MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
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Thursday, November 8, 2007
9:40 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair
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BRUCE STUART, PH.D.
NICHOLAS J. WOLTER, M.D.

P R O C E E D I N G S

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

DR. SOKOLOVSKY: Good morning, everyone.

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

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

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

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

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

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

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

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

It's worth nothing the difficulty of finding reliable income and asset data for the disabled Medicare eligible population. The numbers we found show that disabled Medicare beneficiaries were twice as likely as the 65-and-over population to have incomes below the poverty line and this chance increases with mental impairment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

multimedia campaigns, SHIPs, and community-based outreach.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

values.

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

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

This leads to draft recommendation two: the

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

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

They emphasize that the main cost of this is

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

Beneficiaries with limited incomes would save money.

The Social Security Administration is responsible for determining eligibility for the low-income subsidy for those individuals who are not deemed eligible. Beneficiaries can apply for LIS without facing the possible stigma associated with going for help at a state Medicaid office. Under the law, beneficiaries who apply for LIS at a state Medicaid office must be screened for other programs like MSP that they might be entitled to. Social Security Administration does not have this responsibility.

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

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

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

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

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

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

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

MR. HACKBARTH: Good job.

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

So questions, comments on the presentation?

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

connect the dots to.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Other thoughts about this approach? And issues it

would raise?

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

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

MR. HACKBARTH: I see your point there.

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

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

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

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

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

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

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

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

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

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

Thank you.

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

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

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

things. But it could be written in different ways.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

think, and if we could choose something better.

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

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

DR. REISCHAUER: It's all or nothing?

DR. SOKOLOVSKY: I think so.

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

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

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

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

I would say that the recommendations are spot on

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

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

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

issues in the years ahead?

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

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

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

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

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

and -- okay.

All right, we need to move on now.

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

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

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

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

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

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

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

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

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

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

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

DR. SCANLON: Right.

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

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

And so I would think if there's any state

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

MR. HACKBARTH: I'm just a little confused. Recommendation three is not could. It says that SSA would screen and enroll them if they qualify. It's not an option.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. SOKOLOVSKY: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Just to take a moment to go through what this

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

On the right there you have the proportion of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Thank you very much. Bruce?

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

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

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

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

But we think there are some plans that simply

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

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

[Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

their members. But it was an N of one.

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

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

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

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

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

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

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

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

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

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

DR. CASTELLANOS: Is there an answer?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So that's a start in that direction.

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

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

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

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

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

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

From talking about formularies, we're going to

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

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

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

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

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

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

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

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

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

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

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

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

2008.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

beneficiary is for staying in the same plan.

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

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

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

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

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

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

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

premiums have to increase somewhat to cover plans overall bids.

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

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

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

PDs tend to have much lower premiums.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

involve budgetary impacts.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And it is potentially possible to take pre-rebate

dollar premiums into account in setting these thresholds. I'm sure plans might have a different point of view as to whether or not that's an appropriate thing to do.

DR. KANE: As I recall, we had a lot of discussion about the impact of Part D on nursing home patients. Is there any new information about how the nursing home population, in particular, is faring under these changes, especially the LIS changes?

DR. SCHMIDT: I do not have a sense of how many of the 2.6 million are in long-term care facilities. It's possible that with a little more time and analysis I might be able to dig that out of enrollment data but it's very difficult to obtain. But I will certainly look into that for you.

DR. KANE: Is it possible just to even get data from the nursing home industry about what's happening? I don't know, maybe that's too much work.

DR. SCHMIDT: It's not an issue of the work. We can certainly ask around and get a sense of that.

DR. CROSSON: With respect to the draft recommendation, I think as you laid out pretty clearly there is, in this consideration, perhaps a set of conflicting

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. MILLER: So there's that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We need to get to our final few here.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. SCHMIDT: Not really.

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

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

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

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

DR. DEAN: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

Okay, well done everybody. Thank you.

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

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

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

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

the ones today.

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

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

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

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

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

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

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

QMB cost-sharing to 150 percent of poverty.

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

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

Thanks.

MS. FRIED: I'll be shorter.

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

the last slide 10.

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

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

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

additional premium.

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

Thank you.

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

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

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

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

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

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

Thank you.

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

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

AFTERNOON SESSION [1:21 p.m.]

MR. HACKBARTH: Everybody needs to go to their notebook and take out the material we've already covered, throw it in the middle. Then we'll light it and we'll have a fire to keep warm.

[Laughter.]

MR. HACKBARTH: We're trying to get the room a little bit warmer than it is right now. I'm usually warm. Jack has taken over my role as the guy who's hot. I'm usually very comfortable but, even by my standards, it's a little bit chilly right now. We'll try to get that fixed.

First up this afternoon is moving toward bundling payment around hospitalizations.

MR. LISK: Good afternoon. Today I'm going to start off our presentation by reviewing some of our analysis results on episode spending, which was included as an appendix in your mailing material for this presentation.

I want to say that the numbers are slightly different from what we showed you last time, due to issues in correctly identifying physician services, claims associated with a hospital stay. But our basic conclusions that we had from the last meeting are similar, except the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. LISK: That is correct.

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

MR. LISK: That is correct.

MR. HACKBARTH: If you looked at hospital costs,

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

MR. HACKBARTH: Yes. Thank you, yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

First, a brief summary of our two implementation

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

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

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

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

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

stay.

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

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

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

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

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

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

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

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

Also, because bundled payment allows for shared

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

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

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

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

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

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

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

would need to be explored in pursuing that option.

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

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

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

adjustment, that may seem a little daunting to them.

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

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

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

Because virtual bundling allows providers to be

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

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

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

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

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

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

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

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

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

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

system. We call this one a system level approach.

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

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

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

would be reduced.

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

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

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

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

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

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

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

MR. HACKBARTH: Any questions, comments?

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

[Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

That's probably enough for now.

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

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

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

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

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

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

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

MS. MUTTI: That would be the system level.

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

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

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

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

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

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

DR. WOLTER: I mean CHF.

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

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

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

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

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

DR. WOLTER: Great.

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

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

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

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

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

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

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

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

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

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

incentive payment there over time.

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. LISK: Right.

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

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

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

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

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

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

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

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

wanted to get some explanation.

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

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

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

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

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

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

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

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

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

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

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

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

MR. BERTKO: The first of many then.

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

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

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

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

The other you hinted at with the hybrid approach,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The one common element of this is the hospital.

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

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

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

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

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

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

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

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

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

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

Next up is preliminary findings on SNF payment

refinement.

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

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

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

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

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

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

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

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

they use therapy minutes to group stays.

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

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

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

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

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

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

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

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

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

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

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

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

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

In the therapy designs, we used an indicator of

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

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

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

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

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

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

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

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

So let's start with the models to predict NTA

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

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

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

incentive to avoid cases with high levels of NTA costs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Commission has supported the use of two short-

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

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

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

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

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

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

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

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

One benefit of establishing such a mechanism would be that SNFs would get information on every beneficiary that could be useful for care planning purposes. The need for information transfers between providers highlights the need for information technology industry-wide.

The next steps for us are to include the NTA in therapy models and see how well the models predict total ancillary costs and then to estimate the impacts on various different provider groups. In the future work, we plan to examine an outlier policy, again building on the previous work that the Urban Institute did for CMS. And we'll bring these results back to you at a future meeting.

That's it and we're glad to listen to your discussion of this.

MR. EBELER: Thank you, very much. This is very helpful. If you would turn to slide seven, where you talk about the elements one that might exclude in the selective model, it seems to me there's three different types there, the age, the IV medications, and the hospital data.

The IV medications is a classic case of something

that can be gamed. It's the variable you might be trying to control. So I sort of understand concern about that one.

The other two, I think, are different. In particular, the variable based on hospital data. Carol, you just captured it at the end. Rather than thinking of that administrative constraint of that data transfer by the hospital as a problem, it strikes me as an objective of the payment change is to assure that that data transfer takes place. Because that's the classic patient handoff.

So I guess that one, in particular, it just takes me that one wants to drive to a system that requires those data exchanges rather than a system that adapts around the lack of those data exchanges.

MS. BEHROOZI: Thanks very much.

It's a clear case, I guess, for why it's important for us, consistent with everything else we're thinking about in terms of reducing the incentives to grow volume of services, to change the way therapy services are paid. So you make that case very well.

But in light of the New York Times article that I guess we all know about in September on private equity buyouts of nursing home chains and their cost-cutting

measures that directly cut into patient care, it's very important, very, very critically important that we don't create another incentive for them to further stint on care. And you've acknowledged that with the prior positions that the Commission has taken with respect to the quality measures in SNFs and adding patient assessment.

But the evidence that was brought out in that article directly pointed to the reduction of staffing, in particular, as one of the ways that the new ownership structures seek to contain their costs and very directly undermine patient care.

And going back to the work that's been presented here in connection with pay-for-performance measures and quality measures by Dr. Kramer pointing to the direct correlation between staffing levels and quality, I really urge the Commission to consider staffing levels as a structural measure of whether SNFs are meeting the standards required to -- whether it's participate in Medicare or be penalized or whatever. But I think that point has been made over and over again and we really have to be careful moving toward a system that is not volume based, that it doesn't become further inducement to stint.

DR. CARTER: I did want to just add that in the CMS demonstration that they are in the process of planning, staffing measures are one of the four domains that they will be using in their pay-for-performance demo.

DR. SCANLON: I think you've done an incredible job of moving the system forward in a very positive way and operating under, I guess, two what I think of as extreme constraints. One, the data you've referenced several times, the fact that it's tainted by the incentives that we have in the current system and therefore we can't really observe what might be needed.

And then I think the second constraint is one that maybe we're all somewhat guilty of, which is that we live with our mindset of the PPS model. I've often thought that our success on the hospital side, in some respects, hasn't made us wary enough of whether or not it works in other contexts.

Toward the end you were talking about the whole issue of if we create this incentive, which is the right thing based upon predicting sort of a person's need but then worry about whether or not they get the services and we'll use pay-for-performance as a safety valve, I have the same

concerns here that I had with respect to home health pay-for-performance, which is we don't have good measures for the person who is not going to get better. And we don't want to discriminate against that type of patient.

And nursing homes, as states introduced case-mix systems over the past 15 to 20 years, nursing homes demonstrated that there were very good at inquiring about what exactly a patient was going to be like before they admitted them. It wasn't something that this was a standard procedure until the case-mix system was there. And then once it was there, there were all kinds of inquiries related to how am I going to be paid for this person? So I think we do need to be concerned about that.

So I think while this moves us forward, there's also a question of whether we should be thinking longer-term about how we pay and whether modifications to prospective payment -- and I happen to be a fan of some kind of risk corridors as a way of dealing with the incentives that would penalize people for too much under provision, protect them for the riskiness that's associated with the fact that we can't always predict exactly what people are going to need, and in the process hopefully generate information that we

would then use for recalibration of rates over time so that we would have better experience to draw upon in terms of the calculation of rates.

I think what we've seen with Part D is that it was possible to go back and to do some reconciliation. Arnie's right that I have been one that has said CMS is incredibly overstretched and therefore has very great difficulty doing certain things. But again we've got to think about this from an investment perspective. If we don't invest in the administrative resources, if we keep the payment system simple enough that they match what administrative resources that we do have, we may end up paying much more out over time than if we were to make the investment in the greater sophistication of resources and improve our payment methods.

And related to the last point is the whole issue of data. I agree with Jack that we should be thinking about what it is that would be the data that we really want to have with respect to both payments as well as the care of these individuals and be setting out those standards. And even if they are an increase in terms of what we're asking for from homes now, that's okay, because we are spending a lot of money on this. There's a lot of people that are at

risk and it should be something that we're willing to spend the money on.

MS. HANSEN: This is more of a question to help me clarify something I may be confusing, and it's going back to the same page seven about the third variable about age that was discussed. I know, from some of my own previous comments, I've always kind of noted that sometimes extreme age, say 85-plus, oftentimes creates some greater needs. I just recall that I've said that.

But on the flip side of this, just wondering if there is any concern in any of this modeling that there would be, in some ways, discrimination of not taking people who might be -- if they looked at something as age, is that one of the things that might be a caution in looking at this as a variable?

It's more, actually, two sides of me kind of going and perhaps you could help me appreciate whether or not this is an issue that should be of concern. The bottom line is I want both the fair treatment of services, but I also want the facility to be paid appropriately at the same time. So how do we achieve that?

DR. CARTER: I'll take a crack at it, and you guys

might want to add in.

Age for this service actually decreases -- the cost of treating older and older patients decrease. And so if our coefficients or the things that we're using in our models aren't accurate, the incentive would actually be to discriminate against younger patients because the costs actually decline as patients get older. I assume a lot of that is because older patients get less therapy and can't tolerate the therapy.

So that at least is part of -- including age in the model would improve our predictive ability and leaving it out might, if our models aren't accurate, could lead to discrimination. But it would be on the younger patients, not on the older patients.

MS. HANSEN: Now I recall that comment from an earlier meeting that we had because I know that kind of threw me a little bit because my whole life has been working with the 85-plus population. So it may be just something that's more subtle that it's possible that people just don't get treated when they're really older. But that's something that we can't really, frankly, measure through this. That's what I think the actual data surprised me a little bit.

Probably there's some more information.

DR. CASTELLANOS: Just to carry on what Mitra was saying, in the real world, Carol, you mentioned providers may be selective in who they admit. I'm going to be honest, they are selective in who they admit.

And there's a real access problem. For these very high complex patients, or we call them train wrecks, we can't get them admitted to a private service. You really have to wait for the hospital SNF to have a bed available because nobody else will take them. They require a tremendous amount of work and it's a cost.

Now, of course, the hospital has an incentive to get them out of the hospital so maybe that's why they take them. But to be honest, with this new payment system maybe we're paying more adequately and appropriately for these high-risk patients.

DR. STUART: I think it's an issue that goes beyond just simply selection of patients. It's the kind of care that they get once they're admitted.

I think focusing on the NTA cost actually is important. We've done some recent work, and there's a summary of that is published on the ASPE website earlier

this year, that looked at medication administration data for beneficiaries who were in a SNF qualified stay compared to contiguous days in which they were non-SNF qualified. What we found is -- and during the SNF qualified months, the number of administrations, medication administrations, during the month was 7 to 30 percent lower than during months in which there was only nonqualified stays.

Now I don't know whether the medication was necessary or unnecessary and it was a relatively small sample size so it doesn't get into the type of medications. But at least it raises the question about what the incentive is -- well, we know what the incentive is. The incentive is if you're just paid a flat amount, is to minimize what's being offered. But this suggests that it gets down into that level of the actual medications that they're being provided.

And I'd be happy to give you the information to get that cite. We've done a little work after that. So if you'd like it, I'd be happy to get that to you.

DR. WOLTER: I really like this chapter and although I don't pretend to understand the statistical evaluation of the different approaches that we might take

here. But I just wanted to connect it to my own admittedly biased world view, which is I think we had a presentation earlier this year in the spring that did suggest that in hospital-based SNF there tend to be sicker patients. We've had 35 percent or so of those SNFs close over the last four years. And in many communities, these types of patients, it's very, very hard to find a place for them out in the community. And for those of us that did LTCH visits a few years ago, we certainly heard that anecdotally in just about every community that we visited.

And then the other thing is we've been wrangling ever since I've been on the Commission about whether the negative 85 percent margins in hospital-based SNFs are cost accounting issues or those rooms were better use for acute care or whatever it is. But I do think we have a group of patients for whom the current payment system is not adequately covering what needs to be done. And I think it has affected some decisionmaking. I'm really happy to see us really trying to tackle this and see if we can't bring something to bear that might serve those patients a little bit better. Whether it will be too little, too late I'm not sure yet but this is good work and I look forward to the

next version.

DR. CARTER: We will be bringing back impact analysis next month, so you'll be able to see some of that.

MR. HACKBARTH: Bill's comments had set me to trying to think through this. Pardon me for plodding along, but what I heard Bill say was that a SNF payment is tricky because there are unmeasured differences in the patients, and that inclined you to think in terms of risk corridors as opposed to a strict fully prospective amount, some sharing of the risk that would attenuate problems if we're not measuring the patient case-mix exactly right. That makes sense to me. I assume that's part of the outlier thinking. Outlier is an insurance policy for institutions that do get tougher cases. So pursuing the outlier analysis and thinking that through makes sense to me.

In the context of home health, one of the things that we did to try to get a feel for whether there was a bias was look at the profitability by case-mix adjusted. Are there particular cases where we see higher profits than others? Have we done something like that for SNF?

DR. CARTER: We haven't. I know when I worked at

GAO we had heard, at least anecdotally, that for the rehab groups the highest rehab groups were less profitable than the high and very high -- which is different from the ultra high. So sort of the middle level rehab groups were more profitable than the low and the very high. And that the other patients were less profitable, but I think that was really more anecdotal information. And we have not done the RUG level profitability analysis.

DR. SCANLON: There's the third issue that was working against you in this, in the fact that with SNFs what we're talking about is Medicare being this 10 percent on average share?

DR. CARTER: A little higher, but under 15.

DR. SCANLON: So you've got this cost variation that is largely driven by the rest of the business, a major part of it which is not related to care but, in some respects, the quality of the facility. And so when one tries to do -- and this has gone on for years -- cost analysis of nursing homes, it's often very hard to identify what are the drivers of costs, particularly when you're trying to look at it from a care perspective.

MR. HACKBARTH: Okay, thank you very much. Good

work.

Next is hospice.

DR. MATHEWS: Thank you.

At our last meeting I discussed a preliminary analyses relating to the so-called hospice cap, the limit on the aggregate average payment for beneficiary that a hospice can receive from Medicare. This afternoon I'd like to present the results of our refined model and other data to help characterize Medicare beneficiary access to hospice care.

The refinements to the cap calculation part of the model, for the most part, involve changes to the way beneficiaries are counted. For example, we now are able to allocate hospice use by beneficiaries who use more than one hospice provider for purposes of calculating the cap. To evaluate access, especially in light of the effects of the cap, we examined changes in hospice utilization by Medicare beneficiaries and changes in the supply of hospice providers. We also developed an illustration of the financial incentives under the current payment system that may provide an additional impetus for hospices to admit patients who are likely to have longer lengths of stay.

Lastly, we identified a number of policy considerations that the Commission may wish to address in deliberating potential changes to the hospice payment system.

We reported previously that a small but growing number of hospices reach the cap each year. That finding still holds, but we do now estimate that a larger number of hospices are reaching the cap than we reported previously. We now believe about 220 hospices, or 7.8 percent of the total number of providers, reached the cap in 2005. The dollars have also increased as a share of total Medicare payments, about $166 million in cap overpayments in 2005, off a base of about $8.2 billion.

While the number of providers reaching the cap has increased relative to our earlier parliamentary estimate, the characteristics of cap hospices is pretty much the same. Ownership and facility type continue to be highly correlated with cap status. In all years from 2002 to 2005, about 90 percent of hospices that reached the cap were proprietary, and over 90 percent of hospices that reached the cap were freestanding facilities.

As we showed previously, hospices that reached the

cap are smaller than non-cap hospices in terms of caseload. On average, they had about 137 patients in 2005 compared to nearly 300 for non-cap hospices. Additionally, they have much longer length of stay, as we showed previously, on average about 139 days for cap hospices versus 68 days for non-cap hospices in 2005.

Using the new counts of hospices, we again looked at cap versus non-cap hospice length of stay in great detail using claims data because length of stay is indeed the strongest driver in whether or not a hospice reaches the payment cap.

As I mentioned a moment ago, the patterns we observed previously regarding length of stay persisted with the new counts. Patients at cap hospices had median lengths of stay of over three times that of patients at non-cap hospices and about double the mean length of stay relative to non-cap providers. Further, the length of stay greater than 180 days -- which you will recall is the six month presumptive eligibility period for hospice -- represented about 40 percent -- just under 40 percent of episodes at cap hospices compared to less than 15 percent of episodes with non-cap providers.

So again, while the number of hospices has changed relative to our preliminary results, the overall picture is pretty much consistent with the earlier results.

Previously, when we looked at diagnosis that was the primary reason for a hospice admission, we presented data on the top eight diagnoses comparing length of stay and the share of total cases represented by those diagnoses for cap hospices and non-cap hospices. At your request, we aggregated all of the diagnoses, all of the claims for 2005 into more general disease categories. Those results are presented here.

The results are a little bit mixed, relative to what we presented previously, most notably in that when we aggregate by disease category we do now see pronounced differences in the mix of cases treated by Cap hospices compared to non-cap providers.

You may recall that the last time I presented results, only one diagnosis of cancer appeared on the top eight. That was lung cancer. But when we aggregate all diagnoses of cancer into a general category, this gives a much more complete picture of the contribution of cancer to the overall mix of cap and non-cap providers. In short, cap

providers have a much smaller share of cancer cases as a function of their case-mix than do non-cap providers.

The second major point of this slide is consistent with the results that we presented previously, which is that cap hospices again had significantly longer lengths of stay across all diagnoses, ranging from 23 percent longer for lung cancer to 122 percent longer for patients with circulatory disease other than heart failure.

So in short, there are differences in the case-mix between cap hospices compared to non-cap providers, but these differences do not fully explain why some hospices reach the cap and others do not. Hospices reaching the cap have lengths of stay that are longer than non-cap hospices for all conditions. Even if cap hospices had the same mix of patients as those that did not reach the cap, their length of stay and thus the odds of reaching the cap would be greater.

So then we asked whether or not the growing effects of the cap are impeding Medicare beneficiary access to hospice care. Again, we looked at access to answer this question by both beneficiary utilization of services and by the supply of providers.

In the aggregate, you'll recall from last time, Medicare spending for hospice has grown about 23 percent annually between 2000 and 2005 and spending is projected to reach about $10 billion in fiscal year 2008.

Spending is a function of both greater numbers of beneficiaries electing hospice and more spending per hospice patient. Both of those measures grew by about 11 percent a year, on average, between 2000 and 2005. There is an additional increase of about 7.5 percent in terms of the number of beneficiaries using hospice between calendar year 2005 and 2006. We do not yet have fiscal year numbers.

As you know from your paper, we examined the growth in hospice utilization by a number of different groupings of Medicare decedent beneficiaries. We looked at utilization by age groups, by sex, race and ethnicity, Medicare eligibility status, and Medicare insurance coverage. I won't go into the detailed results here because the short story is that hospice utilization by Medicare decedents increased by roughly 50 percent in the aggregate between 2000 and 2005. Basically the rate of utilization increased across every strata of the Medicare beneficiary population that we looked at.

One detail that was of interest was that the increases in utilization were particularly pronounced among Native American beneficiaries. Their rate of utilization doubled between 2000 and 2005.

Utilization continues tp be higher for managed care decedents than for fee-for-service. Over 40 percent of Medicare decedents who had been in a managed care plan used hospice in 2005, compared to about one-third of fee-for-service decedents. However, the rate of increase in hospice use by fee-for-service decedents was almost double that for managed care enrollees during this time, so the differential is less in 2005 than was in 2000. The differences between fee-for-service and managed-care utilization raise a couple of interesting policy questions that I'll loop back to at the end of this presentation.

We also attempted to get a sense of access to hospice care by looking at the supply of providers. During the period from 2000 to 2006 in this slide, we see a pretty robust growth, about 5 percent on average annually through this time. This is also the period of time, you'll recall, that hospices began to receive the re-payment notices with respect to their overpayments.

What's interesting here is that the number of nonprofit and government run hospices has been stable over this time, with virtually no growth, whereas I think almost all of the growth between 2000 and 2006 has been due to an increase in the number of proprietary providers which has grown at about 12.5 percent annually over this time.

Again, it's the for-profit hospices that are disproportionately affected by the hospice cap, so this was a little bit of a surprising finding. We felt that if the cap had been having the impact on providers' willingness to enter into Medicare, we would have seen it here.

We also looked at the number of hospices newly participating in Medicare compared to those that voluntarily left the market. As you can see here, the number of new entrants exceeds the number of voluntary closures, especially beginning in 2004. About six times as many hospices began to participate in Medicare as closed between 2004 and 2006. I also want to point out here that closures that we've portrayed here also include mergers. So these aren't necessarily hospices that have left the Medicare market altogether. And there is a fair amount of merger activity that has been going on in recent years.

So again, if the cap is having an impact on hospices' willingness to participate in Medicare, it doesn't readily show up in data up to the present time.

We also kind of drilled down on this issue a little bit further, looking at hospice access in those areas of the country that had the highest proportion of hospices exceeding the Medicare payment limit. We looked at the ratio of hospices to Medicare beneficiaries in the five states that had the highest rates of hospices reaching the cap in 2005 compared to those states with the lowest rates.

Interestingly, access as defined by this measure, was highest in the states with the highest share of hospices reaching the cap. Access was highest in Oklahoma, with 2.9 hospices per 10,000 beneficiaries, 14 times higher than the ratio of hospices to beneficiaries in New York. Further, the states with the high rates of hospices reaching the cap also experienced much higher rates of growth in the number of providers on average between 2000 and 2005 than did states with no hospices reaching the cap.

It's possible that the high rates of growth resulting in high numbers of hospices per capita have created localized instances of market saturation that help

explain the patterns we've observed. I'll come back to this point shortly.

But in short, it's true that greater numbers of hospices are reaching the cap. The effects of the cap can be very hard on individual providers. But when we look at the growth in the number of hospice providers, growth in beneficiary use of hospice, and the geographic concentration of the effects of the cap, at the moment we do not see that the cap is causing a general problem with Medicare beneficiary access to hospice care.

At the moment we still have no analytically solid explanation for the difference in length of stay between cap and non-cap hospices. There is a financial incentive that may serve as an inducement for longer lengths of stay. We mentioned this briefly at the last meeting. I've presented a rough sketch of these incentives here and in your paper. We assume higher cost at the beginning and end of an admission, as we've demonstrated previously, and a constant cost across all of the intervening days. We're also assuming a constant level of payment per day per episode for purposes of simplifying the illustration.

In general, the longer the length to stay, the

higher the Medicare margins, with the largest rate of return in this example coming from the move from a 10-day to a 45-day stay. The rate of margin increase diminishes as the stay becomes very long because the payment-to-cost relationship is dominated by the days in the middle of the episode. These patterns would vary, of course, under different costs and payment assumptions.

So at this point, we kind of asked ourselves what does the fact that a greater numbers of hospices are reaching the cap actually mean with respect to beneficiary access? Remember that the cap is driven largely by length of stay, so the short answer is that it means that length of stay at these hospices is getting longer. The financial incentive that I just described likely explains part of this increase but not all of it. There are also local market dynamics at work here as well and I'd like to take a little bit of time to discuss this point.

We have observed, as you'll recall from a few slides ago, that there are differences in the case-mix of patients served by cap versus non-cap hospices. Hospices affected by the cap argue that this is because they are admitting patients who more accurately mirror the decedent

population in their communities and include patients with longer lengths of stay. Hospices that do not reach the cap, located in these same communities as cap hospices, have a different mix of patients with higher shares of cancer patients, on average. But we do not know which group actually mirrors the mortality profile in any given community. So we don't know if the non-cap hospices are playing it extremely safe with respect to their patient mix or whether the hospices that are hitting the cap are expanding the patients that they are taking in.

However, it's important to remember here that case-mix does not fully explain the differences in length of stay. Cap hospices have longer length of stay for all disease categories and thus appear to be doing something different with respect to their admissions practices.

It's possible that the patterns we observe with respect to length of stay reflect differences in new entrants versus established hospices in a given market. Hospices that have long operated in a market may have established referral networks that ensure their admissions have lengths of stay that allow them to remain comfortably under the aggregate payment cap.

New hospices in the market, which tend to be proprietary, do not automatically benefit from these kinds of referral networks and thus may have to seek a different patient population in order to generate revenues. This may take the form of identifying patients with nontraditional end of life conditions, which might explain the move away from cancer as a predominant diagnosis. This could reflect an increase in access to hospice care.

However, it has also been suggested that new hospices in a market could also compensate for a lack of a referral network by taking patients who might nominally meet the admission criteria but who are more likely to live beyond the six month presumptive eligibility period than other patients. We see evidence for this possibility in cap hospices longer length of stay across the board and in their higher percentage of patients who live beyond 180 days.

If such practices resulted in a longer length of stay for patients who have had traditionally short stays, this could be seen as increasing access. MedPAC has previously stated that extremely short stay patients are unlikely to benefit fully from hospice end of life care. But this hasn't been the case. Length of stay at the median

or has been persistently in the range of about two weeks since 2000. All of the increase in utilization, as measured by length of stay, has been for patients with stays above the media, those who have already been getting more care than half of the Medicare population enrolled in hospice.

So where do we go from here? In the short term, staff are developing information on Medicare's payments to hospices, an analysis of hospice costs, and a brief overview as to whether or not hospice saves money relative to conventional curative end-of-life care. Over the longer term, the Commission may wish to consider a number of policy issues including an evaluation of the eligibility criteria for admitting patients to hospice. Here the question is both cap and non-cap hospices are using identical admissions criteria but admit patients who turn out to have very, very different lengths of stay. So do the criteria need to be tightened? And if so, how should this be done?

It's an important issue because without resolving this question it's looking like hospice is starting to stray into the realm of a long-term care benefit. Currently, 8 percent of Medicare hospice enrollees do not die within the benefit in a given year, up from 4 percent in 2000.

Beneficiaries who do not die in a given year also have a much longer length of stay, a median of 236 days in 2005, up from a medium of 179 days in 2000. Length of stay for all decedents at the 90th percentile of the distribution was 168 days for all patients across all hospices in 2005 but it approaches 300 days for some freestanding hospices -- cap hospices in that year.

At the same time, as I mentioned a moment ago, stays below the median have persisted at the two week range since 2000. So patients who appear to need extra hospice care the most aren't necessarily getting it.

Length of stay also relates to the incentives in the current per diem payment system. The incentive is to provide longer lengths of stay but what is the right length of stay? If we can't figure that problem out, what are the alternatives to the current per diem-based payment system?

Third, given the differences in length of stay, the question arises as to whether or not hospice payments -- or as has been proposed -- should the hospice cap be adjusted for case-mix? If so, I think we need to consider the kinds of coding incentives that could come into play if such a change were implemented, given some of the rapid

changes in the mix of patients who are using hospice that we've seen over the course of the last several years.

Lastly is an issue that we haven't detailed in your paper but relates to the managed-care point that I raised several slides ago. We're going to look into the factors that account for the higher rate of hospice utilization among managed care enrollees and try and figure out whether this higher use rate relates to the fact that hospice is carved out of the managed care benefit. It's the only part of the Medicare benefit that's treated in this manner and you may want to look at that issue closely to see if it makes sense to do so.

At this point I'd like to conclude my presentation and stand by to answer any questions that you might have or otherwise facilitate the discussion.

MR. HACKBARTH: Help me, Jim, set the stage here. I think everybody would agree this is important benefit and the payment system is one that's overdue for some careful reevaluation. At this point, we're not facing any mandated studies or anything like that that would drive us to address particular issues right now?

DR. MATHEWS: No.

MR. HACKBARTH: At what point or will we at some point be able to look systematically at hospice margins? How far is that in the future?

DR. MATHEWS: I would defer to Mark.

DR. MILLER: We have the data. We've been grinding through the data. It's hard to put a specific date on it because this is the first time through it. We're still understanding some of the properties of it. We're still seeing patterns in it that we're not quite sure what we're looking at. There's still some technical things that we feel like we have to work through. We were hoping a November/December type of time range, but now I'm not as sure. Like I said, we've just kind of entered into the data analysis. It will be a question of how far we can get when we start feeling comfortable.

MR. HACKBARTH: The reason I ask is that margin analysis isn't the end all of payment analysis but certainly it's a staple of what we do when we're trying to examine the impact of a payment system. And to leap ahead and start proposing changes in a payment system without looking at basic information like that just seems like it's putting the cart before the horse.

DR. REISCHAUER: But I would think that, in some respects, that's a fine place for the cart. When you see proprietary organizations entering a market at a very rapid pace, it doesn't suggest that there are large negative margins.

MR. HACKBARTH: And I think that's probably a reasonable inference. Certainly that's the inference that we often draw in other payment systems when we see rapid entry, and when we do our payment adequacy analysis, we think that that's an indicator that's pointing towards adequate or more than adequate payment. So I would not disagree with that.

But again, my point is where do you start in trying to make payment changes? And what information do you need to do that? I agree with your inference but I'm not sure what payment changes I would make based on that inference at this point.

MS. DePARLE: Thanks. I wanted to go back to the average length of stay or the length of stay questions you raise, which I think are fascinating. The chart on page six, I think is where -- it's sort of hard to read.

As I read this, whether for hospices that have hit

the cap or those that haven't, the average lengths of stay are still well below six months. And at the end, you cited some numbers, 8 percent I think you said, that were above patients who lived beyond 180 days. Is that right?

DR. MATHEWS: Yes. I'll give you a couple of numbers again related to the 180 day. With respect to cap hospices, 40 percent of their episodes extend beyond 180 days. In non-cap kept hospices, the number is up 15 percent. The number I mentioned in the end, 8 percent -- is that what you just mentioned?

MS. DePARLE: Yes. I thought you said 8 percent live beyond 180 days? Was that a different --

DR. MATHEWS: That number was 8 percent of patients enrolled in hospice do not die in hospice in 2005.

MS. DePARLE: That year. Are you looking at -- are you suggesting that they were a hospice patient for more than 12 months? Or is it simply you're saying that they enrolled and you could enroll in December of 2006 and die in January of 2007?

DR. MATHEWS: Yes. It's a function of both factors.

MS. DePARLE: So you don't know really that they

stayed in for 12 months?

DR. MATHEWS: That's correct.

MS. DePARLE: Because I'd be interested in seeing that. Is this the data on the number of days and the agencies where they were staying beyond 180 days, is that in a table in our text document or not? Because I'd like to stare at that a bit. That, to me, is really interesting.

DR. MATHEWS: This chart here?

MS. DePARLE: Yes, but I guess I'd like to see it broken down some. I'd like to see a little more of the detail below that. Because it seems to me that's kind of getting at the issue. As I said, as I look at page six, what I see there doesn't concern me or actually makes me think still that we -- and some of the things you suggested make me think still that we continue to have a problem with the benefit really being accessed at the appropriate time by patients.

I don't know, but I would think being in hospice for two weeks -- hopefully it's better than not having had the benefit. But you're not getting much benefit. It's not the ideal. It's not what the vision was for this benefit.

DR. MATHEWS: That is correct. And it is

interesting that that measure has not moved by more than a day up and down over the course of the last six years, while all of the change in length of stay has been above the median. And that length of stay has increased dramatically. So trying to figure what to do about the short lengths of stay is indeed a problem and we're just now starting to try and figure out why that is happening, why that short length of stay is so persistent, and what kind of things might be able to be done about it.

MS. DePARLE: Yes, and on the flip side, in the 1990s there were some fairly isolated but persistent instances that the OIG did some work on with hospices where average length of stay was six years and things like that. If that's what we're talking about, to me that's a problem and we need to know about it. But that's a different problem than any suggestion that the average length of stay is inappropriately increasing overall. That wouldn't give me the data I would need to understand that this benefit was somehow being used inappropriately in the places where it was above 180 days. Because to me the numbers on page six at least don't indicate a problem in that direction. If anything, what you said would lead me to think it's below

that.

Anyway, I'd just like to see more detail on this because, Jim, I think you're right, that is the crux of the issue here.

Just two other questions. On the chart that you presented, I guess it's the last chart, the states with the most hospices per capita have the highest hospice cap rate. First, when you say number of hospices, is that the number of entities that have a hospice license? Or is that number of beds in some way?

DR. MATHEWS: These are number of unique provider numbers in the state.

MS. DePARLE: So do we know if they're actually providing care? Because it could be -- I guess in hospice you have to be to get your license. So they have to be providing care to somebody.

DR. MATHEWS: These are all active providers, yes.

MS. DePARLE: They could have a very low census, though. I guess we don't know.

DR. MATHEWS: Many of them do.

MS. DePARLE: You were trying to answer the question about access. To me, in order to understand that,

I have to know a little bit more, I think, about how many patients they're actually serving. And maybe you then have to look by state, and in some way get a proxy for how many decedents there were in a state during a period of time, Medicare decedents, to kind of get an idea of what kind of access there is. This really gets layers of an onion, but that seems to me to be something we want to look at.

And I notice that New Mexico isn't in here and we had an article that was given to us as part of our materials that said that 29 percent -- according to Palmetto, I guess, the intermediary, 29 percent of the hospices in New Mexico were hitting the cap in 2005. And yet, it's not on here. So I kind of wondered.

DR. MATHEWS: The issue there is there are a set of numbers floating around that are attributed to Palmetto that do provide these percentages. The issue there is that Palmetto doesn't necessarily serve all of the hospices in the states to which they were assigned. So when you look at all of the hospices in the state, the percentages are much -- not much different but they are off by a noticeable amount.

MS. DePARLE: Okay, that makes sense.

DR. MATHEWS: That said, if I recall correctly, New Mexico is probably number six or seven on this.

MS. DePARLE: So they just fell a little bit below.

DR. MATHEWS: Yes.

MS. DePARLE: And you don't have 2006 data, because I've also heard suggestions that for 2006 it will be a dramatically higher number. That is plausible, given that in 1999 or 2000 it was zero and now it's something big. But I don't know if that's correct or not.

DR. MATHEWS: None of the FIs have completed their 2006 cap calculations. Some of them have only just now started. One of the FIs that I have talked to is anticipating a significant increase. None of the others are estimating major changes from 2005 to 2006.

MS. DePARLE: Thanks.

Glenn, if we are going to take the time, as you suggested, for really delve into this, I'd be really interested in hearing from a panel of clinicians about some of these issues. We've talked about do we really know what the benefit is? What's being provided? What's ideal?

Back when the benefit was first conceived, the

notion was six months. I don't know what the right thing is and it would be interesting to hear -- if we can't do it here, maybe that could be something the staff would have time to do at some point.

DR. MILLER: If I could say one thing. The implication of the state table, you were saying we wanted to know whether people were getting more served? Was that your point?

MS. DePARLE: The question Jim tabled was are there issues of access to the hospice benefit related to the cap? And he presented some data to get at that. But I think I need to know more than just the numbers of hospices. I need to know what is their census, compare that to the number of decedents in a state with a certain diagnosis.

DR. MILLER: I got that. But Jim, the part you went through in summary here -- but it's detailed in a paper -- is the number of people being served; is that correct? When you went through by demographics, insurance status, and all that?

DR. MATHEWS: That was in the aggregate, but I did not do that demographic analysis where you looked at ethnicity and age and insurance status, then further broken

down by state and cap/non-cap.

DR. MILLER: I got that, but I just wanted to be clear that at least at those cuts -- and we looked at it in some detail -- all across the board, increases in the number of people being served. I just didn't what that point to get lost.

MS. DePARLE: Yes, I got that.

DR. MILLER: He blew through it here because it was too many charts.

MS. DePARLE: Yes, it would make sense. There are more people being served. The question, though, is is it the right number? Or are people who need the benefit able to access it? I don't have any reason to think they aren't, but if we're going to look at that I want to make sure I have all the information.

MS. BEHROOZI: Jim, there's so much information in here, so I hate to ask for more. But kind of following up on the subject about margins, you asked the question in the paper whether -- what are some of the factors that are driving the reaching of the cap? Could it be an altruistic desire for patients to have the benefit of hospice care or a response to profit incentives? And then you make the point

later, at a certain point there's a tipping point where the cap starts eating into the margins.

And not even being an economist, I get it, that a proprietary provider is not going to go into this business if they don't think they can somehow manage to that tipping point. So two things I'd like to know. I guess one would be just a point of information that I might have missed in the materials. That is what tools do they have to manage to that tipping point besides patient selection and condition selection and things like that?

And then the second thing is on the data, can you look at by how much certain types of providers exceed the cap? Like do proprietary providers just get over the line so that they don't exceed the tipping point too much and start digging into the margin somehow better than not-for-profit providers who might be more altruistically motivated or something like that?

I don't know if that's possible or not.

MR. HACKBARTH: And a related question would be looking at a given provider, do they go across the cap every year? Or is it a one time event? Any information on that would also be helpful.

DR. MATHEWS: Sure. I can investigate the question of the tools that providers have to manage the cap and come back with additional information right now. But at the moment, short of discharging a patient who is approaching that payment limit, I think probably they are very, very careful about who they admit. That might be a function of their ability to establish relationships with acute care hospitals and are thus able to have a full set of clinical information about patients they admit and that sort of thing.

Glenn, I have some preliminary information about hospices that repeatedly hit the cap, but I will make sure that's solid before I discuss it publicly.

DR. CROSSON: I was glad to see that the chair and the vice chair can be on different sides of the go for it issue, given the nature of the issue.

But I wanted to step back a bit from the details and talk a little bit about how broad or how narrow we want to go. It seems to me that the cap is a mechanism to try to prevent -- as was said -- the hospice benefit which, when it was created had a pretty clear purpose in mind, from eroding into a long-term care benefit. Not that there isn't a need

for long-term care, it's just that this is probably not the way to do it.

So it sort of raises the question in my mind is is there a better tool? Is there a better way? Do we know anything about better ways to manage this kind of benefit?

So I was looking for that in the paper and I found this sentence that I chose to interpret the way I wanted it. It says "Given this strong incentive, that is for longer lengths of stay, the Commission may wish to consider moving away from a per diem-based system towards a system that links payment to the resources that an efficient provider would use to treat a given patient."

So that raises the question of whether prospective payment by diagnosis might at least attack the length of stay issue. I'm not sure about how necessarily how to get at the question of the different diagnoses going on here.

But I think there's also another consideration for this that would play into this and I would second what Nancy said about us, in one way or the other, getting some information from providers. Because I think, just in my own experience, that the original notion of hospice that I remember very well from about 20 years ago is not the notion

now. I don't know whether this is -- I think it would be an overstatement to say this is a change in science as much as it is a change in the thinking about what dying people need.

So now we talk more about palliative care. And the folks who are the leaders in palliative care have a very different notion about what's needed for patients, beneficiaries, than the original hospice movement. So the hospice movement had the motion that for people you could determine at some point whether treatment was no longer going to be of value. And that there would be a cliff and the person would go into a set of interventions that were designed to relieve pain and fear and provide comfort and the like.

Whereas, the palliative care movement, which is gaining a lot of adherence in the country now, is predicated on the idea that that cliff is really not reflective of reality. In fact, for many patients anyway there needs to be a gradual withdrawal of treatment and a gradual movement towards what we would have considered hospice sorts of care. And that requires a good deal of flexibility and judgment and is in conflict, actually, with the hospice benefit as it currently exists.

So I could imagine, depending on how much time and resources we have, that we would want to take a look at the hospice benefit, at the payment part certainly, but even some more fundamental notions about whether the hospice benefit really now fits with the science or the direction of care for dying people and whether it needs to be reworked in some fundamental way. And prospective payment by diagnosis might be part of that.

MR. HACKBARTH: Didn't we have an analysis a couple of years ago that in a very preliminary way looked at the relationship -- the potential for using case-mix and a prospective system?

DR. MATHEWS: We did obtain encounter data and claims data from a large proprietary chain and we contracted with RAND to analyze that data. They found that there was no significant relationship between the patient's diagnoses and their costs that was not wholly explained by the patients length of stay.

DR. MILLER: As I recall, it was somewhat, the analytical design is somewhat frustrated by the data that they have and the payment system which was driving a per diem type of behavior. And then they were trying to look at

diagnosis, which didn't really matter to payment. And so they were kind of coming to that conclusion and saying given the payment system and the data it's very hard to reach any other conclusion.

DR. MATHEWS: That's correct.

DR. MILLER: It was a fair amount of frustrating.

DR. CROSSON: I'm not quite sure I followed that. So would that not argue for looking at prospective payment? What am I missing?

MR. HACKBARTH: In my interpretation of this -- and feel free to correct me, Jim, was if you had a hospital prospective payment system model in your head where you can say there's a diagnosis and we can set a payment rate for a patient with a given diagnoses, that they cluster around a certain number of costs per case, based on the limited data that we had available to us that pattern doesn't seem to follow with hospice. It's not diagnosis driven. For a given diagnoses, you've got a wide variation in the amount of utilization.

And so it's the diagnoses based per case payment model you've got in your head. Right now the data don't seem to --

DR. MATHEWS: That's correct. The only data that we would have to develop a case-mix system right now would be the length of stay associated with each diagnosis and there is a lot of variability there. So if you were to go down that track, it would solve both your short stay problem and your long stay problem in terms of the incentives built into a per diem payment system. The problems that you would have to deal with before you could get to that point would be one, the current distribution of length of stay does indeed reflect the incentives to provide more care. So that's the circular aspect that Mark mentioned.

The second is you looked at the growth of some of the non-specific diagnoses in recent years and you would have to come up with some reasonable controls regarding how a patient's terminal disease was coded for purposes of admission to hospice. Is it going to be a chronic heart failure? Or is it going to be the adult failure to thrive that dominates for purposes of putting the patient in the group?

Another point is that you'll recall we discussed last time CMS is beginning to implement a data collection effort from the hospice providers that would require them to

report information on the actual number of visits that they provided during the course of an episode and the kinds of clinical staff who conducted those visits. So you could use that kind of information in conjunction with what you know about length of stay to begin to fill in some of those gaps and get to payments based on resource use rather than simply payments based on a duration of time.

But again, that's a little bit off into the future.

DR. DEAN: I guess I just had a question. I was really struck by the variation in the states. Is there differences in licensure by states? Do you have any indication of why there's a tenfold difference in incidence of hospices per beneficiary in these states as opposed to in the high versus the low ones? Are there unique state issues?

DR. MATHEWS: The effect of state certificate of need requirements are, indeed, very significant here. New York and Florida, for example, as I recall, do have fairly stringent CON requirements whereas the states that have extremely high growth do not.

MR. DURENBERGER: What is it about New York or

someplace like that? Politics?

What is the impact of certificate of need?

MR. HACKBARTH: Typically you associate certificate of need with major capital investment, bricks and mortar, and trying to prevent people from making investments like that, which will in turn generate utilization. Hospice doesn't quite fit the traditional CON model.

MR. DURENBERGER: So the question is the flipside of that is if this palliative benefit is a very valuable benefit, not just as expressed in Mississippi, Alabama, Oklahoma, et cetera, but just generally, how can certificate of need be used against the development of hospice in places like New York, et cetera?

DR. BORMAN: Just to this point, as I recall, some of this variation was mirrored in the map we had in a session about long-term acute care. And this distribution is very similar. And I think it reflects the geographic variation and the mix of the post-acute resources. And so -- we have a fair number of people, for example in Mississippi, that do go to long-term acute, go to these ventilator specialty hospitals and so forth.

One could envision some of that same population going to hospice because they would have a less than six month projected life span related to the very significant inpatient illnesses that they have. So I think, at least for that West South Central region, that there's a lot of overlap there and it also reflects that. I can't speak to the certificate of need piece but I think there is significant overlap with that map.

MS. HANSEN: I think that I was observing some of the shift. Many of us were part of the whole period of time when hospice first started and seeing some of the changes that are reflected here. So I do think that this whole question of is this turning a little bit more into a two level program: one in kind of the shorter stay, too week kind of constant that we've been seeing over time? In fact -- and I'm not the hospice expert at all -- but I think even earlier it used to be seven days. So that it's always been fairly short. And having had a family member who has used hospice, I know what more of a personal dynamic that often happens to patients and their families about that.

But the longer stay does really speak to the palliative direction and the fact of people with especially

dementia which are really noted in this chart. So defining what the program has become is probably a very helpful component.

The other thing is, going back to related to the certificate of need, I just wonder if there's a way as we look at this to define some of these programs that Nancy asked, like how big are the programs? Also, are we able to tease out the difference of hospice beneficiaries being treated at their own home, as compared to almost a bricks and mortar type of location?

And then third of all, the nursing homes. Because the other thing about growth -- and again this is just observation or perception -- it seemed to me that the growth of hospice of people who are in nursing home locations had a growth spurt for a period of time. And that was something that's quite different when you basically use the service of hospice or the funding of hospice but for people who are actually residents in nursing homes, as compared to the way the program used to be in the early 1980s when it was both in their own personal home or possibly in a small location where there were beds that were staffed by people.

So just understanding the morphology of this over

time.

And then just getting a sense of cross-relating that to especially the past five years of growth. That would be helpful. Thank you.

DR. MILSTEIN: This well illustrates our prior discussion of if only we had better information we could make better decisions. Along that line, are there any health services researchers that are examining issues like impact on quality of life, impact on total Medicare spending associated with this mix of patients, the subset of patients that seems to be growing within the benefit? In other words, the long stay patients with diagnoses not previously associated with the benefit?

If there is any relevant health services research on the relative patient perceived benefit and an impact on total Medicare spending associated with the subset of patients it would probably -- at least personally speaking -- enable me to make a better vote on this issue.

MR. HACKBARTH: I think you told us last time, Jim, that there have been a number of studies that tried to look at the total cost for patients receiving hospice services versus those that don't, and the studies have sort

of pointed in different directions.

DR. MATHEWS: That is correct, and I did commit to providing a synthesis of that literature. In my own mind, I had been thinking it would go well with the margins discussion when we do start talking about what do hospices' costs look like, what is the cost benefit analysis. But if that doesn't play out timely, I can get the other information to you as a separate package.

DR. MILSTEIN: Thank you. It would be especially valuable, obviously, if that prior research data could be segmented for the subset of patients that we're thinking about.

MR. HACKBARTH: Any others?

DR. REISCHAUER: This is sort of a description of the cart, and maybe you'll provide the horses later which will refute what I have to say or suggest that there's some rationality to it.

If you hypothesize that service utilization or costs per day rise gradually from the point of entry until death, maybe spike a little at the very end, then the profit maximizing or margin maximizing point for bringing somebody into a hospice is the point that produces a length of stay -

- an average length of stay that ends you up $1 short of the cap. So it's the longest conceivable length of stay you can have.

Now if you're small your ability -- first of all, the further away you go from the actual point of death, the less your ability is to predict exactly when that's going to occur. And the smaller you are, the less ability you have to use large numbers to average this out and the more likely it is that you're going to miss and go over the cliff at the end.

So I think the rise in the number of hospices which are hitting the cap is perfectly consistent and is a result of the payment incentive structure that we have. And the question you have to ask, every business there's risk of making a profit or losing. And in the outside world for other entities we don't really care how many widget manufacturers there are. What we ask is are there sufficient numbers of widgets at an efficient price for the people?

And so what you want to do is look at the places where significant numbers of hospices are hitting the cap and ask is there an access problem developing in those

areas? Rather than get worried about the individual hospices going under or having to pay money back.

That's the hard-hearted economist analysis.

MR. HACKBARTH: Setting aside whether if you started with a clean piece of paper you would design this particular payment system and all its features including the cap, set that aside for a second. What I hear you saying is that the cap may fall on hospices that tend to be the most profitable in an industry that right now generally looks profitable.

DR. REISCHAUER: Are trying to be the most profitable, right.

MR. HACKBARTH: Bill, last word and then we need to move on.

DR. SCANLON: Continuing in the hard-hearted economist theme, there's the issue that we're talking largely here about revenues. We don't know what the cost side of this is because an additional day of --

DR. REISCHAUER: [off microphone] [inaudible.]

DR. SCANLON: I know but I meant I think this is a real big issue because for two different hospices, an additional day in hospice does not mean an additional cost

of the same amount, at all.

So what CMS is doing in terms of trying to collect information on actual services delivered, to Arnie's point, is critical to truly understanding what it is that's going on here and what should be a payment policy. Because the strategy of adjusting what you do in terms of once someone is in hospice is a very big part of what might be a coping strategy with the cap or a profit maximizing strategy.

MR. HACKBARTH: Okay, thank you, Jim. More on this later.

Let's see, next is dialysis, creating incentives to improve dialysis quality.

Nancy, you can go when ready.

MS. RAY: Good afternoon.

In past meetings, we have discussed quality of care among dialysis patients. We have noted areas were measures suggest that quality has improved, dialysis adequacy and anemia status, for example. In other areas it has not, nutritional status. I'm here today to discuss practices that may improve dialysis care.

As you listen to today's presentation, you may want to think about the different ways that Medicare can

affect the delivery of care. For example, Medicare could require that providers furnish the service as a condition of payment. Alternatively, Medicare could measure and reward providers' performance. Or Medicare could do some combination of both. We are not asking you to make any decisions today. This is a first step and we're here just to gauge your interest.

We looked at the potential for services to improve dialysis quality and efficiency. We started with nutritional care based on your discussion last year. Some commissioners raised concerns about the nutritional status of dialysis patients. We also looked at three other areas because there is some literature to suggest that the current state of care could be improved. That includes a vascular access care, preventive services, and case management.

To help us think through the issues here, we convened an expert panel of 10 medical providers, nephrologists and a dietitian, who care for dialysis patients, to get their input. And to be clear, we asked the panel to focus their discussion around these four areas. And we also reviewed the literature.

So the issue here is that the proportion of

dialysis patients who are malnourished is substantial. CMS data suggests that the proportion of affected patients has remained relatively constant over time. Patients who are malnourished are at higher risk of mortality and hospitalization than their counterparts.

Providing adequate nutrition is critical to prevent and treat nutrition. The expert panel discussed these four options and I'm going to focus on oral nutrition. The expert panel thought at least half of dialysis patients would benefit from oral supplements. However, it is not a Medicare covered service. The OIG prevents providers furnishing it for free. The anti-kickback statute prohibits providers from offering Medicare patients free services because it could influence patients' selection of a provider and could affect competition. It could also lead to overuse and overspending of Medicare covered services.

Some state programs do cover oral nutrition. Patients have to meet a clinical criteria and physicians have to submit clinical information to the state. It is also provided in an ESRD demonstration but this demonstration is ongoing, it is too soon to analyze the outcome of the participants.

There are measures available to identify patients who are malnourished and to track nutritional status. The panel talked about using several measures, serum albumin and change in weight loss and C-reactive protein levels. CMS tracks serum albumin levels nationally but not by provider. There is the potential to collect this information via claims. CMS's proposed conditions for coverage would require that facilities electronically report certain data for all patients and one of the measures would be serum albumin.

Moving on to vascular access, the issue here is that vascular access complications, such as infection and sepsis, increase risk of hospitalization and mortality and are costly. Complications are estimated to account for up to 25 percent of all dialysis hospital admissions annually.

There are three types of vascular access: a catheter, a graft, and a fistula. The fistula is considered the best for most patients because it lasts the longest and has fewer complications than catheters and grafts.

The expert panel talked about some options for improving vascular access care. These are up on the slides: routine monitoring of the vascular access site reduce

related complications. CMS reported recently that about one-third of patients with a graft or fistula did not have their accesses routinely monitored for stenosis. Some panel members thought lowering staff turnover would be one way to improve this aspect of care.

Some panelists also thought that having a vascular access coordinator would improve care. The coordinator could, for example, coordinate care between the facility, nephrologist, surgeon, interventional radiologist, and hospital, as well as provide education to patients and staff members.

The panel agreed that catheter use should be decreased and fistula use should be increased. Of course, not every patient may be a candidate for a fistula and it would not be appropriate for Medicare to require that. CMS does have a voluntary quality initiative called the Fistula First to increase the use of fistulas.

Measures are available to track the type of vascular access and complications, including the percent of patients with a catheter, fistula and graft, number of related hospitalizations. CMS currently measures vascular access care nationally but not by provider. And again, this

would be one of the measures that is in the proposed conditions for coverage that providers would have to report for all patients electronically.

There were some unresolved issues from the panel and these were focused on the measurement and implementing P4P in this area. There was disagreement among the panel members about whether payment should be linked to vascular access care for facilities and physicians treating dialysis patients. Some thought that facilities and physicians should equally be held accountable. Others thought that the physician has a greater role than facilities. Still others thought that surgeons in pre-ESRD care have a greater role.

Specifically to pre-ESRD care, the panel raised the issue that some dialysis patients -- and these would be the ones under age 65 -- may have limited access to needed care until the 91st day after starting dialysis when Medicare coverage begins.

We asked the panel to discuss preventive services that have a positive effect on patient survival and they identified two: diabetic foot checks and dental care, as such services. About half of all dialysis patients are diabetic. Amputations are common among dialysis patients.

Untreated dental disease is linked to poor outcomes among dialysis patients and is a barrier to obtaining a kidney transplant.

There are some unresolved issues, as well, here. As the next step we would need to think about with respect to diabetic foot checks, implementation issues such as who would furnish the foot checks, the facility staffers or physician. And how results would be communicated to other providers the patients see.

With respect to dental services, Medicare does not cover most dental services. As a next step, we would need to think about the cost and equity in covering services for dialysis patients and not for other patients.

Dialysis patients have multiple comorbidities. There is some hope that case management might better ensure patients get needed care and lead to improvements in outcomes. Both ESRD disease management demonstrations include a case manager, but again we don't have results from those demonstrations yet.

The panel, in particular, thought that a case manager might be particularly needed within the first 90 days of dialysis when mortality rates spark. Of course, the

measure here would be rate of mortality at three, six, 12 months and beyond.

In this discussion about case management, the panel also discussed the importance of advance care planning for dialysis patients. CMS's physician quality reporting initiative includes a measure on advance care planning.

So this table summarizes the major issues discussed by the panel and highlights key issues to consider in moving forward with nutrition, vascular access, preventive care, and case management.

As you move forward, again you can also think about the alternative ways to improve care, that Medicare could require providers to furnish the service and then measure and report outcomes on a provider level basis; or Medicare could just simply measure and report outcomes.

For nutrition, there would probably have to be some sort of change of law with this latter approach to allow providers to give out the cans for free or at reduced cost. And of course, either approach could be coupled with P4P.

Thank you.

DR. CASTELLANOS: Nancy, I think you did a good

job on this. I know we had the chance to discuss a couple of things.

One of the issues with this dialysis patient population is that they are a very unique set of patients that have significant problems not only related to their dialysis but to their comorbidities. And for the most part they are not being seen by physicians except in their dialysis unit. Even though if you get a care manager or a case manager, as suggested, and they can make arrangements for the patient to see somebody or do this, the patient in reality doesn't have a primary care doctor who is managing their care. That's the reality. And that's unfortunate.

Now the physician in the dialysis center bills under what they call a monthly capitated payment system. He or she gets paid for prescribing and monitoring the outpatient dialysis care. So during the dialysis, that physician is being paid for and he's monitoring the dialysis. Unfortunately, what happens is these patients have multiple comorbidities and are not seeing another doctor for that.

What I'm suggesting is two things. One, and we had a discussion on this, that one, they allow E&M billing

while the patient is in the dialysis center for the non-dialysis care, or just increase the bundle to provide that care by the nephrologist. I can tell you that most primary care doctors -- and I think Tom would agree -- that these patients are so complex, you don't know which medicines to put them on, you don't know the dosages of the medications, and they really prefer to defer that to a nephrologist.

It would increase access to care. It would help quality of care. And it would probably significantly decrease hospitalizations. For the average patient, they're admitted about twice a year, dialysis patients.

The other issue is a matter of coverages. Now for a person who's 65, that's not a problem. But for a person who's under 65, they have to be on dialysis or with chronic renal failure or some form of treatment for 91 days before they qualify. And then the physician has to permanently state that that patient has permanent renal failure.

We see a lot of patients -- I deal in dialysis and I deal with chronic renal failure. We see a lot of patients that have renal failure based on trauma, based on drug toxicity, overdose, acute illnesses that we start out on dialysis. And some of them can get off dialysis a month,

six months later. But as soon as they get off dialysis, they lose any coverage. But they still have significant residual damage. And these patients still need to be followed.

There's another issue on this I'm going to say in the same thing. It's very similar to the renal transplant patients. Once a person is transplanted and is on immunosuppressive drugs, Medicare covers that for a period of three years. After three years, Medicare does not cover those drugs anymore.

Now if the patient is 65 and has Part D or Part B, that's a different issue. But there's a lot of patients that we transplant that are below age 65. And they lose this benefit and it can cost up to $12,000 a year for immunosuppressive drugs.

And so what happens? They stop their drugs, they reject their kidney, and they go back on treatment, which is $75,000 a year.

So what I'm suggesting that perhaps some form of coverage is extended to these patients who were on dialysis, still have residual care but perhaps if properly managed can prevent end-stage renal disease and can say off dialysis.

And what I'm suggesting is that patients that have had transplant, perhaps we extent that period a little over three years.

MS. DePARLE: Thanks, Nancy. This is great. If Sheila Burke were here, she'd say thank you to because, as you'll recall, we had conversations about our frustration at the data that you presenting us with on nutrition, in particular and feeling that we're not really making any progress. So the next step, I think, is for us to decide to make some recommendations here. But this is very good work.

The clinical panel, by the way, Glenn, that's the kind of thing I was hoping we might be able to do in hospice. I think that would provide a lot of insight to all of us.

MR. EBELER: Thank you. This was very interesting.

I want to ask about this vascular issue and the catheter. It strikes me as interesting. It appears, as I read this, that there are a limited number of conditions under which that's clinically preferred and that one would want the other approaches more. It seems to me it's fine to

start with the voluntary Fistula First effort in that situation. But at some point, if we know other things are more clinically appropriate, and we know that has a higher complication rate, and we know that has higher costs, why would we pay it in situations when it's not clinically appropriate? There's going to be any number of cases where we just need to say that out loud.

So is there an option at some point down the road to simply say we won't be doing that any more because it's not good for people?

MS. RAY: Fistulas are better than catheters and grafts. I think what a clinician would say is that there still may be a minority of patients that, for whatever reason, may need a catheter. For example, a patient who is not receiving needed care before getting dialysis crashes in the emergency room, needs dialysis right away. They have to put a catheter in. So that is an example, I think, where --

MR. EBELER: And I would be totally deferential for those clinically appropriate situations. But as I read it, we have a third of the patients on those. It sounds like the paper is saying there's a lot more catheter use than is clinically appropriate. At some point we should say

we shouldn't be paying for stuff that's not clinically appropriate.

MS. RAY: And that's one way. I guess another way to think about it is perhaps some sort of P4P and reporting mechanism could also be looked at as an option.

DR. BORMAN: Just to the point of this particular question, the catheter usage is most often done and most appropriately done in the acutely changing circumstance, as Nancy said. This is also driven by some issues of when the patient presents and what the acuity for the dialysis is.

And it relatively seldom rests with the individual creating the initial access, whether it's by catheter or by graft. It represents the person who referred them, because it takes longer for the fistula to mature. And so if a patient needs dialysis even in a month, the odds of having a mature official are pretty small.

The other thing is that this Fistula First initiative, while it has all kinds of wonderful things around it, is also leading to some rather inappropriate things in that patients are being referred with a demand for primary arteriovenous fistula who don't have the veins who are really a candidate for it. Yet when somebody says

that's not the thing to do because it's not going to develop properly, there's this sort of rote insistence on we've got to meet this percentage DOKI standard and we need to do fistula first.

So you have to be a little bit careful about this and remember that your dissociating the people making the decision to refer the patient from the people doing it. You've got to be careful about who you not pay.

DR. CASTELLANOS: There's another issue and it's a financial issue. Physicians get paid higher for putting in a catheter rather than creating a fistula. Not very nice.

DR. KANE: This is a classic example of what's wrong with our system, if I can say so, just be blunt about it. It's fragmented care. The coverage drops at the wrong moment. It's like the dual eligibles a little bit. If you try to cure them and they go off coverage, they're going to be sick again.

This is so classic, it makes you want to just say throw the whole system out and start with universal coverage. But since we can do that --

[Laughter.]

MR. HACKBARTH: Do you want to make a

recommendation?

DR. KANE: I'd like to, but obviously that's not -- but I guess one of the things as I was starting with is saying let's not call it a dialysis payment bundle to start with, and maybe we'll get to the right direction. Call it a renal failure payment bundle, or even an approaching renal failure payment bundle. I don't know how you identify the people at risk but obviously diabetics are one population.

This is like where SNPs should be focused maybe, or a disease management group. To me, this is where you really want to encourage coordinated delivery systems of care that involve nephrologists and other physicians, the surgeon and all the people who know how to take care of this. This is just obscene what's going on, to me with a very complicated patient group. Who, by the way, some of them are emergencies. But an awful lot of these you know it's coming, especially half of them being diabetic. You know it's coming. I just can't understand why this wouldn't be a bundled renal failure -- why we wouldn't try to encourage our ESRD to be a bundled payment with a responsible disease management group and not just focused on them getting dialysis but on their disease and its proper

management.

So I would just, for a beginning, just rename it not dialysis payment bundle but renal failure payment bundle and think about how can we encourage coordinated systems of care.

Like I think Karen was talking about, there's a lot of coordinated specialized care around cardiac and maternal care. But why can't we encourage that in this one program. The one disease Medicare covers automatically regardless of age is just one of the most unfragmented non-systems of care I've ever seen.

MR. HACKBARTH: What percentage of these patients were not Medicare patients until they developed renal failure?

MS. RAY: About half are under 65, about half of all new patients are under 65.

DR. KANE: It's kind of like the dual eligible problem. You don't want them to go on Medicaid so you want to see them coming. Medicare would be better served to say if this person is at risk if they're under 65, enroll them and we'll pay for it. Because it's pretty clear that they crash into your system and they're going to get the

catheterization, they're going to get fragmented, they're not going to get the right drugs. This is insane.

We've got to look beyond our borders just to do what's humane in the hospitalization rate.

I don't know, is there a way to detect these people in the general -- I'm sure there is -- in the general population before they have total kidney failure and 91 days of -- who thought of that, 91 days of dialysis?

MR. DURENBERGER: A health service researcher or an economist.

[Laughter.]

MS. RAY: Just two follow up points. I can come back to you but there are ways for screening patients who are at risk. There are five stages of kidney disease. I won't bore you with that. But there are ways of screening patients. That's the first thing.

The 90-day waiting period, I think its intent was to ensure that the person is truly -- requires maintenance dialysis and not as an acute patient.

DR. KANE: But given what Ron just said, it doesn't seem to be doing that. I'm just wondering if it's not costing us more to wait 91 days to create a package of

services that keeps the Medicare quality up and costs down, even if they're not chronic forever, because you don't want them to be chronic forever. But they may need to be -- have a chronic disease management program forever.

MS. THOMAS: Just to add, not surprisingly, we've had a whole parade of SNPs coming through our offices and there are indeed SNFs that are targeted toward the ESRD population.

DR. BORMAN: Just a couple of quick things unrelated to the vascular access. One is that my recollection at being at the CPT Editorial Panel when things were brought forth about the CPT codes for dialytic care, that it was presented to us as a comprehensive service, not payment to monetary dialysis.

So I think that the panel we were under the understanding that what was being proposed was, in fact, comprehensive primary and secondary, tertiary -- whatever you want to call it -- care for these individuals. There could be some value to going back to the CPT Panel minutes, to the service descriptions provided to the RUC and other places because, with all due respect to the panel -- and I think you've presented them well -- that you convened, and

that was a great idea, I think there may be some reasons here to have sort of a selective view of history on this one. And there might be some clarity offered from the past.

Another piece of this relates to the management of infections, for example. There's a certain piece here that is patient dependent, that is the patient who has an early sign of vascular access infection and doesn't come to see anybody. So there is an uncontrollable piece of this.

There is also, in relation to whether it's the center or the physician or who it is, the surgeon who placed it, I think everybody has some responsibility. And how a dialysis technician sticks a fistula, puts in two fairly good sized needles, their devotion to prepping the site and how they care for it certainly influences the duration of the access. This is a multi-factorial problem.

My last comment I'd just like to touch on the nutrition piece here. I think that there are lots of good data out there that relate to the relative unsophistication of albumin as a measure. And I'm fascinated that this came up. I would be willing to speculate that it might not be possible to get an end-stage renal disease patient to a normal serum albumin level, even with the best medical

efforts and infusion of lots of albumin, because of their underlying disease. It certainly will relate to whether they have a protein losing nephropathy or not.

So while I support the nutrition is a factor here, I think that these measures that are being suggested are a ways away from being mature enough to incorporate as the foundation for any kind of policy recommendation.

MR. HACKBARTH: Others?

Nancy, I've been sitting here thinking about your comment, and it's a powerful one and resonates with me, and I suspect others. My understanding is actually that the current debate about this is deferring Medicare eligibility, pushing back eligibility and that's being actively discussed. I've heard from some employers who are very concerned about it.

MS. RAY: Right. That would be specifically for people who come into the program with employer-based coverage. That's right.

DR. KANE: Wouldn't you want to reverse that and say I'll tell you what, let Medicare take it over, put them in our own disease management program, and then do coordination of benefit with the employer for what they

would have paid otherwise. And you'll save money. It seems like you would save money and improve the quality of care than to try to shove something back onto an employer who may or may not have the proper coverage or disease management relationships. It just doesn't seem like it's working.

MS. BEHROOZI: Just on that, and not only would it save money for Medicare but overall, because Medicare pays a third of what private payers pay for the very same services.

MR. HACKBARTH: Okay, thank you, Nancy. Well done.

We are to our last one for today, delivery system reform.

I think David and Jeff have been anchors now a couple of meetings in a row here.

MR. GLASS: And tomorrow, as well.

MR. HACKBARTH: That's because we can count on you to bring it home strong.

MR. GLASS: That's one way of looking at it.

We're thinking of adding a chapter to the March report with ideas for improving program sustainability through payment and delivery system reform. The first

chapter of the report would be our traditional context chapter and this new material could follow the context chapter and present MedPAC's direction for delivery and payment system reform.

We want to know if there's consensus on these goals for reform, and the basic goal is to improve program sustainability. The evidence that the current system is unsustainable will be developed in chapter one and then the program -- and the basic evidence is the program is spending more but not getting better quality and taxpayers and beneficiaries will not be able to afford the program as it consumes an ever growing share of GDP and the Federal budget.

We would then develop, in chapter two, why solving that problem is going to require a change to more efficient delivery systems and why that means, in turn, we need fundamental changes to the Medicare payment systems to create the incentives for changes in the delivery system.

Even if reform increases quality and reduces cost growth substantially, sustainability could still be a problem. Other changes to Medicare financing or benefits might still be necessary but they're not the subject of this

briefing. So we're going to discuss some approaches for payment system reform but bear in mind that these are exploratory and will undoubtedly have been issues that would need to be worked through in the future.

This is the big picture for a long-term direction of payment and delivery system reform that we'd like you to consider. We're now in the first column, under current fee-for-service payment systems. The basic problem with all fee-for-service systems is that they reward increasing volume, although to varying degrees. In general, if you do more you get paid more. Also, because they're distinct and separate, there's a problem coordinating across payment systems.

The Commission has recommending using the tools in the middle column to try to overcome some of the problems in fee-for-service systems. A comparative effectiveness entity to give providers and payers information on what works best, pay-for-performance programs within existing fee-for-service payment systems to reward higher quality providers, reporting resource use to inform physicians of the consequence of their practice patterns and how they rank relative to their peers. And bundling of individual

services within a payment system, as is done using diagnosis resource groups in the inpatient PPS. That's to encourage efficiency within the bundle.

However, there are two important limitations to these tools. First, the marginal reward may not be sufficient to overcome the incentive for more volume in the fee-for-service system. A 2 percent quality bonus won't drive someone who is seeing five patients an hour to seeing only three.

Second, working with individual systems inhibits changes into the delivery systems that either cross borders or extend over time. For example, as Dr. Kaplan from Virginia Mason discussed with the Commission, physical therapy may be less costly, more effective, and provide greater patient satisfaction that an MRI for back pain but right now there's no reward for that substitution.

So we're exploring three approaches for overcoming these limitations. They pay for care that spans provider types and time, and hold providers accountable for quality and resource use.

These are potential approaches, and the first proposal would be to establish medical homes which would

emphasize primary care and increased care coordination. These are two areas the Commission has encouraged in the past. Physicians wanting to be designated as medical homes would have to have some level of IT and means to provide care coordination, either within the practice or under contract. Looking over time, the goal would be to maintain patient's health and thus reduce unnecessary admissions.

One tough issue is whether beneficiaries should be required to opt into the medical home and possibly be locked in for some services. Many issues would have to be worked out, as we discussed in the June 2006 report.

Physician-hospital bundling would combine DRG hospital payments and inpatient physician payments into one payment. This would emphasize cooperation between hospitals and physicians who do inpatient work and increase efficiency during a hospital stay. It would be triggered by a hospital admission but could be extended to include a post-discharge period, readmissions, and possibly post-acute care.

So Anne presented several options for bundling earlier today. As she mentioned, one of the problems is it does not change the incentive for more bundles.

The broader concept is the accountable care

organization. That would be groups of physicians and possibly a hospital as well that would take responsibility for a population of patients for a broad services over some period of time or episode. They would be held accountable for performance and quality and resource use for that population and have an incentive to control volume. Payment could be fee-for-service with some add-on or possibly some form of capitation or even a virtual system. Of course, this would present many difficult issues of its own.

The goal of all of these approaches is increasing value for the Medicare program, its beneficiaries, and the taxpayers. The means is creating payment system incentives for providers that reward value and encourage closer provider integration which, in turn, would make the use of tools such as P4P even more beneficial. Each of these proposals will present many thorny issues to be resolved and will require careful consideration of unintended consequences. Nonetheless, because of the potential these proposals have to improve quality and reduce cost growth we think they may have value.

Jeff is now going to discuss the related issue of how physicians and hospitals might come together in response

to payment changes and what we will have learned from past experience.

DR. STENSLAND: There was a great deal of integration of physician and hospitals at different levels in the 1990s, we wanted to take a look at that experience and see what happened in the 1990s.

First, by bundling physician and hospital payments, as well as forming an accountable care organization, either of those are forms of payment integration. By tying physician and hospital payments together, Medicare would encourage new forms of physician-hospital entities. This could come in the form of employment to physicians, it could be a PHO, it could be in the form of doctors owning the hospital. All of these physician-hospital entities would be more attractive under a system of bundled physician and hospital payments.

During the 1990s, some physicians and hospitals successfully integrated their finances and their clinical processes. For example, many of these integrated systems now use a common electronic medical record. However, in other markets the physician-hospital organization collapsed as physicians and hospitals could not agree on how to share

payments. In another set of markets, we find some physician-hospital organizations survived but they had financial integration but they failed to ever really have much clinical integration.

To get physicians and hospitals to jointly focus on the quality of care delivered, we also may need to tie payments directly to outcomes. This is, as Anne said earlier, we might need have some sort of P4P program tied on to either the ACO or the bundling of payments.

If Medicare moved to a bundled payments or ACOs, we would probably see a diverse range of physician-hospital relationships spring up across the country. As we saw in the 1990s, some would be harmonious but others would be contentious. As Anne talked about earlier, the challenge is to get the physicians and the hospitals to work together and to really focus on creating value for the patient.

We now want to hear your thoughts on whether we've listed the right goals for payment and delivery system reform. First, we understand there is some consensus to improve efficiency and sustainability by promoting the tools you recommended. These are the first bullets we have at the top of this slide. Those tools being comparative

effectiveness, pay-for-performance, and measuring and reported resource use.

But the next question is whether you agree and whether there is consensus that new approaches are needed to integrate care across provider types and across time? And if so, how do you think we should continue to explore these three types of ideas such as the medical home, physician-hospital payment bundling, or ACOs. These approaches are not mutually exclusive. You may want to implement two or more approaches simultaneously. For example, as Anne said earlier, physician-hospital payment bundling creates an incentive to increase admissions. Therefore, you may want bundling to be accompanied by a counterbalancing incentive, such as the medical home or an ACO, which have a built-in incentive to constrain admissions or to keep the patients healthy enough so they don't have to go to the hospital.

Now we'd like to open it up to hear your thoughts on whether we have the right direction there for Nancy's 10-year plan.

MR. HACKBARTH: Before we leap into the specific comments, let's just spend another minute refreshing our recollection about why we're doing this and the context.

At the retreat we agreed that we needed to sort of thing longer term and outline a longer-term vision or strategy for how not just Medicare but maybe the broader system needed to evolve over time. And then consistent with that long-term direction, work through with the more specific details on how you take steps down that path.

And so the role of this paper, this chapter, is to lay out that longer-term vision, provide some examples of changes that might be consistent with it -- namely bundling and ACOs and medical home -- and then on a separate track, earlier today, we started to delve into the details around bundling and how you might actually do that and make it work.

So we did the detailed discussion earlier today on one of the issues. Now we're sort of stepping back and trying to think more high-level about the messages that we want to send to our large audience. So that's the context for all of this.

DR. KANE: First, I just wanted to modify my 10-year plan concept, which is I think it will take 10 years to get something good in place. But the question is how you get there? One way is to try to do things sort of in year

one, two and three, that actually could stop you from getting to year 10 because they're just rushed or they're not thought through or they're counterproductive.

That's why I was heading towards demonstrations and single episodes and not wholesale change until you really have a lot of research out there on how to do it right. So I kind of feel like we need to think where do we really want to be in 10 years? And how do we back up and get there? Rather than say how do we create risk adjustment for a hospital stay plus 15 days out, which may not be where we went to end up. We may want to end up that it's the episode in its entirety that we want to pay on the basis of. And so how do we get here? And then demonstrate and do research to get there in a way that makes sure that when we're there, it's the best possible system and hasn't gotten stopped along the way because we did something that just got such push back the way we did in the mid-90s that the whole thing kind of collapsed, like managed care.

I guess my point is a 10-year plan, I think, should have a big upfront investment in trying to understand where do we want to be in 10 years and how do we get there, not how do we get through the next three years trying to do

incremental things. In my mind. That's one topic that perhaps it would be great to talk about.

The other thing is on your questions for approaches, I would add a fourth bullet point, is how to get the MA plans to lead the way. Because right now they are not doing what they should be doing. Private fee-for-service does not take us in the direction we want to go. I'm not even sure the MA plans that aren't private fee-for-service are doing anything other than paying fee-for-service, especially with what's going on in terms of the excess payment. So I would add a fourth bullet, how do we make the MA plans lead the way since they are theoretically better organized than the traditional unmanaged system to create the kind of change we want to see?

MR. DURENBERGER: My friend on my right said why did we save the best for the end of today, the most challenging? But I think we were right when we said this is a really important thing for us to do this year. We're even more right in the context of the fact that a lot of politicians are talking about this for 2009.

As long as I have been involved, that even precedes going into the United States Senate way back in

1978, I've been looking for a book or a chapter that was entitled delivery system reform. Everything I've been involved in as, in one way or another, been delivery system reform. We did all of the rate setting, the regulatory approaches, when we did the price regulation, and we've done behavior modification, and managed care organizations. And it's all about changing behavior, which is basically what delivery system reform is all about.

So in a sense the title here, or even the vision that you spoke to, needs to be followed by something more than medical home, accountable care organization, and bundled payments.

And I think it needs to start with a set of goals that are perhaps a little bit broader or more definitive of the program's obligations to 43 million of us and the people that will follow us. And so if we express it in terms of -- I think we would start with improving access, quality, effectiveness, productivity, those kind of things because I know that's how we want a delivery system to do. And we follow that -- I would suggest we follow that -- and I don't have the right words -- but the best way to change behavior in this system is to reincentivize all the professionals

that are in the system. That then gets us to what you have to do to change the financing in order to provide that.

But I remember old Walt McClure, way back before I ever thought about politics, saying that the U.S. medical system is remarkably inventive. And if you just point it in the right direction it will take you where you want to go better than any other business or industry in this country. It is a very unique profession and everybody that goes into this is very, very different. In theory, we've never captured that.

So anyway, I like that as a way in which to phrase the second goal because everything we talk about here is about how do you get the right incentives to get the kind of behavior that you want?

And then only thirdly would I come to sustainability, I suppose, and those kinds of issues. But that's about as far as -- I want to suggest because we are at the end of the day, I just think that if, in fact, we're going to continue with that chapter and we're going to try to get people to read about something more than things they've already heard about, that setting those goals in that way for what we want to follow in terms of financing

reform and things like that -- and I'm not saying we don't include the tools that we've been talking about. I'm just saying I'm just fearful, looking at this, that way we are missing an opportunity presented by the title and a lot of the other things that we would like to do there.

MR. HACKBARTH: I hear Dave and Nancy, in ways, saying something similar with a little different emphasis. What it sounds like to my ear is there's not enough careful thought to the buildup. We're sort of too quickly getting to some solutions without laying out more systematically here are the goals, here are the barriers that we see between us and achieving those goals, here are the sort of things that need to change in the system if we're going to be better able to achieve the goals. And then you talk about payment and other innovations that will help get you there. So it's a little more systematic buildup.

DR. KANE: Some of which we don't how they will work out in practice, so we need to try them out before we implement them in full.

DR. WOLTER: I just wanted to sort of reemphasize your introduction from my perspective. I think that, as I now am in my sixth year on this commission, and I watch how

health care policy evolves, there is really a pattern of annual responses to sort of the latest stuff or who now is in Congress and who isn't. And it's frustrating actually, to me. And I think that if you want to look at some of the things that have to happen, if we're going to fundamentally be able to deliver more value to beneficiaries, certainly the delivery system issues are very high on the list because of the fragmentation and lack of coordination, especially in those high volume-high cost areas. So obviously, I'm a huge supporter of laying out some principles that I hope we would go back to over and over and over again over 10 or 15 years.

That would be a huge contribution because generally speaking that's been hard to do in the evolution of health care policy just because of the way our democracy works. So I think that has a lot of value.

I think implicit in what Dave said, the delivery system, as Jay Crosson has said, delivery system matters. And when you have an organized delivery system, you have a chance to place some accountability in a different way than when you don't. And so that would be a major thrust, obviously, of what we'd want to do.

In the SGR report, if you eliminate the discussion

about the SGR itself, there were lots of other good things. Those had to do with pricing reform, evolution of pay-for-performance perhaps, so that we had system-level accountability as well as individual accountability, clinical effectiveness. I think there are some things in policy now that lead us in the direction of more fragmentation. Those would have to do with conflict of interest issues, hospitals doing joint ventures with physicians, which drive volume. And I think if we could address some of those things, as well, in terms of principles that would be good.

The regulatory reform issues that we mentioned earlier would be on the list of something that's going to take a long time. We talked about medical education. Is there training going on about quality, team play, system approaches to quality?

There's kind of a list that's maybe even a little more robust in a way than what's in here, I guess, and do we want to think about that as if we do want a framework that we could go back to over and over again over the years.

And then we all define our sort of mental model about tactics, I suppose, based on our life and professional

experiences. I would hate to get caught up in the analysis paralysis of a few more demos until we learn how to do something. And I really worry about that, Nancy, terribly.

Having said that, obviously we can't design this thing and launch it and make everybody do all the same things in a very short time period. That's clearly not ever going to work. And most transformational change does evolve out of current circumstances. I've sort of been interested over the years in complexity theory and how it applies to organizational development. And I think that in that you try to find where are the butterfly wings? Where are the trim tabs? What are two or three or four or five things we could do that are major signals that the world is going to be changing in terms of how we deliver health care in this country? I think some version of episode bundling would be one of those. And it will take five or six or seven or eight years to really work that through.

The pricing changes are another thing. What other disruptive innovations might there be that are practical but start to move this along?

And then of course, we can't design with perfect knowledge how this will look in 10 years. But we certainly

can start putting some things in place that will make it more likely than not that the evolution of this will lead us to a better place even though some of that is unpredictable today. But I think it takes persistence. Persistence is hard to come by in a political system where the environmental stuff changes so often. And if you can only imagine change around what currently exists, then you aren't going to have something different in five or 10 years.

So I'm obviously very supportive of this. I think it would be a huge contribution as the Commission continues to try to build on principles in the years ahead.

DR. CROSSON: I support this direction. I also support the notion of perhaps framing the issues better before we get to the -- I mean, for me it flows from the charge that we're given long-term. The charge, at least what I have in mind, is to try to improve the quality of care to beneficiaries and over time the sustainability of the program. That's the starting point.

I think a lot of the discussion we've had in the three-and-a-half years I've been on the Commission now suggest that there are two things -- at least two things missing that are obstacles to that. One is the lack of care

coordination that is inherent in the delivery system we have for most of the country.

And the second one, which relates more closely to the Medicare program, is the lack of incentives for appropriateness of care which is sort of the other way of saying inappropriate volume. Those are two things that if we could change would more likely get us to the goals, to the first two goals.

Now as we look at the notions here that we've got at the moment, I think you could argue that each one of them does it. I think they do it in ascending order of likelihood to promote care coordination and appropriateness of services. I think even in the presentation that was clear.

If you look at the impact of the medical home, I think that is a level of care coordination. It doesn't really, to me, extend much beyond the primary caregiver. But at least it is some care coordination.

The impact on appropriateness is probably limited to the improvement in volume of services related to quality improvement, which is what I think we said. And I agree. When we looked and we talked a lot about it earlier today,

the physician-hospital payment bundling issue, does then I think create incentives for coordination between some physicians and the hospitals. And it may have an impact on appropriateness of services by reducing inappropriate readmissions, which I think you also stressed.

But I think it's later, when we get to the idea of fully integrated organizations, integrated clinically and financially, that we get closest -- let me just say integrated clinically and financially combined with appropriate payment incentives -- that we get closest to a model or a set of models that drive care coordination and appropriate services.

And then I would just make one point about the paper in terms of describing the physician-hospital relationships. I think that I don't completely agree with describing this as a dichotomy between the PHO model on the one hand and physicians working for the hospital as employees of the other hand. Because I think it's likely, in the end, that we would end up ideally with something different. Because actually the model that you have, the dualistic model, doesn't describe my own organization because we're neither a PHO in the way it's described nor

are the physicians employed by the hospital.

When we actually have is a model of joint accountability and, to some degree, joint governance, joint responsibility for services. And I would think, I would hope, if it's actually going to work in the end that somewhere in the middle there needs to be a third model.

MS. HANSEN: I just would say basically for the bulk of the comments on the other side of the table I just would really both concur and ditto in capital. Because I think some of the things about the framing have been said.

The key words that I just would like to just triple ditto onto are the ability to say at the end of it -- I think, Jay, you said it specifically -- it's about what's going to make a difference of having Medicare funding produce care for Medicare beneficiaries? And then from a financial standpoint what's going to make it sustainable? It's really almost as basic as that. If we can really put it at that high level, what is it going to take over 10 years to do this?

The things that have been said, I concur. I would also just add one more than I didn't hear quite as explicitly stated, and that is the ability for all of our

care deliverers -- be they physicians or other staff -- have the competency of geriatric knowledge, which is not something that has been stated. And it's been again tossed around a bit when we talk about GME in the past.

But I'd really like to elevate that because I know there's all the specialty knowledge and people think that by virtue of the fact that you're dealing with elderly complex people, you know geriatrics. But people who understand the issues of complexity, of care coordination, and just how quickly people turn who are fragile individuals -- be they skin ulcers or dehydration.

There is a body of knowledge and increasingly maybe a body of science that really needs to be taught early. And it's hard for faculty who don't understand this and don't practice this to be the teachers of future generations. I just want to bring that, that if we're talking about preparation there's a content piece to people who are living longer, growing older. Again my theme of the fact that 85-plus age people are the fastest growing number of people. So there is a body of knowledge that we should really ask for some accountability for.

And then also, just the ability to understand

quality improvement and process improvement. I think it was brought up but that's something that is not taught in any of the professional schools and appreciated relative to delivery system improvements.

And then finally, as all these comments are being said, some of you know that I come from a 25-year history of a program that has actually even taken the anathema of bringing together Medicare and Medicaid coupled with changing the financial incentive system as well as the delivery system. Somebody said it takes patience and it really does. And people say that was -- and I'm just, frankly, glad that I had a personal opportunity to go through that needle in a haystack of timing because it was a very hard thing. People ask why does it happen? Why isn't it kind of replicated all over?

Basically, it's asking for changing the DNA of the way care might be provided to individuals in this category. So it does mean some really systemic issues of change that -- I've used the phrase of culture change in a way that's hopefully not taken lightly. But it does take that. It takes the 10,000 miles of doing this. And hopefully as a Commission and as a statement of being responsible for the

Medicare quality and solvency, that we really acknowledge we just have to really do some fundamental rethinking about this.

Much like, Nancy, you said earlier, and we all appreciated with both humor. But the reality of it's not just about dialysis. It's really about a system.

So however we can take that leadership role in this commission to do this, let's frame it, let's say that this is a long road and we do need a map to get there.

So that's my only major exhortation in the process of having this opportunity.

MR. BERTKO: Okay, my turn to be a contrarian.

First of all, I think we need the chapter again. But like Nick, I think we've said nearly everything we need to say about how to do it in principles in the SGR report. So the contrarian part says why don't we just become explicit? One part of that would be saying we need a carrot and a stick. They carrot is financial, you make more money if you do something right. The stick is you're stuck forever in SGR hell, whatever you turn that out to be.

[Laughter.]

MR. BERTKO: The second part is we're all smart

people, I enjoy listening to this. But frankly, we're not going to solve the problem.

And so my second suggestion is we ought to create -- and Nick will probably cringe at this -- a delivery system demo czar. And then let that go out and have a whole bunch of demos that are doing all kinds of things, from ones like Jennie's to Nick's to we heard the person up in Connecticut. And put a timeline on there, a recommended timeline, and say in five years we're going to choose a couple of days and it will be over. So just to try to get things kicked off and get done.

Probably impractical but again, anything we say that would be explicit about getting the fix started I think would be useful.

DR. MILSTEIN: The nice thing about going last is you just get to reinforce prior great comments.

I agree with this idea of getting clear on what we think success would look like and then working back, with Nancy's idea.

As I listened to what we've read about, at least in the last three years I've been here, the vision that we'd be trying to reverse engineer would suggest on a one-time

basis about a 35 percent reduction in spending, all other things being equal. That's if you believe Elliott Fisher and evidence of differences in production costs among providers for those services that are valuable. About a 40 percent improvement in quality reliability, using adherence to evidence-based medicine as one of your indices. And about a 10 point jump in patient experience. We're now running, for most things, in the low to mid-80s. So at least 10 points higher.

And then how do you get there? I'm going to steal one of Jay's comments from a couple of sessions ago. It was sort of like look, the way that the laws work in the United States of America is the physician's pen governs 85 percent of the resource flow. And physicians also happen to have, by far and away, the most influence on patient behavior.

And so the first step in reengineering this is thinking about how do you create a psychological environment around physicians such that every day when physicians get up in the morning, of the three things that are on their worry list -- because most people don't have more than about three things on their worry list -- is the question of what innovation might I test in care delivery today that might

reduce total spending and improve quality and patient experience tomorrow? Right now that is not what's on the minds of physicians when they wake up.

And how what might we get there? This is now, I guess, a summary of prior comments made. First, we'd need to make provider payment, medical education payment, and insurance plan design much, much, much, much sensitive to superior clinical outcomes and conservative resource use.

We heard testimony about two years ago, I think from Sam Nussbaum and somebody from the hospital industry, saying what is the minimum amount of total physician and hospital comp that would have to be very exquisitely tied to performance on resource use and quality if you wanted to see major movement? I think the answer was no less than 10 percent of total physician comp, not Medicare but total, and at least 2 percent of total hospital comp. Well, we aren't obviously anywhere near that in any of our recommendations.

The same with benefit design. In other words, I don't think that the payment lever alone is enough to cause that change in environment around our clinicians. I think we would also need patient flow to begin to tilt toward better performing providers to really be assured of reverse

engineering what we're looking for.

And then the second thing we would need is -- and I realize this is extremely controversial and difficult but I might as well say it -- is much, much better coordination between Medicare program incentives and incentives of other payers in the United States. If we're going to tolerate a Balkanized payment system, Federal laws govern these other plants, things like ERISA. You'd have to get more orchestration, as we recommended in principle. We'd have to get, I think, more specific about it.

And second to last, we'd need -- and this reinforces John's point. We need much faster knowledge turns in our payment innovations. In other words, right now the rate at which we test and then make judgments about payment innovations and benefit design innovations is exceedingly slow, nowhere near fast enough for us to continuously come up with policies that would drive towards that kind of a radically improved outcome. In other words, our rate of testing is just not fast enough.

And last but not least, and this gets to the earlier debate we had, is I think we would need much greater tolerance of policy failure. Right now, I won't repeat the

prior discussion but is it broken? Or is it not broken? If it's broken, I think it tilts you in favor of taking more risk with current payment policy. Whether you think it's broken or not may differ among us, but I'm on the side of it's not working very well.

DR. CASTELLANOS: Arnie, you said you wanted to be last. I'm going to let you be last.

The other issue is I think there have been so many good points said that anything I add to it is not going to emphasize it.

And last but not least, Arnie, you're absolutely correct. When I get up in the morning, that's not the first thing I think about.

[Laughter.]

MR. HACKBARTH: Karen, is that the first thing you think of?

DR. BORMAN: No. It probably earlier than my day. Just a couple of comments on the very fine discussion that's been going on.

First off, I would say that we all, I think, agree that there are problems and there are problems that we need to address. I'd like to maybe throw out a plea for let's

find a few positive things to say. We agree that for the population as it's evolved to with the baby boomer leading edge, the complexity of diseases, the multiplicity of therapies that we have to offer in drugs, that we're not doing as good a job as we would like to see ourselves do at this point in time and for the foreseeable future.

But I think we do have to acknowledge we've had some incredible successes in the world of medicine in this country. I think we need to be just maybe a little bit careful about being always negative and not pick out that there are some positives. And we may not intend that. But I have to tell you that for the average person listening or reading to some of our materials, it's pretty dark. And I think we need to maybe acknowledge that there are some things that we're doing well. And I want to be a little bit careful of eroding entirely people's notion that we have a system that's even worth setting in the door to be a part of. I would just offer that.

And there are some things that I would share, related to some recent comments, that I think or I hope you would consider helpful, are that I agree with Jennie and others about the education piece. I would suggest to you

that if we put it in the framework around a discussion, it really needs to be education of all kinds of providers at all kinds of levels. This isn't something that is because Medicare pays for GME, we now move into the GME curriculum. This is really an issue in nursing school, in pharmacy school, in medical school. It relates a little bit to perhaps even what we teach in undergraduate, in collegiate circles. I think we need to remember there's lots of pieces of Federal and other governmental monies that go into the medical system in a lot of ways through the NIH, through student loans, in addition to just the GME payment.

And so I think we do have the opportunity to ask of the system across a broad range of providers and levels of education that we set our priorities more appropriately and not just zero in just on the GME piece. But we ask lots of levels of education to get better.

I would point out that at least on the GME level that there is an increasing recognition of it, and that's embraced in the notion that many of you may be familiar with, the six general competencies, which was a fundamental rethinking in judging the quality of residencies for accreditation. I can tell you that certainly in lots of

programs, lots of things have been introduced that weren't there before.

For example, we ran our morbidity and mortality weekly discussion conference using the NSQIP reporting occurrences as a background for the discussion. Those of you who don't know, it's the National Surgical Quality Improvement Program. And it has a standardized list of complications. We used that every week. And if you don't think that that starts to inculcate in people some familiarity with a reporting system -- it may not be the one they use in 15 years. I'm here to tell you that repetition does some things. So I think that there are lots of initiatives that are going on. We're not going to see the fruit of those for a few years because of the longevity of the medical education pipeline.

And that doesn't mean to say we shouldn't keep pressing but there are initiatives going on. That's an example by what I mean of there are some positives out there that are current, not just history.

And I think that another potential piece is we've left out a little bit some considerations about the 21st century and maybe even beyond beneficiary here and sort of

what are their characteristics? What can we do to incent them to be partners in their care?

I don't doubt that my pen controls a lot of resources. But I've got to tell you, if my patients did everything I told you like some of you seem to believe is the case, then I could be a lot happier camper a lot of times with patients. And so I do want to encourage that we consider the beneficiary an active partner and that we encourage them to make positive choices and to also accept some responsibility and accountability in whatever system we go forward with.

In terms of sort of the big picture of how specific we get, I would look to, again staying on the strategic level, maybe a very, very large menu of potential tools rather than focusing on two or three. We can certainly highlight things we've already endorsed. I think there's a ton of things out there.

And one thing I did forget to mention as an encouraging thing -- Arnie, and I hope this one makes you feel better, there are places were the traditional lab research year or years where we've allowed residents and encouraged them to go off and get advanced degrees in health

policy, medical management, that kind of thing as a substitute for gene splicing. Both have their place. But that was not something that in my residency timeframe was an option.

So again another example of we are moving down this road, maybe not as fast as we'd want to and aren't there yet. But let's find a little bit of positive and let's create a broad range of tools and on medical home maybe sort out the features of that that make it positive and not necessarily constrain ourselves to a small definition in one set of providers.

And that's enough. Thanks.

MR. EBELER: This is a terrific discussion. I'm trying to think about what a chapter looks like --

[Laughter.]

MR. EBELER: You guys will take care of that; right?

The tension here is obviously the need and desire to articulate a long-term direction and set of goals, principles, whatever, which I think was a very important addition at the front end here, with what I would argue is an equal need to show how that frames our recent and

potential future recommendations. Which is I think what we've done here.

I guess I want to make sure we strike that balance. I think it's very important to be able to put the commission's recent recommendations, the tools here, in the context of this very useful strategic thinking which I agree should be added in here at the front end as well as pointing out, in addition to those things, the future steps that we think are coming down the pike.

What it really does is it gives people a way to think about what we're recommending in the long-term.

I'm not suggesting that it's bounded by the list that we've got here, but it just strikes me that the task here is to combine this very valuable longer term direction with a bit of a roadmap. There's a point where it's got to be a practical roadmap because otherwise we have a variety of audiences we're addressing here.

MR. HACKBARTH: Well put, Jack. I do think that what I hear in the conversation is concerns about balance. On the one hand, we have people who are worried that it will be too soft and vague and not very action oriented.

On the other hand, we have some people who are

concerned that we're going to leap to narrow solutions that may or may not be good solutions without any consideration of the big picture in a longer term agenda. We need to figure out a way to find the balance between those things, talk about long-term goals, what the system does well, what it does poorly, lay out a longer term direction that -- as Nick says -- allows us and others to maybe be persistent and consistent over time. But then also get to some specific policy steps consistent with those directions.

So we'll continue to work on the balance and how to refine those messages.

We've already started to delve into the bundling as one of our particular examples. And we've got lots of work to do. We had a very good discussion earlier today which identified many, many issues that we need to work through.

It's but one of even these three strategies that are policy approaches that we've laid out. I am, for one, particularly concerned about the primary care -- I'll use the crisis word for lack of a better one right now -- and developing some meaningful proposals to address that. And so I don't know if the medical home is a solution or not but

I'm very eager to begin addressing that piece of our system failure. And that will raise a whole bunch of other complicated issues and it raises a question for me about how much of this we can digest at once, how many of these things we can take on at once.

That's a rhetorical question but one that we'll need to be talking through, Mark.

Okay, enough on this for today. Thank you. We appreciate your doing a good job of being the last presenters in the day. Everybody was awake and contributing.

Now we'll have our public comment period with our usual ground rules. Before you begin, the ground rules are no more than a couple of minutes, please identify yourself before beginning.

MR. CHIANCHIANO: Thank you, Dolph Chianchiano from the National Kidney Foundation. I appreciate the very thoughtful discussion about approaches to improving the quality of care for dialysis patients.

And I wish to underscore some of the comments made by the commissioners to the effect that improving the care for dialysis patients is intricately connected to improving

pre-dialysis care. That's when decisions about vascular access are made. That's when malnutrition problems begin. And I appreciate the comments about a competence of approach to pre-dialysis care. We certainly would favor that. But two incremental suggestions.

First of all, there is on the books a Medicare benefit for medical nutrition therapy. This provides a payment for nutritional counseling for individuals with a GFR below 50, which is especially stage three or four, of chronic kidney disease. It's an underutilized Medicare benefit. It was created by the Benefits Improvement and Protection Act. I would encourage greater utilization of that benefit.

Secondly, we would also advocate the creation of a new benefit that would provide for education of patients in stage four kidney disease to give them the empowerment tools that they need to be a productive member of the health care team.

Thank you.

MR. HACKBARTH: Okay. We are adjourned until 9:30 tomorrow.

[Whereupon, at 5:31 p.m., the meeting was

recessed, to reconvene at 9:30 a.m., on Friday, November 9, 2007.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom

Ronald Reagan Building

International Trade Center

1300 Pennsylvania Avenue, N.W.

Washington, D.C.

Friday, November 9, 2007

9:44 .m.

COMMISSIONERS PRESENT:

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

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: I apologize for the late start.

The first topic this morning is Medicare Advantage and findings on quality of care. Carlos?

MR. ZARABOZO: Today I'll be giving you an update of recently released information on the quality of care that Medicare beneficiaries receive in private plans, along with some analysis that we've done using publicly available data on plan performance. I'll review the three major sources of data on quality in Medicare Advantage and discuss what the data from two of the sources show. Then I'll provide more detail on our findings for one particular set of data. These findings only pertain to Medicare Advantage plans, not to Part D drug plans.

The three major sources of data on quality in MA were described in detail in your mailing material. One source of detail is that Medicare Advantage CAHPS survey, which is a survey of members' experiences with their health plan and with their providers in the plan. CAHPS results are not included in this presentation because 2006 data are not yet available. However, CAHPS results should be available in time for this year's Medicare open enrollment

period, the Advantage open enrollment period beginning on November 15.

Another source of data is the Health Outcomes Survey or HOS. HOS is a longitudinal survey of MA enrollees' health status over a two year period. For HOS we do have summary results include data through 2006.

The primary source of information on quality in health plans is HEDIS data. Health plans report process measures and intermediate outcomes measures through HEDIS along with other types of information. HEDIS is a product of the National Committee for Quality Assurance, or NCQA. HEDIS is the most commonly used source of health plan performance measurements and is the basis of many report cards and rankings of health plans.

In Medicare, plans have been required to report HEDIS measures since 1997. However the Medicare Modernization Act of 2003 exempted private fee-for-service plans and medical savings account plans from the HEDIS reporting requirements. These plans also do not participate in the HOS surveys, which are a component of HEDIS. However, there are CAHPS data on these two types of plans.

With regard to PPOs and what they have to report

for HEDIS, special rules apply. Medicare requires PPO plans to report on measures only for network providers and PPOs are not obligated to report on issues involving extracting of medical records.

I should note here that Medicare beneficiaries can obtain CAHPS information and HEDIS information about each plan through the Medicare.gov website or from 1-800-Medicare. In the past only five effectiveness of care HEDIS measures were displayed on the website for MA plans. However, CMS is revamping the website so that more HEDIS measures are shown for each plan, beginning with the upcoming enrollment period.

Evaluating the various data sources what we have found is that the most recent data on quality in MA plans show a need for improvement. They also show that there is substantial variability across plans in their performance and the performance of newer plans is generally poorer than the performance of older plans.

Beginning with a look at the HOS summary data, here is the table of HOS results for the seven cohort survey to date. This table is taken directly from the HOS website. Plan results are categorized based on the expected changes

in health status of enrollees. The health status categories are better health, poorer health, or unchanged status on physical and mental health measures over the two-year period. Plans are classified in terms of whether or not their enrollees fall within the expected ranges of health status. When results are reported, as in this table, a plan is deemed to have better or poorer outcomes if the plans' results are significantly different from the national average across all plans.

Looking at the most recent time period, shown in the last row, enrollee health status changes were within expected ranges from 2004 to 2006 for most plans. However, compared to earlier time periods or cohorts, more plans showed poorer health outcomes and fewer plans should improvement in health for their enrollees.

The number of reporting plans is about the same for each cohort after the first time period. As you can see, in the most recent time period, the entry in the bottom right-hand corner of the table shows that 13 plans have enrollees with poorer physical health than expected, compared to at most five in any prior time period. The next to last column shows that in the middle time period 20 or

more plans had better physical health among their enrollees than expected. For the 2004 to 2006 cohort, there are only two plans in the better physical health category. In mental health, five plans had enrollees with improved mental health, while in earlier cohorts there was a much higher number showing improved mental health. Seven plans had results indicating that the mental health of their enrollees was significantly worse than the national average.

Turning now to findings based on HEDIS, six weeks ago NCQA released this year's State of Health Care Quality Report, which is their annual report showing the performance of Medicare, Medicaid, and commercial plans. One issue that NCQA highlighted this year is that Medicare scores did not improve as much as the scores in other groups of plans. Medicare plans improved in seven out of 38 measures, far fewer than in the case of commercial or Medicaid plans.

For the 30 measures that are common commercial and Medicare plans, commercial plans had better scores on Medicare in 16 measures.

In releasing this year's report, NCQA stated the Medicare numbers for 2006 and similar results for last year's numbers highlight a need to refocus on quality

improvement efforts, as they put it, in the Medicare program.

We're using NCQA HEDIS findings displayed here to show whether there was improvement in Medicare scores between 2005 and 2006, and also to show how Medicare plans compared to commercial plans.

We've independently analyzed the HEDIS scores for Medicare plans in 2006, using public use files available from CMS. One of our findings is that, as NCQA has also noted, there is substantial variability in HEDIS scores across plans and I should mention that NCQA is looking at simple averages across plans and we're also looking at simple averages here.

In your mailing material, there was a table showing the range of scores across individual Medicare Advantage plans on different HEDIS measures, including the minimum and maximum scores and the median scores in 2006. The data showed a great deal of variability in plan scores.

Here we use one particular measure to illustrate the a degree of variability in Medicare HEDIS scores in 2006. These are the scores showing the percent of enrollees with type 1 or type 2 diabetes continuously enrolled in the

plan during the measurement year who received a retinal eye exam in the year or who had an eye exam in the preceding year showing no retinopathy. The bar at the bottom of the graph shows that one-forth of plans have rates under 50 percent for this measurement. That is, fewer than 50 percent of enrollees who needed the exam received the exam. At the individual plan level, the lowest rate was 15 percent and the highest rate was 91 percent. The median rate was 61 percent across all the plans that reported on this measure. Nearly all plans reported on this measure. There were 276 plans in our data and all but 17 of the 276 plans had a score for this measure.

In looking at the 2006 Medicare HEDIS data, another thing that we found in our analysis of that there were noticeable differences in the performance of newer plans compared to older plans. This graph shows the difference between older plans and newer plans on the eye exams measures. Here we are defining older plans as those operating in Medicare prior to January 1, 2004. Of the 276 plans in the data, 155 were older plans, 121 are newer plans.

On this particular HEDIS measure, the bar at the

bottom of this graph shows that 45 percent of the newer plans have scores below 50 percent on this measure, compared to only 10 percent of older plans with rates below 50 percent.

Looking at the top two score ranges, that is scores of 80 percent or higher at the very top and scores in the 70 to 80 percent range in the next grouping, older plans are much more likely to be in these higher ranges. 43 percent of older plans have scores falling within these two highest ranges shown here, 14 percent at 80 or higher and 29 percent at 70 to 80. By contrast only 11 percent of new plans have scores in these upper ranges with 3 percent at 80 or higher and 8 percent between 70 and 80.

In analyzing 2006 HEDIS scores for older plans versus newer plans, we found that on almost all measures average scores for older plans were better than for newer plans. Looking at the 40 measures that we analyzed, which is 38 effectiveness care measures plus two measures on customer service, older plans had better scores on 35 out of the 40 measures.

An issue that we noted in the mailing material is that not all plans report on all measures and in some cases

only a small percentage of plans are reporting on a given measure. Newer plans are less likely to report on certain measures. Taking this into account, if you only look at the 15 measures where at least three-quarters and new and old plans both reported scores, newer plans had a better score on only one of the 50 most frequently reported measures. Older plans were better on 14 of the measures. And for nine out of the 15 most frequently reported measures, the average scores of older plans were more than 5 percent higher than newer plans scores.

As I noted, looking at all 40 measures, newer plans do have better average scores than older plans on five measures. However, in the case of three of these five measures, only about 10 percent of new plans reported scores. This compares to 75 percent of older plans reporting on the three measures where new plan scores are better than old plan scores.

I'd like to mention a couple of points on how the new plans differ from the old plans. First, I should clarify that new in this context only means that the particular Medicare contract began on or after January 1st, 2004. That does not necessarily mean that we're dealing

with entirely new startup organizations. Some of the contracts are with entirely new plans but some of the offerings are from established plans in given areas that are newly entering into Medicare contracts.

The newer plans do tend to be smaller plans and they are more likely to be PPOs. However, for most measures, PPO scores were higher than scores for new plans that were not PPOs. On the question of whether the plan size is the factor that explains why the newer plans had lower HEDIS scores, if you look only at plans with fewer than 10,000 enrollees, you find that the older small plans had better HEDIS scores across the board than the new plans with fewer than 10,000 enrollees.

Another point having to do with the size of the new plans is that overall enrollment in the new plans is much lower than in the old plans. For the HEDIS measurement year we're looking at, 2006, the 119 new plans -- I removed two private fee-for-service plans for this count -- had about 12 percent of the enrollment among all the plans reporting HEDIS measures for 2006. However, the enrollment of the newer plans is growing faster than enrollment in the older plans. The newer plans had enrollment growth of 22

percent in the past year, compared to enrollment growth of only 1 percent for the older plans.

Within the set of plans we're looking at, the new plans now comprise 15 percent of the enrollment as of last month, compared to 12 percent of the enrollment in 2006.

So to recap our findings, we found that the most recent publicly released data on quality in MA plans showed a need for improvement. Our analysis of plan level HEDIS scores shows there are significant variation in performance across plans and the performance of newer plans is generally poorer than the performance of older plans.

I'll conclude by reviewing what the Commission has said in the past about quality in Medicare Advantage. The Commission has said that the quality of care should be measured in both sectors of Medicare, the traditional fee-for-service program and the Medicare Advantage program. By having data on quality of care in each sector, beneficiaries can choose between the two sectors using quality as a factor in their decision. Currently, the collection of information on quality is more extensive in Medicare Advantage then in traditional program. Right now beneficiaries can really only judge differences in quality between one Medicare

Advantage plan and another without being able to compare MA quality to the quality of care in fee-for-service Medicare overall.

Having said that, not all plans in Medicare Advantage provide data on quality. Specifically by statute, as I noted before, private fee-for-service plans and MSA plans are exempt from the reporting requirements applicable to all other MA plans. In testimony before Congress and in our June report to the Congress, we called attention to this difference among plan types and have suggested that all MA plans should be subject to the same reporting requirements.

The other point to mention is that information on quality is a necessary component of pay-for-performance programs. The Commission has noted that MA already has the type of quality data necessary for a P4P program and the Commission has recommended a portion of plan payments be used to fund a P4P program in MA.

Thank you and I look forward to your comments and questions.

DR. MILSTEIN: That was wonderful, thank you.

I know that earlier in the program's evolution, the Health Outcomes Survey was applied to a random sample of

the Medicare fee-for-service population.

MR. ZARABOZO: Yes.

DR. MILSTEIN: Appreciating that we're looking -- that the portrait of the Medicare+Choice, at that point, versus the fee-for-service program that, at this point may be five years dated or six years dated, if you had a chance to look at those comparisons in general on the Health Outcomes Survey which, from my perspective, is the bottom line in terms of what's the net impact of this delivery system on change in health status over two years for Medicare population. Did the Medicare+Choice plans significantly outperform, under perform or perform about the same as the Medicare fee-for-service plan?

MR. ZARABOZO: As you mentioned, there was a pilot to do fee-for-service Health Outcomes Survey. I did not look at the difference between Medicare Advantage -- or Medicare+Choice at the time -- and the fee-for-service population. But I can look at that.

DR. REISCHAUER: This is very interesting and thank you for the presentation and the chapter.

You made some references to differences between new and old PPO, new, non-PPO, old. I was wondering, did

you cut this at all by geography?

MR. ZARABOZO: No, I did not.

DR. REISCHAUER: To see if there were any patterns. Could we?

MR. ZARABOZO: Yes, that can be done.

DR. REISCHAUER: Should we? Maybe not.

MR. ZARABOZO: As I mentioned in the mailing material, the reporting unit is the H level or contract level or the R level, in the case of regional plans. So that, for example, a regional plan that has let's say 23 states, for example, with one H number is reporting one number for all of those X number of states that are included in the R level. So it can be done.

MS. HANSEN: I was wondering about that.

MR. ZARABOZO: For looking at geography, the CAHPS information is better because it goes to smaller geographic units but there are plans that limit their service area to smaller geography.

DR. REISCHAUER: Thank you.

MR. EBELER: Thank you.

I actually find the data disappointing, as someone who comes out of this field, has worked at one of these

organizations, and has represented parts of this field. This is not what one hopes for from here. It, in my mind, sort of really reinforces the recommendations that we've stressed.

It also suggests to me something Nancy mentioned yesterday that's sort of a need to look at this program sort of backward map almost, what we expected from this in the context of the delivery system reforms we discussed yesterday and where we're going.

One analytic question a little bit different to Bob's. There was a study, I think it was very Larry Casalino, that suggested that plans associated with organized delivery do better than plans that don't, particularly on the HEDIS measures. Is it possible to cut the data that way?

MR. ZARABOZO: Yes, we can do that.

MR. EBELER: I don't know what it will show in the new data but it would sure be worth knowing.

MR. ZARABOZO: Looking at the rankings that NCQA does and U.S. News and so on, Kaiser, for example, is very highly ranked and those kind of organizations are typically highly ranked and have higher scores.

MR. EBELER: The only other suggestion and the other question is how to present these data in a way that capture attention. One of the things I would suggest is pointing out not just the norms but the gap from where we are to where we should be, 95 percent or the 90th percentile, and pointing out how many people would be getting what they're supposed to be getting if we were at those levels.

You used an eye exam chart here, but the truth is when you're at 70 percent and we should be at 95 percent, tens of thousands of diabetics are not getting something. Just representing the data that way, just as a way to try to capture attention of the shortfall here.

MR. ZARABOZO: Assuming the identification, the denominator, that we know the denominator.

MR. EBELER: Yes, and we can only do that where you're comfortable. But even if there's just five examples. It's just that we get so used to norming against a norm that's mediocre that the goal is to sort of strive for something excellent. And not just for Medicare Advantage, in all of Medicare. If there's a way to do that I think it would be helpful to the audience.

DR. DEAN: These various measures, have they been -- and maybe this has already been answered. I'm not sure. But the various measures, are they internally consistent with each other? Do they really tell us -- I guess my question is do they really tell us what we need to now? In other words, do people who write or do programs who rate high with these particular measures, do their enrollees actually end up better off at the end of the year? As Arnie says, it's the outcomes that we're really after.

And what concerns me is that, having worked in the health care systems, if you're going to measure one thing, we'll improve that one thing. We'll refocus our attention. But unless we're very careful about what we pick, there's a limited amount of attention span and we're likely to not pay attention to something else.

And so picking the factors that we're going to report for the long-term is terribly important. And I know obviously HEDIS is widely used. And I just wonder, does it really tell us what we need to know?

And I guess a little bit of a second question, has there been any attention -- another problem, I think, with a lot of these programs is that the enrollee periods are short

enough and people are bouncing around from one program to another, there's not been a lot of incentive on the part of companies to invest the effort to get people to do things that will save the company money in the long -- save the insurance company money in the long run. But likely that enrollee won't be there in two or three years.

MR. HACKBARTH: I agree with Arnie's take and yours, that ultimately it's about outcomes. That's what we should care about. But there are short-term/long-term issues. Some outcomes, improved outcomes, may not show up for long periods of time. And so you use process measures to complement them, get people, reward people for doing the right things in the short run that in the long run we hope will improve outcomes.

For that to be a reasonable expectation, you need to make sure that you choose process measures that are evidence-based and linked to outcomes.

DR. DEAN: Right, exactly. And it's hard to do.

MR. HACKBARTH: But you wouldn't expect a perfect correlation in the short run between outcomes and process measures, just logically, because there are different time frames involved.

MR. EBELER: Glenn, what's interesting about these measures -- and again, I think what's disappointing about the results is these are not a series of measures that the regulatory process has foisted on the health plan community. These are a series of measures that the health plan community worked through NCQA to develop and be accountable for. So they are not been the big bad CMS doing this. These are things that folks signed up for.

MR. HACKBARTH: Another point that you mentioned was turnover in enrollment perhaps being a disruptive source and discouraging investment and long-term improvements. What are the data, Carlos, in terms of stability in enrollment? It used to be that was relatively stable --

MR. ZARABOZO: It is still relatively stable. Of course, now we have the lock-in, so that beginning with 2006 people are locked in, essentially, to their plan for the year. This is the measurement year, 2006.

The particular measure, the eye exam measure, has been around since 1999. Again, as I mentioned, you had to be in the plan for the entire year to be included within the measure.

NCQA is continually updating, as Jack has

mentioned, the measures. The one measure that is going to be dropped is the beta blockers after heart attack measure because performance is so high and there's such little variability, so it gets to your point of when you measure something there is improvement. But again, the retinal eye measure has been around since 1999 so it's been there a while.

DR. KANE: I actually have more questions than comments. One is, is this the real rate of difference or is there a well known lack of documentation piece here? In other words, is this a measure of how well they're documenting their care or the fact that they're actually not delivering their care?

MR. ZARABOZO: The results are supposed to be audited. If there's some question about the measure being reported, it can be not reported as being not a valid measure. That's why this measure where almost over 90 percent of the plans are reporting are the measures that I was principally working on.

DR. KANE: So this is actually just not giving the care is your sense? Or we should take it that way?

MR. ZARABOZO: It's possible that they were unable

to track that the care was given is the other thing. Particularly the eye exam measure is an administrative measure, not a medical records measure.

DR. KANE: So we don't know whether this was because the eye exam was given by an optometrist or an ophthalmologist and they haven't gotten the information system to connect it to their --

MR. ZARABOZO: It is supposed to be ophthalmologist actually. So there is a possibility of not having a record of this having happened.

DR. REISCHAUER: We've been tracking this information for a number of years and they know you're going to, they really have to be stupid not to try and collect it.

DR. KANE: Unless they're bringing in a population whose traditional systems of care are not yet tied into the -- in other words, it's a poor plan design. Because it does seem odd that they would be that bad, given a measure that they do well in on the commercial population.

The other question, I guess, and I don't know if you know the answer, is why were the two exemptions? Why were the private fee-for-service and medical savings, why were they exempted? Is it the feeling that they couldn't

get the documentation and that the other plans could?

MR. ZARABOZO: They're not network plans is, I guess, the reason essentially.

DR. KANE: Wouldn't they be able to -- just to push that, would you still be able, from the claims that you're paying, to know whether --

MR. ZARABOZO: Information that comes from claims, you can get that information, yes.

MR. HACKBARTH: Let me approach that same issue from a little different direction. Where do we stand, Carlos, in terms of being able to compare plan results to traditional Medicare results in the same areas?

MR. ZARABOZO: We were going to get the CAHPS information for fee-for-service, which again was fielded in 2007, and compare that to the Medicare Advantage CAHPS information.

MR. HACKBARTH: Just the satisfaction results?

MR. ZARABOZO: The satisfaction and the flu shot rates and a couple of other things that come out of that.

MR. HACKBARTH: Where I'm going is probably obvious. I would think that for private fee-for-service plans, or even many of the big network HMO plans, the

primary determinant of their results is the quality of care in the community. Now since they're contracting with more or less everybody, or in the case of private fee-for-service they don't even have a limited network. So to say that these are plan results, in some sense, is a misnomer. They are a reflection of the state of care, for better or worse, in that particular community.

So to say we're going to hold private fee-for-service plans accountable for quality is, in a sense -- if the plan is, by definition, a free choice plan, the number of levers that they have to pull to improve quality is more limited than Kaiser Permanente or some of the other models.

DR. KANE: Yes, but they could still identify their diabetics and send them education and do outreach.

MR. HACKBARTH: Just to be clear, I'm not opposing the quality of the reporting requirements, but you need to think about what the results mean. I think for many plans, and not just private fee-for-service, they're as much a reflection of the state of local health care as they are of plan performance.

So I'd like to have Medicare numbers and the private fee-for-service numbers alongside and then Kaiser

Permanente's numbers alongside that. I think you'll consistently see Kaiser Permanente up towards the top and organized systems like them up towards the top.

DR. KANE: In our market, for instance, Harvard Community Health Plan, Harvard Pilgrim Health Plan, -- dumped their old managed network plan and now only offer private fee-for-service. So they're taking the same people and they're flipping them into this -- I honestly don't understand what that -- I mean, I have some idea.

DR. STUART: And they are being paid more.

DR. KANE: That's why.

DR. STUART: I'd like to go back to Jack's point, and Glenn mentioned it too, is that ultimately we'd really like population-based measures for these.

Carlos, you may have already done this, but there is another data source. If you haven't, it's not quite as current but it does have a lot of this information in it, which is the Medicare Current Beneficiary Survey Access to Care. The currently available survey is 2005. 2006 should have been released by now. It hasn't been but it is due early in the year.

And every other year it has a panel of very

detailed questions regarding care for people with diabetes. That would be a natural way of comparing people in fee-for-service and in MA plans. And I believe in 2006 there is a distinction between MA plans that are managed care, as opposed to private fee-for-service. I'm not positive about that.

But at least you'd be able to address some of these questions for specific issues. You're not going to get A1C measures and some these others. But you will get other measures that you don't have in NCQA. It would provide at least a basis for comparison, like next year you could say well, we've got these 2007 figures that we presented to the Commission in November of 2007. And now next year we'll go back and we'll compare what we found in 2007 in access to care.

And I think it would be just very useful to have this as a tagalong data source that would provide some additional information here.

MR. ZARABOZO: And it does carry the plan identifier, I believe, in MC BS information.

DR. STUART: You can get the plan identifier.

DR. MILSTEIN: Given that the Health Outcomes

Survey is an NCQA approved measure, what was or is the rationale, first of all, for ceasing its application to the Medicare fee-for-service population?

And secondly, for not making the results available to beneficiaries who are interested in selecting an MA plan?

MR. ZARABOZO: I'm not sure of the reason for the discontinuation of the fee-for-service HOS, but it seemed to me that the primary use of HOS in CMS is for the health plan improvement, working directly with health plans and through the QIOs at some point. Now I looked at the 8th scope of work for the QIOs and it's not specifically mentioned. But I think in the past that use the HOS data to work with the health plans.

DR. MILSTEIN: If it's possible, maybe in the interim, to find out why it's not -- I appreciate that it would be very useful for internal plan quality improvement purposes. But since I would be -- using my own parents as a frame of reference -- of extreme interest to them if they're trying to decide among MA plans or whether to switch to an MA plan, is there an explanation as to why it should not be made available to beneficiaries?

MR. HACKBARTH: Bob opened by saying that he was

interested in results, and then Jack said he was disappointed in the results. I'm struggling to get to disappointed. I'm more depressed than anything.

[Laughter.]

MR. HACKBARTH: And a number of things depress me about the results. But one of them is that I fear that we're going backwards. The policy changes that we've made in this program are converting Medicare Advantage from a program that's leading edge to where we reward organized systems that reduce costs and improve quality to we have such high payment levels that we're going to private fee-for-service, which has little potential to do either.

These results are just a reflection of our -- we're not evolving. We're devolving, and moving away from better care for Medicare beneficiaries, more efficient care.

DR. WOLTER: I would certainly agree with that and I think that our position points up there are right on target, although we might want to be much stronger in the things that we say. One of the large private fee-for-service plans that's come into Montana, I saw a string of e-mails from a lot of the little small physician groups that were being burdened with all these requests for sending

copies of records. And it was primarily, I understand, so that they could get their severity information. It really wasn't focused on quality improvement activities.

And I think that to pay 15 or 20 percent above fee-for-service when there's absolutely no activity going on around looking at better coordinated care or focusing on high volume/high-cost disease, all the themes that we're trying to advance here, is very, very bad policy.

And so I think that if we really strengthened the notion that if we're going to pay Medicare Advantage, we really want not only reporting but we want performance. And that would be another way to move towards some -- as you know, Glenn, I think more national fee-for-service neutrality than county level. But I think we should be strong on this, short of just saying we should eliminate private fee-for-service, which many people think would be a very smart recommendation.

MR. DURENBERGER: Nick has clearly made the point better than I, as a practitioner. But to put a point on the conversation about the plan basically reflects the status of quality in a community, it is also -- even though I come from a community that has started to do this quality than a

long, long time ago through the Institute for Clinical Systems Improvement and a variety of other things like that, it's also a community in which the health plan is important to that effort. And it's basically, if you will, a kind of a partnership although people are not -- they work together in a larger sense, not in a specific sense.

But there has to be a motivation on the part of both the plan to press for improving quality in the community and a motivation on the part of the physician. And how that works is really key to the point I think you're making about Medicare Advantage.

And if, in fact, we continue a policy that simply rewards people for selling more policies and more plans without producing a result of some kind in the community, not like nationally are you this, that or the other thing, but community by community in which you're selling those plans, we're not making a contribution to improving access to the kind of high quality.

When I did my little informal survey that I reflected in my commentary, the plans in various of these states we come from all said they pay a lot of money to get accredited. They pay not quite as much, but a lot of money

to go through all of this process. And they do it because they know that part of their responsibility in the communities in which they sell these health plans commercially and Medicare and Medicaid and so forth is to assist the provider community in knowing what are the rules, what do we have to do, how do we get rewarded.

So that sense does not have to be unique to our part of the country. But unless we change -- from a Medicare standpoint, unless we change the rules about why are we paying you a subsidy and what do we expect by way of performance, then we're going to be in trouble.

MR. HACKBARTH: Other questions or comments for Carlos?

MR. EBELER: One question that we discussed yesterday that need the staff had identified for information on Part D that's hard to come for come by. Are there information needs on MA that we're bumping up against or not? It's just that -- it's not a guided question. I'm just wondering do we get the data that we need on what's happening at MA plans? Or do we need additional information?

MR. ZARABOZO: We're going to be getting the HOS

data through a data use agreement, and again the CAHPS data is also coming. On quality measures, I don't know that we are missing anything.

MR. EBELER: Are there any other areas?

MR. ZARABOZO: If Mark wants to address this?

DR. MILLER: First of all, are you asking about quality or the others?

MR. EBELER: I'm asking more broadly.

DR. MILLER: Because we do think that there are data and a couple of commissioners have raised the question about -- and we've had some discussions about the encounter data that's coming from managed care plans on the A/B, side, so that's why I was trying to figure out how broad the net was. So certainly that question has been raised and I think there's going to be some additional discussion about that even as soon as next month's meeting.

On the quality side, and I'm feeling my way here and so is every may -- I think we've said things about -- and I'm not talking about new data sources here but trying to make sure that we're getting comparable data across sets of plans. Different plans have different reporting requirements. We've raised that issue. We've raised the

fee-for-service to managed care issue. And then we're going to talk about SNPs momentarily and special measures associated with them over and above the standard set.

Any of the analysts that work on MA, are there --

MR. ZARABOZO: As Sarah mentioned, we're dealing here with the H contract level data. If we could get plan level data on quality -- I don't know if that's possible actually -- it is possible. We are missing that. So the geography question, benefit package questions related to quality, those kinds of things could be answered with plan level data on quality.

DR. REISCHAUER: It strikes me the H level data isn't useful for almost any question one would want to answer.

DR. STUART: Carlos, you noted that there were a number smaller plans in particular that failed to report these data. What sanctions, if any, are imposed on plans who do not report these data?

MR. ZARABOZO: On the so-called not report, NR, I don't know. But in the state of California, for example, for the Medicaid plans, if you have an NR, they track it down. They say you cannot report this in the future. You

must be able to report this particular measure. So you have sort of a corrective action plan. A not report means you will report at some point and show us how you're going to be able to report this.

MR. HACKBARTH: But under the NCQA system, not reporting is an option. To the extent that we're relying on NCQA's analysis of the data, there may be plans that are complying with Federal requirements to report but the data aren't being analyzed by NCQA because they're not flowing through the NCQA system? That's a question. Is that a possibility?

MR. ZARABOZO: I think it's to Medicare and then to NCQA is the way it works, I think, CMS. But as I mentioned in the mailing material, the NR can either be we are unable to report this because the measure is not valid, there's something wrong with the sample or whatever. Or we are choosing not to report it. At the moment, CMS has said that they don't know when it is choosing not to report versus unable to report for technical reasons.

DR. MILLER: Just to add, we're not aware of any penalty if a person is not submitting to data, whichever way it ends up getting -- I think that was sort of the

overarching question there.

MR. ZARABOZO: I don't whether there is a penalty or not. John? No.

DR. DEAN: Maybe this is obvious, one of the things that makes this even more complicated is the whole issue of what the enrollee or the consumer views as quality and what we, as sort of the professionals, view as quality may be very different things. There is a data that show that if you ask people where they had a good experience, they'll give you one thing. If you evaluate that care from a technical point of view you may get a very different result. But they're both important. They are both crucially important. And how you merge those two measurements in a way that has some -- that will move us forward is a very difficult thing.

MR. HACKBARTH: I agree with that and I've always been, as a result, a bit ambivalent about the inclusion of satisfaction data in a pay-for-performance program. At one level, of course, patient satisfaction is important. And I think it's especially important when you're talking about satisfaction with the clinical activities and the access to physician and that sort of stuff, as opposed to satisfaction

with the plan, health plan features.

But right now we have a system in Medicare where there is ample reward for plans providing satisfaction in terms of free choice of provider and more benefits. That's what we're paying for right now. The problem the current system has is it doesn't reward excellent clinical performance which may not go hand-in-hand with high satisfaction results.

And so I've always felt, as I say, ambivalent. I think that to have both included in a pay-for-performance program could actually dilute what you care most about, the clinical performance, and sort of have a double reward for the stuff that's easy for patients to identify for themselves and they reward by voting with their dollars and their feet.

DR. KANE: But some of it's related to how fast the phones are answered or whether you got access to -- some of it's access information about how fast you get appointments.

MR. HACKBARTH: And those are things that patients pretty readily can figure out for themselves and they reward with their dollars and their enrollment decisions. Where

patients are less able to discern is often the clinical activity.

DR. KANE: Clinical if you can't access to the doctor. How long do you wait -- some of those satisfaction things are around how long did you wait on the phone.

MR. HACKBARTH: [off microphone] To experience them directly. They're visible. [inaudible.]

MS. BEHROOZI: People who aren't in the plan yet, who want to choose a plan.

DR. DEAN: But it also affects compliance with the things that we recommend. Some of it just convenience and those kind of things. But it also is going to have an impact on outcomes because even we can recommend all the right things. But if we do it in a rude manner or whatever, they're not going to do it. So everybody's wasting their time and money.

DR. REISCHAUER: [off microphone] We don't want to measure it twice.

MS. HANSEN: Glenn, if I could also weigh in on this, I do think that there are a lot of misunderstood access issues that perhaps whether these measures are the right measures in that way. Something has to be done. I

believe there is a not-for-profit organization called Health Grades that tries to bring this a little bit more together. Whether or not it's the best tool, but it's the concept of trying to merge these two in a way that brings some evidence-base side to it.

If we maybe could take a look at how to get to that, as you say not to discount it but understand what relevance it does mean to quality.

MR. HACKBARTH: As I say, my overwhelming feeling is one of ambivalence about this. I think it's a complicated issue to try to figure out exactly what you want to reward through a pay for performance. I think there are certainly patient elements of that. I just want to be clear about that. But I worry about just simply do CAHPS, which is a blend of different types of satisfaction measures and then weight that equally with clinical performance and you've got the optimal several measures? I'm not sure that's the case, is my point.

DR. STUART: I'd like to reiterate the potential payback that you could get from analysis of access to care data in the MCBS. Much of it is related specifically to MA plan questions in terms of did you get the right information

from this plan? It's not based on NCQA so you can't make that crossover. But by golly, there's more information in that database than any other source of information that I'm aware of.

MR. HACKBARTH: Okay, well done, Carlos. We need to move ahead.

Next, Jennifer is going to present on special need plans.

MS. PODULKA: Good morning. I'm here to continue our discussion from last month about Medicare Advantage special needs plans.

Special needs plans were added as a type of MA plan by the 2003 MMA and they are paid the same as other MA plans and are subject to the same requirements. The only differences are that all SNPs must cover the Part D drug benefit and they are allowed to limit their enrollment to their target population. This authority will lapse at the end of 2008 unless the Congress acts to extend it and SNPs targeted population includes three types of beneficiaries: those who are dually eligible for Medicare and Medicaid; those who reside in an institution or in the community but are nursing home certifiable; or the third group are those

who are chronically ill or disabled.

There are aspects of SNPs that raise concerns. We are concerned about the lack of Medicare requirements designed to ensure that special needs plans provide specialized care for their targeted populations and SNPs' resulting lack of accountability. This raises questions about the value of these plans to the Medicare program. For example, dual eligible SNPs are not required to coordinate benefits with Medicaid programs and many dual eligible SNPs operate without any state contracts.

Since they were introduced, SNPs have grown rapidly both in number and enrollment. Currently there are more than 400 SNPs and if all applications are improved next year there will be more than 700. By, by 2008, 95 percent of beneficiaries will live in an area served by a special needs plan. Currently, SNP enrollment has grown to more than 1 million.

Organizations that have entered the SNP market include those with specialized experience with Medicaid and special needs population but also include plans without this experience who have chosen to recently add SNPs to their menu of plans. A question is whether this represents a

marketing strategy or a real investment in providing specialized care to targeted populations.

This is a bit of catch-all but I thought there was a few things that you should know. First, all SNPs are required to be coordinated care plans. And SNPs, along with employer-sponsored plans, were the only source of MA enrollment growth in local HMOs and Medicare between 2006 and 2007. I say this because this may be encouraging news, given the Commission's concerns about growth in less managed forms of MA plans. But on the downside, of course, this means that SNPs also receive the same additional payments as all MA plans.

Second, SNPs 2006 benchmarks and payments relative to fee-for-service are similar to regular HMOs, which I'll show you more on the next slide.

Third, one possible explanation for rapid SNP growth is that the risk adjustment system, which was fully phased in just last year, is not working like it should. First, it could lack precision in predicting resource use because it's based on a finite number of diagnoses, and there are degrees of variation within these. Or secondly, it might not accurately track relative resource use in a

managed care population.

To the extent that there is a problem with the current risk adjustment system, it would affect all MA plans and not just SNPs, and we will continue to evaluate this.

As I mentioned, SNPs' benchmarks and payments relative to fee-for-service look really good. They are similar to HMOs, as opposed to the private fee-for-service plans on the bottom line.

Which brings us to the overall question. SNPs, or at least their authority to limit their enrollment, expire at the end of 2008. The question of whether to allow them to continue comes down to whether SNPs need to limit their enrollment to do something special. In other words, can whenever SNPs do be accomplished just as well by regular MA plans?

A key motivation for creating SNPs still applies to allowing them to continue, and that is providing a big umbrella to cover all special types of plans and demonstrations. If CMS authority ceases, then some existing SNPs could change into regular MA plans. They wouldn't necessarily have to stop operating. Other SNPs could revert to or apply to become demonstrations. Of course, is would

mean that CMS or the Congress would need to continually reapproved these types of demonstrations and any new projects that wished to implement lessons learned from these would also need to apply.

If SNP authority is extended, then SNPs should be expected to provide specialized care for their enrollees that regular MA plans cannot provide as effectively or as efficiently. SNPs may be able to tailor unique benefit packages that allow them to provide more efficient, higher-quality care through specialization. However, there are SNPs that clearly do not meet the standard. Given that the MMA language that authorized SNPs was very general and CMS has done little to further focus SNPs, we suggest several aspects of the plans that should be refined if they are to continue.

By refining what we expect of SNPs in several key areas, we can help to ensure that there is sufficient oversight of these plans and that they serve their enrollees efficiently and effectively. The draft recommendations that will follow hopefully incorporate what we've learned from numerous discussions with stakeholders. But before I get into the SNP-specific recommendations I'd like to remind you

that SNPs are an MA plan type and therefore all the commission's MA recommendations apply to them such as the ones on payment and quality. And specifically on payment, remember that as long as Medicare continues into to overpay MA plan times, any extension of MA such as SNPs carries a budgetary cost. Some of the following draft recommendations may, in part, mitigate this cost but any extension bears that cost calculation.

Oh, and one other thing. These have been renumbered from the mailing materials so they're kind of flipped but hopefully we can keep track.

The authority for SNPs to limit enrollment is scheduled to expire at the end of next year. An evaluation by Mathematic Policy Research is due to CMS at the end of this year. But because most SNPs had only begun operating for a year or two by the time the study was conducted, there may be insufficient quality and other data on which to evaluate them. In light of SNPs' rapid growth in number and enrollment, we want a rigorous evaluation of SNPs upon which to base our decision before recommending that they be made a permanent MA option.

Therefore, draft recommendation one is the

Congress should extend the authority for special needs plans that meet the conditions specified in recommendations two through eight for three years. It should also require the Secretary to evaluate the plans on the basis of specialized and general performance measures, use of a health advisor or care coordinator, the health status of beneficiaries or risk adjustment, and any other criteria that the Secretary considers appropriate, and report the results within that time.

All SNPs hold the potential to improve care. However, the current evaluation will not give us enough data to assess these plans. Additional quality indicators, state contracts, and narrowed definitions of chronic diseases will improve oversight of these plans and we would like to reevaluate them when they meet these criteria before deciding whether they should become a permanent MA option.

In other words, the Secretary would need to implement all new rules, collect performance data from plans, evaluate their performance, and report the results within the three year time period. And this would inform future decisions about extending SNP authority.

A note about the spending implications here. I

will present on this slide the spending implications and that applies to the entire package. It's not necessarily just a straight extension, but the extension with the other recommendations. I can talk more about that on question.

So the spending implications are that it will increase Medicare spending relative to current law by $50 million and $250 million for 2009 -- the first year it would take effect -- and by less than $1 billion over five years. The beneficiary and plan implications are that the beneficiaries could continue to be enrolled in and plans could continue to operate during an additional evaluation period.

SNPs must measure and report the same quality measures as other MA plan types. If SNPs need to limit their enrollment to a target population to provide specialized care, then the quality of that specialized care should be measured by appropriate measures.

So draft recommendation two is that the Congress should require the Secretary to require special needs plans to report additional, tailored performance measures and evaluate their performance within three years.

The recommended performance measures should

include quality, resource use, consumer satisfaction, and any other aspects that the Secretary deems appropriate. Examples of these measures include those currently being developed by NCQA and CMS specifically designed for SNPs but might also include RAND's ACOVE measures which are designed for health problems specifically affecting seniors. All SNPs should be evaluated on some additional measures. While there are other measures that should be specific to SNP types, for example there are ESRD SNPs, and we would like to see these evaluated on the same measures applied to the ESRD demonstration so that we can get a comparison. All of these measures, together with existing measures that compare SNPs to other MA plans, should form the basis for a rigorous evaluation that would have decide whether SNPs should become a permanent MA option. The performance measures should be established, plan's performance on them should be evaluated and the Secretary should publicly report the results within a three-year period.

The implications are that beneficiaries should receive improved quality of care while plans would have the burden of reporting the information.

We are concerned that an existing lack of clear

information is an impediment to beneficiaries learning about and making an informed decision on joining a SNP. Because the CMS website template is structured to compare all MA plans in a consistent manner and CMS has not restructured the template to reflect SNP offerings, these plans are often not accurately describe. For example, the Medicare Compare website shows cost-sharing requirements for dual eligible SNPs that charge no enrollee out-of-pocket cost-sharing because it's paid for through state Medicaid programs.

So draft recommendation three is that the Secretary should provide accurate information on special needs plans that compares their benefits and other features to other MA plans. This information should be furnished to beneficiaries through the website and written materials.

The comparative SNP information could be included on the Medicare Compare website, for example as a drill-down option. However, because the majority of beneficiaries do not directly use the website or visit counseling programs that have used it, written comparative SNP information should be mailed to beneficiaries annually.

The implication is that the recommendation would improve beneficiaries' ability to make informed choices will

having minimal impact on SNPs because this information is already collected on the plans' benefit package they submit each year.

On draft recommendation four here, I believe Glenn has some comments but I'll set this up and you all can discuss it during the discussion period. If SNPs are allowed to limit their enrollment, then they should better manage the care of their enrollees than a regular MA plan. Linking enrollees with an individual responsible for coordinating their care would be a minimum step toward managing care and also allow CMS it quantifiable measure to collect during a survey.

So draft recommendation four is that the Congress should require special needs plans to link all enrollees with a personal health advisor or care coordinator and the Secretary to evaluate enrollees awareness of and satisfaction with this service within three years.

CMS should determine standards for who can qualify as a health advisor or care coordinator, for example a primary care physician, nurse, or social worker, and set standards such as minimum ratios of advisers and coordinators to enrollees. The nature of this care

coordination may differ by SNP type. For example, dual eligible SNPs might rely more on social workers to coordinate benefits than on medical personnel.

CMS should then survey SNP enrollees about their awareness of and use of their personal health advisor or care coordinator. Again, these data should be collected, evaluated, and reported within the three year time period.

Implications are that beneficiaries should receive improved quality of care while some plans, at least, might have to hire staff to perform this function. However, we've heard from a number of plans that they already use this and so the burden on them would be merely reporting.

Most SNPs limit their enrollment to their targeted special needs population exclusively. However, SNPs may apply to CMS for a waiver from this requirement to enroll any other beneficiaries as long as their total membership includes a disproportionate percentage of their targeted population. CMS has defined this so that the percentage of the target population in the plan must be greater than the percentage that occurs nationally in the Medicare program. Although there may be legitimate reasons for SNPs to enroll other beneficiaries, for example to allow members who

temporarily lose eligibility to remain enrolled, these exceptions should be limited and the current definition may be too liberal and untargeted.

For example, CMS has already made specific accommodations for beneficiaries who move in and out of Medicaid eligibility by letting plans know that they can continue to enroll them for several months.

So draft recommendation number five is that the Congress should require the Secretary to report annually on the number and circumstances of special needs plans that are granted a waiver to enroll a disproportionate share of their target population and to require them to enroll at least 95 percent of their members from their targeted population.

We would expect plans to report on the use of the waiver and CMS to report on the waivers it has granted on an annual basis, and in its evaluation of SNPs, to be completed within the three year time period.

Implications are that some plans would either have to alter their enrollment or cease to be SNPs. They could, however, return or continue as regular MA plans. As a result of any plans shifting or changing, relatively few beneficiaries would have to switch plans or return to fee-

for-service and we think that any changes now could prevent larger changes and disruptions in the future.

Chronic condition SNPs are broadly defined. Not all chronic condition SNPs may be sufficiently specialized to warrant formation of delivery systems and disease management strategies. For example, there is a chronic condition SNP for beneficiaries with high cholesterol, which might be important to manage but it is a condition common enough that one would hope that all MA plans can effectively do so.

Therefore, draft recommendation six is that the Secretary should convene a panel of clinicians and other experts to create a list of chronic conditions and other criteria appropriate for chronic condition SNP designation. Chronic condition SNPs must serve only beneficiaries with complex -- this would be the recommendation -- with complex or advanced, late stage, chronic conditions that influence many other aspects of health; have a higher risk of hospitalization or other significant adverse health outcomes; and requires specialized delivery systems.

The list mentioned in the recommendation and any other criteria should be issued as a proposed rule with

comment and final rule within a three-year period, again to inform future decisions about continuing SNP authority.

Implications for beneficiaries should be minimal, however some plans may have to change their targeted conditions or cease to be SNPs. Again, they could return to the regular MA program.

Although they were intended to coordinate Medicare and Medicaid, dual eligible SNPs are not required to coordinate benefits with Medicaid programs and many dual eligible SNPs operate without any state contracts. Without a state contract to cover Medicaid benefits, it is unclear that a dual eligible SNP would behave any differently than a regular MA plan. However, based on our discussions with SNPs that do have a contract, it may reasonably take several years to establish one. Ideally, contracts would cover long-term care but we recognize this may be difficult as few SNPs with state contracts have taken risk for this high-cost service.

Therefore draft recommendation seven is that the Congress should require dual eligible special needs plans to contract with states in their service areas to coordinate Medicaid benefits within three years. The Congress should

require dual eligible special needs plans to limit enrollees' out-of-pocket cost-sharing to no more than Medicaid cost-sharing and bids should reflect actual negotiated rates and cost-sharing.

I want to note that recommending that all dual eligible SNPs should contract with states within three years means that by 2012 all existing and any new dual eligible SNPs could only begin operating as a SNP if they started with a contract in place.

Implications for beneficiaries are that they should enjoy greater coordination of Medicare and Medicaid benefits if they're enrolled in a plan. For plans, if they are unable to contract with the state, there would be a significant impact in that they would have to cease to be SNPs. However, they could continue as regular MA options.

Last one. I want to note here that this applies not just to SNPs, but to all MA plans, so it's somewhat unique.

Special needs beneficiaries have more opportunities to join or switch MA plans outside of the open enrollment period than regular beneficiaries. Dual eligible have a special election period which begins when they become

dually eligible and continues as long as they remain dually eligible. As a result, they can change plans on a monthly basis.

Presumably, dual eligibles were excepted from lock-in to give them greater protection than other beneficiaries. However, we find that the provision has had unintended consequences.

We are concerned about reports of marketing abuses directed at dual eligibles. One consequence of these is that beneficiaries can find themselves enrolled in MA plans, not just SNPs, where they are subject to much more cost-sharing than they would be under fee-for-service. And another consequence is that beneficiaries can be subject to month-to-month churning among plans, harming continuity of their care if their providers do not participate in each plan that they enroll in.

So draft recommendation eight is that the Congress should eliminate dual eligible beneficiaries' ability to enroll in Medicare Advantage plans outside of open enrollment, with the exception that they are allowed to disenroll and return to fee-for-service at anytime during the year.

The implications for beneficiaries are that they would receive greater protection from plan marketing abuses and it may have a significant impact on plans by reducing plan enrollment.

Those are the recommendations and I look forward to questions and comments.

MR. HACKBARTH: Nice job, Jennifer.

If I could, I'm going to go back to recommendation four. Jennifer mentioned that I had expressed some reservations about that. Before I go into my reservations, let me just say I support the overall thrust of the recommendations, which is to make sure that special needs plans have some content and substance and are truly useful to Medicare beneficiaries.

On draft recommendation four, which is the one requiring SNPs to link enrollees with a personal health advisor or care coordinator, I'm sympathetic with the goal. I think that the concept is a sound one. My reservation has to do with making it a legislative or regulatory requirement.

My own take on how this program should work is that we should have payment policies that basically require

organizations to be efficient in order to be successful, and then we ought to complement that with significant rewards for providing measurably better quality. And then we ought to leave it up to the organizations to figure out the best way to achieve those ends and not dictate particular organizational structural requirements because I think that there are potentially multiple different ways. And that's where the private sector can and should be left to innovate, as opposed to that being a government mandate.

I worry in particular that a requirement like this, of a personal health advisor or care coordinator, you run the risk that on one hand you either make the regulatory requirements so general that it becomes meaningless and is strictly formalism or alternatively you try to put real teeth in it and you become unduly restrictive and the message is we know the right way to do this when, in fact, there may be multiple right ways to do it.

And so rather than get into that business, the formalistic structural business, I would again say that the right thing for us to do is have payment systems that reward good results and let plans figure out how best to achieve those results.

DR. DEAN: On that particular point, as they were going over this, it brought to mind a patient of mine who just enrolled into the special needs plan we have in our area, which is a cardiovascular special needs plan. He gets part of this care from the VA, he sees me regularly to check his protimes and manage his heart failure and his anticoagulation. And he's happy as a clam with his new plan. It's given him a bunch of benefits he didn't have before.

But conceivably, if this applied, you would add yet a third directive. And here's this poor guy trying to do what the VA tells them, trying to do what I tell him, and also trying to do what this new person tells him. And I think we really don't gain anything. So I think it supports your point.

MR. HACKBARTH: Other comments on four? Why don't we just focus on that for a second.

DR. REISCHAUER: Glenn and I agree on this one but there has to be a conforming change to recommendation one, as well.

MR. HACKBARTH: Okay.

MS. DePARLE: I agree on this point but I do think

-- and I'm sitting here struggling given what Tom just said. We have said that we advocate something like a medical home, not just for chronically ill beneficiaries who are enrolled in Medicare Advantage plans but for all of Medicare beneficiaries. And so I'm sympathetic to the thinking behind this recommendation because I think that's part of what it was trying to achieve. Maybe there are multiple ways to achieve it. I'm thinking about your patient, Tom. I guess you're his medical home, which is fine.

DR. DEAN: I hope so.

MS. DePARLE: And that's good. But this is one of those things that is harder to do than it is to talk about.

I do think there is this idea that I've heard about requiring each of the special needs plans to do an individual plan for each of the patients that enrolls. Again, that may be one of those things that seems obvious, and of course they're doing it, but they're not. I would at least support having that, if not in the text, if not in the recommendation at least in the text, that that's one way of doing it. This might be another way. There are several ways to accomplish it.

DR. DEAN: I would say that I think we can't

assume that these people are living in a vacuum right now. They're all getting something somewhere. And I think some sort of a requirement, and what you said may well be -- it needs to fit with and improve upon what they're currently getting. But there's going to be a huge spectrum. Some of these folks are getting good care and some are getting no care at all.

If they're not getting any kind of coordination, then this requirement applies well.

So some kind of individual plan, I think, would make a lot of sense. Whether you could push the companies to do that, I don't know. That would be a big headache.

MR. HACKBARTH: Just to be clear, and pardon me for pounding on this, if I were running a plan I may well elect to do this. That's not the issue. The issue is whether regulation will be an effective tool for accomplishing the end.

So let's focus again on recommendation four.

MS. HANSEN: Having run a plan, I do concur that there are ways to do it and that I would lean on what Nancy-Ann just had to make sure that there is a real dedicated focus for an assessment as to how they do it. Because it

could be electronic record at this point to do it, to the complex of have really having a personal adviser. But that's really the judgment of the administrator being responsible for outcomes. And hopefully then the incentives for rewards would be tied to that. And so the whole question is how big the reward is and that's a different issue.

But I think the method of proscription would be a little bit too tight here.

MR. BERTKO: Just quickly, Glenn, to agree with what you said and to pick up on Nancy-Ann's suggestion for a care plan, that might fit within recommendation six well enough. That is you have certain ones that people have looked at and said in the text around that and this should include a care plan, which could be fairly generally like Jennie has described.

DR. SCANLON: I, too, have concerns about four being too specific. But at the same time I think we have to have something that suggests that there is some type of process or structural requirement to be a SNP. One of the things that we've gone from -- the history is we've gone from demonstrations, where possibly there was a model

specified in terms of getting a waiver that this is something that they were going to do. And in moving to the broader authority, we've said we don't ask you to do anything special. And the world in which we're going to reward results of the payment system is a world of the future. And we've got close to 800 SNPs for 2008. And I think we've got to think about is in that context.

In that context, I don't want to structural or process requirement should be but I think there needs to be something that we can hold people accountable immediately, as opposed to at some sort of future point.

DR. MILSTEIN: Along these lines, is recommendation two strong enough? In other words, recommendation two indicates that we recommend there should be some additional evaluation of these plans. Along the lines of what Bill was just suggesting, should we consider strengthening recommendations such that we signal that we believe that on quality measures that are common to regular MA plans and special needs plans, that for the populations that special needs plans have elected to serve, the special needs plans' performance ought to be significantly better then is the performance of regular Medicare Advantage plans

treating those same populations, since those populations are not only in special needs plans.

I hope that was comprehensible.

The right now it just says the Secretary shall additionally evaluate. But I personally think it might be a point to consider a stake in the ground and saying you actually have to do better on the population --

MR. HACKBARTH: So recommendation one is a time-limited extension coupled with evaluation. And so what I'm hearing Arnie say is as opposed to focus on structure, focus on results and say this program should only be reauthorized beyond that if these plans are demonstrating superior quality.

DR. REISCHAUER: Yes, but there's a lot of different dimensions to better. And one is clinical measures. Another is sort of ease of patient processing. Some of it's amenities. It could be all sorts of cost-sharing dimensions.

I'd hate to be the analyst who was forced to come up with the aggregate measure of better.

DR. MILSTEIN: Glenn, I think your idea I would support. But I was also thinking about whether it could

denominated on a plan specific basis, so that the continuation forward into the future would only be allowed to those plans that actually did better and then perhaps leave it to some poor analyst in the Secretary's office to figure it out.

DR. SCANLON: It's more than the poor analyst. It's the lawyers for the Secretary, too, that are going to have to litigate this because they're going to be challenged at every turn.

I guess the concern I have here is in terms of the extension and making the extension conditional is that we need to deal with the reality. You've already got 800 plans out there. And in some respects, it's a little bit like once you're there it's very hard to dislodge something. And if in three years we have 1,200 plans out there, it's going to be hard to come back with -- and while Arnie is right, in terms of they should have done something better, if they haven't done something better or if it's ambiguous whether they've done something better, it's going to be hard to say we're not going to extend this authority anymore. So I think we need more about requirements now.

MR. HACKBARTH: Certainly, we have ample evidence

in the Medicare Advantage program of momentum that's very difficult to reverse, although this may be a little bit different in that the loss of SNP certification, if you will, would not mean you go out of business or everybody's disenrolled. You just become a regular MA plan with the same rates.

DR. REISCHAUER: Most of them have a parent already. They're just a spinoff of something that already exists.

DR. SCANLON: But then why are we even debating this? It's kind of like why is there a spate in terms of reauthorization? The issue on our part should be the whole idea of trying to get something special.

On the other side of the coin, though, I think that the year-round marketing makes a huge difference in terms of the attractiveness of this. And I don't know, those who know plan operations better can tell me that there's something else that makes it attractive. But I know that there's an interest in continuing this authority. And the question is why? Why have we had such unusual interest? This was all so unexpected, that we would have had such intense interest on the part of the SNPs.

MR. HACKBARTH: Let me try to get some other people involved.

DR. WOLTER: I was starting out by just reacting to this recommendation but then I got a couple of other thoughts listening to all of this. I sort of agree not to mandate something like this.

Having said that, it's very clear that with these complex chronic disease patients -- which another recommendation addresses -- the care between the doctor this is what makes all the difference. And so some robust text discussion of chronic disease management and the infrastructure that's required to do it well is going to have a lot of value, which would connect back to the work we did a few years ago on chronic disease management. I think it was Karen Milgate that did that work.

And if you remember, we had some recommendations there about organized practices versus sort of virtual groups. But in both cases, there were ways for nurses and others to be sure that the care was being very well managed between physician visits.

And there's the Wagner chronic disease management model. This really isn't rocket science. I don't think

we're doing something ephemeral here in these recommendations.

As far as outcomes, you could look at remission rates, you could look at admission rates. There are tremendous things that we could be looking at. These plans can have a lot of value, both clinically and financially, if the appropriate structure is put on them. So this is really a good direction, maybe we can just flush it out a little bit more and connect back to some other work we've done in the past.

MR. HACKBARTH: So you're proposing to keep recommendation four or drop-it but beef up the textual discussion of --

DR. WOLTER: I'd be fine with not -- requiring this, you could meet this in some rote way and not necessarily be doing all the right work. But I think to point out that chronic disease management infrastructure and the management between visits that nurses and others do is really where the action occurs in terms of both dollar savings and better -- there's the SF6 and 12, the functional status things. There are measurements we could put in place that would tell us how well these plans are doing.

MR. HACKBARTH: Let's try to sum up on this particular one. I expressed my concern. It's not the end of the world to me one way or the other. And I'm happy to go where most of the group wants to go on it.

Can I just get a tentative show of hands, sort of a straw vote, not an official vote, on whether we want to keep this one or not?

DR. SCANLON: What about an alternative?

MR. HACKBARTH: Let me just ask about this one as worded and if there's not broad support for that, then we can talk about an alternative. Who would like to see it kept pretty much as it is? Nobody?

Go ahead, Bill, offer your alternative.

DR. SCANLON: The alternative is I think, going along the lines of what Nick was talking about in respect to the text, which is to say that we really want something real in this plan. And I don't know whether it's care management, care coordination, which is a process but it's not as specific as this one the way the wording is now. And I don't know what the right words are but it's along the lines of we really want there to be some kind of management.

MR. HACKBARTH: Unfortunately, we're at the point

were we need the right words.

And incidentally, I agree with Nick. That's just assume that we need to beef up the textual discussion as part of it and try to focus on what the wording of the recommendation is.

MS. BEHROOZI: This is one of those Nancy-Mitra things, I heard Nancy just say it aloud, that we require that they identify with their plan is, what their management plan -- is the words that Nancy used -- would be, whether it's doing assessments and care plans, whether it's having an individual care coordinator medical home kind of model. And then somebody has got to have the authority to deem that acceptable. But at least to make them come forward with something. How about that?

DR. REISCHAUER: The question here is do they have to do it for each individual --

MS. BEHROOZI: Yes.

DR. REISCHAUER: -- or a general strategy?

MS. BEHROOZI: Yes.

DR. REISCHAUER: And I think each individuals is where all are.

MS. BEHROOZI: Yes.

DR. REISCHAUER: But have it rather vague exactly what it is.

MS. BEHROOZI: Right. So they have to have a plan of how they will do that for each individual, yes.

DR. KANE: I like the idea of having that as part of six, as among the criteria that you have to meet this is one of the criteria, that you have to have a care plan for every individual.

MS. PODULKA: Six is only specific to the chronic condition SNP, so that would be excluding the other two types.

DR. KANE: We may want to talk about that, too, when we get to targeting.

DR. MILSTEIN: I spent seven years trying to enforce Federal structural requirements in health care delivery and the plans are -- I completely agree with the idea of a plan but I don't think it's enough. I think something along the lines of a plan and a mechanism for rapidly detecting and responding to deviations from plan would make -- because plans of care are everywhere to be found. It's the ability to react quickly when actual course of care deviates from plan that is missing.

MR. HACKBARTH: I agree with that, Arnie. And recommendation two is the one that's directed towards implementing a set of specific measures that allow us to detect whether, in fact, they're doing something better or not.

DR. MILSTEIN: But suggesting that the requirement be -- that you not only have a detection system but documentation that you respond quickly when your measurement system suggests deviation from plan.

MR. HACKBARTH: Mark has a solution to this.

DR. MILLER: No, no, no.

[Laughter.]

DR. MILLER: Although just before I say this, I think one concern raised at the outset of this is do you end up saying things that end up being unenforceable? So I think as much as we want to say all of this, we really have to think about how much it can be executed.

But trying to build something from what is said, instead of making it congressional, direct it to the Secretary. It's a regulatory requirement. Put something out in notice and comment that has two components. You have to have an individual care plan. And in submitting their

application to be a SNP, they also have to describe and articulate how they will do coordinated chronic care management within their model specifically as one thing that they have to talk about and hurdle that they have to pass to be approved. And take it out of the Congressional thing.

But I think there's also the caveat at the onset of what does that really mean and how enforceable?

DR. REISCHAUER: Can I suggest that the plan has to be shared with the patient? That creates a certain enforcement mechanism right there.

DR. STUART: This is really quick and it gets back to the fact that the Commission is seeing these recommendations today. These are different from the ones that we had in the written materials.

And I think that in the interest of time, we're not going to get the wording of these things today. But if Mark and his staff could put together the basis of a new set of these things after we get a chance to discuss a couple of other of these recommendations. Because I think some of this is going to migrate from one recommendation to another.

MR. HACKBARTH: We can do that but just to remind

people, the original goal was to have recommendations for final vote at this meeting so that we could make our position known on this to the Congress.

DR. MILLER: Draft recommendations today.

MR. HACKBARTH: I'm sorry, I was thinking we did these draft at the last meeting. Okay. We do have additional time.

DR. STUART: I'd like to bring up item six because this is, I think, tied in in terms of these are the folks that you want to do it to. And I recognize the reason for this recommendation is that I think it was triggered by the SNP that was given authorization for lowering lipid levels. And we don't want to see somebody come in with a dandruff control SNP.

However, I am concerned about the language here, about -- it implies that the only people that can be brought into these plans are train wrecks. And I would think that what you really want to do is to capture some of these individuals before they become train wrecks. So I'm thinking, if I had a SNP that was focused on diabetes, I would not want to limit it just to the people that were diabetic and amputees. I'd want to get the people who were

at risk for these bad complications and it to show how, in fact, we could reduce the rate of complications over time.

Now maybe this was your intent. But depending upon the wording here, it doesn't come through. And so perhaps the way to do it would be to limit the SNPs to conditions for which there is a high risk of complex and expensive outcomes.

DR. REISCHAUER: The "late stage" words here, given Nancy's --

MR. HACKBARTH: So everybody see where we are on six? That sounds like a sensible modification.

MS. PODULKA: We've heard from anecdotes that without the advance or late stage -- advance or late stage is an "or" to complex. That the complex by itself, complex and risk of adverse health outcomes would actually apply to hyperlipidemia. So if you have high cholesterol, it's a complex condition that can affect many other aspects of the health and eventually lead to adverse health outcomes. We've really struggled with how to capture diabetes, even perhaps some early-stage diabetes, without letting in someone else, dandruff control.

DR. REISCHAUER: Wasn't the Secretary having a

panel that was going to look to see what conditions were really applicable, and so the dandruff and high cholesterol would drop out?

MR. HACKBARTH: I think this is maybe, in particular, an example of where it would be difficult for us to craft the magic words. And I think it's the sort of thing that a group of experts ought to draw the boundaries around.

I thought the issue around high cholesterol was not that it couldn't have important health implications but rather that it's so common that it really doesn't define a special needs population and all Medicare Advantage plans ought to be capable of addressing such a common medical problem.

And so part of it is the potential for severe consequences for the patient, but also part of the test is prevalence. Some things you don't need specialized organizations for.

DR. KANE: Requiring specialized delivery system could help get rid of that, too.

MR. HACKBARTH: I feel so much better that we don't have to resolve this today.

[Laughter.]

MR. HACKBARTH: I'm not depressed anymore.

[Laughter.]

DR. REISCHAUER: Then you can't join our depression SNP that we have.

MR. HACKBARTH: So we'll work on that language. Could I ask that we just go back through them in order, as opposed to jumping around? I think we'll be able to work more efficiently that way.

Let's focus on number one. In the interest of time -- I'm going to go want one, through the package. I started at four, and I apologize for that. But now I'm going to do it right and go through one by one.

What I'd ask is that if your comment is basically editorial in nature, I'd like to change the words a little bit, let's do that off-line through e-mail or something else and reserve this time to focus on major substantive problems that people have with the recommendations.

So draft recommendation one.

MR. DURENBERGER: This is a general comment but for the last 40 minutes I've been having a déjà vu moment which is, for 25 or 30 years now I've been listening to this

sort of discussion. And it's usually -- I could also call it a Republican moment where Henry Waxman is on the other side of the table and he's saying we've got to have a health and we've got to have this and he's reciting. That's the moment I've been having.

The concern that I have, I think, is that we're AFLAC-ing -- to use a common term -- quack, quack, quack. We are AFLAC-ing a very precise condition on the part of people. While we have a Medicare Advantage policy or program that we are not really confident has been prescriptive enough in the folks that generate it. It may be somewhat off-base and I'm glad, too, we have a month to think about it. Because before I vote for this, I'd really like to go back and focus on why we can't suggest that the Medicare, the general Medicare Advantage program consider a way in which benefits designed specifically to prevent institutionalization and prevent chronic illnesses and so forth. But when they do occur, and so forth, and we have disease management and we have other things.

And I don't know what I'm talking about, except I really think that going back and focusing on the basic Medicare Advantage program, what kind of benefits structure,

what should the performance expectations be? And within that, deal with dual eligibles and institutionalized and severe chronic illnesses, is better than opening up the gate again to AFLAC-ing 722 different versions of AFLAC and it will be 1,400 around the specific conditions.

I'm hope I'm wrong about that and I'm only sharing an instinct that's built up over a few years of watching this sort of thing at work. So I'll try to get over that in the next month, but it makes it difficult for me right now and I need to express it to vote for that recommendation.

DR. STUART: This is, in a sense, a technical issue but I think it has some potential impact in terms of the likelihood of these recommendations being adopted. That's the savings estimate. Because on the one hand I've heard that if the SNPs are not reauthorized, then the companies can simply fold these people into their regular MA plans. And if they fold them into their MA plans, there's no savings, there's no extra cost.

And so if this cost is specific to the SNP, then I think it overestimates the saving or the additional cost that would be associated with having the SNP provision.

DR. MILLER: Unless I'm missing something,

Jennifer, the estimate assumes how many people go back into plans and how many just drop back out into fee-for-service?

MS. PODULKA: [Nodding affirmatively.]

MR. HACKBARTH: And here we're working from the CBO estimate?

DR. MILLER: We've consulted with them on the magnitude here, right. The reason that it has a cost is because in current law there is a sunset to this. And so some people would drop back into fee-for-service and therefore their cost would go down in the baseline. But if you continue them, they won't drop back and that generates the cost.

If somebody could just nod, like a Scott or a Jennifer.

MS. PODULKA: [Nodding affirmatively.]

MR. HACKBARTH: At the end of the day what matters is what CBO thinks on these things and not what we think.

DR. MILLER: Right, there is that.

MR. HACKBARTH: So anything else on recommendation one?

MS. DePARLE: I said this earlier. I would support a longer timeframe of extension, like five years or

even four years, in part because I think the list -- you have to balance the urgency of doing something on this against the realities and the practicalities.

As my friend, Dr. Scanlon, often reminds us, trying to get all of this done and the amount that we're asking the secretary and CMS to get done. And also relating to comments I'll have on some of the other recommendations, given the discussion this morning about the relative lack of progress we seem to be making with quality and Medicare Advantage plans overall, I hope -- this should be the laboratory, to me. SNPs should be the laboratory for what can we really achieve with this population. I hope somebody of the performance measures would be outcome related, as my friend Arnie keeps saying, as opposed to just -- so that will take more time.

MR. HACKBARTH: Pardon me for being -- for truncating the discussion here. I think Nancy-Ann has raised a reasonable issue and clearly expressed. Rather than having a prolonged discussion about it, I'd just like to see a show of hands. Who would like to keep it shorter, let's say at three years and leave it as it is?

And then who would like to see a longer period?

So it's a significant division. So four years is obviously the right answer.

[Laughter.]

DR. REISCHAUER: There's no requirement that after three years you have to make them permanent or not, as opposed to say we had a lot of progress going on here, let's do it for another three years. It's unlikely that even within five years we're going to be completely comfortable with this organization's --

MS. DePARLE: But you want them to have the information upon which to make the decision about whether to extend or make it permanent. And I'm just expressing real skepticism about whether we can have that.

MR. HACKBARTH: We will resolve this someplace else.

MS. PODULKA: If we would like to discuss different time frames, I'm going to have to come back to the Commission with a new budget estimate. There will be a very real impact to any change in the number of years.

MR. HACKBARTH: Anything else on one?

MR. EBELER: I'm sorry. I'm just reflecting on this discussion. It seems to me the structure of one, as an

alternative, could be an extension but only for a narrower number of plans that are truly defined to meet special needs and a process of phasing a number of other plans into MA.

It strikes me that that's the policy objective we're talking about. We are really trying to divide this group a little bit. That's just a different structure.

MR. HACKBARTH: Let us play with these ideas on one.

Draft recommendation two.

MS. DePARLE: In the text, I would like performance measures to be defined as being not just beta-blockers after heart attack kind of stuff. Yes, that we get into some outcomes.

MR. HACKBARTH: That will be textual discussion. As Ron points out, obviously we'd have to make a conforming change to that duration on whatever we decide there.

Moving on, draft recommendation number three.

MS. HANSEN: This one would be as is is fine. But perhaps in the text that ties back to other ways to inform beneficiaries other than the website and kind of classic written materials. We talked about whether the SHIP other ways to make sure that again beneficiaries are going to be

informed with these kind of findings. So it just ties it back to yesterday's work.

MR. HACKBARTH: Okay, and I think we can maybe tinker with the wording of the recommendation but also emphasize that in the accompanying text.

Number four we talked about at length. Number five.

DR. STUART: I have a question in terms of why there are waivers at all. I understand that that some CMS demonstrations were given waiver status under this because they had -- their policies were such that they could enroll people other than meet these particular conditions. But I'm wondering why new SNPs would be given a waiver policy and whether, in fact CMS, is still doing that.

MS. PODULKA: CMS is continuing to grant disproportionate share waivers and that is a policy debate, to decide whether you want that to continue in the future. There are two options generally, if you want to continue it. One is to allow a certain percentage. The second is to have a list of specific exceptions, such as for spouses or for people who move in and out of Medicare eligibility. Doing a percentage is somewhat more of a catch-all than coming up

with a finite list.

DR. REISCHAUER: Jennifer, I don't know if I've misunderstood you, but I thought you said that disproportionate meant relative to that the general population. So if 8 percent were diabetics, you would qualify with 9 percent.

MR. HACKBARTH: That's the current definition.

MS. PODULKA: Absolutely correct. It's quite liberal, in some cases.

DR. REISCHAUER: Which is an interesting definition of disproportionate in the waiver. So it makes no sense at all.

DR. KANE: In a way, I don't like picking a number like 95 percent at this point, because I don't think we know what that means. I think we should say the waiver should only be granted under -- and maybe be specific about what qualifies for waivers. And then find out what that means.

But the 95 percent and looking at the -- I just feel like you're saying let's find out -- report annually on the number and circumstances of waivers. And by the way, the waivers cannot be used to get outside your target area, you have to have 95 percent targeted. Partly because I

don't know what it means and I don't think anybody does.

MR. HACKBARTH: So are you suggesting that we just go to more general language?

DR. KANE: I'm suggesting we say that they should report annually on the number and circumstances. And the waiver condition should be more specifically related to -- and whatever those conditions might be, spouses, in and out of Medicaid, or use the -- or could benefit from the specialized delivery system targeted to that population but maybe not dually eligible yet, for instance. As opposed to saying 95 percent you've got to be on target. I don't know where the 95 percent comes from.

That doesn't mean we won't get there eventually but I just don't know that means at this point.

DR. STUART: I think the waiver really undoes a lot of what we're talking about in terms of having coordinated care. Even if you've got a spouse, if this SNP is directed toward care of diabetes and the spouse doesn't have diabetes, I don't see what the point is.

DR. KANE: To me it's more that the dual eligible population. Again, if you have a specialized delivery system for people who are Medicaid eligible and Medicare,

there are the people who might also use that specialized delivery system. And maybe what you're saying is make that a chronic disease SNP instead of a dual eligible.

MR. HACKBARTH: Let's not try to resolve the exact language right now. I think people are sympathetic with the goal that these plans ought to be targeted on people who will benefit from them. And maybe the best thing to do is avoid specific numbers or specific types of exceptions and stick with a broader statement that emphasizes that and then have some accompanying text that elaborates on our view.

DR. MILLER: I know you want to move on. There's not a way to be really dispositive on this, like these people. What I think we've done is we've talked to a lot of SNPs, people in the industry, the Agency. There's decidedly some interest in getting guidance out there on this, that this is a problem and wish that somebody would stand up and make a statement about it.

The 95 came from the line of thinking -- and this is not airtight logic. You kind of start with the 100 percent, why are we making any exceptions? The cases that we run across seem pretty unique and unusual but not necessarily to say you can only do it in these circumstances

and then miss something. And I think that's what brought us to the -- give them some small degree of play, put a strong word out there we're -- really this is 100 percent, really. And that, I think, is the line of reasoning here. And then try and get behind what is going on.

I think if we end up with language, gosh we should do this, I think there won't be a lot of drive to kind of correct the current situation.

That's the only thing I would say.

MR. HACKBARTH: Well presented. What's the reaction to that? Stick with 95...

I'm seeing a number of nods. Who would like to stick with 95? I want to get done here.

Okay, we're done.

Number six.

MS. HANSEN: Just to Bruce's point, especially with a chronic disease one it's not about train wrecks, per se. But I think the intention has been accepted that we're talking about people who are not just a one disease type of condition. But it could be comorbidities and polypharmacy. That doesn't mean people are train wrecks necessarily. So some way of conveying some degree of complexity without

having to go that far.

MS. DePARLE: I think she's made the point and this harkens back to our hospice conversation yesterday. The word late stage, I don't want that to convey that they're on death's door before they can get into one of these.

MR. HACKBARTH: Number seven.

DR. MILSTEIN: Jay asked me to speak up.

But this one, I think, is good in the overall part of it. But to say that you've got to contract with the state agency could be problematic in places like California -- and I'm just repeating his comments. California has a per county two plan model. And so when you say contract with the state, you might be contracting with a whole bunch of entities. This one I would support, and I think Jay would, if we can have some flexibility about in terms of how that contract would be enforced.

MR. HACKBARTH: As I recall, Jay's proposal was contract or subcontract.

MR. BERTKO: Yes.

MR. HACKBARTH: Something along those lines.

MR. BERTKO: Right.

MS. DePARLE: I said yesterday, I work with a plan who's been trying to do this and even that isn't working. Kaiser might have the ability to subcontract. I'm not sure that every small special needs plan could.

So I'd just ask that we look at this more. It needs to be reciprocal. If the states aren't required to play ball here, I don't think it's fair to require the plans to.

DR. SCANLON: I think we need to be clear about what's at stake here, because the one problem with the dual eligible SNPs is that the dual eligible population is not homogeneous. The only thing they have in common is they're poor. We go from the very frail that are potentially nursing home users or nursing home eligible to relatively healthy people who just happen to be poor.

And so there's this question from the states' perspective what do they want to do about that population? In terms of contract with a plan, it makes a huge difference with they're contracting with an On Lok and they're trying to serve the population that they would be serving with long-term care versus the person that's healthy for whom there are very few Medicaid benefits they're going to be

getting anyway anymore because of Medicare covering drugs.

So the key part of this, it's almost like two recommendations here. The fact that we're going to limit enrollee cost-sharing is a critical part of this, which is independent of a state contract. Because for the healthy people, it's more the coordination of benefits in the insurance sense, who's going to pay, not the issue of coordination of care, who's going to manage these different services so that is to the benefit of the individual?

MR. HACKBARTH: [off microphone] What would you do with the recommendation?

DR. SCANLON: Potentially separate out the cost-sharing from the state contract or think about -- I'm comfortable with saying they should seek the state contract. But I'm not sure that it's necessarily something that should be an absolute requirement. That's kind of where I am on this.

MR. HACKBARTH: Others on this issue, very quickly.

DR. REISCHAUER: Yes, I think the dual eligible one, the logic behind it is very different from the others. As long as states are going to be responsible for ponying up

the money, I don't think we can impose on them a rule that they have to take all MA plans that are dual eligible SNPs if they have thought of a different way -- as California has -- to try and hold down its Medicaid exposure here. So it's not equal across the country, but that's the way our system works.

So I would stick with the contract or subcontract and realize that in some states it's not going to be possible. Until we take Bill's other recommendation about federalizing the low-income assistance, which is the right way to go, this is going to be a price we have to pay.

DR. CASTELLANOS: I think Karen mentioned this yesterday, too. It's really difficult to coordinate these plans from a provider viewpoint. If you think it's hard for the provider, what do you think it is to the patient?

So we need to try to attempt some form of coordination, not just for the provider, the physician, the hospital, but for the patient also.

MR. HACKBARTH: Last, recommendation eight.

Hearing none, we are finished.

Thank you Jennifer.

DR. REISCHAUER: The ninth inning closers are here

again.

MR. HACKBARTH: I must say your challenge today is greater than your challenge yesterday.

MR. GLASS: So let's move right along to hospital construction.

In one word, yes, it's really going up.

[Laughter.]

MR. GLASS: Even if you adjust for inflation, it's still doubled in the last five years. So we looked at this little bit, took it apart a little bit to see if we could figure out anything else to say.

If you look at it over the really long haul, we're still at a peak, a historical peak. The only thing close to it was when Hill-Burton was in effect. And that's also when Medicare start paying cost-based reimbursement, also when they started municipal bond market lending to hospitals. So we've now achieved what was achieved with that triple threat back in the Hill-Burton age.

MS. DePARLE: You say this includes ASCs and imaging centers?

MR. GLASS: Yes.

MS. DePARLE: So when Hill-Burton -- for the

earlier data, did that include ASCs and imaging centers?

MR. GLASS: This data actually includes all of it, but of course there weren't very many at the time. That's really less than 10 percent. It's not what's driving this.

So are we done with it now? It doesn't look like it, according to this. If you look at that green line, the stuff in design is dwarfing the stuff that was actually broken ground on in 2006. So it looks like this may well be continuing for several more years.

One explanation could be well, maybe there's a lot more hospital use per capita. But in fact, it turns out that it's the other way around. So that's not a very good explanation for it.

MR. DURENBERGER: [off microphone] Is the definition of hospital the same throughout?

MR. GLASS: All of the ones that go back the long way are using this McGraw-Hill data, yes. That's the same.

MR. DURENBERGER: [off microphone] Became every time you use the word hospital does it include --

MR. GLASS: In most of these, yes.

DR. STENSLAND: Not for the hospital use figure.

DR. WOLTER: It's a little deceiving to say

hospital use, because that's really inpatient days.

MR. GLASS: No, actually it's not. I was trying to go fast. I'll slow down a bit.

The measure of hospital use is adjusted hospital days, which adjusts inpatient days to take into account outpatient care at the hospital.

DR. WOLTER: That did they adjusted inpatient days.

MR. GLASS: That's what adjusted means. It's shorthand for yes, this also includes outpatient. We tried that. We tried to deflate this by everything you can think of.

DR. REISCHAUER: But you shouldn't deflate this by per capita. It should be total number of whatever it is, patient days. You're talking about hospital construction. You aren't talking about hospital construction per capita.

MR. GLASS: This is hospital use per capita. The construction was per capita, also.

DR. REISCHAUER: It was per capita?

MR. GLASS: Yes. We've really tried to -- if you look at value of hospital construction permits per capita -- the one up on the thing there.

DR. REISCHAUER: I was looking at the first one wasn't.

MR. GLASS: I'm trying to go fast.

No, we tried to do it per capita so that in case population was increased and that was the explanation and all that sort of thing. So we've tried to correct for that in the hospital use.

It turns out they're building a lot of new hospitals now, which is kind of interesting, if you look at this one. That's really at an all-time high. If you put it all together, it turns out new hospitals and additions really are predominating over renovations at this time.

So what is being billed, you asked us to look at that question. Here are data sources that are somewhat limited. But again facilities and expansion seem to be driving it. It's increased outpatient and inpatient capacity, though the number of inpatient beds is not going up in the nation as a whole. So some must be going away while they're doing the new construction. Either they're changing a room with two beds in it to a room with one bed in it or they're closing some old hospitals or old wings or something.

So one of the surveys looked at the question of what services are hospitals planning to add over the next few years? It turns out the top ones are radiation therapy, cath lab, and wound care.

What's interesting is cardiac care, which used to be at the very top of the list, is now less of a focus. Maybe everyone already has a cardiac wing or the change in Medicare payment maybe had an effect on that question.

One of the things going on is this evidence-based design. And the point of that is it actually increases costs by about 5 percent but by use of natural light, standardized patient rooms, larger single rooms for patients, and that sort of thing, it might have some effect on lowering length of stay and improving care. So it's hard to say. Maybe some of this will pay for itself in some sense.

Now Jeff is going to take apart some of this below the national level and see if we can see any factors that are driving it.

DR. STENSLAND: First, we looked at where is the construction occurring? The first thing we did is we looked at rural and urban. And we found even for the most rural

counties up to the biggest urban areas, they all are seeing a big growth in construction.

Then to look at whether there's a particular geographic area where it's all happening we drew this method. This map just has the urban areas. The reason we used just the urban areas is that many of the rural counties only have one hospital. So if you're looking at construction for a rural county, it's going to jump up and down to the idiosyncratic nature of that one hospital. But the urban areas tend to have enough hospitals that if you look at construction over a five-year period you can see the trends.

Basically the message here is that there's a high level of construction in some areas all across the country and it doesn't seem that there's any one particular geographic region that's driving this.

Maybe we can just skip through the next three slides and go to the summary slide, this one here.

We looked at the descriptive statistics on what factors might be driving this. We also did some regressions, various multivariate regressions, and we came to the same conclusions no matter how we looked at it. One

was that faster population growth tended to lead to a little more construction. This is things like Salt Lake City and Las Vegas tend to have a little more construction than other places. But also the interesting thing we found is that even in slow-growing places like Cleveland there's still a lot of construction growth.

We also looked at hospital margins. And we did find that in areas of higher hospital margins, they tended to have more construction growth. They have more money to spend, they tend to spend more money.

The interesting thing is that wasn't the only factor either. Even in areas with fairly low total hospital margins, they still saw an uptick in construction spending.

There was also some reports in the popular press that the hospitals were leaving the center city and going out to the suburbs. So we wanted to test whether really it's the counties with the low Medicaid shares that are getting the hospitals, and the places that have high Medicaid burdens are losing. We did see that places with high numbers of Medicaid patients have a little bit lower construction, but once again even places with high Medicaid burdens still had pretty strong growth in construction from

the 1990s period into 2000s.

We looked at certificate of need laws and we really didn't find a significant effect. But I want to put a little asterisk by that because when we talked to hospitals, what a certificate of need law is varies from state to state. And there may be some states where it's actually much more restrictive and actually functioning, and other states where it's very loose and it isn't functioning. But on average it really didn't have an effect.

Then we looked at age of facilities. Part of the problem here is we don't have something that tells us that the cornerstone of the building is 1956. The data we have is depreciation expense in the most recent year and accumulated depreciation expense. So you could say if somebody has $1 million in depreciation expense in this year and they have accumulated depreciation expense of $10 million, you estimate that the life of the building is 10 years.

The problem is that the Medicare cost report data on the depreciation, accumulated depreciation, is fairly poor. When we looked at it, we found very limited results, only that the counties with the very newest hospitals tended

to have a little less construction. But in general, I think I wouldn't put much stake in that, the quality of the data is poor.

Now stepping back and what do we get out of all of this is we could say that all of these factors that you would expect -- the main factors: population growth, Medicaid share, hospital profit margins -- they all have some effect but they're really only explaining a small portion of the variation from area to area.

So now we'll get to the summary. Every year we look at access to capital and we probably should go back to the main point of why we do this every year is to say is access to capital adequate?

In this case, we do see that access to capital is adequate, at least to fuel a building boom. This is the biggest building boom probably in the history of the country, looking at the data. But some may argue this shouldn't be a surprise. This maybe shouldn't be a surprise since we're wealthier than we ever have been in the history of the country and maybe we're at a point now where consumers are demanding single rooms, better technology, more outpatient space, private baths. If we want all of

that, all of that may cost money.

The other factor is that there wasn't a lot of the new hospital construction in the 1990s, as David showed you, so there might be some sort of cyclical effect.

But on the flipside, others may argue that really what we have here is a medical arms race that's going to end up driving up utilization. And of course, there is the potential that both these two sides could be somewhat right. For example, if somebody has an older building, they build a new building, it now has private rooms, private baths, new cardiac surgery center. The hospital across town might think to compete with them I need a new hospital with private rooms, private baths, a new cardiac surgery center. So both of those two rationales could be partially true.

The first question is whether Medicare policy, in some way, caused this building? Or somehow did Medicare policy contribute to the building boom? It doesn't appear that Medicare policy has been the major driver behind the construction. Medicare payment rates may have had some effect through the growth of cardiac surgery and imaging services. But nationwide it looks like there's other factors that are the main drivers, things such as that many

hospitals are getting old. But more importantly, interest rates are down and private payer margins are up and that could have a great effect on the construction.

Not that was looking backward. But looking forward, the next question for the Commission is whether the building boom what will drive Medicare policy? First of all, capital costs may arise. However, you should bear in mind that capital costs for a hospital are only about 10 percent of the total hospital costs. So you would need a big increase in capital cost to get a big increase in overall cost. For example, a 20 percent increase in capital costs would cause Medicare margins to decline by about 2 percent, just to keep it in perspective.

The other concern, of course is that additional capacity may drive up additional volume of the kind of things that Wennberg would call supply sensitive services.

That's the story. And then I guess the policy question that follows all of that is whether Medicare payments will end up rising up to these higher Medicare costs that will follow the building boom?

MR. HACKBARTH: Jeff, could you just go back to the implications for Medicare costs and just go through that

example again? So the capital costs are on average about 10 percent of costs. And do the part after that.

DR. STENSLAND: So capital costs on average are about 10 percent of costs. So even if say construction spending grew by -- capital costs grew by 20 percent, then you would have 10 percent times 20 percent, which would equal a 2 percent increase in total costs.

And if costs went up by 2 percent in total due to additional construction, not due to some sort of increase in the market basket, then without a resulting increase in Medicare payment rates we would expect a 2 percent decline in margins.

Of course, this is all purely hypothetical.

MR. HACKBARTH: It is a hypothetical but that seems like a big number to me, not a small number. When you think of -- set aside the fact that we have minus five -- or whatever the number is now -- projected margins in Medicare but just look at the hospital industry long-term, 2 percent on the hospital margin is a big deal. It's not a big margin business.

And so what that example says to me is that this is a major financial implication for Medicare and other

payers, as well.

DR. STENSLAND: We could quantify it, too. We haven't quantified it. We could probably come back to you with some real rough ideas -- is 20 percent in the ballpark -- by looking at how much is built versus how much do we have. We haven't done that yet.

DR. WOLTER: Just on the issue I raised earlier, in our case when we do the adjusted patient days, we say adjusted patient days to make it clear that it's an adjustment for outpatient and inpatient. I don't know whether that's going to be important or not but it is a little confusing on that slide.

And then the other thing I would say is that captures outpatient hospital work and inpatient hospital work. It would not capture the myriad of other hospital building that goes on, whether that be clinics or other sorts of services that wouldn't be captured in the adjusted patient day figure. So I think we just need to be careful to understand that there would be other building going on that wouldn't be captured in adjusted patient days.

And then as I look on page three -- and by the way, I'll start by saying I'm concerned about medical arms

race and I'm concerned about fueling things that might drive utilization, no question about it. If we can tease some of that out of this, I'm 100 percent behind it.

But having said that, and I'm kind of going on my own experience, we are doing some building now because we're at an unprecedented 90 percent occupancy in the hospital. We are doing more diversion than we've ever done, and this is not in a rapid growth community.

We're remodeling over and over again a facility that was built in the 1920s, which by the way age of plant doesn't capture for some of the reason that you've said.

And so there are some real needs out there. And I was going to say, as I look at page three, I don't think we can say we're at an unprecedented building spurt yet because it looks to me like the volume is about what it was back in 1970. And so that is about the life of plant, right?

So maybe this next few years, if your projections are accurate, we can get to the point where we say this is unprecedented. But there is some revitalization of very aged plant that's going on and I think we just need to be cognizant of that as we hopefully bring a balance to this conversation.

We are, for the first time in 15 years, going to the bond market. Really, the minority of our dollars are going for inpatient use. Some of the dollars are going to work with small rural communities to help them with critical access hospitals that were built in the 1940s.

And so I just hope we bring balance to the conversation but I'm all for trying to get a handle on maybe what's appropriate and what isn't.

DR. KANE: A couple of things. One is when I looked at states in the past 10 years or so and looked at their capital spending, the 1990s was really a repressed time, partly I think because we lost a lot of hospital beds in the 1980s and 1990s. So a lot of hospitals just conserved cash and didn't invest in the 1990s, partly because uncertainty, I think, about where the managed care market was going.

I think the other thing to keep in mind though, I think some of this is the repressed 1990s are coming out in the next millennium. But part of it is also did you age adjust the per capita? Because my understanding was we're kind of getting older. And if you look at the new services, it's cancer, heart disease, and diabetes are the three

places that will benefit from those new services. So that's kind of reflective of what I think the new population demographics are going to be in the next 20, 30, 40 years. This is the preparing for the baby boom to get old spending -- it could be. It looks like it might be to me.

And then finally, in thinking about the impact on cost, the hospitals that I'm familiar with in terms of what they're doing are often saying this will create operating efficiencies. The fact that we're now putting like services together and building information technology into them. So I think yes, it might well be a 2 percent capital cost increase. But we don't really know what the final operating cost implications are.

I guess it's hard to just take this out of context and say one line item is going up and we have to pull out all the -- not that we don't want to be sure it's for good things. But it doesn't surprise me that there's a lot of spending now. The demographic seem to me to require that. And I think there's a lot of potential for operating efficiencies to come out of better design.

MR. GLASS: That's part of the evidence-based design question.

MR. BERTKO: Can I just briefly added to Nancy's comment, not only is age adjustment there but there's also what I would describe as the actively at work part of it. So as people transition from work to retirement, their costs go up. A 57-year-old who's actively at work has about two-thirds the cost of the 57-year-old who is retired, for a whole variety of reasons.

DR. STENSLAND: We did look at age adjustment in the multivariate analysis. The descriptive statistics didn't have it in there and it didn't come out as a significant predictor of which counties had a lot of growth. The age adjustment was very blunt. It was only a share of the population over age 65 in the county.

DR. REISCHAUER: But what you want is the perspective, the next 20 years.

DR. CASTELLANOS: I'd like to give a perspective from the physician viewpoint. Can we go back to slide five for a second? It basically shows a hospital use lower than in the 1970s. This is exactly what we want.

But today patient in the hospital is an entirely different individual that it was in the 1970s. They're much more complex. Their sicker. They require the ICUs.

There's a lot of new diagnoses that we're dealing with now. We didn't have AIDS at that time. We have a tremendous amount of that now. A lot of new treatments. This reflects, again on the wound care we talked about. We talked about cath labs, we talked about radiation therapy. And this all is reflected in the longer lifespan that we have and a decrease in our cancer incidents.

I think what you really need to look at is what we do in the physician community, we look at appropriateness. Is this appropriate? You talk about a building boom. I want to talk about baby booms. Thank god the hospitals are making money and reinvesting it in. We're going to need this over the next 20 years. We're going to have the baby boomers. Thank god the medical schools are increasing their population to deal with this group of patients and I'm glad that the hospitals are doing it, too.

I don't think everything is that bad. I think appropriately the hospital has expanded to deal with what we're dealing with today.

DR. MILSTEIN: As I listened to this presentation and some of the comments, you get a sense of there being two ways that money is being spent on hospital construction.

One, pro-social and very useful ways in terms of redesign of hospitals to be more efficient, to be more quality reliable. And then there's another category that I think is wasteful and potentially destructive. And that is building capacity in circumstances in which either A, there's a lot of evidence of excess supply sensitive services and/or B, in circumstances in which hospitals have not applied operations engineering 101 to optimize throughput of their existing capacity.

And based on what innovative hospitals have done over the last five years, I think the opportunity in that category is very large. I think you'd have to conclude based on the evidence available there's an opportunity for a 30 percent at least improvement in number of patients treated per hospital bed if hospital operations were better engineered.

So I ask a question because I'm not sure -- I haven't been able to figure out the answer. Is there a way that we might change Medicare hospital reimbursement policy that might discourage capacity building in the second category and encourage it in the first category? If a hospital were to say well, I wanted more money, despite the

fact that the evidence is that my medical staff and the hospital together are off the charts on supply sensitive services, and we have not implemented operations engineering 101 in terms of optimizing current hospital production capability, I would not want us to -- I would not want Medicare to aid and abet that.

On the other hand, some of the other applications that Nancy outlined and John mentioned are worthy investments.

MR. HACKBARTH: It would be great if we could do that and I agree with your point. I suppose, in theory, that's what a certificate of need program should be able to do. The evidence on their doing and is less than encouraging.

MS. HANSEN: Actually, it's building on what if type of scenarios. Looking at whether payment policy could -- going back to reinforce and pay for those most efficient and effective hospitals like some of the Plaintree hospitals that have really started to change the throughput and the design.

And then secondly, this is more of a question that relates to whether or not there's any way to figure out if

fewer mistakes were made, the rehospitalization need issue is able to be somehow factored into that. Because it's based on kinds of utilization and the fact that many people get rehospitalized. So basically that's taking in capacity. If we're able to reduce using our other policy that only paying for so much, whether or not there's a way to factor in how much less hospital capacity bed days we would have to use so that you'd spread it over a larger population.

And then the final one is is there a way to also hypothesize -- there will be new ways to treat very acute people that have already occurred. Some people will have to be treated in this much more almost military intense way of the future. But more acute things are not only in the acute surgery centers but other types of places like hospital at home types of models.

So it's almost a disruptive technology approach consideration.

It's more of a context factor. I think the use of bricks and mortar to treat people could be thought of also differently.

MR. DURENBERGER: I love the work these two guys do and I just have to say one thing for Jeff. He came out

to Minnesota and we did one of these medical arms race things a couple of weeks ago and he made a marvelous contribution to the debate. And we had people from various states there as part of a discussion. And it was somewhat the specialty versus general and so forth. But he made a much broader contribution and I'm grateful to have had the opportunity to invite him out. And I just want everybody else to know the contribution that he made to the discussion.

Two quick thoughts on this. One is just on the subject of hospital construction and all that sort of thing. It might be interesting to know how much of that also comes from private philanthropy because we know that there's an increased number of people who like to see their names attached to somebody who saved their lives or their child's life and there's much more money to be had, and to the degree that that contributes.

The other one is the Federal research dollars. There's some interesting papers written recently about -- there's one nice one about UPMC versus Penn and what they can do with $500 million a year or something like that in grants, including some construction and so forth. And it's

not to condemn it. It's simply to better understand the problem.

Where I end up, my second observation I guess, is that this really belongs as much as possible, while it's appropriate to consider it in the context of payments and so forth, it really is a very, very important piece of work we need to do in the other project they talked to us on yesterday which is what role does financing reform play in delivery system reform? So just to endorse it as very, very valuable work, there are probably some other dimensions that we've all thought that they could add to it.

But that our greater contribution with this kind of information will be to deliver -- the issues around delivery system reform. Because people in Congress and so forth who are looking at the high cost of health care need to better understand what is contributing, I mean the a good things that are contributing to that, whether it's evidence-based design or whatever and then some other things, as well.

MR. HACKBARTH: This is a very complex phenomenon and there are good things happening and not so good things happening. In terms of the policy intervention, if any, I

think where Dave is, if you could quickly magically create incentives for efficiency and quality. Capital spending will take care of itself. People will direct the money towards those ends for which they are rewarded. This is a symptom, except that is a problem. I think everybody would agree some of it isn't. Some of it isn't. It is a problem. It's a symptom of a system that doesn't have proper incentives in it. And to try to fix it in isolation may lead to more frustration than positive results and you've got to change the underlying dynamics.

Good work. Thank you. I appreciate your patience with us.

Now a brief public comment period.

Please identify yourself and keep your comments to no more than a couple minutes. Thanks.

MS. SUBER: I'm Nora Suber with AARP and I wanted to thank you for your thoughtful recommendations on the special needs plans and say that we agree with the majority of your recommendations, especially as they were originally drafted. We do have some concerns with some of the changes that were suggested and I just wanted to touch on those.

On the first recommendation, we agree that the

SNPs should be extended for an additional three years. As of yet, we don't think they have proven why they are "special" and we believe that they should be reevaluated in three years. It doesn't make sense to us to extend them until and unless they prove themselves because they are quite costly to the program, as you know.

On the fourth recommendation, we believe strongly that MedPAC should recommend that Congress or HHS should require that each individual have a health care adviser. We think this shouldn't just be in the chapter text for fear that the point will be lost. It's not just to make sure that the individuals' care is coordinated, but in the case of dual eligibles in particular that they also have help having their benefits coordinated, especially between Medicare and Medicaid. This is especially important if you decide to not require a state contract. And also, if you decide to limit the monthly enrollment for dual eligibles.

On the issue of state contracts, we believe it would be helpful if you could note that CMS could assist states in establishing state contracts. We have heard that CMS can often be a barrier.

On recommendation number seven regarding dual

eligibles, we agree that they have been targets of abuse by private fee-for-service plans and SNPs. But again, we think it's extremely important that they have a health adviser to help them understand how to navigate the system, both their care and their benefits.

Thank you.

MR. HACKBARTH: Okay, we are adjourned.

Thank you.

[Whereupon, at 12:07 p.m., the meeting was adjourned.]