MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

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9:52 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair
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JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
NANCY M. KANE, D.B.A.
ARNOLD MILSTEIN, M.D., M.P.H.
WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, PH.D.
NICHOLAS J. WOLTER, M.D.

AGENDA PAGE

P R O C E E D I N G S

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

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

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

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

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

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

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

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

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

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

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

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

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

We have looked at a range of collaborative

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

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

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

In this presentation we will focus on a few of the

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

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

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

So with that, I will turn to Zach.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

expects to do the same for 2008 and 2009.

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

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

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

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

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

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

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

Perhaps reflecting how adeptly the system has

responded to incentives, it was awarded the Malcolm Baldridge National Quality Award in 2007, the highest presidential honor for organizational performance excellence.

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

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

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

care dollar.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the case in many communities.

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

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

DR. KANE: I actually appreciate the comments

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

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

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

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

what tools are they using?

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

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

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

So I think that there certainly is some of that

going on.

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

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

There are definitely examples.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I have heard from a number of hospitals when this

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

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

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

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

MR. HACKBARTH: Good point, Arnie.

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

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

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

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

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

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

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

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

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

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

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

That's my speech for today.

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

bundling.

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

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

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

change.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The issue of readmissions has received growing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

thorough on it.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. STUART: Poor choice of words.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

those ideas.

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

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

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

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

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

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

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

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

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

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

about earlier.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. MUTTI: In the virtual bundling.

DR. REISCHAUER: In the virtual bundling.

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

DR. REISCHAUER: For those hospitals that volunteer?

MS. MUTTI: No. This is the default.

DR. REISCHAUER: For everybody?

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

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

utilization.

MS. MUTTI: Right.

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

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

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

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

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

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

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

savings but it's been shown possible.

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

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

DR. MILLER: Carry on.

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

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

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

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

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

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

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

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

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

[Laughter.]

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

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

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

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

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

[Laughter.]

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

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

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

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

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

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

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

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

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

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

Nancy-Ann, would you agree with that?

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

MR. HACKBARTH: Yes, right.

[Laughter.]

MS. DePARLE: Include me in that, too.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Alternatively, mandatory Federal financing could come from general revenues.

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

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

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

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

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

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

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

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

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

financial interests of the board and staff.

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

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

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

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

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

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

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

Regardless of the board's structure, there are

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

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

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

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

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

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

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

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

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

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

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

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

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

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

there.

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

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

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

And that kind of raises the option of this is a

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. REISCHAUER: By Congress or by the president.

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

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

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

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

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

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

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

such a creation sponsoring.

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

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

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

circumstances, but which treatment administration approaches.

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

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

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

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

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

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

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

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

including NIH.

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

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

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

I think one of the most important ways to sort of

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

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

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

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

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

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

And then we get a complicated pathophysiological

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I'm exaggerating to make a point.

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

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

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

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

MR. HOGAN: Thank you.

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

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

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

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

But we have evolved since then. And now we can

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

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

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

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

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

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

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

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

That's all. Thank you.

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

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

AFTERNOON SESSION [1:25 p.m.]

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

MR. WINTER: That is the list.

MR. HACKBARTH: Laundromats, car washes.

MR. WINTER: Baseball teams.

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

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

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

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

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

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

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

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

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

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

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

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

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

item or service.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. WINTER: This brings us to the question of whether there should be a Federal law requiring manufacturers to report their relationships with physicians. As Hannah said, data collected under existing state laws are difficult access and the state laws do not apply to device companies. It's worth nothing that two bills have been introduced in Congress to mandate public reporting by drug and device manufacturers.

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

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

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

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

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

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

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

The general public and researchers could use a

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

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

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

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

A third issue is that there would be a burden on

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

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

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

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

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

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

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

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

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

Now, Jeff will discuss reporting of physician

relationships with hospitals and ASCs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CASTELLANOS: This is a subject that I deal

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

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

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

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

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

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

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

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

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

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

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

[Laughter.]

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

Thank you.

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

as essential.

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

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

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

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

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

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

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

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

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

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

the things you need to do.

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

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

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

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

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

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

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

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

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

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

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

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

physicians for these devices.

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

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

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

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

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

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

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

at the organization for not having acted more quickly.

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

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

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

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

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

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

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

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

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

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

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

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

rid of them all, do the Permanente thing.

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

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

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

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

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

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

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

that is necessarily a really great idea.

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

[Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

MR. WINTER: Good question.

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

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

But there seems to be more momentum, judging from

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

DR. DEAN: Thank you.

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

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

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

beneficiaries.

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

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

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

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

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

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

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

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

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

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

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

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

kind of --

MR. DURENBERGER: Argus Leader.

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

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

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

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

[Laughter.]

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

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

[Laughter.]

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

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

Next up is promoting the use of primary care.

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

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

we're going to talk about medical home programs.

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

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

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

services as less profitable.

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

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

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

But the Commission has raised some concern

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

beneficiaries.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. BERTKO: Yes.

[Laughter.]

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

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

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

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

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

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

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

Your question is how close could you get?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

conversations about concern on the pipeline of physicians, and that if we don't send signals to certain specialties over the long run -- and I kind of expected -- you guys got close and I thought that was part of it but maybe I got --

MR. HACKBARTH: The reason I stopped short of saying that is that if the rationale is around supply of physicians in training, I think you've come up with a potentially much broader -- it's not only in primary care that we have potential issues with long-term supply and training.

So I don't think that differentiates or focuses the discussion sufficiently. Maybe we need to come back at some later time and look at general surgery or urology or other specialties that have similar looming issues. I think that rationale is too broad for the current purpose. Hence, I want to look at this as -- and you don't have to go along -- but I look at it as fundamentally a value proposition.

These services, adequate payment for them, are critical to a well functioning, efficient, high-performing health care system.

That also leads me, Bruce, back to your initial point. I don't want to just spread this money around. I

want it concentrated on the people that are intensively engaged in this activity, not incidentally engaged in it. So I would be inclined to look at physicians that -- in fact, Arnie proposed this to me on the phone, so let me give due credit. Give this to physicians who have a percentage of this activity of their total Medicare billings that exceeds some high threshold.

This is a bonus for the people that are really focused on this.

We've got to start going through our list, and I apologize for yakking too much.

MR. EBELER: I think recommendations one and two make sense in the context of recommendation three. I don't mean to lump then when we're splitting, but you need to shore up in the short-term the existing if fee schedule, inadequate as it is as a transactional fee-for-service -- stipulate to all the issues we have with it. But it is how we do things.

And sort of shoring that up, at the same time we move to a different way of streaming money out to primary care physician for medical home, I think makes sense. So I think this is the way to go.

The other thing is we've got to go. This is one of those things, we can talk about it a lot. But folks are being paid today under these structures. We're worried about it. And recommendations for action are needed.

So I think this is the right way to go. Like I say, if and only if we also go with three, which is the longer term train heading a little bit out of this structure in getting a different stream of money.

MR. HACKBARTH: Let me abandon my splitter. John wins. In the interest of time, if nothing else, feel free to address both recommendations we don't have to go around separately.

MR. BERTKO: Do I get another turn now?

[Laughter.]

DR. REISCHAUER: No, you won the battle.

DR. CROSSON: Thanks very much. I'd like to start with just one technical question, if we can look at slide nine for second.

That gets to what Glenn was talking about a few minutes ago now about targeting this and targeting primary care services. I want to pick on the pediatric number. And that may be unfair since this is MedPAC, but it happens to

be an area that I practiced it.

When I looked at it, it seemed a little low. So as I reflected on my pediatric practice some 20 years ago, it would have seemed to me that pretty much everything I did, I guess most of it that was office practice, would have been primary care.

I'm just using that number because it's here and because that's --

MR. HACKBARTH: It's probably an artifact. This is Medicare data.

DR. REISCHAUER: This is Medicare data.

DR. CROSSON: Oh, this is only Medicare data?

MR. HACKBARTH: Yes, so that's an artifact, probably, of the data.

DR. REISCHAUER: There are two people.

[Laughter.]

DR. CROSSON: All right, then I can't speak to it directly. But I would just wonder even internal medicine, what is considered a primary care service by an internist versus a non -- that would be procedures? Or what would it be, that's a non-primary care service.

DR. HAYES: Yes, it would be procedures. It would

be visits to hospital inpatients. It would be if they do any consultations. But it would be primarily procedures.

It would be chest x-rays in the office. Some of them do colorectal cancer screening services, that kind of thing.

DR. CROSSON: Thanks. Later, I'll ask you about where you got the pediatric data from.

MR. HACKBARTH: Jay, just for the record on that, since this is Medicare data, those are disabled that qualify for Medicare through that channel, who would tend, I would think, to be specialty dependent to a greater than average degree.

DR. CROSSON: Thanks, that's helpful.

On the larger question, now that we have developed a unitary approach, I would support all three recommendations. I think they do get together.

I think, in terms of what we are trying to do here, I would agree with what Glenn said. In fact, in the definition on slide four, it says what we're trying to do is promote primary care. And that is defined as comprehensive health care provided by personal clinicians who are responsible for the overall ongoing health of their

individual patients.

And I think that may, in fact, exclude some of the E&M services, for example, delivered by some of the physicians who are on that slide that would not qualify to meet this definition.

So I do think if this is the definition, then trying to target the payments here -- and that would be by both selecting the specialty as well as the services -- makes some sense because we're going to have to shift money. And to the extent that it's properly targeted, we're going to do better. So that is not a shotgun approach but a narrow shotgun approach.

I think the third recommendation speaks to much more of a rifle shot approach, which is really targeting it with strict criteria at that level.

Now having said all that, I do think in thinking about what we're doing there's a little bit of the chicken and the egg part here, at least in the short term. And that has to do with the fact that while there may be long-term projected shortages of various specialties, there is a very short-term projected severe shortage of internists and family practitioners. And in fact, if we don't do something

about that, given the lead time for individuals to choose specialties, we may not have the individuals around to do what we would like to see.

So while the goal is value in the delivery of certain services, I don't think we should shy away from -- nor I think do we in terms of the first two recommendations -- shy away from the short-term effect on trying to make sure that we have an adequate supply of physicians who can provide the value later on.

MR. HACKBARTH: A couple of weeks ago GAO submitted a report to Congress on the supply of primary care physicians. There was a table in the report showing the growth in various specialties over I think like a 10-year time horizon or something like that. If you look at the GAO data, it actually shows that the number of primary care practitioners is stable, even growing modestly, and growing faster than some other specialties.

Of course, what they're including there is foreign medical grads who are coming into the system as primary care clinicians in large numbers. And I make this mistake often, I see the numbers on U.S. medical students choosing general internal medicine or family practice, and those numbers are

collapsing. But to some degree, the void is being filled by foreign medical grads, which raises a whole bunch of other issues including the impact on their home countries among them.

But strictly speaking, the total supply, including foreign grads, is stable to modestly increasing.

MS. BOCCUTI: Can I just mention one other thing with regard to that report? The other issue is you can be an internal medicine resident and go through the residency, and then subspecialized later. So there is some issues about looking at practicing primary care versus just residency selection. So we want to look at that a little further, too.

DR. DEAN: Just on that very point, I've had a conversation with the fellow that runs the general internal medicine residency at the University of South Dakota. And he made exactly that point, that most of his residents see it as a stepping stone.

So I think it's dangerous to count the people in training.

DR. MILSTEIN: I certainly support the first recommendation. I think it's a terrific idea. My metaphor

is this is not a Band-Aid, this is a tourniquet, given what's going on in the pipeline of primary care. And the evidence that if you want really good primary care for sick people, you have to make it a little bit more muscular than it is today.

I support the second point based on the point that Bill made, that is if you were to ever take apart what's currently going on in many primary care physicians' offices and ask for what percentage of the work activity do you need a physician, an M.D. degree, it would not be a pretty picture.

So that's why I support the general direction of the second recommendation because what we want to do is figure out how we incentivize and encourage physicians to figure out how to generate more health with less total spending, including substituting for their own labor when it's not really adding value -- which I think is Bill's point and I think a very valid one.

Let me now move to the second recommendation and say that I wholly support its directionality. But I would hope that we would consider substantially strengthening its content. I will just pick three things in particular that I

hope we might consider.

The first is use information technology. I know this is not the intent of it, but information technology has been used very effectively for physician billing for quite a while. I hope what we mean here is use information technology for those applications that have been shown to make a material difference in quality and efficiency. And I think the term of art for this is active clinical decision support. That's what the research suggests. Active clinical decision support supported by health IT generally both the numbers in the right direction on both quality and efficiency.

On the 24-hour patient communication and access, I hope that means rapid access. Because when you take apart delivery systems that are doing a great job on both efficiency and quality in the Medicare program, one of the things that they have done is they have won the patient's confidence that if you call, you're going to get a rapid call back from someone who knows about you. And so hopefully in the details we can spec that out.

And last but not least -- and this is the one I feel most strongly about -- has to do with the nature of the

rewards that we have in mind for these medical homes. My fear is that if we keep it pegged as low as the current recommendation, which is a quality only modest reward, it's under scaled to the nature of the problem we're trying to solve.

And so my view would be to unleash the creativity of physicians and nurse practitioners that are running these medical homes and model this closer, in terms of reward structure, on the physician group practice demo, where there's really no limit on the upside associated with knocking the ball out of the park on quality improvement and efficiency improvement.

And I think per our last discussion, we also would want to make some sort of a provision for substantial rewards for those that are already at the absolute top of the list, top decile on efficiency and quality, who may have a little bit less upside.

But I think the physician group practice demo is a terrific model for reward. I think what's exciting about it is it potentially generates some very substantial rewards for primary care physicians who are willing to take responsibility for the patients that are in their panel to

improve both quality and total spending over the course of a year.

MR. HACKBARTH: I want to flag this last issue and I hope we'll get some other people to react to it. When I talked to a few of you about how to structure the rewards for the medical home, I heard two broad schools of thought. One, which Arnie just stated.

A second was boy, you need to be really careful about strong rewards for reducing costs because the model starts to look too much like primary care capitation with gatekeepers of the 1990s, which did not always work out well.

And so I hear two different messages from commissioners. And so I'd like to hear more discussion of that issue.

DR. MILSTEIN: Can I clarify what my recommendation is? Because it's not to turn -- as we did 10 years ago -- turn the physicians loose on -- primary care gatekeepers whose primary role was to lower costs.

I think what I have in mind was something closer to the physician group practice demo where, in order to generate substantial rewards, you have to move those quality

numbers up substantially.

It also raises, Glenn, something that we did not discuss but I think it's probably worth bringing out before somebody else does. It has to do with the denominator size for smaller practices. It's absolutely right, if we want to have some confidence when the numbers move that it's real and it's not statistical noise, it will be biased toward aggregations of primary care doctors rather than single physicians. But I don't think that's all bad.

DR. WOLTER: A few thoughts that I have are, and I know this will go against everyone's grain, but I wish we could do most of this in a way that's not budget neutral. The reason I say that is the budget neutrality thing is going to create some push back from many places, and I think there's ample literature that increasing the percentage of primary care tends to be associated with more efficiency and lower annual costs per beneficiary.

And just as a general thing, when we do every little niche project budget neutral, sometimes it gets in the way of the bigger picture being managed in a more cost-effective way.

So I do worry about the budget neutrality effect

on this project over time, because it's budget neutral only to this specific set of payments. It's not necessarily looking at what an investment in primary care might do in the big picture of serving the Medicare program.

And then the conversation earlier about the dollars going to all of the primary care E&M codes, you know that one list of specialists who do E&M codes, this is a little bit related to the point Bob made. Having administered physician compensation plans for many years now, and the scars that go with it, most of those specialists, in the work they do outside of those E&M codes, end up with incomes of 50 to 200 to 300 percent above primary care doctors at the end of the day because of the other types of work that they're able to do.

So I think we're on the right track to have this sort of two-triggered approach in terms of how we identify this if we really do want to target primary care for the reasons that have been discussed.

This clearly does not recognize some of the other workforce issues we have. I practice critical care. You can't find critical care doctors now to do the kind of work that's really critical, and sort of the generalist who

manages a critical care unit. And the same is true with general surgeons, as Karen would point out if she were here.

But I think we need to address those issues in a different place, perhaps. I think we're on the right track with this recommendation.

The RUC process has been talked about a lot as why are we where we are when we've just had a five-year review. One of the issues I have seen with that is when CMS went back and did the 10 percent neutrality adjustment after the five-year review was completed, the 10 percent plus reduction was applied it to the RVUs themselves, not to the conversion factor, which did make a difference to primary care reimbursement.

And it also made it impossibly difficult to manage that inside of a group practice. So that's kind of a detail below the 60,000 foot level but I wish we could ask CMS to change how they did that.

And then as far as the medical home goes, I think that there are some additional infrastructure skill sets that would be important. One is what you might call population management, where registries are created in these practices related to the patients who get enrolled with

their chronic diseases. So that you have a known denominator that you can manage to. And that does involve IT. There's no question about it, and clinical decision support.

I think the e-prescribing aspect of this could be an important early tool that could be important.

And then I know that the American College of Physicians has proposed some tiering in how they're thinking about medical home where some patients who are, relatively speaking, healthier receive coordination of care, preventive care, that sort of thing. And then the patients with the chronic diseases, there might be a payment per member per month that's at a different level. And we might think about that.

I do worry about what the amount of payment might need to be if we're asking for an infrastructure to carefully manage patients. And also, it needs to be said, a lot of the work of managing these multiple chronic disease payments really requires mid-level support so that you have nurses and others helping manage the patient between visits. And so that's another cost that somehow has to be looked at depending on the enrollment types of patients who go into

the medical home.

DR. DEAN: Obviously, this is a topic that is pretty near and dear to my heart. I guess anything that obviously supports or encourages primary care is something that I would see appealing.

Having said that, I have some skepticism about the approach of the modifier.

I think maybe we have some semantic issues. I think the thing that primary care, the value that primary care brings is care coordination. If that's the case -- I think I said earlier -- that really doesn't lend itself very well to a CPT structure. It's just hard to fit it into a CPT box. And so I think we may well need a different mechanism to recognize that.

I guess I would say, just as a picky point, it says that primary care is at risk of being undervalued. I think we've established pretty categorically, it is undervalued, and I'd like to see stronger language there.

And I think that one of the values of a care coordination payment that has not been mentioned, that you did bring up nicely in the paper, is the fact that a lot of these services do not require face to face contacts. In

fact, a lot of them it's a waste of time of both the physician and the patient to have a face-to-face contact. And yet that, given the current structure, is the only way that there's any reimbursement. And so I think that we need to look at ways to recognize services.

But at the same time I fully understand why that requirement is there, because you have to somehow verify that there really was a service provided.

MR. HACKBARTH: And this is one of the reasons, Tom, that I don't see these approaches as mutually exclusive. See, I see the medical home as the more direct approach to dealing with the care coordination and the importance of activities that currently don't have codes.

As Nancy has pointed out, another tact you can take is to expand the codes and offer billing opportunities for different services. But I worry that often those services just don't lend themselves to the fee-for-service mentality. They are best paid for on a per patient per month basis. Building all of the code infrastructure may not be the way to go.

So again, you've laid out the reasons why I think these are complementary approaches as opposed to mutually

exclusive approaches.

DR. DEAN: The issue with all the pipeline issue, I think certainly this would be a small step in the right direction. I think drawing people into primary care is a much more complex issue and it does have to do -- money is an issue. But we have major educational structure influences. We have perceptions of where does the primary care doc fit in the hierarchy of medical decision-making? Are we really just the kind of ones that take along after the specialists have made the decisions -- which I think is really not the case. And yet that's the perception.

We also have the perception that is frequently given to medical students that to be a family doc you have to know everything. And nobody can know everything and so you're foolish to try. Well, in fact, that's obviously not true. And yet we see that thinking evolving.

The University of South Dakota is, in their mission, a family practice oriented medical school. Well, everybody that comes in says they want to go into family practice. I mean, they're not stupid, they know what they have to do to get in.

[Laughter.]

DR. DEAN: And yet we see that commitment eroding as they move through the specialties.

We hear it from the specialists that say well, I know that what family docs do is good but I'm not smart enough to be a family doctor because I can't know all that stuff. And I want to deal with an area that I can really get my hands around and feel be comfortable with. And so we see that happening.

Plus, certainly money is an issue. There's no question about that.

But also, the ability to really have an active role in patient decision-making, I think, and to have some credibility within the whole medical hierarchy, is something that is a concern because people want to have the sense that what they're doing has some value.

So I think there's a lot of cultural issues. There's a lot of fear issues in terms of that I'm going to get in over my head and not able to do what needs to be done. It's a very complex issue.

Just a comment on the issue of access to specialists, which is a complicated issue. But it seemed to me that there would be a way to structure some financial

incentives that would allow the people that buy into the idea of entering a medical home would accept at least the fact that they would have to consult their primary care doc in order -- and not necessarily the primary care doc necessarily has to sign off on it.

But at least if we know that it happens -- and frequently they don't. They just go off and we find out later that they want to see the specialist for reasons that really made no sense at all. If we just had a chance at having some input, because I think we really do have to be afraid of the gatekeeper concept because that really got some negative press or some negative reception.

Finally, the last concern I have about the medical home from a rural point of view is that the criteria -- I think what we do in our little practice, we meet most of these criteria without half of those requirements for the extra personnel, and the extra things. And we can largely handle it because we're little.

And so I worry that, in fact, we're providing that service but we're not going to be able to meet the criteria that are set out for certification. And so I'm not sure what the solution is.

I think, Nick, you said there is a proposal for different tiers of medical homes and maybe that's a start. But I think that the issue, in the final analysis, is are you providing the service, not so much what the structure should be. But I don't know.

MR. BERTKO: So I'm going to say I'm a bigger supporter of the second part, the medical home case management fee type.

The first comment would be the good news here is this doesn't need to follow the other one. We've got, I think Cristina said but John didn't, what, 10 or 15 years in practice or something like this in Medicaid, as well as newer things out there. So if one were just to grab out that experience you could probably design one that would work reasonably well. It's not as if we're going off into the dark.

The stuff we're doing in the first alternative is new stuff.

Secondly, to address the incentives here, Tom mentioned it in one direction. I will tell you that from a lot of experience with plan design, as you might imagine, Part B premium reductions are nearly invisible. So I would

go in a different direction and I would keep it extremely simple. You can still go to a specialist that's not referred, but there's a $20 copay for regular people and a $5 copay for low income. And the $5 co-pay is just about the same size as the $3 brand copay, or $3.50, whatever it is in 2008. So it's a really simple type of mechanism.

And believe me, copays in that sense work really well. This would be separate from anything that would happened with Medigap. You could have a Medigap policy that pays everything, but if you go to a specialist that's not referred or not connected the way Tom suggested, you pay the $20 up front.

MR. HACKBARTH: So in effect what you've done is create a special flavor of Medigap for --

MR. BERTKO: No, I haven't changed any Medigap. You can have all the A through K --

MR. HACKBARTH: Well, to the extent that you're saying that copays can't be covered --

MR. BERTKO: Copay cannot be covered. That's all I'm saying.

MR. HACKBARTH: So there's special supplemental coverage rules for people who elect to enroll in the medical

home.

MR. BERTKO: So here comes the next part of it. Again, we need to have this happen as much as possible. So I would follow the Part B enrollment. Let it be an opt-out enrollment. You're in. You get several notices. Your physician, who is inferred, gets several notices. And you can leave anytime. You don't have to worry about a lock-in. But you would be into it until and unless you opt out of it.

The next point here is I particularly agree with, I think it was Tom, your point about -- maybe it was Nick's -- the budget impact here. Almost all of the research says greater use of primary care physicians leads to budget savings no matter what utilization says. It was a recent JAMA article I mentioned at lunch.

And then the very last one is we ought to be candid. The first alternative does promote primary care but it really says fix the RUC, and do it by specialty. Avoid the other crazy things that are happening with some specialists who still need this. Fix it as it should have been fixed for the last 15 years and compile all of that.

Sorry, you've heard that sermon before.

DR. KANE: First, I'm supportive of both proposals

and I'm hoping some practices can do both to start to make up for the financial disadvantages that primary care is at.

But I just wondered if we could explore a little bit how CMS or the fiscal intermediaries could support the medical home a little bit. So for instance, in hearing John talk about how hard it's been to get the data together for the pilot, it needs to be very clear that medical homes could really use some support from the fiscal intermediaries around the total package of services or the out-of-referral use, whatever we want to call it.

As Tom said, you don't know until afterwards, and sometimes you still don't know, that your beneficiary has gone outside of your circle of care.

So I think there's a real need for a really timely way to feed back what your beneficiary's use is across the whole episode or time period that you're caring for them.

The only place I can think of who can do that for you as the fiscal intermediary, unless you're in some kind of managed care arrangement.

I think the other piece of information that medical homes could really probably use to the benefit of Medicare generally is if we start to bundle A and B

payments. So you've got a patient you want to refer to a hospital for a blah, blah, blah. It might be really helpful to know where the Part A/B bundles are the most effective and best quality, rather than having the primary care guy try to guess. Have the primary people -- empower them with some of the information to manage his care better.

Then that goes to my point of it would be great to be able to reward the medical home not just for care coordination and for what they do themselves but for how well the manage the whole package. Certainly not capitating them, but sharing savings if they manage to refer appropriately for inpatient care or follow up.

Across the whole episode of care, the primary care physician can have a huge impact. I know my group makes a lot of money just by avoiding ER use. And there should be some way to reward them for that, not just for what they do on the primary care side.

So I'm just saying try to empower them. I with all of us who think this is great, let's make it stronger.

But I think there's a lot that CMS and the fiscal interviews could do to make that a much more powerful experience so that we're not chasing after the information

without any way to do that.

MS. HANSEN: Probably three areas, and one of them will be related to a context.

I am supportive of the recommendations, the two segments of it, but with some substance that some people have identified.

One of the things, in terms of just going to page 16 with the medical home component of it -- let me just backtrack.

The first recommendations are -- I guess Arnie's comment is put on the tourniquet. So I do see that as the first fix, per se. But the medical home is where I think the total promise may come in relative to some of these items here that maybe could be -- it's implied but maybe some further drill down, because I think we had some earlier conversation as to really what are we defining as primary care from the prevention kinds of things to the care coordination aspect.

And just to talk about a picky thing, I just wondered if the third bullet could be conducted care management rather than case management?

But with that whole piece of doing the medical

home, the budget neutrality component that I think Nick brought up, I also want to say that perhaps between the studies about primary care but whether or not, when you start a whole method that's somewhat different, it will cost more in the beginning. It's just like any kind of ROI. That it would perhaps not be forevermore but maybe just the commitment that in the beginning there would be some increased costs that we would expect in order to eventually get to that kind of efficiency.

So I don't know what the time factor is but I don't want to go in right off the bat saying it has to be budget neutral which oftentimes, in demos kind of kills the demo when they haven't had the time to really prove their effectiveness.

The other thing is two elements that I think about, and maybe this is implied in the health technology. It's just that pharmacology is such a big part of this, relative to the medical home. Because again, we're talking about complex individuals. We're not talking about the simple care management folks with one or two things of prevention. But when it comes to the complex areas that really the big dollars go with, the ability to make sure

that there is almost some geropharmacology that's built into that whole component of the medical home.

MS. BOCCUTI: Are you suggesting perhaps requiring like an annual medication review? Or are you saying to have somebody on staff that specializes in that?

MS. HANSEN: I think a medication review and reconciliation would be very helpful, since that's oftentimes what gets people in trouble relative to the issues of going into the ER, going into hospital care.

And then finally, the other element of medical home -- and maybe again it's implied but I think it needs to be maybe strengthened. All of the research that's been going on about care transitions, like post-hospital care, needs to be built into the accountability of a medical home. Because I think our data is that about one out of five Medicare beneficiaries per year enter a hospital.

So if that's the case, just knowing the odds of care transition issues will come up. And that's where the whole rehospitalization stuff comes in. So if the medical home is to really be truly effective as to what gets "bundled" into the medical home, but it's really about the managing of care, having a primary system. We're not

talking about what physicians they are or advanced nurse practitioners. So I'm not going there.

But it's just that this is the work that has to be done to really have an effective product of a medical home. And investing in it in the front end will cost more.

And then finally, another dimension of this that doesn't easily get reflected, just the complexity of cognitively impaired individuals. I brought that up before.

I don't know quite how to pinpoint it. I just know it's one of these things that kind of is an extra appendage hanging out there but has a real component of care coordination issues, cost issues, just the ability to figure out some way to do that.

My last point, which is something that -- I've started to learn that you've got to say things about six times, Nancy.

One of the things that strikes me with this, as we talk about medical home, let me bring it back to the patient or the consumer. Whether or not there is a way to -- in long-term care there's the example I've given -- there's the concept now that states' Medicaid have picked up relative to money follows the person.

So it's the idea of when you think of the chronicity of the individual, when they're not real frail they need prevention. But then, when they get really complex, there's a bundle of money that's like this little balloon traveling with this older person moving along.

If there's a way to figure out the cost of care over a period of time, depending on the kind of complexity they go into, whether they have a stroke suddenly, what's the added factor of cognition, for example, or mental illness? These are things that really drive up costs as well as coordination.

So I don't know if there's a way to track this of money follows the person, regardless of institutional structures. This has come up with some of the long-term care rehab facilities where when we looked at geographical maps in the past some places don't have that. But home health agencies still deal with it. So it's not the structure but it's really the profile of the individual.

So I don't know if there's any longitudinal way that we can follow the person clinically over time and just make sure that the money goes with them and that the medical home will do a lot more care coordination and geropharma

watching in a complex patients.

So it's a third thought that I have that's off the table but it's another way to do it other than thinking about these chunks because they're just bigger silos.

Thank you.

DR. CASTELLANOS: Most of the comments I wanted to make have already been made.

One is everybody's talking from the primary care doctor, how he feels about having patients seen by a specialist. Let me give you a specialist viewpoint, which I am. You saw on the slide, about 22 percent of my practice is primary care.

Quite honestly, of those 22 percent, a good 80 to 90 percent of that could adequately be taken care of by a primary care doctor. What this does to my schedule, it busies my schedule up and it doesn't allow me to provide the urology care that I need to within my specialty. But a lot of times I see these patients because nobody else is available.

So I think from a specialty viewpoint sure, some of the specialists may get a little bent out of shape out of it. But I would rather have Tom call me, tell me what's

going on with the patient, let me evaluate it, and then send it back to Tom to manage. I think that's the appropriate way, and that's the cost-saving way of taking care of the patient.

As far as the recommendations go, I think we're going in the right direction and I really like that. And I support the recommendations or the directions we're going.

There's no question the medical home, in my opinion, is finally paying the primary care doctor for what he does. He's doing it already now. He's doing the coordination of care. He's doing the rectification of the medications. He's looking at the patient. He's looking at the social issues of the patient. He's dealing on all of these issues where, under our E&M codes, he's really unable to code for that.

And finally, on the medical home, I think he's finally able to do it. But it's also elevating him to a very prominent position within the medical community. He's a vital cog in the wheel. He really is. And without him, it doesn't work.

As we saw in our papers today, 95 percent of our patients want a primary care doctor or somebody who is going

to be captain of the ship.

As far as education, I really want to stress this again. We've talked about the pipeline. We've talked about education. In the papers that were given to me, on page three and page 12, there was some mention of it.

Again, you're focus is in the postgraduate training, which I think is important. But the decision to go into a specialty by the physician in medical school is done in the second or third year of medical school. So if you're going to waste your money and time talking about trying to get people into that field after their medical school graduation, you're going to miss the bus.

So you really have to stress this. This is part of the same thing, as we've talked about it. Right from the get-go, right in the beginning of medical school, stress some of the important issues that we're trying to talk about here.

I could spend a lot of time doing that, but I've said so much about it before.

And the final thing is paying this out of -- I think we ought to think about how we're going to pay for this. Obviously, the buzz word in Washington is budget

neutral, and everybody agrees it's easier to do it that way. But what this does, it doesn't provide the new money that's necessary to establish these medical homes.

There's going to be some savings. Perhaps it can be paid out of savings. Perhaps it can be paid out of new money. By doing it in a budget neutral basis, you're going to get a little bit of a backlash from the other non-primary care doctors. And what you're going to find out is everybody's going to want to be defined as a primary care doctor now. The OB/GYNs already say they're primary care for the female. The urologists, they say they're primary care for the male.

So I think we're going to have to really look at how we're paying for this and not always just consider taking out budget neutrality.

MR. HACKBARTH: We're going to have to move ahead, Arnie. I just want to quickly touch on two things.

The first is the budget neutrality issue. As I recall the papers, the first option, the conversion factor bonus, was explicitly presented as a budget neutral option. My recollection is that the medical home option was not presented as budget neutral.

MS. BOCCUTI: As a pilot.

MR. HACKBARTH: Right. And let me just briefly talk through the reasoning there.

The conversion factor bonus, as I said, can be presented with different rationales. The paper focused on making up for the passive devaluation that's happened in the past. So it's making up for deficiencies in the RUC process. We all agree the RUC process needs to be fixed going forward. But the fact is there's been under payment in the past and that could be how you set the value of the conversion factor.

If you're making up for chronic under valuation of primary care through the RUC process, I think it's a logical step to say well, that money ought to be financed by the people who were overpaid through the RUC process. So I think there's a plausible budget neutrality rationale there. We can discuss it further but that was, I think, the thinking here.

As for the medical home, this is a pilot. There are going to be certain up front type costs, for example for the lump some payments, that are clearly going to add money. They are payments over and above the existing fee schedule.

Now what you're testing in the pilot is whether, in fact, that money will be offset by savings and specialty consults and unnecessary hospitalizations avoided, et cetera. Don't know the outcome, but that's what you're testing.

So there, I think, it is plausible to incur some up front costs as part of the task of exploring a new option.

Now one of the things that we'd have to grapple with for next time on a final recommendation is how much up front costs we contemplate. Because one of the things that will happen with this is that CBO will score it if it becomes a legislative proposal. It would be helpful for us to not just throw it out there and say score it whatever you think but try to give them more concrete parameters on what we think we are undertaking. So there will be more on the cost of the pilot next time.

Last issue, before we move on. In this discussion we haven't talked about pilot versus demo at all. That came up this morning in the context of bundling.

There's been some turnover in the audience. So for the benefit of the audience, I just want to say a word about why this is characterized as a pilot, as opposed to a

demo, especially inasmuch as there is now a demo mandated by statute now under development in CMS. People may say why are they even talking about a medical home pilot.

The use of the term pilot signifies, for me at least, a couple of things. One is a statement about scale. A pilot, to me, connotes a larger scale than a demo. Although, as Bill pointed out this morning, there are some demos that involve a great deal of money these days. But that's part of the statement, pilot, large scale.

The reason I think that is important or the Commission may want to consider that, is large enough scale to find results quickly. Whether they are results for better or for worse, I think we need to accelerate the process by which we test ideas -- seemingly good ideas -- and decide whether they can contribute to the program.

The second part of a pilot is that lay out parameters in advance of what constitutes success and be real concrete about those. And if the pilot is successful, allow the Department to go ahead and implement, in this case, the medical home idea as a regular part of the program without going back through the legislative process.

So when I use pilot and we character this draft

recommendation as pilot, it's those two points that we're trying to drive home, scale and no need to go back through the legislative process if it works.

Now Bill laid out, as always, a series of well thought arguments about why you should be careful about going down the pilot approach. We don't have the time to go through all of that again this afternoon, but I wanted to be clear as to why we were characterizing this as a pilot.

DR. SCANLON: If I remember right though, in terms of scale there was a provision in the CHAMP Act to expand the scale of the medical demo without making it a pilot.

MR. HACKBARTH: Yes. In fact, the CHAMP Act, which of course was not enacted -- it passed the House but not the Senate -- provided for tripling the size of the TRHCA , at least in dollar terms, of $100 billion to $300 million; correct?

MS. BOCCUTI: That's how it was scored. That wasn't, I don't think, in legislation to triple it. But as CBO looked at the way the designed CHAMP, it would have effectively -- that's how they determined that it would be implemented.

MR. HACKBARTH: Thanks.

Okay, we are going to move on now to Part D and performance measures.

Thank you all, Cristina, Kevin, John.

DR. SOKOLOVSKY: Good afternoon.

Drug plans provided benefits in 2007 to more than 24 million Medicare beneficiaries at a cost of nearly $50 billion. But policymakers have limited information to evaluate how well the plans are performing.

In the period leading up to implementation of the drug benefit, the Commission conducted a number of studies to find out private payers managed and evaluated their drug benefits. As part of that process, we held an expert panel to see how experts in the field considered drug plan performance.

Last month, working with contractors from NORC and Georgetown University, we convened another expert panel to see now perspectives had changed over the last two years and identify ways to measure plan performance over time. The panel was composed of researchers, plan representatives, pharmacists, beneficiary counselors, and large private payers.

The panel didn't come to a consensus but discussed

the advantages and disadvantages of different measures.

We also conducted focus groups in three cities during the summer and at each site we met with groups of beneficiaries, groups of physicians, and pharmacists. In this presentation, we'd like to share the results of these efforts and have your ideas on how to evaluate Part D. We also have two draft recommendations for your consideration.

Our expert panel discussed the need for measures to evaluate how well plans meet costs, access, quality, and customer satisfaction objectives. Most of the measures discussed by the panel can be collected from data that the plans already submit to CMS. This is data that is either on the CMS plan finder website, in quarterly reports that plans submit to the agency, or in claims data. However, the panel had most difficulty conceptualizing performance measures that would adequately capture how well plans provide access to needed medications, and how well they meet clinical quality goals. In these areas, the panel had ideas but no real measures.

Physicians and pharmacists in our focus groups stressed that poor communication between plans, pharmacists, and physicians could result in delays before beneficiaries

receive needed medications. More standardized messaging between the plans and the pharmacists could reduce administrative costs for providers and improve beneficiary access.

The CMS plan finder contains lots of information for beneficiaries to use when selecting plans. It provides composite performance measures of drug pricing information, ease of using the drug benefit, and customer service. Plans received from one to five stars for each measure.

Panelists like the star format, but they had concerns about how well the measures were calculated. They felt that some of the composite measures did not capture the dimensions of access, quality, and customer satisfaction that were most important to consumers.

The website, by the way, has lots of other information. It includes plan premiums, network pharmacies, and estimated out-of-pocket costs for beneficiaries who have specific medical conditions or health status. Beneficiaries can also enter the names of the drugs they are currently taking and see which plans cover them.

Panelists believe that beneficiaries really need just a small number of easy to understand measures and that

would be most helpful in choosing a plan. But they did agree that a broader set of measures was necessary to help policymakers monitor plan performance.

A good measure should be validated to see that it actually measures the broader concept. It should be able to differentiate performance among plans. And finally, people should be able to understand how the measure was calculated.

Many measures discussed by the expert panel could be calculated from data already collected by CMS but the panel didn't believe that current data was sufficient to measure access and quality performance goals.

Beneficiaries in our focus group, as well as in the published literature, list cost as the most important factor in determining their choice of plans. They said that Part D has made prescription drugs more affordable and most report saving money. Some physicians also noted that their patients were more likely to fill prescriptions now that they have drug coverage.

Although plan premiums may not typically be considered as a performance measure, several of the panelists stated that the premium was the summary cost measure and was most relevant for beneficiaries and the

Medicare program to use in judging plan performance.

Other panelists thought that beneficiaries would find an estimate of typical out-of-pocket costs for people with specific medical conditions helpful. But they did caution that it would be difficult to construct such a measure. For most conditions there are a variety of drug regimens that a physician might prescribe. A particular regimen of drugs may be more expensive in one plan than another but a different drug regimen may lead to the opposite results.

We are continuing to think through a type of measure that could be developed and would appreciate any ideas you might have on this.

Panelists suggested that a measure of generic utilization was an important sign of the value that beneficiaries and taxpayers were receiving from their plans. Evidence indicates that most plans rapidly shift utilization from a branded drug when a generic variety becomes available. The Pharmacy Quality Alliance, an association of different stakeholders which is meeting to determine quality measures, found that measure of generic utilization was not a good performance measure because, in fact, the rate of

generic efficiency was very high and there was little variation among plans.

However, panelists pointed out that high levels of generic utilization may actually have unanticipated consequences for some beneficiaries. By law, beneficiary cost-sharing is set at an average of 25 percent of total costs. Plan representatives told us that plans with particularly high levels of generic utilization may have to raise copayments for more expensive branded drugs in order to meet statutory requirements. As a result, beneficiaries who require these drugs may end up actually with higher out-of-pocket costs. This is an issue that the Commission may wish to examine in greater detail in the future.

Panelists believe that it is very difficult to accurately measure access to needed drugs. For example, if you just count the number of drugs listed on a plan's formulary it won't really be a measure of access. It wouldn't tell you whether the drugs are readily available or if they're restricted by high cost-sharing or management techniques like prior authorization.

Some ideas for measuring access were discussed. One possibility is to measure the share of prescriptions

delayed at the point of sale. One plan representative noted that although plans do not currently submit this data to CMS, they could do so.

Some panelists thought that such a measure would have the potential to show variation in access among plans. However, they cautioned that this measure has to be able to distinguish between delays that are due to actual barriers and not things like beneficiaries failing to pick up a prescription.

Other measures of this type could include looking at what eventually happens at the point-of-sale. For example, is the prescription filled as it was written? Is it filled with an alternative drug? Is it paid for by the beneficiary out-of-pocket? Or never filled at all? Again, lots of ideas but no one really had an idea of how to do this, even though they essentially that this was one of the most important ways of measuring plans.

This leads to draft recommendation one. The Secretary should develop a measure of beneficiary access that calculates whether beneficiaries get a prescribed drug or its alternative without undue delay.

This recommendation we don't think would have

spending implications but we haven't yet been able to verify that. If plans are rated on this measure it may improve beneficiary access. Plan reporting costs may increase somewhat.

The implication here is that we need to have a much better way of knowing whether plans differ in providing access to beneficiaries for their needed medications. And if they do, why. We expect to continue working on this issue and would appreciate any suggestions you might have.

Many physicians in our focus groups said that Part D has affected their prescribing patterns. They were generally willing to prescribe generic drugs and prescribe drugs that they think are most likely to be covered by most plans. But if a drug is not approved by the plan, it can result in considerable time for the physician and the office staff, whether changing a prescription, filling out a prior authorization, or making the case for an exception. Many said that they will only do this when it would be clinically unjustified to substitute one drug for another. For example, physicians routinely told us they wouldn't switch a patient that's stabilized on one mental health drug for another drug.

So they try to learn from the pharmacist which drug will be approved without additional paperwork. However, the pharmacists told us that, in fact, plan messaging does not always identify alternative drugs or say why drug has been denied. One gastroenterologist in our focus group really give a very dramatic example of this. He said that there are five proton pump inhibitors that he prescribes, that he can give his patients with a particular kind of gastric problem. Each plan will have one of these drugs on their preferred list. So he has taken to writing five prescriptions for each patient and tells them to take it to the pharmacy and just keep submitting them until one is accepted.

When a plan does not provide needed information to the pharmacist, delays will result. The pharmacist may go back and forth with the plan and the physician submitting alternative drugs until one of them accepted. And sometimes the problem may not be that it's the wrong drug but that the plan feels that the quantity prescribed is too high.

Now our impression -- and of course there is no data on this -- our impression was that most plans do provide information. But when a plan doesn't provide it, it

takes a disproportionate amount of time to handle it.

Pharmacists tell us that even in the easiest situation, where the plan tells the pharmacist the approved drug and the doctor switches the prescription, the script is rarely dispensed on the same day. Most cases are resolved within a few days so the beneficiary has maybe a modest delay in getting his or her prescription filled. But in unresolved cases beneficiaries may pay full price or not get the drug at all.

So draft recommendation two says the Secretary should require plans to include information to pharmacists when they reject a prescription, telling them why the drug is not covered and if an alternative would be accepted.

This recommendation, again, we don't think should affect spending, but we have not confirmed this. It should increase the timeliness of beneficiary access and reduce administrative costs for both physicians and pharmacists.

E-prescribing may resolve many of these issues eventually but it's hard to estimate how much time it will take before e-prescribing becomes a regular part of clinical practice. And again, if the necessary information is not being transmitted to the pharmacist, it may not be

transmitted to the physician either.

CMS doesn't currently provide clinical quality performance measures for PDPs, and the development of such measures is still very much in a formative state. Finding meaningful measures to evaluate the quality of pharmaceutical care for Medicare beneficiaries is hampered in part because there are no evidence-based guidelines to evaluate drug regiments for older individuals with multiple comorbidities. If drug claims were linked to other Medicare claims data, we might in fact begin to construct an evidence-base for quality pharmaceutical care.

Panelists and quality organizations like the Pharmacy Quality Alliance favor measures that seem to focus on patient adherence to drug regimens. They note that -- and this is the Pharmacy Quality Alliance. They say that for every 100 prescriptions, only 15 to 20 are refilled as prescribed.

Plan patient adherence activities could involve things like contacting patients taking drugs for chronic conditions who have not refilled their prescriptions and reminding them to do so. However, panels pointed out that incentives under Part D may be misaligned for PDPs to

encourage patient adherence. Plan administrative costs would increase if they contacted patients or their physicians and they would bear the risk of increased utilization. Further, unlike MA plans, they wouldn't benefit if increased endurance lead to reduced medical costs.

Lastly, CMS uses the CAHPS survey to assess overall beneficiary ratings of drug plans and how helpful the plans are when the beneficiary needs information. Panel participants found existing CAHPS rating measures difficult, since all of the national plans get the same two stars for overall customer satisfaction, which is unlikely to be useful to beneficiaries. And the plans told us they were concerned because they had no idea how these measures were calculated.

CMS also provides performance measures related to plan call centers. Current measures here rate beneficiary waiting times and the percentage of calls that are disconnected before the caller reaches a customer representative. Panelists believe that these were important measures for consumers.

CMS doesn't collect data on physician or

pharmacist satisfaction with particular plans. A survey of providers might be very useful in getting at some of these issues.

Now I await your comments, particularly on the draft recommendations.

MR. BERTKO: I've got a bunch of questions and comments. And Joan, please don't think I'm shooting the messenger on this one. When I read it, I said your focus groups are all over the place. So a couple of comments to start with.

Could you go back to your second recommendation, the messaging one? To the best of my recollection, and only from a couple of plans, the messaging that comes back to the pharmacist runs through the credit card VISA messaging system, and that is quite limited. So I forget the exact number of characters you can have, whether it's 20 or 40. It's like when you're sending a message off in a block to somebody when you have a response.

You may need to actually investigate a little bit more the size of this, whether most of the plans use it -- which I think they do, because they use similar formats; whether there are standard codes, because that could

eliminate a whole bunch of it in terms of rejected because. And then what's left there to spit out the alternative drugs.

Comment number two, the GI example. I am stunned at that. I went to a little family practice plan. The guy pulled out his handheld and says oh, you're under the BlueCross formulary now. Dink. Here is what I can prescribe for you.

Writing five scripts seems -- this is not e-prescribing. This is you plug your handheld into your computer and it downloads the scripts you have. Did you guys cover anything like that?

DR. SOKOLOVSKY: Yes.

MR. BERTKO: What did they say?

DR. SOKOLOVSKY: First, I should say that there was another gastroenterologist in the same focus group and he said I wasn't going to say anything but I do the same thing.

MR. BERTKO: Write five scripts?

DR. SOKOLOVSKY: Yes.

MR. BERTKO: You're kidding.

DR. SOKOLOVSKY: But the other thing was that we

did have one physician -- and only one physician as I recall -- in any of the focus groups who was using Hippocrates. And he said it was not always accurate, that sometimes you had -- because plans consolidated, you would find the wrong PBM listed, the drug that they would list as being covered by that plan wasn't being covered by that plan.

MR. BERTKO: I'll ask maybe our physicians and see whether they use it or not.

Another separate point here, you made a statement which I think is true but not complete. And that was that the 25 percent coinsurance has to be balanced out. And that is a true statement for what I would describe as the defined standard plan.

However, you can avoid that just by calling an enhanced plan. Generally, the charge on it is a little bit different but sometimes not substantially more. And so if you wanted one with lots of cheap generics and a relatively low copay, something under the 25 percent, you can buy it for a couple of bucks more.

You find out by looking on the plan finder.

That's another thing here, which is my other comment, which is beneficiary responsibility. Access on

here from your write up and from what I think I heard today, is extremely hard to define. I don't think you had anybody define it.

And my comment also is that the beneficiary population is really heterogeneous. You've got people who use almost no drugs. You've got people that use the common drugs, the vast majority. And then you've got folks who have either high costs or need very specific drugs.

And so can you have a single one through five star mechanism that does that? I would find that impossible, perhaps, to determine but instead having a grid -- take common conditions, 10 conditions, and then what's the access for each of these conditions, for a diabetic, for a person with cardiac conditions, et cetera. Because otherwise you get this thing which doesn't seem to be able to work right for anybody.

Again, I'd go back there -- I'm not even sure that that's an answer to it, but defining access seems to be extremely difficult.

And you get back to, like somebody mentioned earlier, the USA Today article with people asking for drugs. Access to drugs they may not need shouldn't be conflated

with access to drugs they do need. And that one, I think, is extremely difficult to tear apart.

But it is something that when you're describing access, you shouldn't say this plan -- I'll take Jay's plan with a fairly tight formulary. Is this a bad plan because he doesn't serve the XYZ drug? I don't think so. Whereas I'm almost sure it's on the plan that I used to work with.

DR. MILLER: But John, that's exactly the point is when she held this expert panel the complaint among the plans were you look at Jay's plan and you say this is a bad plan because it doesn't offer a gazillion drugs, whereas the other plans have more drugs -- and Joan, I'll get all this wrong -- there's tiers, there is specialty tiers, there may be prior auth. And the actual plans were saying this isn't fair.

MR. BERTKO: Yes, that's right.

DR. MILLER: So I get your point that they were saying this is a problem, they didn't have a specific measure. But what they were asking us and asking CMS is to devote resources to try and break this concept down, I think is what Joan is up to here.

MR. BERTKO: I was trying to say that.

In fact, you prompted something else, which is the last part of access to drugs, which you kind of got to but I'm not sure you said specifically, is what are the utilization review limitations on various drugs? And different plans have different -- whether it's step therapy or quantity limits or prior authorization. I think you can get to three or four major categories and then it may need to become by drug.

I haven't looked at plan finder for a long time but supposedly some -- but probably not enough of that -- is there. And maybe that would be some useful comments.

MS. HANSEN: I think, Joan, you're asking us for some input. I actually still am, unfortunately, a little confused about this whole thing that when I just asked you for clarification about when there are no generics and you have to use a brand name and then the 25 percent is really significant, and that there's some discrepancies of the plans.

So I guess I just would appreciate some understanding better. And maybe I just didn't even get it when you were trying to explain that, too.

So I guess the bottom line is how do we get

through some of the inconsistencies, I guess, is the bottom line, that we can help address by this question?

DR. SOKOLOVSKY: I'm not sure I understand your question. Are you asking me to explain the tiering system and how it works?

MS. HANSEN: I think it's almost trying to figure out, from a beneficiary point of view, how do they get a solution for what they really need without an unfairness built in to the issue of the cost-sharing in some cases because of this artifact of generics, vis-a-vis the brand and the statutory issue that you brought up? How do we get a solution for the beneficiary that's more consistently fair?

DR. SOKOLOVSKY: I don't know if we have a real good answer to that. If somebody is capable of going through the plan finder and putting in their drugs, they can find the best solution that they can find.

When we did earlier work on this, we found that only 11 percent of beneficiaries either used it to themselves or had somebody helping them use the plan finder. This may change as more of the baby boom generation ages into Medicare. But right now it is a problem. And the

specialty tier, which now virtually all plans have, you can't put a drug on the specialty tier unless it's at least $600. But if it is, then it's coinsurance, not a copay there. It can be 25 percent but we have seen instances of over 30 percent for coinsurance there.

And people who are taking those drugs, not all necessarily but many of them, may be people who are extremely ill and there is no alternative for them.

MR. EBELER: Thank you for the chapter and the presentation. I think the recommendations do go in the right way.

I think we have to take head-on this question that you alluded to in your presentation and mentioned in the chapter, where the comment is reporting on access and quality. And, in effect, using technology to reach out to beneficiaries to fill scripts is counter to the incentives of the plan. That is the reason why you have public reporting, not why you don't have public reporting.

It just strikes me that it is critical to get those kinds of data on the table. We clearly need a clearly defined access measure. But on the quality measures as well, it just strikes me the logic has to be reversed there.

You have public reporting to give you a mechanism to assess against whatever financial incentives you have.

And second, I just think that Part D only plans, as well as the MA plans, just need to sort of in this public-private partnership work with the public sector to reach out and create that kind of appropriate access, not fight against it. It just strikes me that's a critical reporting element.

DR. STUART: Thank you, Joan.

I read this with interest and I came to the recommendations, which actually were not in the chapter that we saw. So I'm seeing these for the first time.

I guess I'm not surprised that the expert panel was confused about this because they're looking for a way to link performance measures to the PDP scope of work. And the PDP scope of work is really narrow here.

I mean what you'd really like a drug plan to do -- let's be honest. You'd want to make sure the beneficiaries get needed medications. You want to make sure that the medications are managed well. And you want to check to see whether you get the outcomes that you would expect to get from good medication management. And none of that is here.

And so you look at this.

Well all know how Part D came about -- well, maybe not. In a dark room.

But if you were to come into this particular session right now without having any background at all about Part D, and you look at these recommendations, you'd say boy, this is really thin gruel. I'd like to see something that goes a little bit beyond this.

I don't have the answer in terms of what the quality measure ought to be. But by golly, there should be a broad-based evaluation of Part D, and particularly of the standalone PDPs. I think the Commission ought to be behind that and say look, this is something that costs us $40 billion to $50 billion a year now. And we're going to evaluate it by whether there's a transmission of rejected claims? We need something more than that. And I think we ought to go on record as having something more than that.

DR. CROSSON: Joan, thank you for your usual high quality work. I had one question and then I think a comment similar to Bruce's.

The question is in terms of the search for an access measure. One of the things I wondered was might not

the best or simplest way to do it anyway would be to just ask people? So that in the survey process -- I don't know all of the questions -- but I wonder if the focus group talked about simply asking and recording the frequency with which beneficiaries listed failure of access as a problem or as a reason to switch plans. So that would be the first question.

DR. SOKOLOVSKY: I would say that in every group we heard somebody had this issue but mostly people were satisfied. So if we had a group of 12 people, there was going to be at least one person, maybe two people, who had a problem of people who switched plans because of that kind of problem. But the others would not have had that problem.

DR. CROSSON: Right. But what I was saying was the question was there was no recommendation from the focus group as to how to measure access. So my question was could you not simply measure it by recording, in some way, the frequency for each plan, the frequency of individuals who listed failure of access and ranked the plans accordingly?

The second point, it's a little along the lines of Bruce's comment, and it has do with the issue of adherence. I just think that that's an issue that is so much more

important than many of us realize, that it's going to be an area that we would like to -- I don't know if we're ready a for recommendation on making that part of the quality assessment yet.

We had a very interesting experience and somewhat humbling experience in our Colorado region right after the rollout of our clinical information system. One of the service improvements that we thought we would get by this was to decrease patient waiting time in the pharmacy. So that as the physician records the prescription in the medical record, it automatically goes to the pharmacies -- and ours are, for the most part, onsite. By the time the patient is finished with the visit, gets dressed, gets down to the pharmacy, the notion was the drug would be ready in a bag and they'd just pick it up and pop down their modest copayment and be off.

After about two weeks the pharmacy manager called up the medical director and said would you mind coming down here, I have something to show you. And in fact, there was an entire storeroom filled with bags that had not been picked up. And this is in the setting where the individual only had to walk downstairs in most cases, and in the face

of rather nominal copayments.

Within this problem of adherence and adherence to recommended refills, there's a range. If somebody decides that they'd rather not pay for a drug for their hay fever, that's one thing. But if people are not, in fact, picking up their antihypertensive agents and then coming back two months later with still elevated blood pressure and then put on a second prescription, you end up with rather dysfunctional care.

So we have a lot of work to do with this. I would suspect that since the nominal purpose of the Part D drug benefit was to try to add coverage for pharmaceuticals in order to provide a comprehensive package of benefits that would work together for the overall welfare of the beneficiaries, that leaving out or not addressing the question of whether, in fact, the people are actually taking the drugs for at least specified medical conditions where we know that the drug is effective and it has long-term health benefits and it has long-term impacts even on the cost for beneficiaries and for the Medicare plan would be a fruitful area of work.

MS. BEHROOZI: Joan, as complicated as a lot of

the stuff is that we've been talking about today, I feel like you got stuck with the hardest job because I feel like everything I want to say comes back down to it's such a fragmented delivery system. We're talking about quality when we're just talking about a payer when you're talking about PDPs, right? I mean, they're not really plans, they're just a way of covering the cost of drugs for beneficiaries. So what can our expectations be of them?

We should be able to have expectations about people's treatment; right? But holding each of these entities along the continuum separately responsible for the whole picture just doesn't work.

Anyway, thank you for the work you put into it. But I don't know what to say about the whole thing except to say obviously there are fundamental flaws with Part D and that's just one of the dimensions of those flaws, the fragmented nature of it and how it perpetuates misalignment of incentives and things like that.

I just wanted to say one thing about draft recommendation two. So we pay for people's drugs, both on the active employee side and on the retiree side. We're neither a PDP or an MA-PD. We receive the employer subsidy.

But we do that, we transmit -- well, we don't. Our PBM, we instruct our PBM to do the messaging to the pharmacist. The PBM says okay, we've done that. The members come to us and say how come I had to pay a copay for a drug that you said was free? So we go back to the PBM and we say what does your messaging say? And I don't know, John, enough about the technicalities of exactly how the message is transmitted. But they tell us this is what it says. It says you are covered in full for X drug.

The pharmacist isn't reading it off the screen to the beneficiary, to our beneficiary, to our member when they're standing there. That's not in all cases. Again, it highlights, I guess, the fragmented nature of it.

Just to have the plans or the PBMs they're using transmit the information to the pharmacies doesn't necessarily mean that the beneficiary or the physician gets the accurate information. It's certainly a good thing to have the plans do but maybe it's a little along the lines of what Bruce is saying. It doesn't quite go to the heart of it.

I'm not against it but for us it always gets screwed up at the point of the pharmacist reading the

message aloud to the beneficiary.

DR. STUART: I just wanted to follow up on the business about having a fragmented system. I think that's the whole point about having an evaluation, is if every PDP plan was successful according to these two draft recommendations and others that we were to come up with -- it would be processed-based because that's all they do -- we could say well, these things work like a charm, they're great. And I think we need more than that.

And so knowing what the impact of a fragmented system is is really important to our business here as commissioners for Medicare.

MR. BERTKO: Let me only reiterate what Jennie said about half an hour ago. If we went to any kind of medical home and you had to download a Part D summary, which would be trivial to execute, you would have a great help with that. In fact, it could be in the PDP's interest to coordinate and manage the drugs as well as the Medicare fee-for-service.

DR. DEAN: I just wanted to make the same point I think I made once before, is that we need to have some mention of geographic access. In our setting -- and I think

there are some regulations relating to it, but they apparently don't have much teeth. I work with the only pharmacy in a 50-mile radius. And they have contracts with most of the Part D plans. But there's one major company that they felt they just couldn't abide by their payment levels and don't.

And so I have a fair number of patients who have to go 50 or 60 miles to get their prescriptions or wait for it to be sent by mail order. And it can be a real problem.

I remember one of the staff sent me some information about the geographic regulations but apparently they are not being very forcefully enforced or I can't remember how stringent they are. But it is a problem in our area.

So some measure of geographic access, I think, would be appropriate to try and work in there.

DR. REISCHAUER: Do people stay in those plans more than one year?

DR. DEAN: Yes, because they're cheap. It really boils down to whatever is the premium. That's what sells it. That's what sells it. And they put up with that.

DR. REISCHAUER: So they don't count gas.

DR. DEAN: You would be amazed at how far people will drive to save a quarter on a loaf of bread. It blows my mind. But they will do that. Talk about false economy, but it happens a lot.

I just mention that of the rural health care system, pharmacy services I think are one of the most threatened elements of the whole rural health care system. And Part D is a big element of that, that they have been so squeezed by the PBMs that we are beginning to have to look at what kinds of alternative structures we could use when the local corner drugstore isn't there anymore because that is very, very close to happening.

DR. SCANLON: John, doesn't this violate the geographic in terms of access? I thought that you had to have a pharmacy within a certain number of miles in urban areas and a certain number of miles within rural areas? And 50 miles is not the number I remember.

MR. BERTKO: There is a requirement. I don't recall off the top of my head what it is. It could be that it's being interpreted on average for a state like Tom's. I don't know though.

DR. DEAN: [off microphone.] I don't know either

what the numbers are. I just know that this is what's happening in my own location.

MR. HACKBARTH: Okay, Joan, thank you. Well done, as always.

Our last session for today is on fee-for-service benefit design.

DR. SCHMIDT: So this afternoon we're continuing the discussion about fee-for-service benefit design that we started last December. We're looking at this topic in part because of the realization that policymakers will need to use a combination of approaches to improve the outlook for Medicare's long-term sustainability. The goal here is to think about whether changes to fee-for-service benefit design could encourage beneficiaries to use appropriate care when they have some discretion about it, be somewhat more sensitive to the cost of the care that they use, and seek care from more efficient providers.

Let's recap what we talked about last September. There are some key shortcomings in fee-for-service Medicare's benefit design that need addressing. First, it has no cap on beneficiaries' cost-sharing liability, and that risk of potentially large out-of-pocket spending, as

well as the difficulty beneficiaries have in predicting what they might owe out-of-pocket, leads most individuals to get supplemental coverage through retiree plans, Medigap policies, and Medicaid.

If policymakers were to make changes to fee-for-service benefits but didn't take supplemental coverage into account the benefit changes could be entirely ineffective. That's because supplemental coverage fills in some or all of Medicare's cost-sharing, so supplemental coverage could undo what the benefit change was intended to do.

If we rank Medicare beneficiaries by their total spending, the top 25 percent of beneficiaries account for more than 85 percent of total spending. So it's very concentrated, as we've talked about. This concentration has implications for how cost-sharing liability gets redistributed if policymakers redesign fee-for-service benefits.

All Medicare beneficiaries are facing pretty steep increases in costs for Medicare premiums, deductibles, coinsurance, and supplemental coverage. At the same time, as we've said, there are some underlying problems that need addressing in the benefit. But due to Medicare's problems

with long-term financing, if policymakers change the fee-for-service benefit they will probably want to do so in a budget neutral manner. So if they were to cap out-of-pocket spending for the smaller number of beneficiaries that account for most of the spending, that would probably involve redistributing the out-of-pocket burden around more evenly.

In September some of you debated what is in the research literature about how out-of-pocket spending affects use of services and health outcomes. This motivated us to go back and review the literature and then try to lay it out in a way that will help all of us think about what is most applicable to fee-for-service Medicare. So that's what we're going to do over the next few slides.

First, let's take a minute to remember what health insurance is supposed to do. One important function is to reduce an individual's exposure to financial risk and catastrophically high out-of-pocket spending. At the same time, insurance shields people from seeing the full cost of care. So insurers and payers believe that insurance should deter use of low value services by leaving some portion of covered services unreimbursed. And here by low value

services I mean that beneficiaries wouldn't have used them if they had had to pay for them themselves.

Some analysts think it's often a good thing to use different rates of cost-sharing for different kinds of services. The idea here is that a benefit should charge less cost-sharing for services when the beneficiary needs the most protection, for example, a surgery and hospitalization in a life-threatening situation. On the other hand, higher cost-sharing may be appropriate for services that are more discretionary. Ron had an example back in September that CMS now allows beneficiaries to pay the out-of-pocket to have vision correcting lenses implanted rather than traditional lenses during cataract surgery.

This all sounds straightforward but all of you know it can be difficult to draw the line between which services are of higher and lower value. One thing that would help draw these lines is a more solid body of evidence on which therapies are comparatively more effective than others, and for which subpopulations of patients they are most appropriate.

MS. MOORE: So now turning to the literature on cost-sharing, I'm going to mention some things to keep in

mind and then take you through the research.

So first, many of these studies don't use a randomized experimental design. Without this it can be difficult to control adequately for non-price factors that influence the use of services such as an individual's underlying health status or propensity to seek care. Specifically, it's hard to completely separate the effects of selection bias, which is the tendency of sicker individuals to seek insurance coverage more readily than healthier persons, from the pure response to a change in cost-sharing. The differences in the way researchers have controlled for these non-price factors have contributed to a wide range of results in the literature.

Other factors to consider include the time horizon of the analysis and the population studied. Some studies are over 30 years old and since then health care costs have grown more rapidly than the economy as a whole. Care that was once provided in the hospital is now routinely supplied on an outpatient basis. Medical technology now includes better diagnostic screening and minimally invasive surgery, and prescription drugs are a more widespread mode of therapy.

Another consideration is study duration, because the long-term response to a change in cost-sharing could be different from the short-term response. For our purposes, we also want to note that a lot of the literature on cost-sharing excludes the elderly.

So the type of insurance product being studied is also important. In managed care cost-sharing is often much lower than indemnity insurance and patients may be less free to use certain providers and technologies, and this could affect results.

In terms of outcomes, price changes can have effects beyond change in service use. Some studies consider health outcomes such as mortality rates but more look at a use of appropriate services or adherence rates for prescription drugs with the implication that a reduction in either of these could have a negative impact on health.

Of course, guidelines for appropriate care may not have been developed specifically with the elderly in mind.

Other researchers, including our own Bruce Stuart, have looked at offsets such as whether increasing cost-sharing for prescription drug expenditures increases overall medical expenditures.

So now we're going to start with the familiar first. As many of you know, the Federal government funded the RAND Health Insurance Experiment -- which I'm going to refer to as HIE -- in the mid-1970s to examine how people respond to cost-sharing. Results from this experiment suggest moderate sensitivity to cost-sharing. So a 10 percent increase in price leads to about a 2 percent decline in the use of services.

To put this in perspective, this response is lower than estimates of price sensitivity for gasoline and new car purchases that were studied at about the same time.

HIE also found that individuals were less responsive to cost-sharing for hospital care and more responsive for well care with acute and chronic outpatient care falling in between. The main effect of higher cost-sharing was that people initiated medical care less. Once they were under medical care, their costs were only slightly lower. So to put it another way, there were fewer episodes of care but costs per episode were only slightly lower.

They also looked at response to cost-sharing by health status and found that the sick were no less likely to reduce their use of medical care than the healthy. And this

is somewhat unexpected because medical services for the sick are generally thought to be less discretionary than medical services for the healthy.

Averaged across all participants, higher cost-sharing did not affect health outcomes adversely. One exception was participants with both low incomes and poor health who had some better health outcomes under free care than cost-sharing.

HIE remains the most comprehensive study on response to cost-sharing, particularly because of its ability to control for selection bias. In terms of relevance to the Medicare program, the HIE looked at indemnity insurance and approximately 80 percent of Medicare beneficiaries are covered under fee-for-service, which is indemnity. On the other hand, the study excluded the elderly and was conducted over 30 years ago.

We also looked at literature on supplemental insurance. Researchers agree that Medicare beneficiaries with Medigap or retiree health coverage have higher use of services and spending on average than those with no supplemental coverage. There are two main explanations for this higher spending.

The first is that supplemental insurance shields people from most or all out-of-pocket spending at the point of service and so people use more than they might otherwise would. The second explanation concerns selection bias. That is the tendency for people who anticipate using more medical care to seek out supplemental insurance more readily than people who don't anticipate needing care.

So to figure out the effect of out-of-pocket spending, studies make an attempt to control for selection bias but there's disagreement because after controlling for selection bias some researchers say that spending by those with supplemental insurance is 25 percent higher. This result is generally consistent with HIE. But a whole another group of researchers find that the higher spending disappears after controlling.

We're now going to look at literature on prescription drug use among the elderly. It's important to note that most of these studies were carried out within the context of managed pharmacy benefits. This literature suggests that the elderly are moderately sensitive to cost-sharing for drugs. Higher copays and capped benefits are associated with lower drug spending. The responses in the

literature range from levels found in the HIE to levels three times as large.

We also find a correlation between increased cost-sharing and lower drug adherence. For some elderly, such as those in poor health or with specific chronic conditions, this lower drug adherence has been found to increase overall spending or result in negative health outcomes. But there is no evidence that this is the case for all elderly.

And I want to really quickly mention a recent elderly-specific study that's noteworthy because it was a natural experiment and can control a little bit better for selection bias, and looked at an increase in cost-sharing in both drugs and physician visits.

The results indicate there were reductions in service use greater than those found under HIE. But there were also offsets in the form of increased hospital use. Both the response to cost-sharing and the hospital offset were more dramatic for those with chronic conditions or high medical spending.

DR. SCHMIDT: So we were looking to the literature to help us think about an issue that John raised last September, whether our estimates for how much more

beneficiaries spend when they have coverage that wraps are on Medicare are too low.

The literature suggest that beneficiaries are moderately sensitive to price and even relatively modest price sensitivity can have big dollar implications when we're talking about a program as large as Medicare.

We also saw that in one specific area of the literature people that have supplemental coverage to Medicare spend on the order of 25 percent more than people with similar health status and no supplemental coverage. But as you just heard, there is some disagreement among analysts as to how large that effect would be after you control for the fact that sicker people tend to seek out more coverage.

So this matters because if this insurance effect, the pure effect of a change in cost-sharing, is larger than what we estimated in September, that would free up resources that would allow us to do other things such as introduce catastrophic protection within the fee-for-service benefit.

The specific option that raised this issue was a case that would prohibit Medigaps and retiree plans from covering the Part A and Part B deductibles. Supplemental

plans could cover all of the rest of Medicare cost-sharing if they wanted to, but not the deductibles.

Back in September our contractor, Actuarial Research Corporation, estimated that this would lower Medicare fee-for-service spending by about $2 billion in 2007 or less than 1 percent per year. ARC's assumptions about the effects of insurance on spending are generally lower than what you would get using results from the health insurance experiment.

We asked ARC to use higher assumptions consist with the HIE and this time they estimated that fee-for-service spending would be about $10 billion lower in 2007, or about 5 percent lower per year. So clearly this assumption makes a big difference.

In response to John, after reviewing the literature, we take your point. We think the preponderance of evidence suggests that supplemental coverage does lead to somewhat higher Medicare spending. But also, given the disagreement in the literature, we think it would be important for us to show some sensitivity to that by using some lower assumptions, as well

Now let's move on to a different question that

Nancy Kane raised in September. You may remember this slide before, which shows how concentrated Medicare spending is. You can look at the two right-hand columns, in particular, for an overall sense of things.

So the top 25 percent of beneficiaries when ranked by their spending account for something on the order of 85 percent of total spending. Nancy asked, given this degree of concentration in spending, whether it makes sense to change benefit design for all fee-for-service beneficiaries?

So maybe a better approach would be to change provider incentives for those who are caring for the sickest beneficiaries, for example getting those providers to coordinate their care, sending those sickest beneficiaries to efficient providers, and those who deliver particularly high quality care, those types of steps.

I think the answer to her point is yes, that makes sense to the extent that you can identify who is likely to be among the highest spending group. And then, in turn, depends on whether people are persistently high spenders over time.

So here's some evidence we put together several years ago for the Commission on that particular question.

On the left you see the data for the top 25 percent of beneficiaries when they are ranked by their Medicare spending. And among this group, 50 to 60 percent of those beneficiaries remain among the top 25 percent in subsequent years. So you can see year one, two, three and so on.

I think this degree of persistence in spending is what has given rise to initiatives for disease management and care coordination within Medicare. However, we need to remember that there isn't yet strong evidence that these kind of initiatives lead to savings.

Also, I should point out that it's hard to predict who will be among the very highest spenders in a given year because there is more year-to-year turnover and mortality affecting these higher ranking groups. On the right-hand side you can see the same sort of slides for beneficiaries who were ranked among the top 1 percent of all beneficiaries in terms of their spending. In subsequent years about 30 percent remained in the top 1 percent one year out but that number drops off over time.

There are still other reasons policymakers may want to change fee-for-service benefit design for everyone. Even if the other three-quarters of all beneficiaries only

account for 15 percent -- so I'm using the inverse of the 25 percent accounting for 85 percent here -- 15 percent of total Medicare spending is still a significant amount of money. And using fee-for-service cost-sharing to steer all beneficiaries towards higher quality or more efficient providers could help change the way providers care for everybody, including the sickest beneficiaries. Or policymakers may want to change fee-for-service benefit design on grounds of equity, to reduce out-of-pocket liability for the sickest beneficiaries and spread cost-sharing around more evenly.

Now let's move on to a question that Jay raised in September about the redistributive effects of the illustrative cases that we looked at. And by that I mean what share of beneficiaries would gain or lose relative to what they pay out of pocket in fee-for-service Medicare today.

Remember that our contractor estimated these effects using a simulation model that we described in the fall and we aimed to keep Medicare program spending budget neutral.

This slide shows you that illustrative case, and

it has a lot of moving parts you can see on the slide. It's got combined deductible and a catastrophic cap and it keeps Medigaps and retiree plans from covering the deductible. It would use 20 percent coinsurance on all services except for hospice.

So beneficiaries that have a hospitalization would have much higher cost-sharing on average because they would be paying 20 percent of covered charges rather than the Part A deductible.

On the other hand, beneficiaries who now pay say 50 percent of allowable costs for outpatient mental health visits or those who are paying on the order of 40 percent for services in hospital outpatient departments would see some relief from cost-sharing.

Now let me warn you that this slide is somewhat different from what is in your mailing materials because for this slide we used a higher assumption about how supplemental coverage leads to higher Medicare spending consistent with what we talked about a few slides ago. And so that, in turn, affect the district of financial outcomes in this pie.

You can see that for the combination of out-of-

pocket spending plus our crude estimates of how the scenario would change Medigap and retiree premiums nearly half of fee-for-service beneficiaries would have lower combined costs and about a quarter would have higher combined costs.

Jay had asked for more detail about the size of those higher and lower costs to get a sense of the intensity of the pain or relief that beneficiaries might feel. This is a version of the same distribution of beneficiaries but a little bit more detail about the size of the spending changes.

You can see that there are three blue pieces of the pie, and those are the beneficiaries whose net spending for out-of-pocket cost-sharing and supplemental premiums is higher. Those three pieces add up to 23 percent of the pie you saw on the last slide. Among these people who had net higher spending, most would pay $100 to $250 more for the year.

Similarly, the three yellow piece of the pie are individuals whose net spending is lower, the 48 percent from the previous slide. You can see that the majority of these people have net financial gains of between $50 and $500 for the year.

We want to leave you with a few questions to discuss. For example, which features of the fee-for-service benefit design are most in need of changing? How do you feel about the issue that we talked about with respect to beneficiaries' response to higher cost-sharing? Should we be more consistent with the Health Insurance Experiment? Should changes to cost-sharing for all fee-for-service beneficiaries be paired with better incentives for providers who care for the sickest individuals? And how might we phase in changes to benefit design over time?

Next month we'll continue this look at fee-for-service benefit design with a discussion of other goals for using cost-sharing. Arnie articulated some of these ideas last fall. For example, policymakers might want to steer beneficiaries towards providers with better track records of quality and efficiency.

John talked about also maybe using it to encourage primary care. Or we might want to use it to move beneficiaries towards therapies where there's a more solid evidence of comparative effectiveness.

MR. BERTKO: Just a quick comment. First, thanks to both of you guys for doing all this extra work. It's one

thing to have my suspicions validated as to actuarial rules of thumb.

The one comment that I would add here that might be of some value is your comment about trying to balance the two estimates with the effects of selection. I would point out that much of this is under Medigap, which has very defined open enrollment rules. There's a window of six months in which people can choose to join in. I think plan C is the exemption from that. But for all of the other plans you have to think about it when you're 65 and go in or not.

That doesn't say selection is missing but it also means that you can't choose the richest plan when you're actually much sicker at say age 74 or age 82. So there will be some selection but I would put it on the lower end of the scale as opposed to the greater end of the scale.

DR. REISCHAUER: You can switch plans. Once you've made an option to go in at age 65 then you're free to switch and still be under --

MR. BERTKO: Right, but the big option is do you have Medigap or not? When you look at the main coverage issues, Part A and Part B cost-sharing, they're virtually

the same. There's not that much cost difference between them. The extra benefits you get from -- most people are enrolled in I think three of the 10 options. Yes, you can switch, but so what?

DR. REISCHAUER: Now you can switch into one with a catastrophic cap, too.

Let me make sure I'm understanding these charts right and then ask you a question. Slide 10, when the bars get smaller, it's because people are dying; right?

DR. SCHMIDT: That's right.

DR. REISCHAUER: So there's missing people.

DR. SCHMIDT: The difference in the height from one year to the next is mortality.

MR. BERTKO: I'm actually on the old MedPAC side of this responsiveness and not on John's for several reasons. One is when we're talking about people at the high end of the spending, there's a big chunk of them for who this is the last year of life. I think cost-sharing is not the first thing that they have on their minds.

Secondly, there are a certain fraction of them that are duals; right? And they don't face any cost-sharing. And there's another chunk who are persistent here

who, if they are in these high spending categories several years in a row, they will be duals. You can age into the situation.

And so I think, going to the RAND study, the under-65 is not necessarily a right way to go to get these parameters.

I also wondered, we talk about these people like there's the top spenders and us, or the rest. I know CBO did some of this and we had a consultant do some work here. But I just wondered if anybody has looked at over your lifetime on Medicare how many people spend zero years in the top quintile, one year, two years, three years, like this. Is it that the vast majority of people at some time or another do fall into this top category, whatever you want to choose it to be?

If that's the case, I think you look at this a lot differently and you sell it to people a lot differently then sort of like you're 65, but do you want to buy this extra protection for catastrophic rather than you're going to need it -- it's highly likely that you're going to need it some time?

DR. SCHMIDT: I'm aware of studies that have

looked over the entire lifetime but maybe someone else around the table. Bruce?

DR. STUART: I was just going to say I think what Bob is saying is he'd like to see it turned around. In other words, he'd like to see at what leads up to cost-sharing being a high spender.

And I don't think that study has been done yet. Although, you've got the data. You could turn it around.

DR. KANE: Aren't there information like you have a one in five chance of needing long-term care, which usually means you're going to --

DR. STUART: Sure, there's that. But what you really want to know is you want to know not just what those bars look like leading up to high spenders. But you also want to know what triggers it. But that's not a cost-sharing issue. That's really kind of a care management issue.

DR. KANE: What we want to know is what chance do you have of being in the top 25 percent? What's your lifetime chance? If you know what it is for long-term care but we don't know what it is in your top 25? I think we must know that somewhere.

DR. SCHMIDT: We know some things like on the order of a quarter of total spending is for people in the last year of life, statistics like that.

DR. KANE: [off microphone.] But a lot of people never spend and die.

DR. SCHMIDT: That's true.

If I could make one comment about your comment about duals. For the purposes of our modeling, I think it's useful to remember that we did not apply rules about what Medicaid could fill in to dual beneficiaries. So they paid no cost-sharing or there were no changes to their cost-sharing in our simulation model.

DR. REISCHAUER: I was just saying that when we're thinking about the responsiveness to higher copayments, why Medicare might be different from the rest is there's a chunk of people who tend to be high spenders who face no cost-sharing.

MR. EBELER: This is very well done. This issue has been with us since the beginning of the program in many ways. The difficulty here is as you walk down the road to policy options, sort of the option that says -- and I do not dispute the data. I am not going to -- the actuaries and

economists have determined that elderly people can't insure against the deductible is a pretty tough option, even though it may make sense.

That's a tough nut to crack. There's always been a discussion of coming up with some actuarial estimate of what the cost is, in effect charging the Medigap carriers a surcharge to make the Trust Fund whole, in effect, for their extra utilization. But it's a tough option.

Particularly in the context of the evolving Medicare Advantage program, and a lot of plans there that have no particular capacity to manage care, but which are paid pretty generously. If we set up a system where the only way the elderly can get their deductible covered is to go in that direction, and we're paying the wrong way in that direction, we're going to save 10 percent over here and spend 12 percent over here.

So I just think you really have to think about moving from the analysis to the policy instrument here because it's a very difficult policy instrument. I've never quite figured out how to pull the trigger on the policy instrument.

DR. MILSTEIN: I think that all things considered,

we're going to get more yield from incentivizing providers than incentivizing seniors. That's my view.

But that if we are going to consider incentivizing beneficiaries, I think it's important that we, in keeping with our theme of encouraging value, shy away from blunt instruments and begin to -- however imperfect our measures may be -- use beneficiary cost-sharing to encourage use of better performing providers. And even though the cupboard is relatively bare, better performing treatment options, if I can stretch the metaphor a little bit.

So that's my view. We have places to start. For example, a modest beginning might be to encourage through lower beneficiary cost-sharing for those who actually do have cost sharing, or some kind of a rebate for those who are dual eligibles tilting toward providers that may be initially are participating in and scoring well in our P4P programs. And perhaps time to sort of synchronize with the point at which our P4P programs incorporate not just quality but also efficiency. Because that's the only way that you could begin to hypothesize impact on Medicare spending trend while lifting quality.

Since it would take -- since we started out with

P4P reporting only and then quality and then we hope phase three is quality and efficiency, maybe we might dovetail such an incentivization of beneficiaries to encourage selection of higher value options with the advent of information on relative provider value and relative treatment option value.

DR. SCANLON: In response to a number of comments, I look at this more from the perspective of how do we get catastrophic coverage into Medicare? We're talking about pretty poor insurance when you don't have catastrophic coverage. And for some people we're talking about $5,000 or $10,000 in out-of-pocket expenses on incomes of maybe $15,000 or $20,000.

To Bob's point about the duals, the good news may be you're on Medicaid. The bad news is how you got there. You bankrupted yourself to get there.

And then compounding the bad news is the fact that states don't all pay the copays. And so therefore you may then have an access problem to deal with as well.

To Jack's point, I guess the other thing is that we shouldn't only be thinking about providing the catastrophic coverage, but let's look at the deductibles and

whether or not the deductible -- you can get insurance for the deductible becomes a different issue if it's unified deductible of say $250 as opposed to the way it's structured now with a very large hospital deductible which a lot of people say doesn't make sense because that's one of the least discretionary services that you're going to use.

And then if we say that you shouldn't have insurance for that, it's maybe potentially more reasonable. But when you start to think about it, if it's a reasonable deductible do I want to pay somebody 40 cents to write a check for a dollar? That's what it comes down to with the supplemental plan, roughly. The loss-ratio requirement is either 55 or 65 percent and we used to have to do analyses to see that they were meeting those loss-ratio requirements. They weren't that far off.

Partly it's individually marketed. So you end up do having a very high load on those. So there's a question here about we may be doing beneficiaries big favors from a number of perspectives in terms of a better insurance policy and not buying something that has a very high cost for the value that you're getting.

DR. CASTELLANOS: I'd like to carry Arnie's point

just a little bit, and I want to be very, very careful how I say this. We've looked at all the Medicare providers. We want all the providers to have appropriateness of care, efficiency, quality, and resource use.

The other end of the equation is the beneficiary. And with cost-sharing, not saying we're doing it but we're pushing them towards appropriateness of care, resource use, quality, and efficiency. So I don't see anything wrong in going in that direction if it's done correctly. And I want to be very careful about that.

DR. REISCHAUER: If you thought about providing catastrophic coverage through Medicare, and now that we have a drug benefit, the package for middle class kind of people is more or less than adequate package not too dissimilar from the average employer-sponsored package. You could see the participation in Medigap begin to decline, I would think. And that would have salutary impacts in a voluntary kind of way.

MR. HACKBARTH: People weren't really buying a lot of drug coverage through Medigap, is my recollection. I thought you were saying that because they have it now they're not going to buy Medigap.

DR. SCHMIDT: Isn't he referring to that if you added catastrophic protection?

DR. REISCHAUER: Right.

MR. HACKBARTH: Oh, I see. You may not have to force it. Okay.

Others?

DR. STUART: This is just a quickie. One of your questions was do you want to use your assumptions here consistent with the HIE.

And I agree with Bob. I think that it's not only old and it doesn't deal with the old, but there was a special feature of that experiment that made it possible to conduct, which was everybody was held harmless. So that if you had people that had high out-of-pocket spending, they knew that they were going to get something back. And so that would lower the estimated effect of cost-sharing. So that's one reason that I would be very careful about that.

The second is that the new studies that have been done in the last decade or so are just better studies than the older secondary data analyses. There are just better techniques out there.

And the fact that you find different measures of

price sensitivity, in large part I think is due to the fact that you've got different populations. You've got some heterogeneity under there. And trying to understand that heterogeneity may be important to the policy decision about what you do with deductibles, depending on who's going to be subject to those deductibles.

So I think that part really does bear some additional analysis. And for that you're going to have to use secondary data. You can't go back to the HIE for that.

DR. SCHMIDT: The newer study, the newer literatures that you're discussing, are mostly on drug benefits; right?

DR. STUART: I'm talking about all of the studies. It's not just drug benefits. It's looking at responsiveness to other services, as well.

DR. SCHMIDT: One thing we raised in the paper is that an issue with newer studies is that many of those are taking place in the context of managed care. And could it be that the price sensitivities in that context are maybe somewhat different from those in an indemnity --

DR. STUART: I think that gets to the heterogeneity, in part. And the reason that many of these

studies have focused on managed care is because there are all of these little natural experiments. One of the things that managed care plans do is that they frequently change their coinsurance policies and so you've got that piece that you can analyze.

But that's what you're trying to do here, too, is that you're looking at something that's going to change and you want to know how people's behavior is going to change in response to that change.

DR. MILLER: So we'll do some sensitivity analysis, is how we're going to navigate this problem. Thank god Joe Newhouse wasn't here when you said that about HIE. There would have been a scrap on the table.

MS. HANSEN: This is more of an observation. As we've been looking at coverage for the uninsured and some of the state plans that have moved ahead, and they do have catastrophic coverage, one thing that became so palpably visible that there is no comparable when you talk about the Medicare population because some of the state plans are saying there's a maximum spend that we have. But then the Medicare plan is wide open, which obviously then potentially leads to -- as you were saying, Bob -- the fact that people

could spend until they get to being a dual eligible.

So I guess that becomes this catastrophic coverage, per se. But it's not a built-in part of the policy side of it. But the policy design now of many of the plans for the states that are trying to cover their uninsured, they actually have a catastrophic top there.

DR. REISCHAUER: There is an experiment to be done comparing FEHBP retirees with Medicare, the people who are not covered by Medicare.

DR. SCHMIDT: Can you lay that out a little more for me? I'm sorry. Can you lay out what you mean a little more?

DR. REISCHAUER: There are retired Federal employees who have BlueCross BlueShield plan and no Medicare. And so they're under a different cost-sharing than somebody in Medicare with a supplemental policy.

DR. SCANLON: It depends on the individual because they had the option of being in Medicare and a lot of them had been in Medicare when the Part B medium was low. Now that it's means tested, maybe more of them are not going to sign up for Medicare. But BlueCross is an example of one of the major FEHBP plans. They will operate as a supplemental

for you so that you have zero cost-sharing when you have opted for B under Medicare. So some people might qualify for the experiment and others won't.

DR. REISCHAUER: I know.

MR. HACKBARTH: Last word, Jay.

DR. CROSSON: I'm trying to sort out sort of where we are with this question. So I'm going to be a little reductionist here.

But it sounds to me like we started out saying isn't there something we could do in the area of catastrophic coverage to prevent people from being bankrupted within Medicare and improve the quality of the insurance policy, if you will.

It sounds like what we said was that one way to pay for that is through an uninsurable deductible, which is about $172. Is that right?

DR. SCHMIDT: Yes, using the higher assumptions.

DR. CROSSON: Okay, so using the higher assumptions.

And with that, and with people then not having to pay for that through Medigap premiums, about 75 percent of people would either save money in the end or have a trivial

increase, less than $50. So tell where I'm wrong here. For $172 up front and a 75 percent chance of coming out virtually even or not, you then get protected against catastrophic loss?

MR. BERTKO: Correct.

DR. CROSSON: Assuming the pricing. Then we wondered whether this is politically salable or not. It seems to me like it might be. Because it sounds like a pretty good deal. Isn't that something that we could test in some way to see what the waters --

MR. HACKBARTH: We'll send you out.

[Laughter.]

DR. CROSSON: I still have two years to go. You wouldn't want to lose me this early, would you?

So what am I missing here?

DR. MILLER: I think some of the things that maybe Jack was referring to and others of us who have probably some scar tissue to show on this -- and I think it's too bad that Anne Mutti isn't still here.

But you might be surprised -- in fact I'll say you will be surprised -- by how people's reaction to not being able to insure against first dollar coverage, regardless of

the amount, plays in the policy process. It's quite remarkable.

And then also, the other thing that happens in these kind of situations, you're right, you look at these kinds of things and you think look, on net most people are coming out better and the dollar amounts are prepared. But you're also, in that light blue one, a bunch of people just took a hit. And that won't be missed.

And so I hear you, and what you said is exactly what we're driving at. I think that is where we're headed with all of this work. Rachel, is that correct?

But I just don't underestimate, there's a whole industry built around insuring first dollar coverage and it's not small.

MR. HACKBARTH: What can we say about the people that are in the blue? What are the characteristics that people who end up losing under this reconfiguration?

DR. SCHMIDT: I think it's going to be people for example who have a hospitalization where they're paying 20 percent coinsurance on covered charges, and that's typically a lot higher than just paying the Part A deductible. But maybe not as high as the $3,100 cap on out-of-pocket

spending. It's that type of a person.

MR. HACKBARTH: And so potentially it's people who are quite sympathetic and it leads to this is a sick tax, people wanted to insure against it so that they didn't have this burden.

DR. REISCHAUER: That was my original point, which was over a lifetime maybe you're in the yellow, 98 percent are in the yellow a sufficiently long time. So the fact that they're in the blue for three years, they're still net better off big time. And without being able to show that...

DR. KANE: Wouldn't the people who no longer provide first dollar coverage be able to provide catastrophic coverage?

MR. BERTKO: No. there would be no policy. That's part of Medicare fee-for-service.

DR. KANE: I see.

MR. HACKBARTH: You're making a private purchase.

But I think that there is still something worth maybe pursuing here. I agree with Jack's political assessment. This has been discussed in various ways over the years. It's never an easy sell but I'm not quite ready to say it's not worth pursuing.

DR. REISCHAUER: I want you to stake your chairmanship on it.

MR. EBELER: I did not mean to imply that we shouldn't pursue it because we need catastrophic coverage in this program and we need to revise the front end cost-sharing.

But this mechanism where you preclude people from buying an insurance product that they have opted to buy for many years is a very difficult mechanism to implement. The question is are there other ways to get there.

Bob may be right. If you make Medicare a decent enough benefit package, over time the market erodes of its own -- it's just not worth it. But it's a difficult place to get to.

MR. HACKBARTH: There are two political constituencies here. One is the beneficiaries and how it's received by them. The other is the insurance industry and how it's received by them. So even if you could persuade the beneficiaries this is a good deal, you still have the other hurdle to deal with. But we'll be back to this.

Thank you. Good work, Rachel and Megan.

Okay, we are down to our public comment period.

Please keep your comments to no more than a couple of minutes. Begin by identifying yourself and your organization. And if you see this red light go off, that means it's time to complete your comment.

DR. GREENO: Thank you. I'm Dr. Ron Greeno. I'm representing the Society for Hospital Medicine. We're the organization that represents the nation's 22,000 hospitalists.

We were unable to comment after the session this morning but I did want to clarify something that was presented in the PowerPoint presentation this morning. And that was the comment that -- there was a comment that the most common model for compensating hospitalists was basically a reward for volume, a fee-for-service model. I would agree that that's true.

The conclusion, though, was that paying based on volume increases incentives for admissions and that is where I would like to make a point of clarifications.

Hospitalist programs do not generate admissions. Hospitalists, by far and away the majority of hospitalist programs all over the country only see patients after they have been admitted to the hospital. In other words, they

only see a patient after some other physician -- either an emergency room physician or a primary care physician in their office -- has decided that that patient needs to be admitted.

And so whether you incent -- we agree that the best way to incent hospitalists is not to pay them on an RVU-type basis. Unfortunately, that is still the vast majority of how the variable portion of their compensation is paid. We agree that there are better ways to do that, including quality and patient satisfaction.

And there is a very rapid movement, quite frankly, in the hospitalist field to move towards those kinds of compensation measures. But I would disagree that paying by RVU increases admissions, because it just doesn't.

We don't control who gets admitted to a hospitalist service any more than an emergency room physician controls who walks into their emergency room. We see who we're asked to see and care for them from that point on.

I just wanted to clarify that for the hospitalists that we represent.

Thank you.

MS. McILRATH: I'm Sharon McIlrath with the AMA.

First, I'd like to thank the Commission for recommending the positive update.

Then I would like to remind you that, though I didn't hear the word once today, we do still have the SGR, that the latest prediction is that there will be 16 percent cuts between now and January, maybe in two steps or maybe in one step.

And then to suggest that in some of the chapters that you might want to acknowledge the role that the SGR may be playing in terms of driving volume and some of the other issues that you were discussing.

Then I would like to respond to the several comments that were made about the inequities of the RUC process. I think it would be useful to go back and review the history of the several five-year reviews. The first five-year review, the RUC recommended significant increases in the E&M codes. Then HCFA did not accept all of the increases that were recommended. They gave those services a lower increase.

In the second five-year review the primary care specialties, in part because they felt that since HCFA had

not accepted the earlier recommendations of the RUC, did not attempt to have an increase.

And the third review, the rationale for raising those services again was because they were never valued appropriately in the first place, and going back to the original RUC recommendation. I mean there were other arguments made but that was the one on which the recommendations were based.

So I don't think that -- maybe it was an unintentional implication, but there was an implication I think in the discussion that it was the RUC that prevented primary care from getting increases. I just think it would be appropriate to remember that there were a lot of other people that were involved in the process and that there are practice expense values that you might want to be thinking about in addition to the work values. It's not all about work.

That the RUC is now looking at -- they have several screens that they've put in place and they have identified codes. They are working through them. It is not going to be an easy process. But trying to identify and make some recommendations to CMS on some of the overvalued

codes. So the RUC is trying to change.

But all of that being said, then I think that let's go back to the recommendation that you had for changing the conversion factor for everyone in order to finance an increase for primary care services, however those end up getting defined. I think it would be useful to have the staff put together some simulations for you on what would happen if you gave certain sizes of increases to primary care. How much would you have to cut the conversion factor for everyone else to do that?

And then if you did it and the SGR was still in place and you had -- let's say it was this year or last year when they did the five year review. It ended up being a 5 percent across-the-board reduction for almost everyone. So let's say it was something similar to that.

So you have a 16 percent cut for most of -- for everybody. Then you have 5 percent on top of that for all services except whatever E&M services that you identify. And then you have say it was an 8 percent, which was similar to what they got. You have now 21 percent minus 18 percent, you still have even primary care sitting there with a very significant reduction.

So as long as the SGR is in place, you can do a lot of things but you're not going to get to the bottom of the problem that everybody is having.

Just also to note that the 55 percent of what the internists do, according to this table, are other services. So you're cutting them on 55 percent of their services and raising them on 45 percent. So where do you end up then?

I just think it just would be -- if you're going to do this, to do it in a budget neutral manner does not make sense. As someone said, particularly when if there are savings from these things, they're likely to be over on the hospital side. I just think you need to look a little longer at how you might fund it.

MS. DODERO: Denise Dodero with the Association of American Medical Colleges. We represent U.S. and Canadian medical schools and major teaching hospitals.

My comment relates to your earlier discussion this afternoon around physicians and financial relationships with other entities, and particularly an observation that was made about the fact that during a physicians' formative years they may be influenced in terms on their thinking on this whole topic.

I wanted to just inform you that the AAMC, over the past several years, has convened a variety of task forces and expert panels and produced a number of documents and guiding principles on this topic. We would be happy to provide those to you or give you access to our staff and member experts.

I would additionally add that, as timing would have it, if you were to go to our homepage -- at least as of last night -- the top topic on there is around conflicts of interest and some recent work by the AAMC. So I would offer that materials or information for your use if it would be helpful.

Thank you.

MR. HACKBARTH: Okay, we'll reconvene tomorrow at 9:00 a.m.

[Whereupon, at 5:26 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Thursday, March 6, 2008.]

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 6, 2008

9:04 a.m.

COMMISSIONERS PRESENT:

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

NICHOLAS J. WOLTER, M.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: We have two sessions scheduled for today. The first is on refining the payment system for skilled nursing facilities.

Carol, will you lead the way and introduce our guests?

DR. MILLER: Actually, I'm going to do that quickly.

I just want to acknowledge and introduce Bo Garrett and Doug Wissoker from the Urban Institute.

They here today, they have done the work in developing the models that we are going to go through and the simulations that you are going to hear about.

Often our conversations go in kind of policy directions but they're here to deal with the technical questions of the analysis.

I just want to acknowledge them because if we go off in the policy direction and they don't get a lot of play here, it's important to know that we couldn't be having this conversation without their work. And going forward, if you pick up these ideas, they will pay play an instrument role with us and the staff educating the rest of the world about

what the underlying structure here is.

So I just want to acknowledge the work of the two of them before we get going.

DR. CARTER: Over the past several years, we have discussed two widely acknowledged problems with Medicare's PPS for SNFs. First, it does not adequately adjust payments to accurately reflect the cost for nontherapy ancillary services. These are things like IV medications, respiratory care, and drugs.

Nursing costs are used as a proxy to adjust payments but they're a poor proxy. NTA costs don't always vary with nursing costs and they are much more variable. So while SNF payments in the aggregate are more than adequate, they are not sufficiently targeted.

The second key problem with the PPS is that payments vary with the amount of therapy delivered, creating an incentive to provide therapy for financial reasons. We've reported that the share of beneficiaries receiving therapy and the amount that they receive have both continued to increase.

Another omission of the PPS is that it does not include an outlier policy to defray the cost for

exceptionally costly care. Over the years we've seen evidence of these problems. Patients who need expensive IVs, antibiotics or expensive drugs or ventilator care are harder to place than other patients. You have raised concerns about the large differences in the financial performance between hospital-based and freestanding SNFs and between nonprofits and for-profit facilities.

I just want to give you a brief overview of what we're going to talk about today. We're going to go over the designs to pay for NTA and therapy services. We're going to describe an example outlier policy. Then we're going to walk through our simulations of the impacts on payments. And then I want to raise some data concerns that we have about the limitations and what we could do to improve the data that are available.

There are two draft recommendations for your consideration.

Just a quick overview and reminder, the SNF payment system consists of three components that get added together. There's a nursing component, a therapy one, and an other, which is a room and board. Those get added together. There are 53 case-mix groups that are used to

adjust payments. The key here is that therapy minutes are used to establish payments.

In our proposed design, you can see that the nursing component would stay the same. We are going to revise the therapy component with a completely different design. We are going to add a new NTA component, and so now you're going to add four components together instead of three. And then on top of that, for the stays that qualify, there would be outlier payments.

In designing the PPSs, the components that establish the NTA and therapy components use a variety of patient and state characteristics, and you can see those on the slide. Under the broad stay classification, the therapy component uses an indicator of whether the patient received more than the minimum amount of therapy required to get grouped into a rehabilitation RUG. Payments don't increase as a function of the amount of service that's provided beyond this minimum, but rather as a function of the patient and stay characters of the patient, such as was the patient recovering from a stroke or a hip fracture?

We explore different designs for each component and then use the one that was the best at predicting NTA and

therapy costs to model how payments would change under a revised PPS. I'm not going to go through the details of the modeling but Doug and Bo are here to answer any questions that you have.

These results we presented back in November so they should be fairly familiar to you. Under the NTA new component, the new component explains the differences in costs of NTA services per day much better than the current design. You can see the comparison at the state level is 23 percent compared to 5 percent and at the facility level 31 percent compared to 13 percent.

One measure that I want to spend a little time on is to assess the accuracy we also used something called the CMI coefficient. This measures the costliness of the facility's mix of patients captured by the payment design. We look for a coefficient of one, which would indicate that payments are perfectly proportional to costs.

In the current design, you can see that the CMI coefficient is well above one, it's 2.34, indicating that facilities with above average NTA case-mix are underpaid for the services they provide, and facilities with below average NTA costs are being overpaid.

In the new component, you can see that the CMI, while not perfectly proportional to costs, is a lot better than the current PPS design. The component would distribute payments for NTA services much more in line with their costs and thereby reduce the incentives to avoid such cases.

Now we're going to turn our attention to the redesign of the therapy component. And here, comparing the first three measures, you can see that the revised design is essentially as accurate as the current one. Where they are really different is in the last line.

The redesign would result in payments that are much more proportional to cost than the current design. The current design tends to overpay facilities with above average therapy costs and underpay facilities with below average therapy costs.

In contrast, the redesign has the CMI coefficient that's much closer to one, so payments will be much more proportional to their costs and there will be much less financial incentive for providers to adjust their mix of cases for financial gain.

As in any PPS, we need to be mindful of the incentive to under furnish therapy services. CMS will need

to monitor the provision of therapy and patient outcomes, underlining the need to assess patients at admission and discharge, which the Commission has repeatedly recommended.

CMS could also lower the risk of stinting on services by adopting a pay for performance based payment using quality measures which we recently recommended. And they could use changes in functional status as one of the measures.

Now I want to turn to the design of the outlier policy. Although outlier policies typically consider total costs, we designed one focused on ancillary costs, which include NTA and therapy costs. Ancillary costs are highly variable and they vary due to differences in patients. A total ancillary cost outlier policy will provide equal consideration to patients with exceptionally high therapy or NTA costs. The policy focuses on per stay, not per day costs because of the financial risk to an institution is the costs incurred over the stay, not on any given day.

The example outlier policy that we modeled is a $3,000 fixed loss on ancillary costs. SNFs would have to incur losses about equal to the average ancillary cost per stay and then they would qualify for an outlier payment.

This created an outlier pool of 1.7 percent of payments.

With the best models predicting NTA and therapy costs and the outlier policy, we estimated the impact that the redesigns would have on total payments. The three policies together shift payments in the directions that we anticipated. The revised PPS would redistribute payments from freestanding and for-profit SNFs to hospital-based SNFs and nonprofit SNFs. Payments to hospital-based facilities would increase 20 percent while payments to freestanding facilities would decline slightly, 2 percent.

By ownership, payments to nonprofits would increase 7 percent while payments to for-profits would decline 3 percent. In aggregate, payments to rural and urban facilities would remain unchanged.

As expected, we found that the revised PPS design would shift payments across facilities based on their mix of patients. It would redirect payments towards patients with high NTA care needs and away from therapy care that is not related to patient characteristics.

Payments to SNFs with high shares of rehab RUG stays would decrease 6 percent in aggregate, compared to current payments. Payments to SNFs with high shares of

extensive services stays -- these are patients needing IV medications, tracheostomy care, or ventilator support -- would increase 15 percent.

Because SNFs vary considerably, their impacts are not uniform. Here I'm showing you just what would happen, who in the distribution experiences large and small changes in their payments. For example, the first row shows the impact on hospital-based SNFs. Although payments to almost three-quarters of hospital based SNFs would increase at least 10 percent, there was won percent of SNFs that would experience a 10 percent decline in their payments.

Looking by patient mix, over one-quarter of SNFs with high shares of rehab only stays would see their payments decrease by at least 10 percent, but 6 percent of facilities would see their payments increase by 10 percent. So it's just trying to give you a sense that there is a distribution out there. Not all of the facilities in one category gain payments or lose payments.

We examined the Medicare margins of SNFs that would experience the largest and smallest changes in their payments. I want to note that there was a mistake in your mailing materials. In this table the last two headers are

switched, and that's on page 26.

Under the revisions to the PPS, the vast majority, that is 83 percent of SNFs would experience the largest declines in payments had Medicare margins that were at least 10 percent in 2003. Conversely, 70 percent of SNFs that would see their payments increase by more than 10 percent had Medicare margins of negative 10 percent or lower.

As a result, the widely divergent financial performances are going to narrow. Aggregate margins would change the most for hospital-based SNFs. Despite the large increases in payments for most hospital-based SNFs, most would continue to have negative margins. This is because the revisions only affect ancillary payments and those make up just over half of the daily payment.

Their very high routine and overhead costs at many hospital-based facilities would still affect these facilities' financial performance.

Now I want to look a little bit at what the impact of the outlier payments had on facilities. The outlier policy that we modeled affected 2.6 percent of stays and were distributed very broadly over 60 percent of SNFs. A slightly higher share of hospital-based SNFs would receive

outlier payments. Although a majority of facilities would receive an outlier payment, only a subset of them would, on net, benefit from the outlier policy. That is, the outlier payments that they would receive from the pool would exceed what they had paid into it. And an even smaller group, 7 percent of SNFs, would see their payments increase by more than 5 percent. So it's a fairly targeted outlier policy that we modeled.

So a summary slide here, our analysis indicates that compared to the current system the revised PPS would more accurately pay for NTA services, pay as accurately for therapy services using patient and stay characteristics, and offer some SNFs financial protection against extraordinarily high cost cases. Because payments would be more accurate, access would improve for beneficiaries who require expensive NTA services.

I would like to point out that this revised PPS does not require any new data but the designs are slightly more accurate when they include hospital diagnostic information. We think this information should be communicated between hospitals and SNFs but note that this would require coordination between providers.

In view of our findings, we propose the following recommendation: that Congress should required the Secretary to revise the SNF prospective payment system by adding a separate nontherapy ancillary component, replacing the therapy component with one that establishes payments based on predicted patient care needs, and adopting an outlier policy.

These revisions would be implemented in a budget neutral way so there would be no impact on program spending. Payments would be more accurate and would increase to some SNFs and decrease to others, and they would improve access for beneficiaries with high NTA care needs. To implement these revisions, CMS would need to make many changes that are consistent with those it makes when implementing or revising the PPS.

In doing this work, we identified several areas where better data would make payments more accurate and allow us to link payments and costs to outcomes. Currently, the SNF diagnosis data is very poor. SNF claims have fields for recording this information but the data are not required for payment. SNF claims also do not include the dates when individual services are provided. Dates would help predict

daily costs more accurately, evaluate utilization throughout a stay, and allow costs to be linked to patient assessment information.

The current patient assessment tool requires SNFs to report on services provided during the past 14 days. This look back period makes it impossible to distinguish between services furnished by the SNF from those furnished during the prior hospital stay. The look back periods may they also generate higher than necessary payments, since services provided during the preceding hospital stay can qualify patients for higher paying RUGs.

And last, the SNF cost report does not require facilities to split out nursing costs from routine costs. While not a substitute for patient level information, this facility level nursing cost information would allow us to examine the relationships between case-mix, cost, quality, and staffing. Many Medicaid cost reports already require this information.

This leads us to our second draft recommendation. The Secretary should direct SNFs to report diagnosis information and dates of service on their claims, services they furnish separately on the patient assessment, and their

nursing costs separately from routine costs on the Medicare cost report.

And now we look forward to your discussion.

MR. HACKBARTH: Well done, Carol, Bo, Doug.

Thank you very much.

A quick question just for clarification, Carol. Would you put up slide 11?

This, as I understand it, does not include the effect of the outlier piece? This is just --

DR. CARTER: It does include the outlier. It includes everything.

MR. HACKBARTH: What's the downside on this?

DR. CARTER: I do think we need to be mindful that providers, given that you're paying them now a prospective rate, we want to make sure that beneficiaries continue to receive services that they require. And that's where using a pay for performance policy would really help to make sure that patient care isn't eroding under a prospective payment system. It's identical to any PPS, where you pay a set rate and you have to worry about the care that patients get after that.

MR. HACKBARTH: Questions, comments?

DR. SCANLON: I think there's only upsides here and I really want to congratulate you on getting us to this point. It's been only about 10 years that we've know that we've had these problems and we now have a way of trying to address them.

It's interesting that Mark made the comment about technical versus policy, because I was thinking of this as we're not really changing policy. We set out to have a PPS and if were going to do a PPS right from the beginning we would've done these things. And so again, thankfully we're here.

The downside that Carol mentioned, I do think there's more than perhaps waiting for pay for performance that we can think about. And maybe we should be thinking about in terms of a policy prescription is that when we know there's a risky incentive that we have in a system that we need to take actions ahead of time, as opposed to waiting for problems to happen and then respond to it.

I guess in the context of therapies, the risk is of under provision. And the question is whether we can borrow something from the home health PPS, which is the utilization adjustment, which is to say we're going to

project the amount of therapy we think you need. But if you go so far below that then we're going to adjust the payment. And it could be in terms of a percentage of the therapy that's received over the course of the entire stay, as opposed to anything on a per day basis.

That was one seemingly risky incentive that seemed to be in the system.

The other one, I guess, was not so much the patients that were at risk but kind of the financial integrity was you raised the issue of the outlier and how maybe it should be adjusted for length of stay. I think it probably should be adjusted for length of stay and we need to think about how to do that, as opposed to waiting for something to happen which would be that we would suddenly discover we have all longer lengths of stay, which might get people into outliers.

This PPS is vulnerable to that because it is a per day PPS, unlike the others.

DR. CARTER: I just want to clarify. You're talking about paying a lower marginal cost after say the median length of stay?

DR. SCANLON: Yes. And maybe even having some

variation in that percentage that you pay. This is something to be thought about, but I think pointing in that direction. Again, the principle is if we've got a risky incentive, let's address it from the beginning as opposed to seeing if we have a problem ex poste, because then it's harder to make changes.

The other policy principle maybe should be that there should be no embarrassment about asking for information when we're paying this much money. One, it's the information coming out of the facilities and they have that.

This idea that there has to be some communication between the providers, I have also no problem with and particularly because of this case. People do not enter SNFs through the SNFs emergency department because they don't have them. What happens is you have to apply to a SNF and explain what services you're going to need before you're admitted. So there's already a communication going on. The question is we should make sure that it's done in a way that we know what's happening and that we know that there's an adequate amount of information that's being transmitted back and forth.

If we want it in the policy I think that's fine, but that's the policy that I would push, that we really shouldn't be embarrassed about asking for information to improve our payment and our understanding of what we're getting and in the process we're protecting beneficiaries.

DR. STUART: I agree with Bill. I think these are excellent recommendations and long overdue. And it's a slam dunk. We ought to do them.

Having said that, I wonder about, even though there are relatively few facilities that are going to take a big hit -- 10 percent or less -- I'd be interested in knowing a little bit more about those. In particular, quality of care in nursing homes has been a big issue in the press recently. It's been around for a long time. CMS has a list of poor performing facilities. I'd be wondering whether there's any correlation between gains and losses and whether the facilities are on that list or what they look like according to other quality criterion.

And then I'd also wonder about whether you would suggest that there be some kind of a phase-in period for this and whether there would be special quality monitoring for firms that would be losing funds under it because those

are the ones that you're probably most concerned about.

DR. CARTER: We talk about a phase-in period in the paper. PPSs and revisions to PPSs sometimes are done with a phase-in period and some are not.

I think if there is a transition it should be short because right now we've got a big mismatch in payments and so the shorter time period that we can make changes to make payments more accurate, I think the better. But I think a two or three-year transition would be okay.

About your other point, we haven't looked at the quality measures. I will say that we did look at the financial performance of the SNFs that would take the largest reductions in payments, and they are the high-performing SNFs. They are the SNFs with margins that were at least 10 percent or higher.

So at least we know something about their financial performance but we haven't looked at the quality measures. But that is something that I think CMS should be looking at. And we, of course, have made recommendations to improve their quality measures.

DR. SCANLON: I would just comment that it's very hard to look at the quality of SNFs across the country. The

special focus facilities that Bruce mentioned, it's a program where each state is to target a few very limited number, probably under five. And they're potentially among the worst in that state. But each state is doing it, so it's not consistent across the country in terms of what might be wrong with those.

And then as you do look at the data across the country from the nursing home surveys, there are such great difference that no one really believes that they're consistently measured, that we have very large proportions of facilities in some states where we have found deficiencies of actual harm and very small numbers in other states. Nobody can believe that the underlying differences among those homes in those states reflects that.

MR. HACKBARTH: It would be interesting to look with our two new proposed measures of discharge to the community and readmission to the hospital, how to the different groups of SNFs look on those of quality measures to see if there are any interesting patterns.

Arnie, did you have a comment on this particular point?

DR. MILSTEIN: No, on the presentation. Not on

this point.

MR. HACKBARTH: I have you on my list. Let me get to some others.

MS. HANSEN: I just want to thank you. This is elegant work done relative to the two recommendations and how you came about it. I think one of the things relative to quality and prevention, I think, Bill, your point about knowing where the stinting could possibly occur and putting in basically a stop or basically a marker for seeking out whether or not that kind of risk could be mitigated. At least that would be highlighted and people would know it in advance so it would be fair.

The second thing is I really appreciate the aspect of asking for data because, in fact, I think, Glenn, I was going to say that the fact that we're going to be looking at the readmission issue on the other side, that without that kind of data we really won't know. And I know there are just a lot of finger-pointing kinds of issues sometimes that inadvertently occurs to issues of quality of say decubitus ulcers, as to where they start. So I think the ability to really have those data elements measured early.

And then finally, I appreciate the fact that one

of your subsets is relative to the staffing component. We've brought that up before. That's important to make sure that we have the qualified staff as one of the metrics there.

So again, I just really thank you, the ability to target this appropriately is the right thing to do.

And just the access issue that was concerned -- I guess this is more of a CMS element, but how we keep an eye on that as to what impact that might have for beneficiaries. Because right now there actually is a reverse discrimination already, I know some nursing homes won't take people just because they know they have high NTAs and they don't want them. So that actually has precluded access. So if anything, I think this might open the door better if they're paid appropriately.

Thank you.

MR. EBELER: It gets a little repetitive. I also think these are very good directions to go and support the directions.

Bill and Jennie captured the data idea. We shouldn't be embarrassed about asking for this. We need it for making sure the program is operating properly for the

beneficiary and the hospital to nursing home data is just the classic handoff where you just need to make sure that that is accompanied by the right clinical information for the next care team. So that strikes me as very logical.

Again, getting to -- we're flipping the incentives for therapies basically in this proposal, as I read this. Are there or can there be developed clinical and functional criteria for when that's appropriate? Because it strikes me that the stronger the professional criteria of the need for the service, the easier it is to monitor and understand what's going on. If the criteria are soft, you really need to worry more about the overuse and then the flip fast under use.

I don't know whether the criteria are clear now.

DR. CARTER: There are slowly being developed sort of clinical pathways and sort of the right -- how much therapy a typical stroke patient needs. They tend to be fairly general. The ones that I have seen tend not to focus on the elderly population. But that's an area that we should look at.

I did want to point out that this payment system does use patient characteristics to project the amount of

therapy somebody is needing. So a patient that is recovering from a stroke or a hip fracture is going to get a higher payment.

MR. EBELER: I don't dispute that. It's just if the criteria are soft, it just seems to me you lean more towards Bill's argument of building in mechanisms and measures so that you can really know what's happening there.

I think this is a great way to go.

DR. MILSTEIN: I'm also supportive of this direction and my comments are just a slight variant on Jack's.

Glenn asked whether what are the potential flies in the ointment. Essentially, what we've done here is we've built a better fitting model by, among other things, allowing into our predictor variable how much clinical activity is going on, things like that. How many patient assessments are done and whether respiratory care is, for some patients, initiated or not.

So if you say what's the down side of that, in order to achieve a better fitting model we have inadvertently tilted slightly in the direction of paying more for more services. That's the essence of this model.

Having said that, I think it's the right direction to go and I think that some kind of anticipation that there will be a small subset of revenue maximizers who may be inclined at the margin to look at these opportunities for actually changing the course of care, maybe through a medical director of the facility that's managing a lot of the patients and writing some of the orders and/or very simple such as -- I don't know whether there's such a thing as potential for broad stay classification creep. I don't know whether that's completely impossible or not. But those are the kinds of things that I would want to think about putting tripwires in place to monitor.

That said, I believe this is a favorable direction. The better fitting models intuitively appeal to me as a positive direction.

MR. HACKBARTH: In the case of the therapy payment, actually what we've done is move away from a system that ties payment very closely to the amount of therapy used or expected to be used to one that ties it more to the characteristics of the patients. So we've moved away from the use payment link.

DR. MILSTEIN: In that category but toward it in

nontherapy ancillaries.

MR. HACKBARTH: Right.

DR. MILLER: I'm not sure I would characterize it like that. On the nontherapy ancillary, it's also true that it's based on the patient characteristics predicted.

DR. CARTER: Right.

DR. MILSTEIN: But not only on the patient characteristics.

DR. MILLER: On nontherapy ancillaries?

DR. MILSTEIN: The models I looked at has both patient characteristics and stay characteristics.

DR. CARTER: They have both, right, they do. I guess I wanted to say one thing that wasn't I don't think quite accurate, and I'm going to turn to these guys.

As the stays get longer, the payments actually get less because they're reflecting longer stay and the stays tend to be less intensive. So I just wanted to make sure that you understood the directions of those.

DR. KANE: I'm along the same lines of Arnie. I think this is great and I guess -- although this isn't my main question -- one question is why wasn't this done 10 years ago? Is there something new and different going on?

None of this looks like it was not available that long ago.

The more specific question is the prior nursing home resident characteristic. I do feel that could be manipulable, depending on what that means. So could you just clarify does that mean any time in the last five years? Any time in the last week? Anytime in the last -- is it related to this particular reason that they're in the nursing home this time?

Because I am a little concerned that somebody might get readmitted to the hospital and then --

DR. CARTER: It's within the last six months.

DR. KANE: So this is going back to what Arnie was saying, there is a little bit of a risk that an unscrupulous nursing home would have somebody readmitted and then come back out. Would that be considered a prior nursing home stay then, even though they were sort of put in to fix the pneumonia or the infection and then brought back out again? Or would that be considered -- I don't know.

I just wouldn't want it to be something that somebody could manipulate along the lines of what Arnie was worried about. Or if it was how we would put safeguards in to be sure that there was no extra churning.

DR. CARTER: It's a non-PPS nursing home stay. Does that help you understand that?

DR. KANE: No, actually that makes me even a little more worried because they're on Medicaid that means.

DR. CARTER: Or something else.

DR. KANE: So there's a lot of incentive to put them back in the hospital and put them into a potentially even higher in Medicare. Is there some way to protect -- am I wrong in thinking that could be a problem? And if I'm right, what should we do to prevent that kind of churning possibility?

MR. GARRETT: It happens that the weight on the prior nursing home variable is negative, so it actually suggests that there are lower expects costs for those patients.

DR. CARTER: Because they are lower intensity patients. Because those are really reflecting long stay patients with much lower level care needs.

DR. MILLER: What I would also say is we've heard you guys. Remember, this is the beauty of going through it twice, March and April. We've heard you guys on okay, are there any particular elements inside the model where we

might be exposed? And then we start thinking through some of the stuff that Bill is saying. Do you put an inlier in? Or do you put some -- to use a word somebody said -- a tripwire to try and look at this? And we've definitely heard you guys on there's some elements we'll look a little tighter at and see if there's anything to put in just to backstop this problem.

But I'm hearing the parameter estimate works a little bit against the gaming. But nonetheless, we have heard you and we've heard that there's at least two or three other things you want us to look carefully at. And we'll come back and make sure that we've wired that for the next time.

DR. WOLTER: I'm obviously very pleased to see this, also. And just wanted to point out a couple of the contextual issues, at least as I see them.

In past discussions, we have seen some data that the product in a hospital-based SNF is different than in a freestanding SNF. When I was part of the LTCH visits we did a few years ago, in some communities we heard loud and clear that, as hospital-based SNFs closed, freestanding SNFs really didn't have the capability to take care of some of

the patients that go into the LTCHs. And about a third of hospital-based SNFs have closed in the last four or five years, maybe more than that.

And so I think that trying to devise a payment system that better captures the clinical conditions that we are treating hopefully will have providers looking at how to provide the capacity to do that.

I know in the past, also, we've talked about there remains overlap between patients who might go particularly to hospital-based SNFs, rehab units, or LTCHs. And could we devise a classification system that looked at ultimately a payment system that would focus on the patient, regardless of the setting that they went into?

At least a few years ago we talked about that as an ideal. Seeing how long it takes to do something like this makes me wonder if we can get to the other. But it would be still a nice goal to look at how could we focus the payment on the patient characteristics regardless of whether they're in a hospital-based SNF, an LTCH, in a rehab unit, for example. Because not all communities have a lot of choice in regard to those services.

So maybe that's something we can keep our eye on

as this unfolds.

MR. HACKBARTH: Carol, could you update us on -- as I recall Congress, asked CMS to set up a demonstration project that focused on identifying patient characteristics and needs and was neutral in terms of the type of facility. What's the status on that project?

DR. CARTER: This is a demonstration to use a common patient assessment tool starting at hospital discharge. And it's being implemented in, I guess, all of the post-acute settings. The tool has been piloted and I think the pilot was done in Chicago. The first market is being implemented I think in March and it's going to be tested in seven other markets, sort of rolled out over the summer.

The results of that demonstration, I think a report is due to Congress in 2011.

MR. HACKBARTH: Is the demo just focused on the new patient assessment instrument? Or there also a payment?

DR. CARTER: They're collecting cost information, as well.

MR. HACKBARTH: So they can compare for comparable patients.

DR. CARTER: CMS, in the long run, is headed exactly where Nick talked about.

DR. DEAN: I just wanted to tag on to Bill's last comment, and I think Jack mentioned it too, about the importance of clinical data being transferred -- and it's probably beyond the scope of what you're doing.

I am on the receiving end of a lot of transfers to a skilled nursing facility in our local critical access hospital that come from a long distance away where they've had surgery in Sioux Falls, which is 125 miles away. And I don't have any day-to-day contact with what's happened.

It's like pulling teeth to get the information that we need sometimes. We made a rule that there has to be direct physician to physician communication in order for us to accept these patients. And you would have that we were asking for -- I don't know what. It's just a constant battle.

Patients come back -- fortunately, they're usually patients that I know, so that's a big help. But they will be on antibiotics or they'll be on a bunch of new drugs. And the information that we get just doesn't justify those things. And so we have to struggle.

Like I say, I'm sure it's beyond the scope of what you're doing, but it's a frustration I couldn't avoid bringing up. I don't know what the answer is but it's an ongoing problem.

MR. HACKBARTH: Any others?

Okay, well done. Terrific work.

And the final session is on hospice cost and payment. Jim, you can start when ready.

DR. MATHEWS: Good morning. I'll say up front, I hope this presentation engenders a little more discussion than the last time I was up here. I think I got a courtesy question. I could start with a few jokes, if that helps. Maybe not

Today I will be talking about the third in our series of presentations on hospice that we began in the fall of last year. I will talk largely about two things today. The first is the effect of hospice on Medicare spending at the end of life relative to non-hospice care. The second is an analysis of Medicare payments for hospice relative to providers' cost.

We have discussed specific details of the hospice benefit previously, so I won't cover those again. But I do

want to make a couple of key points by way of preface to the substantive part of this discussion.

First, the Medicare hospice benefit was established to give beneficiaries an alternative to conventional medical treatment for terminal conditions at the end of life. Hospice provides an enhanced benefit package that is consistent with the preferences of those who do not want aggressive end-of-life care.

Second, the passage of this benefit as part of TEFRA was conditioned on the premise that it would be less expensive than conventional medical treatment at the end of life. Arnie, you and other commissioners asked about this when we discussed hospice in November.

In response, we conducted a comprehensive literature review of analyses of the cost of hospice relative to conventional end-of-life care. These range from evaluations of the National Hospice Study in the early 1980s, to studies published just last year.

In evaluating these data, I would recommend not getting too caught up in the specific dollar amounts. Rather, it's more constructive to focus on the overall trends as they pertain to potential changes in Medicare's

hospice payment system. Such changes are warranted, given that Medicare spending for hospice exceeded $10 billion in 2007, more than the program spent on inpatient rehab inpatient facilities, critical access hospitals, long-term care hospitals, CORFs, psychiatric hospitals, ambulatory surgical centers, or clinical lab services. It is no longer a niche benefit.

However, that payment system has not been fundamentally updated since its inception 25 years ago. We believe that the payment system embodies conflicting incentives that create substantial tensions that undermine the long-term stability of the hospice benefit.

There are a few common points that can be extrapolated from the literature on the effect of hospice on Medicare end-of-life spending. First, beneficiaries who elect hospice incur less absolute spending in the last two months of life than beneficiaries who did not elect hospice. This spending differential is achieved largely via the substitution of less costly hospice care for more costly inpatient services. So a beneficiary in hospice may incur $4,000 in Medicare spending in their last two months life while a comparable beneficiary who does not elect hospice

may incur twice that amount of spending.

Medicare spending for beneficiaries electing hospice may be lower than non-hospice enrollees in the third or fourth months before death, but maybe not. Patient-specific or other factors may affect the cost relationship in these months. In rough terms, spending levels are comparable for hospice and non-hospice beneficiaries in these months.

The cost of patients enrolled in hospice is higher than the cost for patients not enrolled beginning as early as the fourth month before death if not sooner, but definitively so by the sixth month before death.

The magnitude of the spending reduction in months one and two is so large, however, that hospice enrollment may still produce lower net spending through five to seven months.

The literature also suggests that over the course of the last year of life hospice has either no effect on Medicare spending relative to beneficiaries who do not elect hospice, or it can even result in higher spending.

So in general, the effect of hospice in lowering Medicare spending at the end of life is a function of the

length of hospice enrollment. The patient's terminal disease also plays a role. As I mentioned a moment ago, hospice use results in a reduction in Medicare end-of-life spending by reducing Part A utilization, largely inpatient hospital admissions. So in addition to length of stay, hospice's ability to result in lower Medicare spending relative to conventional end-of-life care depends on the amount of Part A utilization associated with the last six months of life for a given terminal disease.

To summarize the first part of this presentation then, hospice results in lower Medicare spending relative to conventional end-of-life care in absolute terms only in the last two months of life. Net lower spending can persist to roughly six months. These estimates again can vary by patient characteristics such as terminal disease. You have a great deal more information on this point in your paper and we can discuss it at length if you prefer.

As we noted earlier, the hospice benefit was established based in part on the presumption that it would result in lower Medicare spending relative to conventional end-of-life care. Since that time, Medicare spending on hospice has grown considerably. Hospice spending tripled

between 2000 and 2007, reaching $10 billion in that year. As we've discussed previously, its growth is fueled by more beneficiaries electing hospice and growth in spending per hospice enrollee.

The number of providers has grown along with spending, but what is interesting is that nearly 90 percent of the growth over this time has been in for-profit hospices, which have grown at a rate of about 12.5 percent a year over this time. For-profit hospices can either be associated with one of about five large national chains or they can be independent entities. Very few nonprofit hospices began participating in Medicare during this period.

Since Medicare pays for hospice on a per diem basis, spending per enrollee is largely a function of the length of time a patient is enrolled. Between 2000 and 2005 mean hospice length of stay increased by over 30 percent. This increase is driven by the increase in long hospice stays, as stays at the median have remained largely stable over this time.

As we have discussed previously, length of stay is generally correlated with the hospice patient's terminal diagnosis. Some diagnoses, such as Alzheimer's disease and

chronic ischemic heart disease, have relatively longer lengths of stay, while patients presenting with diagnoses of renal failure or sepsis have much shorter lengths of stay.

But we found that diagnosis doesn't explain all of the variation in length of stay that we see among different hospice providers. You may recall our discussion in the fall of hospices affected by the aggregate per beneficiary payment limit, or the cap. Cap hospices had mean lengths of stay double that of non-cap hospices, and over 40 percent of episodes at cap hospices exceeded 180 days, compared to 15 percent of episodes at non-cap hospices.

We hypothesized that cap hospices may be treating a disproportionate number of patients with conditions that typically have longer lengths of stay. This turned out to be true, but it was also the case that cap hospices had uniformly longer lengths of stay for all patients. So patient mix alone didn't explain the differences that we saw.

Given that CMS and its intermediaries generally issue the same guidance to hospice is regarding characteristics of patients suitable for hospice admission, we speculated that other nonclinical factors may be

influencing the growth in the length of stay.

In particular, we wanted to see if profitability could be a factor in explaining the increase. In the fall of last year we presented a hypothetical model illustrating this hypothesis in which margins increased with longer lengths of stay. This is because hospice episodes are nonlinear in cost. They are more expensive at the beginning and end of the episode, but Medicare's payments are generally linear. Therefore, a hospice would be able to increase its profitability by lengthening the relatively more profitable interim days to offset the less profitable days at the beginning and end of an episode.

We saw some oblique evidence of this possibility in the relationship between hospice's ownership status and length of stay. The lengthening of hospice episodes since 2000 coincides with the large influx of for-profit hospitals participating in Medicare.

To evaluate this hypothesis, as well as to evaluate hospice financial performance overall, we needed a systematic analysis of hospice payments and costs. This had not been done previously. A number of commissioners expressed interest in hospice margins when we last discussed

the topic in November.

We therefore constructed an analytic database using hospice cost reports, claims, and provider data for 2001 through 2005. We found that data quality was an issue and applied a number of edits and screens to cull aberrant data, resulting in a loss of slightly more than 20 percent of providers in each year. We then calculated the margins according to standard MedPAC protocols and checked our results against the few available point sources of information on hospice profitability. These included historical data from a survey by the National Hospice and Palliative Care Organization that included financial data, estimates of margins in the health services research literature, and financial analysis of the large publicly traded for-profit hospice chains.

Overall, we found that hospice aggregate margins tend to be in the low single digits across all years that we looked at, but with a couple of noteworthy modalities. Freestanding hospices have higher margins than provider-based hospices, which had negative aggregate margins in all years. Freestanding hospice's Medicare margins were 6.3 percent in 2005, compared to negative 5.6 percent for

provider-based hospices. On average, margins are about 15 percentage points apart for the two groups across these years.

Provider-based hospices had higher costs per day than freestanding hospices, in part because of overhead costs allocated from their parent provider, be it a hospital, home health agency, or SNF. There may be other factors that could explain part of this differential, such as differences in the intensity of hospice care or differences in staffing mix but data to do yet exist to assess these factors.

Nonprofit hospices had negative aggregate margins in all years, averaging about 17 percent lower than for-profit hospices margins across the years. As we note in your paper, other revenues for nonprofits can be significant. For-profit hospices have strongly positive margins in all years, ending up at nearly 12 percent in 2005. Again, there is some interesting variation within the margins of for-profit hospices.

Looking at margins for urban and rural hospices, we found that there was about a 3 percentage point difference between urban and rural hospice margins for all

years except 2005, when they converged. When we examined our provider of services data, we found that the number of rural for-profit hospices increased by 25 percent in 2005, which might explain why the gap narrowed in that year.

We also calculated margins for hospices affected by the cap versus other hospices and found that margins for cap providers were substantially higher than others. These margins do include the overpayments that must be returned to the Medicare program, but we'll come back to that shortly.

We observed an interesting pattern in which margins rose from a low in 2001, peaked in 2003, and then declined a bit through 2005. We observed this trend across almost all hospice groups. We do not yet have an explanation for it, but now that the information is public we anticipate working with CMS and the hospice community to assess why this might be the case.

We also examined margins by Medicare participation date. We wanted to look at this aspect because we had heard that many new entrants into the program were in essence required to admit patients with longer lengths of stay and thus incurred a greater exposure to the Medicare hospice payment cap. According to the conventional wisdom, this was

because of existing referral relationships between more established hospices in a market and other elements of the local health care community.

As you can see in this slide, in each year from 2001 to 2005 hospices that began participating in Medicare after January 1st of 2000 had consistently higher margins than those that began participating in the program before 2000. This trend is consistent with the majority of hospices coming into the program after 2000 being for-profit entities.

So what drives this distribution of margins? Again, recall the hypothesis that longer stays are more profitable. We saw implicit evidence of this in the previous slide which showed margins for hospices affected by the cap. These hospices tend to have much longer lengths of stay than non-cap hospices, yet they are also the most profitable, putting aside the question of overpayment for a moment.

We wanted to test the hypothesis explicitly, however, and thus looked at hospices; margins as a function of length of stay.

In each year from 2001 to 2005, we grouped

hospices into length of stay deciles and compared their Medicare margins. We found that there was a nearly linear relationship between length of stay and hospices' margins. In all years hospices in the lowest length of stay decile had the lowest margins. In all years except 2005 hospices in the highest length of stay decile had the highest margins.

We're not sure if the explanation for the dip in hospice margins for the highest decile in 2005 but we see a similar dip in the EBITDA margins for one of the large publicly traded hospice chains. We will try and have a little more resolution of this issue by the next meeting.

Again, we analyzed the margins for cap hospices in detail and we found that there is considerable variation within these margins within each year. In 2005 one-quarter of cap hospices had Medicare margins of 4.7 percent or less while a quarter had margins of 28 percent or more.

We also note that So not that much of the cap hospices' margin is attributable to the overpayments. Subtracting the overpayments considerably erodes the profitability of these hospices. While the hospices in our database that exceeded the cap had an aggregate margin of 19

percent in 2005, subtracting those overpayments results in an aggregate margin of negative 2.9 percent.

The extent to which returning the overpayment affects hospices' Medicare profitability depends in part on the providers' cap liability and any subsequent behavioral response. There can be differences in hospices' response to a cap assessment. For example, when we reviewed the SEC filings for two large hospice providers, we found that in general when their cap liability reached a certain threshold in a given year they reported taking action that resulted in a lower liability the following year.

Mitra, you had asked about this point the last time we met and we can discuss this further.

By contrast, other providers that exceed the cap in one year do so again by a larger amount in the next. The average cap liability, expressed as a percentage of total payment represented by overpayments, increased from about 19 percent in 2002 to 24 percent in 2005. So the aggregate liability is growing. Again, the interquartile range here is large. In 2005 the cap liability for the lowest quartile was 9 percent but was over 35 percent for the highest quartile.

Similarly, there are differences among hospice providers in their response as indicated by the number of hospices that reached the cap in multiple years. Glenn, you asked about this in November.

We found that many hospices that reached the cap in a given year did so in subsequent years as well. For example, of the hospices in our analysis that reached the cap in 2002, almost 41 percent subsequently exceeded the cap in 2003, 2004, and 2005. Of the hospices that reached the cap in 2004, two-thirds did so again in 2005.

To sum up this part of the presentation then there are a couple of key points that relate to the incentives in Medicare's hospice payment system from the providers' perspective. First, because of the nonlinearity of hospice episode costs, short episodes can be unprofitable. Episode costs are higher at the beginning and end of an episode while Medicare's reimbursement is generally steady. Therefore, hospices have less opportunity to make up the higher beginning and end of episode costs in short episodes. Additionally, costs of certain types of short stay patients may also negatively affect hospices' financial performance.

Second, a corollary to the first point, under the

current reimbursement system profitability increases almost linearly with length of stay. The cap serves as a check on the hospice length of stay and thus profitability. Hospice providers are differentially able to deal with the effects of the cap.

Overall then, Medicare's payment system for hospice embodies two conflicting incentives. From a strict Medicare financing perspective, Medicare spending is lowest for hospice decedents compared to non-hospice decedents in the last two months of life. Therefore, the program's strict financial interests are in short hospice episodes. Longer episodes can increase spending relative to the cost of end-of-life care absent the hospice benefit.

By contrast, the incentives from the providers' financial perspective are very different. Short episodes are the least desirable in that they are the least profitable. Hospice profitability increases with length to stay. Any fundamental reforms of the payment system will involve reconciling these two contradictory incentives. I think this can be done.

It will also be necessary to take into account beneficiary considerations in reforming the payment system.

There is no doubt that many beneficiaries, if not most beneficiaries, who elect hospice at the end-of-life receive great benefit from it, especially if they have no other source of health care maintenance at this critical juncture.

But information on the quality care of care or even the types of care they receive is minimal. CMS's data collection that will begin this summer will be an essential first step towards obtaining such information. In the meantime, we will present what information does exist on hospice quality and content at the April meeting. At that point, we'll have covered the majority of the major issues surrounding Medicare's hospice benefit and can begin to deal with a number of specific policy considerations.

With that I will in conclude and try to facilitate your discussion in any way that I can.

MR. HACKBARTH: Thank you, Jim.

MS. DePARLE: Thanks. Jim, thanks.

I think you've done a great job of really delving into a lot of the questions, while raising new questions that we didn't even have when we talked about this last summer at our retreat. It really does feel like I'm peeling an onion here. But 25 years after this benefit was created,

it seems quite appropriate that we're spending the time trying to do that.

On the data collection that you just mentioned that CMS is doing, I think the last time you presented it, either here or separately you and I talked about that. Can you talk a little bit more about what it is they're going to be collecting? Because I've talked to some people in the industry who are concerned that they won't be collecting the kind of data that we and they might need to answer some of these questions.

DR. MATHEWS: Sure, I can talk about that.

Effective in July of this year CMS will begin requiring hospices to report information on the services that they provide and the specific practitioner who provides that service. CMS's initial effort is going to be limited in a couple of different ways. First, they have limited the scope of the kinds of practitioners who will be required to be identified on the claims. It will start with nurses, RNs, LPNs, home health aides, physicians, and nurse practitioners who are serving in the capacity of the enrollee's primary care physician.

So one concern from the hospice community is that

that limited range of practitioners identified as the first step of the data collection instrument does not fully reflect all of the care hospices provide.

CMS responds by saying those are the services for which they have revenue codes ready to go that can be immediately put into place, and that given that this is only the first phase of their data collection they would anticipate expanding this later.

MS. DePARLE: What are the other practitioners that the hospices think should be collected data from?

DR. MATHEWS: They basically say therapists should be included, counselors should be included, pastoral care should be included. They also provide a number of other types of visits during the course of a hospice episode, such a supervisory visits to the patient's home to make sure that everything is going according to the plan. I'm not sure what the position is with respect to those kinds of management functions.

There are a couple of other concerns that the industry has raised. One is that the initial CMS effort will not ask providers to report time increments for these visits. So that while we will have -- and this is essential

in my perspective -- information on the number of visits provided, and we do not have that information at all, we won't be able to qualitatively say or differentiate a 15 minute visit from a two-hour visit.

Again, I've talked about this with CMS as well and they would like to do that in the future. They simply do not have the claims processing structure in place to collect that information now.

Again, I think that is a legitimate concern, both from the providers' perspective as well as from an oversight perspective, but it's one that CMS recognizes and is trying to deal with.

A third concern that the provider community has raised is, I believe CMS is requiring hospices to associate charges with each of the visit types, which is something they have no experience with up to this point in time. The community is worried that by putting charges on these line items that they might run afoul of the False Claims Act, given the fact that they are not used for reimbursement. CMS has issued a change to their requirement, their program memoranda requiring this data collection, specifically stating that False Claims Act considerations will not come

into play here.

MS. DePARLE: So I hope you will just keep track of where the data is going. It sounds like you're going to.

Secondly, I know you've personally spent time -- I know Glenn has and Mark and others probably -- with hospices who have come to Washington. I think I said this last time, I do think it would be useful for the Commission to hear from some clinicians. I don't know what the best way to do that is but Nick Wolters was alluding this morning to the trips he made to LTCHs when we were trying to understand what the service was. I think that would be useful to us as we're taking the time to really figure out what's going on in this benefit.

DR. KANE: I'm on the same boat. I understand the hospice benefit in the context of cancer care and how it might differ from conventional treatment. But I think as we get into the other diseases, particularly Alzheimer's or some of the diseases, I don't really understand whether there ever was a big inpatient end-of-life component to that.

Is there something even written about how hospice care is different from the conventional care for each of the

major disease types? Because the only one I can visualize clearly is the cancer differences. Just to help understand because just describing in terms of costs incurred is kind of hard to say -- it might be perfectly fine that they're the same for months six, five and four as conventional because it's conventional treatment. At what point does it deviate from conventional treatment? And why?

I'm having trouble imagining it from non-cancer diagnoses. So I just wondered if there was even something written clinically about these differences so we could just get a better handle on what the theory is at least?

DR. MATHEWS: To the best of my knowledge there is virtually nothing written on the content of hospice episodes differentiated by patients' terminal diagnosis. You would have to go back to the results of the National Hospice Study evaluation, which did have a few insights on to the differences in intensity of care stratified by cancer patients versus other patients.

Again, I may not have completely covered the waterfront here, but I have not seen anything elucidating differences in the intensity or content of care by diagnosis.

DR. KANE: But one of the issues might be whether there is conventional care hospice differences for some of these classes of patients, I guess. Maybe there never was one.

MR. HACKBARTH: I think this is a good question. Looking at the data that you've presented though, it seems to me that it implies that there are a variety of different patterns of care among hospices for at least broad categories of patients. It's not like there's a uniform hospice standard out there. We see a lot of variability, at least in use in financial performance based on the type of hospice.

DR. MATHEWS: That is true. But again these are very aggregate financial data and we do not have much of an understanding at all about what is driving some of the results that we see.

So for example, I mentioned the difference between margins and costs for provider-based versus freestanding facilities, and I mentioned that the provider-based facilities do have higher costs. In part, some of that might be allocated overhead from the parent provider, but there could be other things as well.

Skill mix, we have zero information about that. Intensity of care, are provider-based entities providing more care during the course of a week, more visits per week than freestanding facilities? No information.

We know there are differences in the mix of patients stratified by freestanding versus provider-based where provider-based facilities treat more cancer patients than freestandings. Arguably that confers some benefit in that their exposure to the cap is lower. But we've also heard anecdotally from a number of hospice providers that since the hospice is obliged to cover the cost of say chemotherapy or other types of expensive drugs used for palliative purposes that these patients are becoming more and more expensive and -- given the fact that they are the shorter term patients -- arguably they might be having an effect on the bottom line for the provider-based hospices.

Again, zero quantitative information for us to start digging in and better understanding the aggregate trends that we see here. And again, I think that's why the CMS data collection effort, even though it's not complete, has some significant gaps. I think it needs to get going.

MR. HACKBARTH: That's helpful.

MR. EBELER: Just a follow up on two things.

First, on the data side, when will we have data based on CMS's first round of data -- when will we know more based on that first round? And then when will they get to what sounds like the needed second phase of data collection to produce more robust data? But when will we know more?

DR. MATHEWS: Based on precedent, given CMS's timeline required to produce final standard analytical files that can be used for the kinds of work that we do, I am guessing it would be next June at the earliest before we would have claims reflecting this second half year's experience with coding the additional information. I don't have a specific timeline from CMS with respect to development of the next phase.

MR. EBELER: The reason I ask is we need to analytically figure out what's going on here and what the actual services are. I do think there is a countervailing pressure that, as things are heading in ways that don't quite sound right, we risk an extraordinarily valuable benefit can become discredited in some ways.

As we think about policy tools, we may need to think about blunter instruments for slowing growth until we

have the more sophisticated information to deal with this in a more appropriate way.

MS. BEHROOZI: Thanks. It's such interesting stuff, Jim, and it's so thorough.

So I again hesitate to ask you for one more thing but I had expressed earlier a concern about the fact that the cap is not adjusted by the wage index adjustment, as the payments are. As it becomes a more expensive benefit and more utilized in some places, I guess, more than others I'm concerned about the differential access implications that we will start producing.

I think we had talked at your first presentation about the fact that there were so few hospices hitting the cap that you couldn't really do enough of an analysis to -- you couldn't see an impact yet on either providers leaving the market or entrants into the market or whatever. But that's going to get worse. It's growing so fast it's going to get worse quickly.

So I wonder if we could slice the margin analysis to somehow examine the impact of the wage index, because if you're talking about the claw back really impacting the margins, and you're talking about not-for-profit providers

already being significantly lower than for-profit providers, I'm really concerned about the presence of not-for-profit providers in the high wage index areas and whether they're just going to leave the market if it becomes too challenging for them. And so people in the high wage index areas will just end up with a different hospice benefit or kind of access than others.

And I think what Nancy brought up about what the conventional care would be for some of these other conditions, I guess with Alzheimer's it would be maybe a nursing home, maybe custodial home care. People would be on Medicaid otherwise, so I guess this is shifting kind of -- again, I think you raised this in your first presentation. Is it becoming sort of a long-term care benefit around the back way? Maybe if there's a way to examine where these people would otherwise be, we can get at that a little bit.

Thanks.

DR. MILSTEIN: I agree with Jack. I can sort of anticipate where this is heading, a need to accept a short-term blunter fix aimed at what appears to be a problem area, the longer stays but doing everything we can to make that at least blunt as possible.

Also, I thought this was a wonderfully clear presentation. Thank you for that.

A couple of questions aimed at giving us the best possible information to minimize the bluntness of any tool that we need to move to. Is there any information on the relationship between either patient or family experience of care and either length of stay or diagnostic category? At the end of the day you can see these longer lengths of stay that are the cost added to the Medicare program, and that is a cost that we might all readily want to pay if the incremental value were there. I suspect when you're evaluating quality of care for hospice care that we would want to differentially weight family and patient experience relative to some of the more technical measures of quality, which would not be unimportant but just less heavily emphasized.

I'm guessing that in the annals of American health services research that there have been some studies on patient and/or family experience of hospice care. The question is have any of those studies examined the impact between patient experience and either diagnostic categories -- especially these newer diagnostic categories -- and/or

length of stay? So that's an area of examination, number one.

Maybe before I ask my second question I'll give you a chance to -- are you aware of any such studies?

DR. MATHEWS: None that make that distinction but I do anticipate presenting information on quality and content next month. And I can make sure to highlight any such aspects of studies that pertain to differentiation by length of stay or diagnosis.

DR. MILSTEIN: Thank you.

My second, if there is any information available, I think it would help us again make our corrective action less blunt is could you share with us -- not at this moment but when you have an opportunity -- the answer to the question how good are current predictive modeling tools at predicting longevity for patients enrolled in hospice programs? Are they horribly inaccurate? Are they reasonably good? Where do they fall in the spectrum of predictive power?

DR. MATHEWS: The short answer is it varies by patient diagnosis. There are some terminal disease trajectories that are very, very predictable. Sepsis, once

a patient starts to go bad the end is usually pretty quick. Cancer patients can generally have fairly well-defined terminal disease trajectories and some hospice providers and their corresponding referral bases have taken that to a fair degree of art or science, as the case may be, in terms of identifying a patient who is appropriate for hospice admission.

Some of the other diseases, the debility, dementia, adult failure to thrive, it's much less clear. And it's not necessarily that the guidance is unclear but rather the trajectory of any given patient is so uncertain that you can look at a patient with debility on day one and say this patient is categorically eligible. You can look at that same patient 180 days later and say this patient is categorically eligible. So that's where the tightness of the criteria tends to fall apart.

DR. MILSTEIN: Do I infer from your answer that this is not an area in which predictive modeling tools have been very widely applied, as opposed to clinician's guesstimates?

DR. MATHEWS: I don't know if I would go that far. There have been some attempts to identify characteristics of

patients say with Alzheimer's, a particular stage in the disease where they are no longer taking solid nutrition, that sort of thing, that from a clinical indication or from a clinical perspective would indicate that this patient is in the terminal disease state.

But we've heard anecdotally of something called the hospice effect, where you can take a patient who looks like they are going bad, get them admitted into hospice, they start providing palliative care, take them off all of their meds and the patient starts to improve. So that's also a confounding factor here.

DR. SCANLON: I think it's kind of interesting to have the two presentations this morning, and when you contrast them. With SNFs we had a problem, we had an incredible amount of data and it took us 10 years to get to a good point in terms of a potential solution.

And in the discussion this morning with say we haven't looked at hospice in essentially 25 years. We're asking all kinds of questions and basically we have very little information to try to address those questions. We're talking about a CMS data strategy that could take how long?

So I'm very much where Jack and Arnie are in terms

of needing to do something in the shorter term. I'll call it an interim step as opposed to blunt. Blunt doesn't sound like you're being thoughtful enough.

I would go to your margins chart on page 10 because that's where I think we have a least one opportunity for the bluntness. Part of our concern here is not just not having looked at this in 25 years but the fact that we've had suddenly this rapid transformation of an industry and of utilization. The transformation in the industry has been this influx of for-profit organizations comprising now the majority of hospices.

If you look at the margin in 2005 with the 11 or almost 12 percent versus the minus 2 percent, we're talking about a huge difference. Those are averages. So what we've got is a distribution around that.

I guess I would posit as a policy position that it's unreasonable for someone to be making 20 or 25 percent on this kind of a benefit from the Medicare program. And that as an interim step we need to think about -- and I think it will have the effect of changing the rate of transformation -- thinking about what kinds of limits we should put on profits from hospices. Because the kinds of

discussion we're having here today, we are a good five years away from talking about how do we design a policy related to the types of services that we want provided and a policy that we can establish accountability for those services, and we can make sure that we're paying for them right.

If you take the last five years and project it forward for five more, we are in a very different situation in terms of spending, in terms of industry composition, and in a very much more difficult position in terms of trying to change things.

So I agree with the idea of bluntness or interim, whatever word you want to use to describe it.

MR. HACKBARTH: It seems to me that these data suggest that things are headed on a path and moving rapidly down a path that is troubling, particularly looking at the change in the composition of the industry and the new entrants. Clearly people see an opportunity, a financial opportunity here. And so, like you, I'm worried about allowing people to race down that path too long.

Bill, in other contexts you have proposed that there be, at the high end of the distribution -- in this case the high end of the profit distribution -- some sort of

sharing as a way of limiting very high profit opportunities. I assume that's what you're talking about here?

DR. SCANLON: Since nobody bit on my suggestion before, I didn't want to use the same words. But yes, that's exactly what I'm suggesting is the idea that -- and there's a point at where the sharing could stop.

MR. HACKBARTH: Why don't you just say a couple of sentences about what you've argued.

DR. SCANLON: I've been trying to think about how can I recharacterize so I can get more proponents. Today I was thinking about using the outlier example, basically as we have an outlier this time it would be in terms of profits, that we actually say that we're going to share those profits, that the Medicare program is going to take back some of that money. You can say that, using that 12 percent, that you can earn up to a 15 percent profit and keep it. And beyond 15 percent, between 15 and 25 percent we're going to share it 50-50. And beyond that we're going to take it all back.

And those numbers are gross. Since the way we've talked about other provider types, we have zero update recommendations with respect to provider margins that are in

the 5 percent to 6 percent range. So we could scale those parameters which I just gave you back considerably.

MR. HACKBARTH: I'm going to refrain from endorsing Bill's idea, at least until he comes up with a better marketing plan.

[Laughter.]

MR. HACKBARTH: But setting aside that, the program as designed has a blunt tool in it, namely the cap. There are issues about where that falls and how that falls.

What this conversation with Jack, Arnie, and Bill says to me is we may need a long-term strategy and a longer-term strategy and, for lack of a better term, the shorter term strategy may use some blunter tools, perhaps along the line that Bill described. And that might be a reasonable trade-off for doing something around the cap. Just doing something around the cap without doing anything else I find very unappealing based on the data that have been presented here.

MS. DePARLE: I raised the cap -- I guess I'm in a very different place than you are, Bill, because I raised the cap originally months ago because I was concerned about hospices who were serving appropriate patients under the

hospice benefit in an appropriate way and, through no fault of their own, were being hit with you owe us money back because those people happened to live longer than had been anticipated, just to put it very simplistically. This is a complex issue, but that's how I saw it as simple.

We're peeling back the onion here and seeing a lot more complexity to it. But as uncomfortable as I am with that cap, I'm thinking that it is not consistent with what Congress, I think, intended. I'm even more uncomfortable with what you're talking about, a kind of a cap on profits. I don't know that we've ever gone there in Medicare, and I wouldn't be comfortable supporting that, for hospice or for anything.

DR. SCANLON: We actually used to be there entirely in Medicare, in terms of a reasonable cost payment system, in retrospective reasonable cost payment systems, in that we said we were going to pay your costs, we're not going to give you profits. And we moved into PPS with the idea that we wanted to try and encourage efficiency. So we went to the economists and we borrowed this idea that if we create an incentive people are going to be more efficient.

But what we didn't do was we didn't ask ourselves

what do the economists say about the way markets work completely? The way the economists describe a market more completely would be to say that when there is really sort of great profits to be made, they are going to be competed away. The price is going to drop because people are going to say gee, you can make 25 percent on doing this. I'll provide it for less and people come and buy it from me as opposed to someone else.

When you've got administered pricing, it's hard to take advantage of that competition. So the issue is if you have administered pricing, what do you need to do? And I would argue what you need to do is to say let's take the market signals. The market signal here is that we've got this very large increase in the number of agencies or number of hospices and we also have this distribution of profits. And therefore, our administered price here is wrong. It needs to be something that is closer to the cost of delivering services.

As an interim step here, it's important to remember we're not talking about taking a service away from anyone. The agencies here, if we only operative on the profit side, the agencies can continue to provide the same

services that they were providing yesterday.

MS. DePARLE: I don't disagree with working on the administered pricing. I'm just saying that, to use Arnie's B word, what you're proposing, if it's a cap on profits at least as I heard it, is an even blunter instrument than the one he talked about.

DR. SCANLON: But in administered pricing I guess the question is where do we go to get guidance in terms of how to set administered prices? In utility pricing this is exactly what they do. The issue is that they look at what it is that's reasonable in terms of some kind of rate of return and then they set a price accordingly.

That's all we're saying here. Part of our problem here -- and hospice is one case, home health is another -- is we have such an ill-defined or undefined product or service that it's possible to come in and say yes, I am providing it. And maybe five years from now we'll be able to say this. If we really understood it we would be able to say no, you're not. And if we get to that point then you don't need to think about things like profit controls.

If you knew that you were buying exactly what you were supposed to, then you would be comfortable not having

some kind of a limit on profit. But at this point in time, with this undefined benefit, we're stuck. I understand, it seems like it's un-American to say we're going to limit profits. But --

MS. DePARLE: I wasn't going to use that word.

DR. SCANLON: But people will. The reality is that this is a part about administered pricing and we're stuck in this situation.

DR. REISCHAUER: I'm not going to endorse profit limitations just yet.

I came down from Mars and I listened to this conversation in the context of the other conversations we've had. Jim has told us that on average, looked at over an entire episode, this service seems to save money, save Medicare money. And it's growing great guns. And you wonder what are we struggling here for? Every other meeting we have the reverse is true.

And so there's sort of two issues it strikes me, and one is the one we've already talked about here which is what is the service and how well is it being delivered? We don't seem to know and we think maybe it could be done a whole lot better.

Competition in this area sort of really is never going to work, Bill, because you only buy it once, in a sense, and the family isn't a particularly good judge of this either.

I was wondering, do we have trend data for people dropping out? You can sign up for hospice and then decide you don't want it. And that could provide some indication, although I don't think many people know what to expect. And there's a whole lot of familial and social change that's going on here that could confound things.

The second issue really is could we refine the payment system to better pay for appropriate care and provide the right kinds of incentives and maybe save some money. Given what you have laid out, it strikes me that there are probably some pretty easy ways to change the payment system. It could take five years to get down to them.

DR. MATHEWS: Even on what's been characterized as sort of a blunt and interim basis, and not even going into profit-sharing types of arrangements, there are probably some things you can do to switch the current incentives. MedPAC, in the past, has expressed concerns about these

extremely short stay patients. We see potential evidence of unprofitability of short stay patients for hospice providers. At the same time, we see the long length of stay being driven by the payment system.

I think there's probably a way, even in a very simple interim basis --

DR. REISCHAUER: A crude kind of way. Yes, right.

DR. MATHEWS: -- that would switch those incentives. And if you did it right you could do away with the cap altogether. And I think that can be done.

DR. REISCHAUER: Getting to the cap, your data shows that 9 percent of the providers hit the cap in 2005. There seems to be a very high recidivism rate in a sense. And you ask yourself how is this possible. And I hate to ask you to do more slicing and dicing, the way Mitra also was reluctant to do, but do we know whether the repeat cap hitters are provider-sponsored ones? Disproportionate numbers of them? Because then you can get into this overhead problem that somebody mentioned. Is the cost really done right?

DR. MILLER: Jim, I thought you did have some information on this in this discussion. Actually, this is

another point I wanted to draw out a little bit.

In our conversations, there is decidedly hit the cap and keep going types. But also, Jim -- and make sure that I'm doing this correctly -- you've also talked about the notion that there are for-profit providers who hit the cap and then manage themselves back out from under.

DR. REISCHAUER: I was going to ask you if we had the breakdown of the post-payback margins for the for-profit people who hit the cap and the not-for-profit ones? Because that would tell you a whole lot.

DR. MILLER: Jim, the people who are hitting the cap, that's dominated by for-profit providers.

DR. MATHEWS: That is correct.

DR. MILLER: And dominated by independent for-profit?

DR. MATHEWS: I don't know if I could go that far. It is dominated by for-profits, dominated by freestanding. So I think the provider based issue, I can explore that for you.

DR. REISCHAUER: But the real question is what is their post-payback margin, not whether they hit the cap or not?

DR. SCANLON: It's 9 percent as a total. So they don't affect much of the distribution above them.

MR. DURENBERGER: I'll just do this quickly because I'm not an economist. I don't sit on the board of any hospice company or any of that sort of thing.

But I'm sensitive to the fact you're going up on the Hill next week to hearings and things like that. And I really didn't want you to go up there with anything that might look like a consensus on this Commission that we're for capping corporate profits. It just isn't it time to do that.

Nor does it make a lot of sense if we're trying to -- I mean, I'm waiting for the time that this will be available to me and maybe I will have some choices and things like that. And I don't mind a little competition in the market or whatever there may be, a little variety. I don't mind people being creative about how to improve my benefit.

I just can't tell yet, as Jim is helping us understand, exactly what to anticipate or how to make those choices or any of that sort of thing.

But I do think there ought to be a potential in

the community in which I live and other communities to be able eventually to make those, or for my family to help me make those choices. And when I see that data like we see there, I see someone's taking advantage of creating those opportunities. That's a presumption. I can't prove it at all. We have all kinds of precedent for these other providers that would say maybe that doesn't happen.

But with regard to this one, in particular, I associate myself with all those who are asking the more appropriate questions, I guess. But I just wanted to say that in the context of the other weight you're going to carry over the next few months in that comment.

DR. KANE: I was just enjoying Bill's comment about limiting the profit. You know, back in the 1970s, in the dark ages, when we did have administered prices, there was a lot of time spent on utility pricing and how to create the right amount of profit. I wouldn't just apply it to this situation, though. I think if we're going to talk about what's the right amount of profit, going back through those models and saying are they useful guides to us in thinking about what's a reasonable amount?

You know, we adjust our updates based on what we

think a reasonable amount of profit is but we pick that number, frankly, out of the industry average or the air. And it might not be a bad idea to look back and say okay, these are administered prices. How much should we be setting aside for profit? What are the theories behind that, and then use it.

I wouldn't just use the hospice, though, as the industry to pick on. There's something clearly screwy going on in the hospice industry. And I tend to think that's because of the definition of the benefit, whether people are eligible just because they're going to die which means everybody is eligible. Or are they eligible because there's a clear benefit in substituting hospice for something more expensive?

And I think that's the part I think we need to focus in on is what is that definition? And how well thought-out is it? Is this a substitute benefit for more intensive care? Or is it a benefit for people who are going to die soon?

MR. HACKBARTH: In the way too many years now that I've been doing Medicare stuff, there have been many instances where people have talked about Bill's idea of

where you're imprecise in defining the product or being able to adjust for differences among patients, having a blended rate of some sort that is in part prospective and in part based on actual costs incurred.

I don't think that's anti-American. That's just, to me, a reasonable idea to consider. Now whether we want to do it in this particular instance or not, I don't know. I'm not that far.

But the fact is that there is imprecision in product definition and measurement in some of these cases. And so I'm open but not yet endorsing it until you come up with a better name.

MR. EBELER: Quickly, I started us down the blunt path, which is probably typical.

If you could flip to slide 12, I just want to piggyback on a conversation that Bob and Jim had. When you think about a short-term thing you do until we actually learn the content of what we're getting out of the hospice benefit, it's pretty easy to look at that chart and think about short-term arbitrary recalibrations of payment rates based on length of stay. It wouldn't be the most analytically sophisticated policy on earth, but I just want

to reinforce the comment you made, that there are things one can come up with here in the short-term.

I would be very hesitant to drop the cap until we know more about how that plays out because it strikes me that the cap is the only thing out there that we are certain of.

The other thing one can do, and Dave mentioned it, there's a whole lot of people coming in here. There's a whole lot of things coming in new that we are skeptical that it is the hospice benefit we think we want when we may need it -- which we all will, it's a benefit we all aspire to, I suppose.

You can also, for a year or two, simply limit market entry. There are any number of blunt tools that one can use until you have the data and content to better analyze this and come up with better policies.

It just seems to me there is a spectrum of things that we could consider in doing that. But again, I just think that chart really highlights the discussion Bob and Jim had about the potential for doing sort of quick and dirty things.

DR. STUART: I just want to make sure that we

understood what the profitability here is and what this margin really is reflective of. As I understood what Jim is saying is that the margin is calculated on an annual year before an adjustment for overpayment. Is that correct?

DR. MATHEWS: That's exactly what this chart shows.

DR. STUART: Okay. so what that means is that the 25 and 30 percent margins that you're seeing in the top decile are before any overpayment is taken out. Now that's really critical because another thing that you told us is that length of stay is predictive of meeting the cap. And since meeting the cap is going to reduce, at some point, your profitability the question that arises for me -- and I'd like you go back to slide 10 on this.

So if you look at that next to bottom row, it sounds like, it looks like these homes that hit the cap are making out like bandits. It looks like they're really making out.

But my question is whether that's the current margin before overpayment? And whether it considers overpayment for previous years. It seems to me that we've got to put this on a dynamic frame and really understand

what the implications are of moving into the cap or moving length of stay, taking long length of stay patients -- which is profitably initially but increases the probability of a cap payment which is going to reduce profitability in the future. And it almost looks like we've got the potential for a real arbitrage here.

In other words, that a firm, either on its own or because it feels that it has to do this, it's looking at these overpayments. It's got these long lengths of stay. One way that it can meet the overpayment is to accept patients that have long lengths of stay. That gives them current revenues that could be used to repay -- I'm really worried about the dynamics on this thing.

DR. MILLER: We've talked about this. And we can tease some of this out. What do you do when you hit the cap? One thing is you keep going and you keep bringing in patients that generate revenue. There are different models. We've had some of this discussion. It gets pretty complex but we can try to tease some of these out.

That is, in a sense, one of the big questions with the cap is do you hit it and keep going? Or do you start changing your business model?

DR. STUART: Right. And it sounds to me like you've got two different kinds of firms here: one that really wants to be in it for the long term. And you can't keep going on a pyramid scheme like this forever. But there are others that may be -- and if they're independents I'd be really concerned about this -- it might be a short-term profitability game in which you could actually make out and then just quit the business.

DR. REISCHAUER: [off microphone] What do you do, declare bankruptcy?

DR. STUART: It depends on what happens over time to the profitability. It really does. You're increasing liabilities over time, depending upon the payback period for the overpayments. So there's a financial angle to this thing that is really separate, I think, from the quality of care and the service burden that's being provided that really needs to be investigated.

Because I think if somebody looks at this table without understanding that it doesn't include this increased liability of overpayments, you're going to get a very different impression. And so, unlike Bill, I'm looking at this and I'm trying to figure out what the after overpayment

margin is. I think you said, Jim, for some of these -- maybe for all -- that the after payment margin was actually negative.

DR. MATHEWS: For the cap hospices reflected in this table here, the only number I can remember off the top of my head is the 2005 number. Their margin goes from the 18.9 percent that we see here down to negative 2.9 percent.

But to put it in larger context, remember in 2005 we're talking about total Medicare spending of $8.1 or $8.2 billion and cap overpayments representing -- again according to this model -- about $175 million. So for these cap hospices it is a big deal, especially given the range of variation that we see with respect to the dollar amount by which some hospices exceed the cap relative to others, and the variation in the percent of revenues attributable to cap overpayments relative to others.

Again, though some of them the overpayments represent 40 percent of their revenues. If they have to give those back, they are down the drain. Others, if they are exceeding the cap by 5 percent or 10 percent, maybe they can still make these kinds of adjustments we've been talking about and get back below the cap.

So again, a lot of variation here but most of the variation at the moment is within this group of cap hospices.

MR. HACKBARTH: We've just got a little less than 10 minutes left and we've had an interesting economics seminar.

I have now four people who come from the clinician side of the world who have been waiting patiently to talk about this. So we need to move on.

MS. HANSEN: A bit more context for this.

First of all, the hospice benefit, as it was begun, is incredible. So from a standpoint of positive -- from a standpoint of beneficiaries, which is the last comment, I think that there is great benefit, per se, for people in the benefit, and when you think about families and patients themselves valuing this.

My question is, and it's already built in but I just want to emphasize, having been on the long-term care side of things, that with the diagnoses of say dementia, Alzheimer's, and chronic ischemic heart disease or those conditions, that really starts feeling like a chronic care benefit as compared to a hospice benefit.

So when the program isn't so well defined it just allows that kind of organic growth of the program. So I wonder if it could be teased out? I know Arnie asked about whether there were any predictive components of it, and you mentioned the Alzheimer's disease. It could range tremendously. But there is, at some point, a profile where it moves into maybe what's called a palliative care period.

And I actually want to raise palliative care, because I noticed that hospice and palliative care somewhat are becoming synonymous as a frame. But hospice used to mean something specific. Palliative care means something also very different and could last a couple of years, in some cases. So the whole question of helping differentiate how the world moved between hospice to palliative care.

Some secondary impact on that, and that it what's interesting from a workforce standpoint, geriatric fellowships for physicians and some of the geriatric nursing advanced practice things have not drawn as well historically, and we all know that.

But what's quite interesting is there's been a hot demand for palliative residency specialization, as well as even nurses. So we've actually moved the workforce shift in

terms of the focus. I don't know what that means. But I just do know that it's interesting that the geriatrics classic all chronic disease comorbidity has now become far less popular than palliative care as a subspecialty.

So I just wondered if you would look into just the backdrop of that? Because that does have workforce implications.

Thank you.

DR. CROSSON: So I will speak in a clinical metaphor because it seems to me that when we're talking about the finances and talking about things like changing the margins and all that, we're really tinkering with a symptom as opposed to the underlying condition. And I think this is the point that Nancy was trying to make earlier.

Something has happened here which has morphed what was intended to be a clear benefit into something that's more like a long-term care benefit. And some institutions have been created to take advantage of that.

It's sort of like how did the hospice benefit end up getting applied to Alzheimer's disease? It doesn't seem like, to me, that's what it was intended for and I remember the beginning of this.

So while we may decide that there needs to be a short-term financial fix, it would seem to me some attention needs to be paid to understanding what the intended benefit was, what eligibility criteria are, whether that has to do with predictive modeling or simply something a little bit even clearer than that, which is simply limiting the diagnoses that are eligible for the hospice benefit, and then wrestling with the question as to whether there ought to be some other benefit created for whatever you want to call it, palliative care or long-term care, assuming that that would be affordable. I'm not sure it would be.

But don't we want to spend some time on that part of the issue, which is fundamental to creating this market opportunity that we don't like?

DR. CASTELLANOS: I'd like to make three points. One is I think the message that we've heard in the beginning, I want to make sure that everybody in the audience recognizes that this Commission is made up of a lot of different people from a lot of different backgrounds. But we all recognize the uniqueness of the hospice program and the benefit to the patient, the family, to the community and society. And it is really a hospice culture.

We're not throwing the baby out with the bath water. What we're trying to do is make the program more sustainable. But I think that message, it came across pretty heavy to me in the beginning and I know all the commissioners, I know how they feel, and they have a very uniqueness to the individual patient. That's important.

Two things that we talked about. One is most of the time in programs we look at the quality issues. I see very little -- and I don't see Arnie here either -- but we don't look at quality much in this program. There's been very little discussion on quality and how we measure it and patient and family satisfaction.

I know, Jim, you mentioned that you're going to provide some of that data next time. But in three periods we hit up to now we always look at quality. I don't see that we've done that very well.

Under the quality issues, Arnie asked to look at separated by length of stay and diagnoses. I would like to see if we could also separate it by nonprofit and profit.

And I know, Jim, you and have had a lot of different conversations on this. And one of the points I always looked at his I know patients change from one hospice

to another, and I'd like to know why they're changing. Is it because of the quality of care or what they get? Or is it change of location or what? I'm not sure if there's any data on that.

And the third question that you and I have talked about is in the data that you provided us in October and November one of the things he showed me is that increased physician costs -- and it was almost 20 percent a year or over 100 percent over a five-year period -- this excludes the medical director.

I'm wondering if we can drill down on those costs? Is it because of the palliative care that we're giving now, the chemotherapy or radiation therapy? Who is providing this care? Because I think that's separate. That's under Part B, which does impact on the Medicare spending.

DR. BORMAN: If I recall correctly, Jim, in one of your prior presentations you mentioned change in the benefit definition sometime within the last few years where it allowed people to requalify for additional days. If you could refresh us on that, or just me personally later, that would be fine. Because my recollection was that when I listened to you about that and saw this that the two do seem

to be married.

And in addition to the ability of companies to form up and whatever, it gets back to this benefit design that offered a potential entrepreneurial opportunity that may or may not have been too good. And so if you could refresh me on that, that would be great.

The second piece is just trying to look at this from a plain Jane general surgeon perspective, and somebody with a number of aging relatives and thinking about hospice and when I might need it. I know that Ron has said we think we have a shared idea of what hospice is. But if bet if we went around and talked to each other, we may actually have some differences in the concept.

And so I think that it would behoove us to make sure we're all on the same page, and that that would be that the object here in a very subjective way is probably death with dignity. That would be the simplest summary. That has lots of different things for every person as they face that.

And then there was this attempt at defining, within the last six months, and the economic correlate of that, I think, is that the expense to whomever, whether it's the individual, the person covering the bills, the insurance

company, the government, is very high in that final time. And so that one would think that we felt that a lot of that care was futile and that it generated a lot of expense and nobody was well served by it in the end.

So that it seems to me that if that is our shared notion of hospice, then what we see happening should, in fact, have a substantial measured difference in care costs in the last two to three months, I mean not just sort this month here that month there and whatever. That, to me, is on a very non-economist savvy viewpoints, if we would predict that the benefit of this is less futile care, less costs in those final few months of life, that ought to be a clear and consistent message that we get out of this information.

So that says either that the user population has changed, which I think we have found that because we have these people with primarily failing mental status pouring into the system. And that's only going to increase, one might think, with population trends.

There would be the question of are costs more because there's fewer people to meet the needs of these individuals? Are there fewer hospice trained staff? Are

there fewer facilities? Are there fewer pastors or whatever? The fact that it could grow so quickly suggests that there are indeed people willing to deliver this care.

And so I think the benefit definition, making sure that we're all clear on what we think is the priority need to meet for the beneficiary. And then saying okay, how can we craft something that does that? And what should be the outcome measure of that? I don't think this is it. And so I think we do need to be careful to be on a page about the benefit and that it really is in benefit design moreso than in trying to turn around and tinker with numbers that -- I had Jack's concern -- I'm glad he said it because it made me feel smarter, that somehow I'm not seeing where the subtraction for the overpayment part went.

MS. HANSEN: In the next report, related to your point there, Karen, the costs again, the updated costs for the last six months of life in general, just to have that as a backdrop piece.

Thank you.

MR. HACKBARTH: Okay. Thank you, Jim. Good job, much food for thought.

We will now have a brief public comment period

with the usual ground rules. Please identify yourself first and your organization. And since commissioners are headed to the airport, please keep your comments to no more than two minutes. And if the light comes on again, it means it's time to start.

MS. FRIED: I don't plan on talking that long.

My name is Leslie Fried. I'm here on behalf of the Alzheimer's Association. I direct the Medicare Advocacy Project.

And I was just a touch concerned with some of the comments regarding access to the hospice benefit for certain diagnoses, in particular Alzheimer's disease.

I just wanted to point out, and it may be in your report -- I don't know -- but Alzheimer's disease actually is the fifth leading cause of death by CDC reports for people 65 and older. So given that people do die of Alzheimer's disease, and that hospice is a benefit for people who are terminally ill and within the last six months of life, it's certainly an appropriate benefit for people with Alzheimer's disease. So I was just a little concerned.

I think doctors certainly have difficulty determining when are people within that six months. That's

why they are recertified every 90 days and then, after the second recertification, every 60 days. But I just want to clarify that Alzheimer's -- people die from Alzheimer's disease.

And that's just based on death certificate. Other people might have Alzheimer's disease but might have infections or pneumonia, et cetera.

So I just wanted to make that point. Thank you.

MR. SCHUMACHER: I'm Don Schumacher, President and CEO of the National Hospice and Palliative Care Organization. And before I did this job I ran a hospice program for 25 years in a couple of different parts of the United States.

I want to thank the Commission for hearing all of these issues, and specifically thank Jim Mathews for what I think is a very detailed and thorough examination of what we all recognize is a huge growth spurt in our industry and a growth spurt that is causing many of us some sleepless nights and quite a bit of worry, not just because of the growth that's taking place but of the concept that we've all been facing for some time that CMS and perhaps MedPAC and perhaps Congress would, in fact, use a blunt instrument

without looking at all of the detail that would go into the affect that that might have on a dying patient and family member anywhere in the United States.

There's a couple of pieces about this benefit which are unique. This is a risk benefit. When you are running a hospice program, you are encouraged, as a part of being a Medicare provider, to take of all beneficiaries regardless of their diagnosis, regardless of their length of time in the program, if they are, in fact, determined to be terminally ill as evidenced by two physicians' signatures.

Therefore it is not a surprise because dying, as you all know, is not an exact science, that there are some patients who are living in hospice programs longer than are other patients living in programs. And I find it rather troubling to think about the fact that if we have longer patients living in programs we have to find a way to disincent hospice programs to take care of them because it's costing the Medicare system more money.

I will say to you, and I know Jim mentioned this the last time -- the Duke study does show, the last study that has come out on cost savings, a cost estimate of $2,300 per patient, per beneficiary, at different points during the

disease trajectory. So I would hope that the Commission would look very thoroughly at the whole range of opportunities to cure this problem.

Do you know that if you're a hospice program in the United States right now you can get a license and not be surveyed for 11 years by Medicare? Do you think that that is an equitable way for you to receive a hospice license in the United States? Talk about wanting to change some things.

I have been to CMS multiple times asking them for more money for hospice surveys. When I was running a hospice program in Buffalo, New York I got a survey once every seven years. A lot of things can go wrong in your hospice program in a seven year period of time.

So if we're talking about blunt instruments, you might want to talk to CMS about ways that they can be more dutiful in supplying oversight of this benefit rather than beginning to take it out on the patients, their families and their providers that are trying to provide care.

The other part of this with CMS, I will tell you I'm very concerned is that this data collection tool that they've put out, we all support data collection. We don't

have enough of it. We need data collection. This is a faulty cockamamie data collection tool that is going to get them a whole bunch of garbage. We have been to them numerous times explaining why.

Just a small example of which is they are requiring us to have those medically necessary visits -- the nurse, the social worker, the home health aide, and the physician -- not only to keep track of in a routine home care setting, but in a general inpatient unit in a hospital. So we are now going to have to get from the hospital, as a part of the chart review, how many times a nurse went into a patient room and if the visit that was a visit, and if in fact it was medically necessary.

This is something that will not give them anywhere near the accurate data information they need to have. I have been and asked for a collaborative workgroup with Secretary Weems. We've asked for a collaborative workgroup with CMS so that we together could put a very thorough data collection tool. We're looking at trying to get some legislation put in so that every aspect of hospice care is tracked, that they can get the kind of information they need to make good decisions and give you the right information to

make your recommendations to Congress.

This data collection tool, I can assure you, will not do that. They're going to have a lot of garbage in and it's going to be garbage out, just like it was when they put together the first cost report for hospice several years ago.

This is a problem in our industry. We don't have the data. We need support to get that data. And we need more oversight coming out of the Federal government in order to ensure that what Medicare is paying for is being provided to every dying patient and their family.

So if we're talking about instruments, let's look at some velvet instruments that might have an opportunity not to punish everyone who is trying to provide services to dying patients but something that will give us a thoughtful instrument to give us the right outcome.

And if we're going to redefine the benefit -- and I do agree with Jim that it's time for us to take a serious look at it -- let's do it in such a way that everybody, especially the patients and their families in this country, benefit and are not punished in any way, shape or form.

Thank you.

MS. LUPU: I'm a little shorter than Don. Dale Lupu from the American Academy of Hospice and Palliative Medicine. We're the professional organization for hospice and palliative medicine physicians.

I wanted to respond to a couple of points. The first is that the Academy is very supportive of all the efforts MedPAC is doing and CMS is doing to look at and better define what kind of care is being delivered.

We agree with National Hospice and Palliative Care Organization that understanding the quality of services that is being delivered is equally important to understanding the payment. And we do need more information and we are aligned NHPCO and being very concerned that the instrument that CMS is going to be implementing is not going to give us the data that we need.

There was a question about the rapid rise in physician services under hospice that Medicare is paying for. The point that we'd like to emphasize is that there has been a significant change in the physician participation in hospice over the last few years, and that is what's being reflected in this data. A 500 percent rise is appropriate when the model that took place for about 20 years was a very

part-time medical director who spent several hours a week, maybe half a day, maybe a day a week primarily in the medical director administrative duties.

And now what has happened is as hospices have come to understand, and as there's become a workforce of physicians who do have these skills as their main professional area, hospices have begun to actually use physicians much more as clinician providers, working very closely with the attending physician but also delivering more care in the home, more visits, more actual clinical care being provided. And that's what you're seeing.

And so one has to look at that 500 percent rise but look and see have we reduced -- is that appropriate care? And we would say we believe when we look at it closely we'll see that that's been a major quality of care that's being provided.

And the third thing I just wanted to emphasize, I have forgotten who asked the question but there was some discussion around really what is the benefit? Is there a different benefit in the nursing home? What are we providing? Is this a long-term care benefit?

I would caution that from a clinical perspective,

although we have some data about populations, the difference in what the death rates are in populations from a clinical perspective, when one looks at an individual patient it is very, very hard to predict what is going to happen to that person.

And we need any blunt tools that we put in place from a policy perspective not to have incentives that push us back to where we were a couple of years ago where the hospices become so risk-averse or the physicians become so risk-adverse saying I can't predict so I'm going to only take the safest patients.

It is going to harm patients and families if we push them back into that under one week of care. That's not good. And so we need to be careful as we're trying to use these instruments to test them well. And we would really advocate for some demonstrations or some testing of policies before we experiment on the whole hospice population.

Thank you.

MR. HACKBARTH: Okay, we're adjourned. See you next month.

[Whereupon, at 11:16 a.m., the meeting was adjourned.]