicaid be?

In the end, the decision was made to bring them under Part D. But there was a proposal advanced to create long-term care specific prescription drug plans. Our understanding, from committee staff at the time, was that that would raise cost concerns under the $400 billion cap of the bill, and also that there was philosophical objection in some quarters, notably then-Chairman Thomas, about carving out a separate benefit for these individuals.

Thank you.

MR. BAKER: If I may make one more comment, under Bureau of Labor Statistics data --

MR. HACKBARTH: Tell us how good we are first,

before you proceed. Just one more time.

[Laughter.]

MR. BAKER: I got a phone call from a New Orleans area hospital CFO a few days ago that was using $1 million a month worth of contract labor for his RNs because there's no RNs left in the New Orleans area. I don't know where the contract comes out of. It could be Atlanta or it could be Houston. But BLS data may not pick that up in the location where the services are actually rendered. And that could create some significant variations.

Also, as I mentioned, hospitals are scrubbing their data. Some of the issues for the BLS is what about shift differential hours, weekend differential hours, charge nurse premium hours, Baylor Plan hours, self-funded disability hours, on-call time, all these types of things. There are some real issues in the use of that BLS data.

And also last, but not least, what about home offices?

Thank you.

MR. HACKBARTH: Okay. Thank you very much.

We're adjourned.

[Whereupon, at 11:43 a.m., the meeting was

adjourned.]