MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, November 5, 2009
10:11 a.m.

COMMISSIONERS PRESENT:
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AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: Okay, the time has come for us to begin.

Welcome to our guests in the audience.

Our first topic for today is Medicare's use of coverage with evidence development. Nancy?

MS. RAY: Thank you, Glenn. Good morning.

I'm here to begin to discuss with you Medicare's use of coverage with evidence development. I'm going to summarize Medicare's activities using this policy, and I will also present two case studies that will show how this policy was applied. I will then close the presentation with a discussion of two key challenges encountered by Medicare and implemented in this policy.

To look at this issue, the Commission contracted with the Center for Medical Technology Policy led by Sean Tunis. Your briefing paper on this presentation has been greatly informed by the work by the Center for Medical Technology Policy.

This is a new issue for the Commission, and so this session is meant to be informational. We are not asking commissioners to reach any decisions this morning.

Coverage with evidence development is an approach for payers, including Medicare, to pay for potentially beneficial medical services that lack clear evidence showing their clinical effectiveness in specific patient populations. Coverage with evidence development provides patients access to medical services while evidence is being generated, thus assisting payers as they develop payment decisions, and helping patients and medical providers make more informed clinical decisions.

Coverage with evidence development provides an approach that permits payers to move beyond the yes/no coverage decisions by paying services in concert with systemic data collection and evaluation.

CED, coverage with evidence development, is an important tool for Medicare to use when developing payment policies. Medicare, because it is a very large payer, has come under particular pressure to find ways to reconcile the tension between developing evidence-based policies and being responsive to the pressure from product developers, providers and patients, to pay for new services and new indications of existing services.

The goal in CED is to provide access to services

while addressing research questions that were unlikely to be done otherwise. CED gives Medicare an opportunity to generate data on the utilization and impact of a service so that the program can develop more evidence-based policies.

Medicare implements CED policies through its national coverage determination process. Under CED, Medicare for services as long as evidence is generated through a clinical research protocol which may take the form of an observational study or randomized clinical trial. Medicare outlines the requirements of the CED study, and at that point interested parties may agree to participate in the funding and implementation of the study.

Medicare has not implemented that many CED studies, roughly about 10. As you can see from this list, coverage with evidence development has been used to pay for surgery, imaging services, devices, diagnostic tests and drugs.

So I'd like to move on to the first of our two case studies.

Although not termed coverage with evidence development at the time, Medicare first used such a policy in covering lung volume reduction surgery for severe

emphysema in 1995. Use of this surgery was increasing among beneficiaries in the 1990s despite extremely limited clinical evidence.

CMS, then HCFA, observed a relatively high 30-day mortality rate following the procedure. Consequently, CMS issued a national coverage decision that paid for the surgery when beneficiaries were treated according to an NIH clinical trial called the National Emphysema Treatment Trial. This seven-year trial showed that some patients were more likely to die if they underwent surgery rather than rehabilitation without surgery, while others achieved a slightly better quality of life or a small survival benefit from this surgery.

Following publication of the study's finding in 2003, Medicare revised its coverage policy to cover all patients who matched the characteristics of patients in the trial, who experienced a survival or quality of life benefit. Since then, use of the surgery has remained low.

Some of the lessons learned from this case study include that useful clinical evidence can be generated at the same time as providing patients access to a service, and Medicare can refine its coverage policies based on

information collected via a coverage with evidence development effort.

Moving to the second case study, in 2005, CMS implemented a coverage with evidence development policy for ICDs, that's implantable cardioverter defibrillators, for primary prevention of sudden cardiac death. Questions remained about the benefits and risks of this device in specific patient subgroups, particularly the elderly and those with multiple comorbidities.

An observational registry was chosen for this CED application to provide access to the service across the Medicare population and because of the need to accumulate large amounts of data for use in subgroup and other analyses. A broad range of private sector groups collaborated on this effort, including medical societies, manufacturers and hospital systems. A private payer provided start-up funding for the ICD registry.

In 2007, the collaborative working group, called the ICD Working Group, concluded that the existing registry did not answer some key questions about long-term health outcomes and that Medicare would need to refine its coverage decision. Consequently, they decided to capture additional

data through a longitudinal study effort for about 3,500 patients. Although there were some initial challenges to fund this additional longitudinal analysis, as of 2009, funding has been secured both from the private sector as well as from the public sector, NIH.

So this case study highlights the capability of registries in collecting enormous amounts of data for research, although the initial design may ultimately need to be modified, and that cooperation and financial support of manufacturers, private health insurers and the public sector can be obtained, but sustained funding could cause delays in some aspects of the study implementation.

So I'd like to shift our discussion at this point to two important challenges that Medicare has faced in trying to use coverage with evidence development to pay for promising medical services.

The first issue is Medicare statutory foundation to use coverage with evidence development. Generally, Medicare has implemented CED through its authority to cover services that are reasonable and necessary. However, the reasonable and necessary provision in the statute does not explicitly refer to Medicare's use of coverage with evidence

development, and the statute does not define reasonable and necessary. Some stakeholders have commented that Medicare's use of coverage with evidence development is outside of the program's statutory authority.

A clear statutory foundation might enable Medicare to develop a formal mechanism to identify and select topics for CED application and more articulated standards regarding the design and implementation of such studies. That is to ensure that the study design and methods are answering the key questions that Medicare needs more information about.

Funding is the second key challenge in implementing coverage with evidence development. There is no designated source of funding to pay for the research costs associated with collecting data, as well as designing the study and analyzing the clinical evidence. Funding is project-specific. Some CED efforts are funded from the private sector while other efforts have obtained federal sponsorship, and some have obtained both public and private funding.

At least one study has not yet begun to move forward because no funding source has come forward, and, as we just discussed, some CED studies have been delayed until

funding has been obtained.

Opinion differs as to where funding should come from. Some observers argue that product developers who realize increased revenue from newly allowed product sales should bear the cost. On the other hand, some observers argue that Medicare should cover these costs because of the benefit that will be gained from more appropriate utilization based on the evidence generated.

Another issue to consider is the influence of the funding source on the design and implementation of the coverage with evidence development study. Some parties are concerned that the private sector may not always provide an impartial source of funding. On the other hand, some parties argue that private sector funding may be appropriate as long as Medicare develops clear standards regarding the design and methods of the study.

So this concludes my presentation.

We are looking forward to your discussion. Some issues that you may want to discuss include the value of coverage with evidence development to the Medicare program, clarifying Medicare's ability to use CED and issues with funding CED's research costs.

As I said up front, this session is information, and we are not asking you to reach any decisions this morning.

MR. HACKBARTH: Thank you, Nancy.

So let's begin with round one clarifying questions. Tom?

DR. DEAN: How is it determined which topics get considered under this process? Is it just purely sort of arbitrary, or is there any?

MS. RAY: It's considered through Medicare's national coverage determination process. So that could be triggered either internally by CMS or externally by somebody coming to the program and saying we want you to consider national coverage. Once the national coverage determination process is considered, Medicare then starts getting all of the clinical evidence available on that service that is available. Again, this is done in a public process in which CMS will then publish a proposed coverage policy, will seek public comments and then will finalize it.

Now the other item I should also raise is that CMS can and has gone to an advisory group, a coverage advisory group called the MEDCAC, and can also seek advice about is

there sufficient evidence on a specific service. The MEDCAC is advisory only. It's ultimately up to CMS and Medicare to make this decision.

MS. HANSEN: Along that line, I know that the Agency for Healthcare Quality and Research, AHRQ, has a whole 'nother set of activities relative to things that they would study about, with picking topics that have a consensus forum and a public comment. So do you that when they do pick topics, as Tom has asked, do they coordinate efforts with the AHRQ work that is being done?

MS. RAY: Are you referring to AHRQ's research under the MMA that called for the -- yes, you are. Okay.

When AHRQ selected the topics for that effort, my understanding is that those topics were of specific interest to the Medicare and Medicaid programs. So there's that aspect of AHRQ's work.

With respect to coverage with evidence development, there is some collaboration between CMS and AHRQ and even NIH, designing studies and so forth. As your case studies have shown, several of the CED efforts received research funding from NIH.

DR. CROSSON: Nancy, I'm going to about Slide 12

for a second, and you can consider this a leading question for later discussion, but it has to do with Medicare's authority to cover services.

You mentioned in the discussion earlier that the terms, reasonable and necessary, have actually not been defined. Thinking about the word, reasonable, one could imagine that that word might mean, for example, what's the chance that a particular intervention would work? Is it one of two? One out of ten? One out of a hundred? One out of a thousand? Or, one out of ten thousand, as a reasonableness test?

Another reasonableness test, though, I think is, and perhaps related to that, is how costly is the intervention relative to the potential gain?

Now my assumption is that that second test has not traditionally been thought of with respect to the Medicare program. Can you think of instances in which it has?

MS. RAY: The instances are rare. Reasonable and necessary is generally interpreted to mean does the service or item improve beneficiaries' health outcomes.

Just the one item that I can recall was I believe the colorectal screening test. I believe that cost was

considered, and that was because of a specific statutory provision in some law that I just can't recollect right now. But, generally, it's interpreted reasonable and necessary to mean that it improves beneficiaries' health outcomes.

MR. HACKBARTH: There have been a couple efforts to further define reasonable and necessary by regulation, one back in the eighties when I was at HCFA and then one in the nineties when I think Gail Wilensky or Nancy-Ann was Administrator. I think in both cases, certainly I know in our case in the eighties, we tried to inject cost into the definition of reasonable and necessary. I think Nancy-Ann's effort was doing the same thing. In neither case did those regulations come to fruition.

DR. BERENSON: To provide just a further on that one, I was there at that time, and the lawyers at the Department thought that the terminology in the statute did permit consideration of cost, but you need to lay out regs as to how you are going to consider cost. Neither attempt was successful. So I think it's an open question.

I wouldn't disagree at all that if the statute was clear on any of these matters, it would help because there would be a fight. So the terminology is unclear, but until

you establish regs as to how you're going to do it, you can't do it essentially.

The question I was going to ask had to do with on Slide 5, the randomized clinical trial option. I assume, for example, in the lung reduction, that what that meant was that beneficiaries had a right to go into a clinical trial in which they might be randomized into a control group and not get the intervention, right?

MS. RAY: That is what happened in that instance, yes.

DR. BERENSON: So, basically, we can call it coverage with evidence development, but I think it's really you have an opportunity to go into a clinical trial, and Medicare will pick up the cost of that. I mean it's not exactly coverage for anybody in the country who, and their doctor, thinks they should have a procedure. It's really directing them into a clinical trial. So I just think we need to be clear about that.

MR. BUTLER: I'm back a little bit on Tom's question about how do you get something on the table. Clearly, what surprised me is that there are only 10. You said the background material said there are only 10 uses of

this so far, right?

MS. RAY: Yes, about 10.

MR. BUTLER: And every one has been for to provide, in the end, payment for a service that wouldn't otherwise get paid, right? That was the impetus.

In other words, it wasn't just that it was a new technology or treatment. In fact, you needed a way to pay for it, right?

MS. RAY: I think it's been used for services where there has not been sufficient evidence that shows their net benefit for Medicare beneficiaries and that I guess that there has been some pressure put on the program to cover and pay for the services.

MR. BUTLER: So my question then relates more to there have been more than 10 examples of payment reform for services, like let's take drug-eluting stents and the long debate over that, and then ultimately adjustments in DRG payments related to that. That took a very different path. Well, it didn't go through this process.

So are there others? And I'm not aware of or clear about other processes for gaining acceptance and payment for some of these things that occur, that are

different from outside of CED.

MS. RAY: And you raise an interesting point because if a service is covered under a broad perspective bundle, like the hospital DRG, it may not necessarily go through the national coverage determination process.

MR. BUTLER: It just says tough. You know. If you want it, you can pay for it. It makes no judgment about whether it's useful or not. We just ignore it from a policy standpoint, some of it.

MS. RAY: Some of it, although within the inpatient PPS, if there is a new service or item, and the manufacturer or the product developer thinks that additional payment is necessary, they can go through the new technology payment procedure where evidence has to be shown to show that it's --

MR. BUTLER: Okay, so one related question, like ICDs was an inpatient DRG payment, right?

MS. RAY: Yes.

MR. BUTLER: Right, with a new category.

MS. RAY: Yes.

MR. BUTLER: So why was that necessarily different from, say, drug-eluting stents or why did one go through and

the other didn't?

MS. RAY: I can't answer that question directly. One of the issues with ICD is that it had the potential to be used by a lot of beneficiaries, which you can also say about stents as well. The consensus was that there was not enough clinical evidence available.

DR. BERENSON: On this one, I actually was talking with Sean Tunis on another matter, and I actually asked him about ICDs. Twenty years ago, ICDs were approved for ventricular fibrillation. Exactly why that then was subject to a national coverage decision, I don't know. As that was there, then when there were broader indications for ICDs used preventatively, not for ventricular fibrillation but for other arrhythmias, et cetera, they needed to go to amend that coverage decision. Perhaps had there not been that on the boards it would have also slipped through.

I mean Sean does make a point that there's a certain randomness into what actually gets subject to a national coverage decision and what just flows through the fee schedule or something else.

And the other point to just make sure everybody knows, in the absence of the coverage decision, the

contractors are making these decisions all the time because they've got claims coming through, and they are making coverage decisions. So we are just talking about a small sort of sliver at the top that are going through national coverage decisions. Largely, the contractors are making these decisions on an ongoing basis.

MS. RAY: Yes, that's an excellent point, and I just want to make an additional comment, that some observers would suggest that a clearer statutory foundation would take the randomness out of the process, would help take the randomness out of the process.

DR. MARK MILLER: On that point, Nancy, when the clearer statutory language was being discussed the comments focused on the reasonable and necessary. Isn't it possible that the legislative language could be more specific about the use of coverage with evidence development and not necessarily have to involve defining reasonable and necessary? So I just want to point that out to people.

Reasonable and necessary and the cost and all of that conversation is all true and is an issue in and of itself, but you could also say make it clearer that Medicare can use coverage with evidence development as a separate

statement.

MS. KANE: Well, this conversation leads me to a question of how might this process relate to the coding battle that goes on? So you've invented a new service or technology, and you decide that the code it most likely might fall under, you're too expensive for that payment class. So then you go to NCD and say I'd like to have this considered to get its own code.

I mean I'm just wondering to what extent this relates to when you lose a coding battle, you try to get a new code for it because you're not going to go into a high enough payment class with the code that you're likely to get assigned. Did that make any sense to you?

MS. RAY: Yes, it does. At least in the services that have touched the coverage with evidence development, I don't think that that's been an issue. However, I'd like to think about that a little bit more and get back to you on that.

DR. CASTELLANOS: Just two questions, one, carrying on Bob's point, the carrier decisions -- now it's called MAC -- do 90 percent of this already, and 10 percent is national coverage decisions. It seems to me that there's

a little bit of an overlap here.

I know when I was involved on the CAHP level we dealt with these problems, and some of them are very similar. We didn't do the studies, but we got the data together. We looked at that stuff and then made some local carrier decisions. Now it would be local MAC decisions, and that's where 90 percent of Medicare's decisions are made, on the local level.

The other question I have is, and maybe you can help me with this. This seems very analogous and somewhat with comparative effectiveness. We seem to be going in these two directions, and maybe we should think about melding these directions.

DR. MARK MILLER: Just to tie a couple things together on more of a kind of broad agenda and direction for the Commission, I see this topic as tied to two things.

One is the topic that you just raised. We've been talking about comparative effectiveness. This is a way to gather information when you're unclear on something. It's just a slightly different path than an NCD and a different path than a local coverage decision which often isn't systematically, or at least systematically collecting

information nationally.

The other theme that ties to this is we've had these discussions, and we're going to have more of them, about CMS's resources and authorities and what it can do. These topics kind of come up periodically, and I know it's hard to keep them all straight in your mind. We're going to be talking more about the demonstration authority as we go forward. You can imagine at some point housing these topics together and saying here's a series of things and legislative authorities that should be clarified for CMS in order to carry out its mission.

So, Ron, it definitely connects to comparative effectiveness, and also I think it connects to this notion of what should CMS have the authority to do, that type of thing.

DR. STUART: I just want to reiterate. First of all, I want to thank you for putting this together. I think this is interesting because it does lead to some of these other questions as opposed to just the narrow issues that we are going to be discussing today.

Then I have a totally unfair question for you, and it falls under the heading of just in time reporting. In

this morning's New York Times, in the business section, there was an article on ICDs and going over the same issues that Sean did and you've reported here, but came to a very different conclusion, and that is that this was a way in which the device manufacturers could keep this process going without having an actual determination.

In other words, the registry was set up. The data were gathered. There was not enough information. After the manufacturers had contributed their initial dollar amount to get the thing started, there was no continuing funding. So the data just sat there.

DR. MARK MILLER: You have hit exactly on the issues that I think are important here: Is this something Medicare should be pursuing? If you think that, should we be clear in statute?

The third thing is then what are the criteria and standards and processes for this to work because I think you've put your finger on it. This stuff kind of happens. Exactly how it feeds back through and how systemic it is on that, I think is an open question.

So to your unfair question, I think it's a good one.

DR. BORMAN: Just, Nancy, there was more to something than I think came up in that chapter or in the materials, that didn't necessarily. I think there was a statement somewhere about that procedures don't go through this kind of process. A new procedure would not necessarily go through this kind of process. So just to comment a little bit on that, and it links up maybe to Nancy's question because I don't know the context in which Nancy used the term, code.

But I would say that most of the new operations, at least on the physician side, do come through a CPT code process. Part of that process is literature. The proposal does require submission of a literature supplement. One, not the exclusive but one, of the criteria for adoption of that level of code, a Category I code, is that there is some level of literature support for the procedure. It may not be all Class I evidence or whatever, but that is one of the factors in that process.

MR. HACKBARTH: Where is that occurring, Karen?

DR. BORMAN: That's at the CPT Editorial Panel level, and that's I think still 17 people, the majority of whom are physicians from different specialties. It also

includes a Medicare representative. It includes AHIP, or whatever the current name is, and a Blues representative. It does at least ask some questions about that.

MR. HACKBARTH: I wonder if we could do a map here. What we're describing here is there are a lot of different avenues that these things flow through the system, and it would help me to be able to visually see a depiction of that.

I have a clarifying question also, Nancy. I'm still struggling to understand the practical consequences of a lack of clear statutory authority for CED.

MS. RAY: Okay. I think it affects the application of this policy in a couple different ways. There have been instances where the program has tried to use CED and has faced considerable pushback, particularly in one case for a service that had moderately diffused.

MR. HACKBARTH: So this would come from a device manufacturer, for example.

MS. RAY: And patients and providers and from product developers. So there is the notion a clearer statutory authority might help address that.

MR. HACKBARTH: Well, let me just pick up on that

because that's where it goes. In that circumstance, I wonder whether the issue is a legal issue which can be addressed through changing the statute or whether ultimately that's a political issue.

The lawyers have said you have the authority to do this. Otherwise, CMS wouldn't be doing it at all. Now their legal reasoning may be a bit contorted as you describe in the paper, and some people may object to that, but at the end of the day the lawyers have said you can do it.

Whether they choose to do it in all cases, it seems to me more is a political question than it is strictly a legal one.

MS. RAY: Well, it's also very opportunistic, I think some would suggest of the CED applications. In certain instances when it was used, there were compromises made perhaps, some would suggest, on the study design and methods used to collect, so that it really didn't necessarily answer Medicare's key question.

MR. HACKBARTH: Okay. Has anybody challenged in court CMS's authority to do this?

MS. RAY: Not that I'm aware of.

I mean CMS has changed, has modified its legal

rationale for doing this, particularly for using the clinical trial CED, as I discuss in the paper. In 2006, in the guidance document, they articulated a different statutory path to use the CED for a clinical trial than the CED for a registry.

MR. HACKBARTH: Yes.

DR. MARK MILLER: The experience I always had in situations like this, in dealing with the general counsel, it was often the palate worked like this: You do not have the legal authority to do this. Or, you do have the legal authority to do this, but the construction of that authority is such that, if challenged, you'll lose or it's of such that you're likely to win. Or, it's absolutely clear you have legal authority to move forward on this.

I think we're in that middle zone where you can construct a rationale. How well it would withstand a challenge I think is where people feel threatened.

MR. HACKBARTH: And, in turn, the next step would be that in turn influences how firm a stand you want to take with somebody who's resisting.

DR. MARK MILLER: You got it.

MR. HACKBARTH: One other clarifying question, we

talked about the inconsistency in whether subject to national versus local coverage decision. As Ron and others pointed out, the vast majority of this stuff is handled through a local decision. Has CMS tried to define in regs what's appropriate for national versus local?

MS. RAY: CMS has laid out how -- that's a good question -- how it goes about making a national, explains a national coverage determination process.

MR. HACKBARTH: Yes, which goes on that track.

MS. RAY: Right. I mean in that document it says there are many reasons that would elevate a service to an NCD. One of them could be that the product developer comes forward and says I want you to consider this. Another would be that internally they see that there's wide variation across the country. So they've laid out the potential reasons for triggering the process.

MR. HACKBARTH: It's sort of a laundry list approach. So, at the end of the day, it's subjective, and they can choose to do it or not.

Okay, round two. Let me see hands.

DR. CHERNEW: So my opinion on this reflects the answers to two questions which I don't know the answer to.

The first one is I don't have a really good sense about whether we think the current system that has these local groups, it has CPT code appeal, it has MEDCAC -- is that too strict or too loose as a general premise?

Do we think the problem is that too many things are getting covered and used that really shouldn't be and we want to think of coverage with evidence development as a way of sort of slowing that down to make sure we have good evidence before we do things? Or, do we think the current system is too tight, not allowing access to appropriately beneficial services and we want to find a way to let these things that really people should have access to in even before we've developed the sort of Class I evidence that we want?

I don't know the answer to that, but maybe you know the answer.

My second question, the second question that I think matters a lot in knowing how to think about this is how important the evidence gathering portion is. So, in a world in which no Medicare beneficiaries were using these services at all, I think you can make a case for this because you couldn't have AHRQ or NIH or anyone doing really

generalizable studies without some way to get -- this would really facilitate the evidence gathering, which I think we think is important.

Alternatively, you could envision a world in which a lot of these things are diffusing anyway, one way or another, or you could do separate trials in different centers, and you don't really need to have Medicare coverage facilitate the evidence gathering because the evidence, in the absence of it, is good enough.

My sense is, and I don't know this, the answer to both questions sort of vary by clinical area, and, in general, we believe that the evidence gathering part is actually an important component of this. But I don't know that to be true. That's just speculation.

DR. DEAN: I actually was not familiar with this process, but I think it has an extremely valuable potential contribution to both the decisions from a clinician's point of view about how to use these procedures as well as how all the financial implications and so forth.

If you look at, for instance, when the FDA approves a drug, they do it with a certain, very limited set of criteria. Once that drug gets out into general use, it's

used in many different ways, a much broader range of patients, and there's a whole lot of things that can happen that don't show up in the preliminary studies that the FDA requires.

I think the same is true of a lot of these procedures, that there will be a certain body of evidence that's there to justify the initial coverage decision, but we really oftentimes don't have nearly enough information about which subgroups really benefit. The lung reduction study is a perfect example of that.

So I guess just as a general comment I would think that we really should support and try to encourage that the statutory changes that are necessary to support this and that the resources that are necessary to support it. We should push to see that those get put into place because the history is there's just tons of situations where things have become standards of care without ever having the justification or the evidence base to support them. Once they get to be standard of care, it's extremely difficult to change the patterns.

So I think this is a great mechanism to both do it and to make use of what are promising things, but to do it

in a cautious way that hopefully, in a relatively short period of time, would give us the evidence that is this something we really should continue to support and go forward with or is this something to say, whoa, this isn't quite as good as we thought it was.

MR. BERTKO: Just to echo Tom, some of Tom's comments in the same way and to maybe use slightly different words, Nancy, I think you implicitly said this, but we should be also concerned with patient quality and, what I think is in Tom's statement, the mortality and morbidity risk of these procedures, given what they've done. So I want to express similar support for continuing to look into this.

Then the question I would have maybe for future thinking is how big could this be, and the question is both. I think the discussion mentioned there needs to be some criteria here. If you were to go through the research and find, say, a set of sample criteria on this: How many procedures would be involved? What dollars might be involved? Would it have the aspect, particularly on the cost side, of changing the GDP plus two, downward, in terms of the Medicare cost trend?

I'm thinking here it's almost a snapshot. You could either look back or there are pipeline analyses of procedures, devices, drugs and things coming down the line. I mean this might be too big of a project, but at least to think about some assessment of how it would affect the pipeline.

Then, as importantly I think, because we do this all the time, what resources for CMS are we talking about here? Is it a huge dollar amount? Is it something that might be matched up with the CDR billion dollars or so and are there synergies there?

So, sorry, that's about 15 questions for you to note and maybe come back to us the next time.

DR. MILSTEIN: I just share enthusiasm for this, pursuing this, because to leave a policy lever as potentially important as the words, reasonable and necessary, kind of ill defined and not well implemented seems to me to be -- what that means then is that you're on a pathway that does not carefully consider reasonableness and necessity of services, which seems to me to not a useful direction.

That being said, one thing that occurs to me is we

periodically bump up against some form of the question of how deep should Medicare go in implementing its value-based -- actually, let's call it quality-based or effectiveness-based objective.

Sometimes we look at this, and we say look, let's really focus on keeping the incentives at the highest leverage point, which we intuit to be how one goes about paying and incentivizing providers because they're the ones at the end of the day who have an overwhelming influence on which treatments do and do not get selected.

And sometimes we say no, we're going to engage and spend effort and encourage the federal government to spend effort at lower levels of value differentiation or, on this point, effectiveness differentiation.

It's funny, when we encounter these opportunities, sometimes we say let's not waste our energy, the federal government's energy at these lower levels. Let's keep on message in terms of focusing incentives for effectiveness in this case or effectiveness in value at the level of how we pay providers. For me, this is right out of that dilemma.

MR. HACKBARTH: Let me pick up on that because I think this is an important question. In my mind, and I'm

not sure that this is the right way to think about it, but it's the way I've tended to think is that a work on payment reform tries to create proper incentives to use resources, efficiency and the production of the known technology in the system to get the best results we can.

Then we have this other force of the innovation in the system, the new procedures, the new drugs, the new devices constantly changing the potential that the system can do.

My concern has always been even if we could snap our fingers and have better incentives tomorrow, if we don't address the flow of new technology, broadly defined, into the system, we're going to continue to have serious long-term costs. So I don't see it as an either/or. I think you've got to both create incentives for efficient production and address the flow of new technology into the system. I see them as complementary.

Does that make sense?

DR. CROSSON: I support this general direction CMS has gone in. I always have. I think the history of it is that it was courageous on the part of some CMS officials and required a certain amount of tenacity and has generally, I

think, in the end been accepted as a valuable thing. I also support us trying to support it by seeing if we can make recommendations to clarify the authority.

I think I can understand from the earlier conversation that perhaps linking that somewhat specific objective to a larger objective of redefining reasonableness and trying to bring into the fee-for-service medical Medicare system, some process of looking at cost, might cripple what otherwise could be a short-term goal.

I do think in the end that going after that idea of what reasonableness really means in a broader sense would be something that would be worthwhile to do.

Having said that, then I'm a little bit confused -- I think just from lack of information -- about how we would, what exactly, and I think Glenn got to this earlier. What exactly are the issues with respect to clarifying the authority, that do not relate to the fundamental legislative authority of the Medicare program?

In other words, I think if we're going to have a further discussion about this, that is, let's support clarification of the ability of CMS to do this, but we're not going to link it to the fundamental reasonable and

necessary authority, what do we link it to? What specific notions would strengthen in this CMS, because I haven't heard that yet?

MR. BERENSON: Just a couple of comments, first, to pick up on Ron's point about the relationship between CED and CER, comparative effectiveness, Sean, I think it was, he wrote a paper that's part of a very interesting Brookings set, talking about CER, comparative effectiveness, in which he laid out sort of the rationale for the need to do essentially a new hierarchy of evidence in which you can't just rely on the prospective clinical trial in the real world. You'd need to be doing these kinds of things.

So he promoted new methods and new data sources with registries as essentially a way to do CER. It's a way to implement CER, to get much more robust information out, and it's a compelling case.

My concern is really very much practical, and it picks up on one of the sentences, Nancy, that you wrote in our paper, which is "Medicare has faced difficulties in using CED once a service has gained a moderate level of clinical adoption."

My greatest, well, not my greatest, but one of my

major concerns here would be selective reporting by those who have to report outcomes for let's say ICDs, and unfavorable outcomes somehow disappear. In other words, we would have to assure real compliance, 100 percent compliance, and make sure that there's no gaming going on. These are big dollar ticket items when we're talking about coverage, if there's any prospect of undoing coverage once it has been granted.

Amongst the other practical implementation problems, I would see a need to assure that this was compliance, essentially. Clearly, in my view, to go that direction, you need statutory authority or something set out in regs that identified what you're going to do to maintain the integrity of the reporting. I just see that as a potential problem with what's a very elegant idea. I see lots of sort of practical problems once the horse is out of the barn.

MR. BUTLER: First, I see if this is done well it's again one of those examples where you could synchronize a bit with the private payer side and inform and help do something that would have a systemwide impact, not just Medicare.

The other piece, and I'm not sure I understand all of it, but I think I kind of view this as again back to a comparative effectiveness out there. If the authority were clarified better, this is almost the funnel through which that has to pass in order to end up in the payment system. You could say in this country that the width of that funnel is a little wider because we have bariatric surgeries or proton therapies, you name it, that kind of pass through a little bit more rapidly than we otherwise would have done if we had a little clearer authority around that.

So that's kind of how I would look at this, unless I've got the idea wrong.

MR. HACKBARTH: Let me just pick up on Peter's first comment about what private insurers do. It seems to me as we further explore this a bit more information about how they make the analogous decisions would be helpful in rounding out the picture.

I think John, from time to time, has said in the past that as difficult as all this is for Medicare, it's even more difficult for private insurers. But some more information that would be helpful.

MS. KANE: Yes, I'm very supportive of trying to

think about how to make this work in a way that generates useful information.

I used to teach a payment systems course for probably 15 years, and the project I would have students do is find a new service you'd really like, you think would really benefit patients and go out and figure how it would get paid for. Nine times out of ten, they could figure out how it would get paid for under the existing payment system without changing. They would just slide it into some code that fit and the stuff that doesn't.

So I guess one of my questions is all the stuff that gets slid into these existing codes, how effective is it and is anybody looking into that?

I guess some of that might bubble into this comparative effectiveness program, but I guess this just raises to me an issue of how can we identify when new services and new procedures are being either slid into the system without a code change and without a coverage decision or when they actually -- probably because they cost more -- go into the coverage decision process because they want a code that pays better.

So I think there's a lot sliding in that we don't

even know about. Should we be concerned about that as well and finding ways to collect evidence that it's effective or not before it gets widely disseminated?

I think it's the tip of the iceberg, what you're seeing get up to the national CED level, and it would be just interesting to kind of get a sense of how many coverage decisions are being made and how many things are happening that don't even go for a coverage decision. I'm not sure how you do it, but I'm pretty sure there's a lot of stuff that's coming, that's getting slid into existing codes and services without being identified as a new thing.

So I don't know. I'd like to see us try to dig out a way to try to identify what the magnitude of that is and how we might better protect Medicare beneficiaries from experiments being done on them that nobody knows about.

MR. GEORGE MILLER: This is a very fascinating and interesting discussion. Certainly, listening to the commissioners talk about the different elements of this brings to my mind, I think, the question on the screen on Slide 5. There's an excellent question, and following Bob's comments that some of this just happened without going through CED.

So I guess my question is, or I just want to raise the issue, are we thinking of the Commission's recommendations thinking about that to CMS?

Are we going to be like a dam or a conduit? Do we want more of this to happen, or less? Should there be restrictions, following what Peter and Nancy said?

I don't know the answer to that either, but it would seem to me there should be a systemwide mechanism to deal with this issue. Or, should it just be something for Medicare and would we go down a different path? If Medicare has one system, would the private community have a different system?

Those are some of the things to wrestle with. I don't have the answer, but this is very interesting, and I think it would be a good opportunity for us to make a statement one way or the other.

Now which statement and which way to make that statement, that's the more difficult thing.

DR. CROSSON: Right. So one process we might look at is one that's been around for about 20 years called the technical evaluation committee, which Kaiser Permanente co-sponsors with the Blue Cross/Blue Shield Association. We go

through the very self-same analysis. It's quite thoughtfully done, updated every quarter, I think, as we follow the development of new technology. Determinations are not determinative, but they are pretty broadly followed now throughout the industry, and we could get some more information for us about that process.

DR. CASTELLANOS: I will be very quick. For the same reasons Tom mentioned, I totally support this. We really need evidence-based medicine to go ahead and do some of the issues that we feel the delivery system reform requires.

Nancy, the answer to your question, really nobody has really talked much about funding, and I think that's an important issue in this. The funding really isn't for to do this. The funding is the research cost to do the study, not the funding as CED is proposed.

But I guess if we get into comparative effectiveness -- and we talked a little bit about funding being quasi-public and private -- I can tell you that the industry, whether it's a device, whether it's a drug company or the x-ray companies, gets a tremendous amount of marketing when these studies occur. I think they should

have some impartial responsibility to fund this because they get a tremendous benefit from this.

MR. GEORGE MILLER: Glenn, could I just follow up in just a second?

So, Ron, do you consider that role to be an investment or should it be a cost of doing business?

DR. CASTELLANOS: Well, it should be a cost of doing business for the device manufacturer, the drug company, supporting the cost of research. This is where the funding needs to be in the CED -- cost of doing the research, which is substantial.

I think it can be both a quasi-public and public, but I think there should be definite private responsibility, impartially.

MR. HACKBARTH: Clearly, this is one avenue for exploration, how all this relates to the major investment that it seems we're going to be making in comparative effectiveness research and how does that influence the funding of this sort of work. So we clearly need to look at that.

MR. BERENSON: I'd like to pick up on there's a lot of agreement around here in terms of what we ought to be

looking, as well as some skepticism about this particular approach. I would like to see that come forward in a more organized framework, if we could.

And I'll pick up on a point that you made, Glenn, very early. We need a map here. I mean we've talked about CED. We've talked about CER. We've talked about CPT coding. You could throw in the mix the approach that FDA is taking with the Sentinel project where you're actually looking at practice after it's there.

I really would like to see that map, so that we could then say well, what are the criteria by which we want to use CER or CED as opposed to a retrospective CER that maybe else could fund? That would help us go through this process a little more formally.

DR. BORMAN: Just quickly, we have to remember that this was a very pragmatic, I think, solution to a gap, a big gap. I think that its strengths and weaknesses clearly merit that it's pragmatic. So the question is: Is this a basis on which to move forward? I think it could be that.

I would echo what Jay said about the Blue and the Kaiser tech panel. It's very well respected, and we have a

lot to learn from there.

I think, Glenn, your point about the technology piece, that this perhaps is a handle toward the technology piece -- which, as many people quote, is a huge driver behind the costs, and I think begs for this kind of process. So I would support us as a Commission continuing to move in this direction.

MR. HACKBARTH: Okay. Broadly speaking, real broadly speaking, we've got two topics on the table. One is how do we collect information about what works, and then the second is what do we do with once we've got the information?

I think it will facilitate discussion if we try to not talk about them simultaneously or in an intertwined way, although clearly they relate, but do some breaking out of the two.

Just one other thought, Nancy, and then I'll let you have the last word.

On the issue of what we do with the information, for example, in this instance, do we modify or give more definition to what constitutes reasonably necessary? Let me state the obvious. That is a hot potato and has been for a long time, as evidenced by the fact that when I was at HCFA

and we tried to do it, we failed. When Nancy-Ann was at HCFA and tried to do it, she failed. And then, most recently, the huge controversy about comparative effectiveness research and whether we ought to do it all and whether it should be used for coverage decisions, whether cost ought to be a consideration -- this is not a news bulletin to anybody, but that piece of it is very hot political stuff.

MS. KANE: I just want to say you said there are just two issues, and I think there's a third one, which is what hits the level. When does the technology hit this level as opposed to a different method of determination?

MR. HACKBARTH: Thank you, Nancy, for getting us started on this new topic, a very important one.

Okay. Our last session before lunch is about the efficacy of Medicare's quality improvement infrastructure, and Hannah and Anne are going to lead the way on that.

MS. MUTTI: In this presentation we begin to consider the efficacy of Medicare's quality infrastructure and whether it could be improved to better complement some of our recent payment change recommendations like readmissions, bundling, medical home. While these payment

incentives are clearly key to promoting quality and efficiency, Medicare has at least a couple of other levers that are also intended to further these goals, and these are: the provision of technical assistance, which is currently offered through the Quality improvement organization program, and conditions of participation, which are the minimum, mostly process or structural-oriented requirements that most providers have to meet in order to participate in Medicare.

Today we are going to focus on the technical assistance aspect of the quality infrastructure, and we hope to come back to you perhaps in the future on the conditions of participation.

To consider whether the efficacy of our technical assistance resources could be improved, we decided to step back and ask what we would a good technical assistance program, what would that look like, rather than look at what we have and ask could it be improved.

Particularly because this is a somewhat new topic for us, our first step was to convene an expert internal panel and ask them to help us think through some of the issues. And to make the topic more manageable for us, we

asked them to focus on the quality issue of avoiding rehospitalizations. It was a panel of 16 people.

We posed a few questions to them, and we've organized the rest of this presentation around those same questions. Those questions were: What technical assistance is needed? To whom should the assistance be targeted? And who provides the assistance, and who decides what assistance they need?

So the first question was what technical assistance is needed, and on this slide we list some of the possibilities, and in the interest of time I don't think I will go through them. Overall, the panel did not reject any of these as reasonable types of assistance. More of the themes that we heard when we asked this question focuses on four points, and the first and most resounding theme was the need for better data and real frustration that the data that they have, providers and QIOs alike, the data that they have is not timely enough and that privacy constraints restrict how it can be used, and that that impedes their ability to do rapid turnaround cycle analysis of whether certain improvements are working or not, and knowing who their care partners are, what their care patterns are, just real

frustration that in order to deal with some of these quality questions, they need better data.

We also hear that technical assistance needs to be tailored to local needs. Different communities and providers need different things.

We also heard that any one of the approaches that I had listed on the earlier slide is not going to do the job alone. A combination of types of assistance is needed.

And, lastly, technical assistance should be provided in a way that does not reinforce payment silos, that the best way to achieve real change is to work across providers and, to the extent possible, whole communities to get change.

MS. NEPRASH: We also asked the panel to whom should assistance be targeted, and this question was motivated by two things: limited resources and wide variation in the quality of care. For instance, spending on 30-day readmissions for CHF in high resource use hospitals is nearly four times that of spending at low resource use hospitals. Hospital mortality rates for surgical patients vary twofold.

The literature on quality improvement also

identifies a distribution in the speed with which providers adopt and integrate new evidence into their practice patterns.

So here you see a bell curve with a small subset of first adopters and an opposite tail of late adopters. This illustration raises the question of whether Medicare should focus on eliminating the left-hand tail by devoting attention to those providers or moving the whole curve to the right -- or both. Quality Improvement theory is somewhat divided on this in that some believe that the best way to improve quality is to encourage innovation among the leaders and let them diffuse it. But other theory and empirical research makes us question that. Do the innovators have the time and inclination to diffuse knowledge on the scale that is needed? And do they have the willingness to diffuse knowledge to potential competitors?

One possibility is that by focusing on the left-hand tail of low performers, we may have a chance to reduce racial disparities in care. Although existing research on race and hospital readmission is limited, broader research -- which you may remember hearing some of this summer -- suggests that, in general, minorities receive their care in

a small proportion of hospitals and those hospitals tend to provide somewhat lower-quality care on certain metrics.

Staff is currently examining the correlation between hospitals with high risk-adjusted readmission rates and hospitals with disproportionately high minority populations. If there is an overlap between these populations, as the literature might suggestion, a possible policy of directing technical assistance towards low performers to reduce their readmission rates could have the effect of simultaneously targeting facilities that serve large minority populations.

One encouraging thing is that the research for pay for performance suggests that low performers can respond to financial incentives and improve their performance. But concern persists that some providers face more barriers. A recent study found that hospitals serving low-income beneficiaries had worse quality and lower ability to adopt EHR. In a survey of QIO directors, 18 of the 20 directors surveyed report a reluctance to work with low performers saying, among other things, that "they barely had sufficient infrastructure for day-to-day survival, let alone quality improvement systems."

So to whom should assistance be targeted? If low performers, we've just discussed some of the advantages of this approach. Or should it be providers that face particular challenges, such as providers that serve a low-income population or providers that are lacking capital? And then how do you go about defining providers that face challenges?

Currently, the QIO program is implementing a focus on the first two bullets here, as recommended by the Institute of Medicine. Another alternative is to target high performers, and here the assistance would be to help encourage them to diffuse their knowledge to others while simultaneously moving the curve that you saw in the earlier slide.

In our internal expert panel meeting, there was considerable discussion on whether the assistance should go to providers or community organizations representing providers and other stakeholders. Such community organizations may exist in certain locales but not in all.

Our panel also was quite focused on the need for data and that everyone needs the data, high and low performers alike. They also noted the value of mentoring --

again, in combination with other strategies -- and that may lead you to target some funding to high performers.

So maybe we are looking at a matrix where the targeting of assistance depends on the type of technical assistance needed. To show an example here, on the top row data goes to everyone, mentoring goes to low and high performers, and short-term financial assistance and help identifying strategies goes to low performers only.

MS. MUTTI: The third question we asked was who should provide technical assistance and who should decide who provides the assistance. Before we discuss some of the options, we first want to provide some background and context.

First, an overview of the various organizations offering or funding technical assistance. First, of course there are the Medicare-funded QIOs which in one incarnation or another have been around for many years, and I'll come back to describing those a bit more in a minute. Over time, though, and particularly in recent years, we have seen the emergence of a lot of other technical assistance funders and agents.

Other parts of the federal government have also

gotten involved in quality improvement activities. The Agency for Healthcare Research and Quality, AHRQ, funds provider collaboratives aimed at reducing central line infections and many other projects through their ACTION program. And now the federal government will also be providing assistance for implementation of EHRs as a way to improve quality and efficiency, as was authorized earlier this year. That funding will go to extension offices to provide technical assistance as well as directly to providers that have implemented EHRs that meet the meaningful use criteria.

In the private sector, there are numerous initiatives as well. These include national organizations like the Institute for Healthcare Improvement, the Joint Commission, also trade associations for hospitals and physician specialty organizations, including the American College of Surgeons with their National Surgical Quality Improvement Program, and the Michigan Hospital Association's work on central line infections. Also, there is provider-initiated collaboratives and activities by health plans in this area.

Let me also just provide a little background on

the current QIO program, which is funded through Medicare's HI trust fund and provides technical assistance to providers through private sector contractors in each state.

The contracts are three years in duration and are called scopes of work or SOWs. The SOW directs the QIOs to focus on certain quality priorities and specifies how performance will be measured. For the current SOW, the ninth, the priorities include patient safety issues like reducing the incidence of MRSA, improving surgical safety. Care transitions is another one which focuses a lot on readmissions. And then we have also got prevention, which focuses on reducing disparities in preventive services, among other things.

The approach QIOs take in offering their technical assistance can vary. They may form provider collaboratives. They may work one on one. They may have conference calls. That can vary.

Funding for this work is about $420 million over three years -- that is the scope of the contract -- which is just more than a third of the total QIO budget of $1.2 billion over three years. Another 18 percent of the QIO budget is for handling beneficiary complaints and assisting

providers in uploading their quality data to CMS so that they receive the full update.

The largest portion, 44 percent, is for data processing and other support contracts and special projects. And this portion is somewhat controversial since some find that there has not been adequate oversight of how this money is spent, and it has been growing and, arguably, siphoning off funds from the clinical quality improvement activities performed by QIOs.

Another important piece of background is that in 2006 the Institute of Medicine convened a panel to evaluate the QIO program, and in the course of its work, it found no conclusive evidence that QIOs were effective. Clearly, it wasn't impossible that they were; it was just hard to prove that they were. And that is the case for a lot of these types of quality improvement programs. But threaded through their report and another one commissioned by HHS are some findings that suggested that management and design of the program was flawed and in need of improvement.

The IOM made numerous recommendations for change, including that the QIOs focus exclusively on technical assistance and no longer review cases or field beneficiary

complaints. They suggested that it should focus on providers with challenges, or poor performers, as Hannah mentioned earlier, and that CMS improve its management of the program by, for example, improving competitiveness of contract awards, better oversight of contracts, and extending the contract cycle from three to five years.

Some of these recommendations have been implemented but certainly not all. The CMS continues to consider them.

The IOM panel did consider some more significant changes, like moving responsibility for quality improvement out of CMS and putting it into AHRQ, but ultimately rejected them and found that QIOs have potential to make an important contribution to quality and should be central to Medicare's quality improvement efforts, especially if these reforms are made.

So, with that context, we come back to the last of our questions, and that is, who should provide the assistance and who decides which assistance the provider or community should receive.

Among the options is for the program to continue as is with QIOs providing all the services required under

the scopes of work under the direction of CMS's central office. Another alternative is to change the contracting requirements to allow more types of organizations to participate as technical assistance agents, perhaps creating more competition and specific expertise among competitors and contractors. This would require making substantial changes in the contracting rules.

A third alternative reflects a departure from the current program and that is to give grants directly to the targeted providers to purchase the services they need from certified sources. This approach has the advantage of empowering the provider or community, by entrusting them to decide the best way to use the resources and allowing them to better tailor their strategies to their local needs. And it allows for coordination of resources with private sector initiatives or federal support for IT. It does, of course, raise the issue of how providers or communities should be held accountable for using this federal money as intended. One check is in place in this example, and that is that the services would need to be purchased from a CMS-certified source, which could include QIOs but also other entities. This grant approach is in legislation pending on the Hill,

and our panel seemed somewhat -- well, quite receptive to the idea.

And perhaps it is not a stark choice between these three options. It may, again, depend on the type of technical assistance needed. For example, the demand for data might be best met by QIOs or some other CMS contractor like MACs, while the demand for more one-on-one assistance in identifying or selecting strategies may be best accomplished through a grant program.

So, in conclusion, we are interested as to whether there are specific aspects of technical assistance that you are particularly interested in and would like us to follow up on and if there are other questions you would like us to consider. There were some broader ones we did not get to by framing it in these questions, like: Should we be thinking about technical assistance more broadly, not just for quality but also for efficiency and reducing waste?

MR. HACKBARTH: Thank you, Anne and Hannah. I think this is an important topic. If, in fact, we are successful in creating a world where performance is more important and payment is linked to performance, et cetera, there are organizations who will need help to achieve our

objectives, and so this is about how can we provide useful help.

So let us see hands for round one clarifying questions.

DR. STUART: You note in the write-up that this process has been ongoing for some time. We call them QIOs now, and a few years back they were PROs, and then before that they were PSROs. But my sense is that the organizations themselves are the same, and so my question is: Is there any turnover? Or is this just a real sclerotic process?

[Laughter.]

MR. HACKBARTH: Yes.

MS. MUTTI: So there is, I believe, limited turnover, and we could get you some numbers on that. There are some contracting constraints that sometimes impede the competition, and we do find that a lot of the same organizations get their contracts renewed, and some people have questioned that.

MR. HACKBARTH: The history does go back to 1972 in PSROs, but, in fact, the mission changed pretty significantly when the conversion was made to PROs and to

then QIOs. So it has not exactly been constant over the last 35, 38 years, whatever it is.

MR. GEORGE MILLER: Yes, on Slide 7, you talk about targeting low performers may address disparities. Can you articulate a little more how that would happen? And the second part of my clarifying question is: Where are these providers? Are they inner-city hospitals? Are they rural hospitals? Are they safety net hospitals? Do you have a definition of where they are located and what cities? I am curious.

MS. NEPRASH: The first part of the answer is that we are right at the beginning of this analysis, very much looking for your guidance on what you are especially interested in. But the theory is that there is a broader finding in the research on health care disparities that minorities get are at a very small number of hospitals especially, and that those hospitals may perform not as well on quality metrics. And so what we are looking at is if the sphere of hospitals with very high readmission rates overlaps sizably with the universe of hospitals that serve these high minority populations, and if so, then targeting low performers on this readmission issue would also begin to

address those disparities.

MR. GEORGE MILLER: Did you look at, for example, the payer mix of those hospitals and/or did you look at the Medicare margins for those same hospitals as well?

MS. NEPRASH: Have not but can.

MR. GEORGE MILLER: Okay, see if there is a correlation, at least in my mind. And do you know where they are located?

MS. NEPRASH: I can also get you that.

DR. MARK MILLER: I think the point here is that we have read about this hypothesis and seen some evidence. We are now trying to go and find it in our data. We are at the front end of this. And all of these questions is what we hope to answer in doing that.

MR. HACKBARTH: Wasn't there an article published sometime this year in the New England Journal of Medicine or JAMA or someplace on this topic? I vaguely recall reading one. Or maybe it has been longer than a year and it just seems like a year.

MS. MUTTI: Well, the one that has come to our mind and is most recent that we have been thinking about is the Ashish Jha article in the recent Health Affairs, which

talks about IT in hospitals serving disproportionately poor patients, and they are likely to be more minority patients, and the payer mix there is low on Medicare, high on Medicaid. So we have some insights into, you know, what associate --

MR. GEORGE MILLER: And zero commercial or managed care products.

MS. MUTTI: Right, right.

DR. CASTELLANOS: Can I ask a question just on that same subject? I was going to do it on round two. You said a quarter of the hospitals in the United States take care of 90 percent of the African Americans, and you said it was also true for the Hispanics. My question is: Is it the same hospitals for the Hispanics as the African Americans? And where are these hospitals located? And are they the same hospitals?

MR. HACKBARTH: Yes, I would think -- oh, I am sorry, Hannah. Go ahead.

MS. NEPRASH: I was just going to say that those findings come from two separate articles but by the same researcher. And I know that they -- so I am not sure how much these overlap for African American and Hispanics being

taken care of in the same hospitals. But they are overwhelmingly urban.

MR. HACKBARTH: Yes, you would think that there would maybe be some overlap, but just because of the geography and where the different populations are located, there would also be a fair number of separate hospitals for the two populations.

MR. BUTLER: One will be related to a round two comment, and that is, my view of these is sometimes the connect point in the organization and the hospital and the QIO is lower than it needs to be. You call it technical assistance, and I would call what we really need is cultural assistance sometimes more than the technical side.

So my question, though, on round one is the expert panel that you asked, who participate in that to give you the thoughts?

MS. MUTTI: I was going to talk about descriptively who they were rather than names. We had representatives from the hospital industry. We had physicians in the room. We had academics. And we asked them to focus on readmissions, so people who had done work on readmissions. We had people who were from CMS who

focused on the QIO program as well as conditions of participation. We had a state surveyor there also to get their perspective. We had accrediting organizations in the room also.

MR. HACKBARTH: AHRQ.

MR. BUTLER: Just quickly, on the hospital side, were the physicians and the others kind of the CMO level, or were they kind of individual physicians?

MS. MUTTI: CMO.

DR. BERENSON: Could you go to Slide 13? The point about more types of organizations to contract with CMS. I think this is right, that in the patient-centered medical home demo, CMS has identified Johns Hopkins and Chad Boult's group there who have particular expertise in chronic care management as sort of a technical assistance for practices in that demo. So I guess my question: Is that unusual? Do demos in particular have roles for technical assistance? And is this sort of the exception where they are using a different organization with specialized expertise? Do you know what I am getting at here? I mean, I just want to sort of know how restricted is CMS to just use the QIOs as opposed to actually using other entities.

MS. MUTTI: Right. I have not come across other examples. I am trying to think through the different quality priorities, and if you think of through readmissions, they are just working with QIOs. There is legislation to broaden it. I have not heard anything on sort of the surgical or preventive, but we can look into that.

DR. BERENSON: Am I right about the medical home, do you know? I think that is right.

PARTICIPANT: Yes, you are right.

DR. BERENSON: Okay. So that might be the exception.

DR. MARK MILLER: My experience is that that is an exception, but within demonstration authority, as you know, they do have a lot of ability to change what they do.

DR. CROSSON: Anne, both in terms of the 2006 IOM report and also the focus group that you had, did you have a sense -- and this has to do with the effectiveness of the QIOs. Do you have a sense of the relative contribution of, you know, lack of capability of the QIO versus lack of receptiveness by the hospitals or physicians? You know, which dance partner seemed to be most out of step and most

in need of dance lessons?

The reason I am asking that is because if it, in fact, is mostly the receptivity, you know, as the Medicare program moves more towards reward systems, for example, the readmissions, one could imagine, for example, specifically strengthening the QIOs in their capability to help solve that specific problem. But if it is mostly a capability problem on the part of the QIOs, we have a different problem.

MS. MUTTI: Okay. We did not ask the panel directly, What do you think of the capabilities of QIOs? The IOM reflects sort of what we have heard in other informal conversation. There is a perception that there is a great unevenness in QIOs, that some seem to be able to get right on things and others do not. But there is no formal study that would prove that.

There were the quotes in the IOM study, because they went out and did interviews with QIO directors, and they asked them about the idea of working with lower-performing hospitals. And this is in terms of receptivity, and I think it kind of went both ways, as Hannah mentioned, you know, the feeling that we do not want to work with them,

they do not even have time for us, they have got so many other challenges on their plate. But also they project that the hospitals are not receptive, but at the same time, their comments reflected that they are not especially receptive to focusing their efforts on those populations. They are just more time intensive, requires more work, so I think the receptivity issue in focusing on low performers or performers with challenges has aspects of both.

MR. HACKBARTH: So both dance partners need lessons.

[Laughter.]

DR. MILSTEIN: I have two narrow questions. First, think about what quality improvement jobs need to be done. It seems to me you've outlined, either directly or by inference, three. You know, one is -- I caught the remedial job, those organizations that would like to improve, don't have the resources or wherewithal to do it, so we need a way of addressing that. The second is, I will call it, the adoption challenge. We know of a way to do it that provides better quality. How do we get providers that do have the resources to adopt more quickly? Then the third, which you did not address, which is the focus of my question, is --

you know, I think it was maybe two or three years ago, we had Virginia Mason come in here, and they are kind of emblematic of what I call the frontier of quality improvement in the country, which is the discovery of higher-quality methods of delivering care.

So my first question is: Have any of the deliberations to date discussed what CMS might do to sort of speed up and improve the productivity of those at the frontier? Because they are essentially discovering the things that we then try to push out into wider adoption. So it is your speed-of-knowledge turns, as a way of thinking about it in quality. Is there any activity that Medicare has ever or is pursuing in that area? Or is it all primarily adoption of things that are generally regarded as better ways of doing things?

MS. MUTTI: I think that it is a component of the QIO efforts. It is sort of implicit in their work, that they are trying to assist the high performers also in discovering new -- you know, they are governed by certain priorities, whether it is prevention or care transitions or that kind of thing that is specified from CMS, but that they are looking to improve performance even among the higher

performers. Some QIOs report they do not particular want to work with the high performers because they feel like there is less room for improvement. So, you know, how much of the energy is focused there I am not quite sure, but it is not excluded from their mission.

Also, you know, I think some of the AHRQ-funded initiatives, you know, these provider collaboratives that are getting together, like the Michigan Hospital Association, are representing that frontier, and so that there is funding coming into that.

DR. MILSTEIN: Great. A second question pertains to something that was referred to earlier and I am still not sure what the answer is, and that is, the scope of what Medicare's quality improvement resources take on. One is referred to as the technical, you know, just help people understand the production process by which more quality is attained. The second is what is often referred to as the psychological and motivational adaptive side, which is, you know, how do you get people -- those delivering care enthusiastic and passionate about adopting successfully these things that we know to be better ways -- that are known to be better ways of achieving health or retaining

health. And here is where, at least by reputation, you know, the QIOs have not been a predominant focus.

My question really is: Is there within any of these resources an explicit focus on the psychological, the motivational side of quality improvement? Because those like the Michigan Hospital Association who have got great results to show in a short period of time say that that is 80 percent of the battle, not the technical side.

MS. MUTTI: You know, our panel definition talked about the importance of cultural change, and we included that in that bullet of technical as mentoring, and we had panelists who commented, you know, I might have a hard time getting change made in my facility, but if I go to another facility, you know, I am better received and, you know, we can start talking about making changes and really getting at the underlying cultural changes that need to be made.

But, you know, the research, a lot of times the research is those people that are going to be the most successful at changing are the ones that are receptive to change. And so I just think that there is that tension of, well, if you are already receptive -- maybe we also need to focus on those that are not receptive to change.

MR. BERTKO: One quick question and then one follow question. The first is you cited the IOM study and then made some comments in follow-up. Is there anything formal that follows it up? Was there a GAO study? Or has the IOM kind of reported back on what has happened?

MS. MUTTI: There is no a GAO study, I'm pretty sure. I've searched for that and would have turned that up. There is a CMS response to the IOM that I think was issued a while ago, you know, soon after that came out, that is generally supportive of a lot of the direction that they were focused on. There has been legislation that has picked up some of the IOM recommendations. It is not clear if CMS supports all of the details like on, say, moving the contract period from three to five years or eliminating the beneficiary complaint function -- you know, those kinds of things. It is a little unclear as to where CMS is, and I do not know where to find the formal documentation on that.

MR. BERTKO: Okay. The second part reflects kind of your question toward the end, I think, Anne, about broadening it to include efficiency. I kind of see quality and efficiency as being close partners here. And while people like my friends at Dartmouth measure things, I am

unaware of any kind of efficiency improvement things that are equivalent to QIOs. There are a lot of revenue enhancement firms, but not necessarily efficiency enhancement. And I was wondering if you have any follow-up to that.

MS. MUTTI: You know, on that I was thinking of some of the directions that the IHI has moved into, not just focus on quality but, you know, throughput is an important factor or, you know, just that efficiency is a factor here and we should be spreading that.

MR. BERTKO: Can we maybe get some more information on that in the next session?

MS. MUTTI: Absolutely.

DR. DEAN: I just wanted to ask a question sort of related to George's comments. In Slide 7, when you talked about the readmission rates in hospitals serving minority populations, is the key characteristic ethnicity or is it income? And is there a way to break that down? Because I suspect that income may be a strong or maybe even a stronger determinant, but I am just curious.

MS. NEPRASH: I suspect that you are right in your suspicion, and the problem so far is that the research on

the connection between readmission and race is limited already in that it is frequently focused on individual conditions or even individual hospitals, and then income as a -- using race as an income for proxy is also -- or as a proxy for -- I am sorry -- is also a concern in the literature.

So I think you are right, and I don't have --

MS. MUTTI: We can report back.

MS. NEPRASH: We can absolutely look more into this and get back to you.

DR. DEAN: I think it is important because it could lead us down the wrong track if we are not careful in the beginning.

DR. CHERNEW: I have a question about the market demand for QIOs at some level. Does anyone pay them besides Medicare? So there is a market if I wanted to get a QIO that I could pay, not --

MR. HACKBARTH: I was going to ask the same question. It would be helpful, and I am sure it varies across QIOs. But how much private revenue do they have? Are these creatures of Medicare or have they passed a market test? That is the way I was going to phrase it.

MS. MUTTI: Right, right. And I think it does vary. I remember hearing some of them, more than 50 percent of their business is the QIO business. For others it is less. We know that most are nonprofit. I think four are for-profit. A lot of them, I remember seeing, have reported that they like trying to get the QIO contract because it gives them better leverage when they try and get other private sector work. So, you know, there is definitely a mix going on.

MR. HACKBARTH: I think that that is a critical issue whether they have passed a market test. My own personal experience in running a large group and being an executive in an HMO is there is a vibrant market of people wanting to provide technical support, cultural change support. It is not like there is a shortage of actors out there. You know, my own experience is some of them were good and some of them weren't so good. But, you know, basically what it seems like we have done is say, well, there aren't enough players in this market and so we need sort of, if not a totally government-supported, a heavily government-supported entrant in this marketplace. And that may be a good idea or a bad idea, but I think it is an idea

that is worthy of questioning and discussing whether this is an effective vehicle for providing the best assistance possible. And so that is why I like this topic. I think it is an important one.

MS. BEHROOZI: [Off microphone] Are we on round three yet?

MR. HACKBARTH: We are on round one and a half. Anybody who has not made a comment because they have been, like, Mitra, patiently waiting for round two, it is your turn now.

MS. BEHROOZI: Oh, no. That is going to ruin my reputation as being a disrupter.

Anyway, to continue the theme of disruption, on your questions on Slide 13, I think we have all -- I mean, you know, I think Glenn summed it up. We kind of are not interested in the first version of sticking with QIOs exclusively but, rather, exploring other ways of approaching how to help institutions pursue quality and efficiency as part of quality. And I would go for -- I would love to explore a mechanism for incorporating all different kinds of organizations into the mix, starting with -- Arnie's mention of Virginia Mason, where did they go for their quality

improvement lessons? Toyota. I mean, that is not even a health care organization. That is not somebody who is trying to be in the business of telling people how to be better health care organizations. So that is, you know, one sort of extreme example.

Where I come from, we do a lot of labor-management projects operated out of a jointly administered Taft-Hartley fund -- not mine; this is not a plug for anything that I administer -- but, you know, focused on achieving quality improvement in, I think, a very different way than when you are talking about the chief medical officer or the physicians or the leadership being mentored or culture change taking place among the leadership of the institution but, rather, working at both ends of the spectrum to achieve change throughout the organization and working on the little things, the maintenance of the cleanliness of the institution, you know, the orderliness of the supplies, things like that that are essential to quality, but coming at it from a very different perspective.

So I know that could get really messy saying, oh, you know, it is a free-for-all and any kind of organization could be eligible for funding contracting with CMS, so maybe

there needs to be some kind of entity that would be the clearinghouse for that kind of contracting or, you know, awarding of grants. But then also at that level, I think diffusion of those best practices is really important, and you do mention that in the paper. But I think that as we are talking about how to bring the help to the institutions that need it most -- and I would advocate, you know, focusing on where it is clearly needed most right now, that we don't just reinvent the wheel in each separate place or do something really great over here and something pretty great over here and nobody else knows about it. But, you know, I think diffusion should really be put up high on the list.

MR. HACKBARTH: Other questions or comments from people who have not had a chance thus far? This would be round two now. We are quite a bit behind schedule, so please keep that in mind as we go through.

MR. GEORGE MILLER: All right. Round two. While I enjoyed the reading, I was a little concerned about the tone, particularly to providers. The sentence on page 3 in the reading said, "Ten out of 20 QIO CEOs independently proposed that the barrier to technical assistance is a lack

of motivation of providers to work on quality." That, in my opinion, just sets the wrong tone because in the report you talk about the Michigan Hospital Association and what they did. There are many examples of hospitals, physicians, leading quality initiatives. So I was really concerned about the tone against providers. So I assume providers did not mean just hospitals. So not taking it personally, but it would be all providers.

And then you contrast that in there with some concerns about the QIOs themselves, that they are different; in different states they provide different levels of services; and they may not have their own technical expertise. And there was empirical research that they may not even be effective. So I think the message of the chapter should be even and not one that says that there is a lack of motivation by providers on quality. I am not sure that is true.

And then when you talked about the low performers, it seemed to me that either it may be a financial issue although we have not fleshed that out, but they serve a higher minority population or they do not have the resources to do that -- not that they wouldn't want to deal with

quality, but they may not have the resources and that technical assistance could be a way to improve quality.

So my major issue, more of a statement than a question, is I was concerned about the tone of the chapter toward providers.

DR. KANE: Well, I have been on the board of a couple of companies that have tried to do operational and quality improvement. One of them that I am still on is Press Ganey, and I have to say that there is -- to disagree for a change with George, there is a problem with motivation, and it is very hard to get these organizations to take on the kind of -- some of these really need massive cultural change. And one of my favorite phrases is, "The fish rots from the head down," and it really starts from the top. And you cannot come in kind of at the middle level and change a whole lot, you know? You really need a massive commitment from the top. Sorry, I know that is not --

MR. GEORGE MILLER: Even though I was a CEO --

DR. KANE: Yes, I am sorry, George.

[Laughter.]

DR. KANE: Not you, George. Don't take this personally. But I think the QIOs have always been seen as

sort of technical, technical. I don't think they are the right vehicle. I honestly don't. So I think, if anything, that the kind of money that gets put into technical assistance, which should really be called much more cultural change and managerial leadership assistance, should probably be targeted to providers who cannot afford to hire outside help on their own. Certainly, Press Ganey has lots of clients, Advisory Board has lots of clients. I mean, there's gobs of us out there doing this, so it's not like there aren't providers out there. But the two things that are missing is motivation, number one, which I think even when CMS requires a measure to be put on the public website, there is a flurry of demand for help when the measure like CAHPS measures look bad. So Press Ganey, you know, that is our -- we got motivation because this is going to be on the public website. So, bang, you know, we have got all these people saying, "Oh, come help us understand why our survey results are so bad in these domains."

So that is some of the motivation that I think Medicare can provide, is just making public metrics and then finding -- and then motivating the providers to fix those metrics. But I do think that motivation is one, but the

other is, you know, some hospitals, some systems really don't have the resources. I don't mean just to pay the consultants, but I mean to really take on -- it is often their docs who aren't collaborating or their culture, it is just not -- and they really need a lot of help, and they need resources to do that.

So it is a huge issue. I don't QIOs are really -- at least my understanding -- up to the task or that the -- I like the idea that, you know, anybody -- organizations are given money to hire them, to hire outside help, but that they are not limited to the QIO.

MR. BUTLER: So ditto on almost everything Nancy said. I would put one Pollyanna-ish view out there, though, that is a little bit loftier and larger. Again, I will refer to the DRG rollout which was in a way a unique partnership between the government and the provider side at a high level.

I am looking at Julian over here. You may remember the road show we put on that was in partnership with the hospitals and with CMS, HCFA at the time, where there was an explanation of what it was and how it would work, and then people like me saying, "And here is how we

are responding in our organization." It was a very high-level -- and I think presuming, let's say we get health reform passed, there's all kinds of payment reform in Medicare embedded in there, and wouldn't it be nice to have kind of a good, solid road show, or however you want to deliver it, that would capture not only what is already in place, other events and all those things, but what is coming in the pipeline as explained by government officials as best they can, in combination with fairly high-level CMO types that says, "And here is what we are doing in our organization," to kind of reset the dial and reset kind of a partnership at a high level. I think we could have an opportunity to do that which could be fun and actually somewhat energizing, because most of the payment reforms I think are being -- can be embraced by the provider side as necessary things.

DR. BERENSON: Glenn and Nancy made the point I was going to make, which is the group missing from your list of organizations providing technical assistance are consultants. And where I want to go with this, in reading the paper it looks like hospitals can turn in many directions from consultants, to associations, to IHI, which

is focusing there. It seems to me the group that really doesn't have the wherewithal and doesn't even know they don't have the wherewithal and need help are small physician practices. And to the extent that there is no market for wanting to provide services to them in terms of improvement, and they need a lot to sort of make the transition, I think -- I am not recommending this, but I think one might think about more targeting of the QIO-type program to physicians in those kinds of practices.

DR. MILSTEIN: I support this general line, but I think the category is broader. It is providers that don't really have the wherewithal to apply modern quality management methods. Now the equivalent organization to the one Bob just mentioned are non-chain nursing home operators. They don't have a prayer. So I think that is where public resources should be focused and not on providers that do have the wherewithal.

DR. DEAN: Just a quick comment. I was struck that we would target high performers, which I think is a very good idea, but we are sort of schizophrenic in how we approach this in the sense we're encouraging a competitive environment and then we want the people that are really

successful to use their expertise to basically give away their secrets.

You know, I think the latter is totally appropriate, and it is the kind of environment that I think we should support. But I think we give a mixed message about which direction we want the industry to go.

MR. HACKBARTH: I think that is a good point, Tom, and, though, there are organizations who that becomes part of their culture, and it allows them -- their leadership position allows them to attract high-quality staff because you feel like, oh, I am not just working for XYZ, I am working for somebody that is regarded as a leader in the field, and they go out and they do the speeches, they help others. And there is a certain cache in that. You know, the Harvard Community Health Plan tried to do that. Don Berwick got his start at Harvard Community Health Plan and then took his show on to bigger and better things. So that can be an organizational strategy in its own right.

Okay. Thank you very much, and this is a good topic. I like it. We will be back to it.

We will now have a brief public comment period. Let me just repeat the ground rules. Please keep your

comments to no more than two minutes. When this red light comes back on, that will signify that your two minutes are up, and please begin by identifying yourself and your organization. And one last advertisement before you begin. For those of you who are not aware, we do now have an opportunity on our website for people to make comments there, and I think it is pretty clearly identified, the button you push to get to that location. Please avail yourself of that opportunity.

MS. LLOYD: Hi. My name is Danielle Lloyd. I am with Premier. We are an alliance of about 2,200 hospitals nationwide that work to improve quality and reduce costs among our hospitals.

On this particular conversation, I just did want to note that through the Premier CMS Hospital Quality Incentive Demonstration, we actually do provide technical assistance as well as knowledge sharing among our hospitals, so diffusing information from the high performers to the low performers, as was being discussed. We aren't a quality improvement organization, however, and we think opening up to other organizations would benefit both the program as well as beneficiaries.

One thing I would note on that, however, is not every organization is going to want to take on a whole region. You might want to take on parts of a population or certain providers in an area, so that might be something that is barring some organizations from getting into this part of the Medicare program that you might want to consider.

The second thing is on comparative -- the coverage with evidence discussion. What I do not think I heard is any discussion about unique device identification, something that the FDA has been working on quite slowly. The health reform bill does have a provision in there to try to speed that up. But certainly to the extent that Medicare requires a specific unique device identifier to start flowing through to the public databases and then the private sector can start doing some of this research, that might take some of the burden off of CMS from trying to do some of this research and both inform coverage with evidence as well as comparative effectiveness research. It will not replace registry information like the ICDs but certainly may facilitate this, and that could be a concrete recommendation of the Commission.

Thank you.

MR. SCHULKE: Good morning. David Schulke, American Health Quality Association. We represent QIOs, so very interested in your last discussion.

Along with the mix of private organizations that are providing quality improvement technical assistance, like Premier and the Keystone Center and many others, the QIOs are a publicly funded national network of private organizations that provide this kind of assistance. And there are some advantages to having a publicly funded national network. The ESRD Networks are another national infrastructure of publicly funded quality improvement technical assistance organizations that you probably should include in your mix of considerations.

Some of the advantages are that when organizations work with QIOs, lessons that they learn in the course of their quality improvement efforts are shared via the QIO with other entities that are participating in that effort. So it is an efficient way of transferring information that is not as efficiently transferred if you fund individual providers and practitioners to hire consultants of their own choosing to advise them to be better competitors in the

market.

So I have seen the QIOs convene meetings where the providers that compete in the market are sharing information with other QIOs and providers in the room about how their best practices were derived and how they have had trouble implementing how they overcome those problems. So it is a very useful mechanism for facilitating speeding the transfer of information, overcoming competitive barriers that otherwise exist.

The QIOs are already working in a wide variety of care settings. In the past, you have thought of them as silos and described them as silos, physician offices, hospitals, nursing homes, et cetera. Because the QIOs are working in all of these places, this is a valuable aspect of the public infrastructure because they are able to get those all now to work on care transitions problems. Those problems are not just the property of the behavior of hospitals or that problem is not just under the control of hospitals, although mostly people right now are talking about it that way. QIOs have been convening all these parties in a community to work together on stitching together a better, safer continuum of care so people move

through it more safely and more effectively.

The QIOs are independent. They are by law required to be independent of providers and practitioners. CMS enforces that in a variety of ways. One of the advantages of this is that the providers and practitioners know that they can trust the QIO is not captured by someone else and they are willing to share information with them, and you get a more open interplay of information, exchange of information.

One of the side effects of that is that CMS has to approve private contracts of any significant that the QIOs might want to engage with, with a provider or practitioner organization particularly. So this has impeded their getting into private business with providers and practitioners. There is a pre-approval process and substantial concerns about the providers paying the QIOs to do work with them as individual organizations because of some of their Medicare responsibilities. So that is a conversation that is worth having later.

And I guess I would like to make two recommendations for you to consider to Congress. One is that when you are thinking about spreading the money around

to a lot more entities, which I know you are thinking about from the conversation, consider that the money is not as great as it seems. The largest category of the spending now and the ninth statement of work is for this infrastructure and support category. I think, we think, we surmise, although it is not a publicly known list of activities and contracts, one of the concerns we have is that CMS needs a budget to pay for quality infrastructure so they are not forced to forage for that money through the QIO field work budget.

Thank you.

MR. HACKBARTH: Thank you. Let's see. We will adjourn for lunch and reconvene at 1:15.

[Whereupon, at 12:10 p.m., the meeting was recessed, to reconvene at 1:15 p.m. this same day.]

AFTERNOON SESSION [1:17 p.m.]

MR. HACKBARTH: Okay, Kim, we are going to go ahead and start. We have a couple Commissioners who will be finishing phone calls and headed in in a minute.

So our first topic this afternoon is a continuation of our work on hospice and the hospice payment system and Kim is going to present some new data on hospice visits. Kim?

MS. NEUMAN: Good afternoon. Today, we are going to get our first chance to look at two new data sources on hospice visits that have recently become available to us. The purpose of looking at this data is to confirm whether the general findings in our prior work on hospice visit patterns are observed more broadly in these additional data sources. The data may also provide additional perspective that can help inform our research agenda on hospice payment system reform.

Before we take a look at the data, I will recap briefly our prior work. As you will recall, we previously found that Medicare's hospice payment system does not match well with hospice's provision of care at the end of life. This is because Medicare generally makes a flat payment for

each day in a hospice episode, while hospices provide more services at the beginning of the episode and at the end of the episode near the time of a patient's death and fewer services in the intervening period. As a result, long hospice stays are, in general, more profitable for providers than short stays.

In March of 2009, the Commission recommended that the hospice payment system be reformed to move away from a flat per day payment system to one in which per day payments for an episode of care begin at a relatively higher rate, but then decline as the length of the episode increases. The Commission also recommended there be an additional payment at the end of the episode to reflect a hospice's higher level of effort near the time of a patient's death. The Commission recommended that this change be made by 2013, which would allow time for additional data to be collected on hospice visits and costs that could inform payment system reform.

Historically, hospices have not been required to report much data to Medicare on the services they provide. Until recently, the only patient-level data on hospice visits available to us was data from one national for-profit

hospice chain. Now, two additional data sources are available.

The first source is Medicare claims data. Beginning July 2008, hospices were required to include on Medicare claims the number of visits provided each week by nurses, home health aides, and social workers. Today, we will look at the first six months of this data. It is important to note that the claims data only include information on the number of visits, not the visit hours. The Commission previously recommended reporting of visit time information on Medicare claims, and that will begin in January 2010.

The second data source comes from a group of 17 nonprofit hospices that served over 120,000 Medicare beneficiaries in 14 States between October of 2005 and September of 2008. The data include information on the number of visits and visit hours for a wide range of visit types.

Now, one word of caution on the data. In terms of the claims data, we are looking at the first six months of data under this new visit reporting requirement. We know from looking at data in other Medicare payment systems that

some providers may take time to adjust to new data reporting requirements and there can be some unevenness in the accuracy of early data.

In terms of the data furnished to us by the group of nonprofit hospices, it reflects the experience of 17 hospices.

But that said, as you will see in a moment, our analysis of these data sources is encouraging, as it is consistent with some of our prior findings regarding hospice visit patterns.

So now to look at the data. Previously, our analysis of visit data from a national hospice chain found that patients with short stays in hospice received more visits per week on average than patients with long stays. This chart shows that in the Medicare claims data more broadly, we are seeing the same general pattern. Shorter stays receive, on average, more visits per week than longer stays.

This chart also shows that patients with short stays receive a greater share of visits from nurses than home health aides, compared to patients with longer stays. This can be seen by comparing the size of the orange and

yellow segments of each bar.

The more frequent visits per week for short-stay patients reflects in part the higher visit frequency at the beginning of the episode and at the end of the episode, near the time of a patient's death. The next chart shows, based on the data from the 17 hospices, this U-shaped pattern in the provision of hospice visits. In each length of stay category, hospice visits are higher in the first and lat seven days of the episode than in the intervening period, with hospice visits being most frequent in the last seven days of life.

And in this next chart, you can see the U-shaped pattern of hospice visits shown in the last table depicted graphically.

So next, we will take a look at how diagnosis fits into the picture. The next chart contains Medicare claims data and looks at the number of visits per week by length of stay and diagnosis. It shows that after taking into account length of stay, there is little variation in visits per week across diagnoses. This confirms a finding in our prior work that length of stay is a more significant predictor of visit frequency than diagnosis.

Now, we will take a look at the visit hours data from the 17 hospices to see if the visit hours patterns look similar to the patterns we have seen in the number of visits. Regardless of whether we measure visits by the number of visits per week or the hours of visits per week, we see more visits per week on average for patients with short stays than long stays. That said, we observe a somewhat sharper decline in visits per week as patient length of stay increases when measuring visits by hours rather than number of visits. This is because patients with shorter stays not only receive more visits per week on average, they also receive longer visits. This highlights the value of the visit time data that CMS will begin collecting in 2010.

The next chart looks at the average visit hours per week by length of stay and diagnosis for the 17 hospices. Similar to what we saw with the number of visits per week, visit hours per week do not vary much by diagnosis once length of stay is taken into account. While there is not a large amount of variation across diagnoses, once we control for length of stay, we do see that in each length of stay category, cancer patients, shown in the orange bar,

tend to receive slightly fewer visit hours per week on average than other diagnoses.

The newly available data also give us a picture of the skill mix of visits provided to different types of hospice patients. Both the claims data and the data from the 17 hospices show that patients with short stays receive higher skill mix of care, meaning more nurse visits and less home health aide visits than long-stay patients. For example, according to the Medicare claims data, nurses furnish just over 60 percent of all visits received by patients with a length of stay of 30 days or less, compared to just under 45 percent of visits received by patients with a length of stay of 91 to 180 days.

In addition to the difference in the mix of visits by length of stay, we also see differences by diagnosis. After taking into account length of stay, cancer patients receive a slightly higher share of visits from nurses than patients with other diagnoses. So putting this together with what we saw in the prior slide, cancer patients appear to receive slightly fewer visit hours per week after controlling for length of stay, but a higher skill mix of visits.

Next, we are going to move on to look at hospice visit frequency by location of the patient. This is of interest because previously the Commission indicated it might consider examining whether a different payment structure is needed for hospice care provided in nursing facilities. If we were to examine that issue, there would be a number of questions to look at. For example, do hospice patients in nursing facilities and the community receive similar levels of service? Does the potential overlap in services furnished by the hospice and the nursing facility reduce the workload for each entity? And do hospices providing care in nursing facilities receive reductions in cost due to reduced travel time and higher caseloads per staff person?

The data we have today can look at the first of these questions. Here, we have a chart that shows average visits per week by length of stay and location of care. In this chart, we see that beneficiaries in nursing facilities and assisted living facilities receive slightly more visits per week on average than beneficiaries at home, after controlling for length of stay.

Not shown in the chart, the difference in the

overall number of visits per week across locations is largely a result of hospices providing more home health aide visits to patients in nursing facilities and assisted living facilities. This may seem like a counterintuitive result, since nursing facility residents have access to home health aide services through the nursing facility. We are uncertain what is accounting for this. It may be that the ability to provide care in a centralized location without travel between patients facilitates the provision of more home health aide visits. It also may be that patients in nursing facilities are more likely to lack family members who are able to provide assistance and support and that additional aide visits may partly reflect that. There are also questions about whether the provision of home health aide visits by hospices might be attractive to nursing facilities in bringing hospices in to serve their patients.

The Medicare claims data on visits also allow us to look at how visit frequency varies by provider characteristics. Both rural and urban hospices and hospices of different sizes show similar amounts of average number of visits per week. We do see some differences, however, in the number of visits per week by ownership type and across

free-standing home health-based and hospital-based hospices.

Free-standing and home health-based hospices and for-profit hospices provide slightly more aide visits per week on average than other hospices. What accounts for the difference in aide visits per week among different types of providers is uncertain. There are a variety of possibilities. For example, it may be that some hospices, for example, nonprofit hospices, rely more heavily on volunteers for home health aide-type services and we do not see volunteer visits in the data. It might also be a reflection of differences in the location of care across different types of providers. For example, for-profit providers tend to serve more patients in nursing facilities, which we have shown have more aide visits. Another factor might be the greater prevalence of long stays among certain types of hospices. The higher margin on long stays might facilitate the provision of more aide visits among hospices with more long-stay patients.

So in conclusion, the analyses of these two new data sources confirm findings in our earlier work and lend further support for the need for a hospice payment system that is better aligned with the U-shaped pattern of hospice

care.

In terms of our research agenda on payment system reform, there are several avenues we could pursue going forward. We could conduct additional analyses of the Medicare claims data to look at the implication of the visit patterns seen for the structure of a revised payment system, for example, how much the per diem payment rate should decline over the course of an episode or how much the end-of-episode payment should be. We could also analyze visit patterns for patients with stays of more than 180 days when data for a longer time period is available.

Second, we could explore the feasibility of using data from the 17 hospices to look at whether there are differences in travel time by location of care and what the implications of that might be.

Finally, we could look at hospice services beyond visits, such as prescription drugs and home medical equipment. While hospice visits are the largest component of hospices' direct costs, other items, such as drugs and equipment, also influence costs. We could explore this further by looking at data on drugs and home medical equipment use for a limited number of hospices. The

Commission may also want to consider whether it would be beneficial for CMS to expand its claims data reporting requirements to include prescription drugs, home medical equipment, and other ancillary services.

So with that, I will conclude the presentation. I look forward to your questions and discussion and any feedback on issues you are interested in pursuing in more depth.

MR. HACKBARTH: Thank you, Kim. Good job.

Before we start the discussion, I just want to say a word about the context for the benefit of the people in the audience who are now just maybe entering the conversation about hospice for the first time. As Kim pointed out, one of the findings of our earlier work on hospice was the significant growth in long stays in hospices. Some time ago, I was talking about that finding to an audience and one of the members of the audience during the question period said, why are long stays a bad thing? She feared the implication of what we were saying was that we thought the stays were too long and that they ought to be shortened by hastening the demise of the patient.

I just want to assure people that is not the

implication of the work. The issue that we have focused on is the timing of the admission to hospice and whether that is appropriate, whether it is affected by the payment system and the like. This isn't about hastening the death of anybody, but the timing of the admission is the issue here.

So let me see hands for first round clarifying questions. Mitra?

MS. BEHROOZI: Thank you. Kim, I feel like I should know this, but can you describe how the payment system works for hospice when somebody is in a nursing home, whether it is a Medicaid-paid stay or a Medicare-paid stay?

MS. NEUMAN: Are you referring to someone who would be a dual eligible?

MS. BEHROOZI: Yes, if they are covered by Medicaid. If it is a custodial stay, I guess they would be a dual eligible. But if it was separately, two separate ways of covering a nursing home stay, if they were there on a Medicare-paid stay also.

MS. NEUMAN: Okay. So if someone was in a nursing facility on a Medicare-paid stay, that would be under the SNF benefit. Patients who are getting care as part of the SNF benefit are, in general, not eligible for hospice. If

you are in a SNF because you broke your hip and that hip fracture is not related to your terminal disease, then in those situations, Medicare provides hospice to those folks in a SNF. But in general, there is a divide between the SNF benefit and the hospice benefit. You are either in one or the other, but not both.

MS. BEHROOZI: If it is that situation that you mentioned, is it simply one payment on top of the other? Is there any offset? I mean, as you said, a broken hip separate from the terminal diagnosis?

MS. NEUMAN: Right. No, there wouldn't be any offset. Yes. And they would hypothetically be providing different services, tending to the skilled care needs of the person, and then the hospice would be providing services for the palliation of the terminal condition.

MS. BEHROOZI: If it's a dual eligible whose stay is covered by Medicaid?

MS. NEUMAN: So if it's a dual eligible, Medicare pays for the hospice portion of services, so that's for the nursing and symptom relief of the terminal condition, and then the room and board piece of the nursing facility stay, that is paid by Medicaid. And the way it works is the

Medicaid payment goes to the hospice who then pays the nursing facility for the room and board.

DR. DEAN: I was going to ask somewhat the same question. On Slide 12, and probably I suspect you don't have the answer to this, but those numbers are, you know, like you say, sort of counterintuitive in a way, and I wonder if we are assuming that these patients are all relatively equivalent in terms of their needs, and I suspect that may not be true. Is there any way -- and maybe there isn't -- to determine sort of the functional status of these folks and the differences that may exist as sort of a risk adjustment? I suspect that may not be possible, but I wonder if some of these difference may be -- the people that are still at home, even though they have a terminal disease, may still be able to do some things for themselves, whereas those that are in nursing homes probably can't. I don't know. I am hypothesizing.

MS. NEUMAN: I think that is right on target, that there are going to be differences in the functional capabilities of the people in the different settings and that that could be partly reflected in this data.

Also, something similar is the idea that the

amount of family and informal support that people have may differ in the various settings.

DR. DEAN: Yes.

MS. NEUMAN: For a patient to stay in the home, they have to have a fair amount of support already there --

DR. DEAN: Right.

MS. NEUMAN: -- whereas a patient in an assisted living facility may have less support, and also probably less availability of services than someone, say, in a nursing facility. So there's probably differences both in functional capabilities and access to other kinds of supports.

DR. DEAN: Just to clarify your answer to Mitra, which that's very interesting, that if a patient is in a nursing home covered by Medicaid, the Medicaid payment would go to the hospice first and then -- so it really isn't a double payment, or it isn't as much overlap as it might seem on first glance. I guess I was assuming they were two separate payments, but --

MS. NEUMAN: Well, each payment is intended to be for a different sort of pool of services --

DR. DEAN: Right.

MS. NEUMAN: -- and the concern of overlap is whether -- the idea that by each entity providing assistance to these individuals that perhaps it reduces the workload of each some. We have yet to be able to determine if that's the case, but that's the theory.

DR. DEAN: But at least in theory, the only payment that would go directly to the nursing home, then, would be just the board and room payments, not nursing care payments.

MS. NEUMAN: Just the normal Medicaid nursing facility room and board payments and the ancillaries that go along with that.

DR. DEAN: I mean, but that would include usually, you know, nursing care and aide care, or care by nurses' aides and so forth --

MS. NEUMAN: Yes, and I think that -- I am using that room and board to mean all the stuff that goes with being in a nursing facility --

DR. DEAN: So it would include the nurses' aide --

MS. NEUMAN: It does include that. Yes. I'm sorry if that wasn't clear. Yes.

DR. DEAN: Okay.

MS. NEUMAN: But when a hospice --

DR. DEAN: So there is a sense of some double payment. I mean, I don't know --

MS. NEUMAN: In the Conditions of Participation for hospices, it lays out the idea that the nursing facility needs to keep providing the services that they would provide to this patient if they weren't in hospice and the hospice needs to provide the services to the patient as though they were in their home, that there shouldn't be any kind of reduction. That's what is in the Conditions of Participation.

DR. MARK MILLER: The concern is that there is still some overlap and some potential for payment error, and in a second situation that we heard about when we were doing this work over the last year or year and a half is you had situations where the nursing home owns the hospice, and she had those kinds of circumstances. And I think the IG has been paying some attention to this issue.

MR. HACKBARTH: Round one clarifying questions?

DR. BERENSON: Yes. Since I wasn't around for previous discussions, I have a question, maybe to Glenn based on what you were saying about what our concern here

is, and I appreciate it's not about the back end, it's about the front end. I would have thought, except for maybe this example where the nursing home owns the hospice, that the hospice is a relatively passive recipient of a decision made by patients, families, and doctors. Do we have reason to believe that the incentive for doing well on a long -- relatively well on a long stay is the hospice is somehow part of the decision to trigger that event, to trigger the referral and the beginning of a stay?

MR. HACKBARTH: Mark or Kim, do you want to answer that, because you actually participated in the conversations with our expert panels. But we did find some issues about relationships, for example, hospices and nursing homes that might be an example of that.

DR. MARK MILLER: Yes. I think there's -- and Jim, you should also step into this conversation, because Jim did a lot of this work before it moved over to Kim. I think when we, both when we went out and spoke to people in the field and lots of people came into the office to talk to us and we had an expert panel with medical directors, there were statements like this.

There was the nursing home situation, where

hospices may actually enter a nursing home and kind of work through the population and say, we can offer additional services, in a sense, kind of reaching for services. And also, certain markets, there had been a lot of growth in hospices, even to the point where some people argue that the markets are becoming saturated, and there has been much more outreach in terms of physicians in saying, you need to start referring to us. And there's also some, you know, the medical director of a hospice in a community can play a role with physicians in the determination of patients and bringing them into the hospice setting. At least in some of the expert panel discussions, there was concern in certain markets where it was becoming so saturated that a lot of that was -- or some of -- I don't want to say a lot -- some of that was going on.

DR. BERENSON: That was basically the genesis of our looking, then, on what we could adjust in payment policy to try to prevent -- to think we could have some influence on that behavior?

MR. HACKBARTH: Well, then the other way we looked at it was just looking at the patterns of care and whether the payment method of a flat amount was consistent with what

you would expect to be the normal intensity of services. On the face of it, in a way, it is illogical to pay a flat payment amount, and if you are paying a flat payment amount, in all likelihood, it would make longer stays more profitable than short stays.

DR. MARK MILLER: And just to, again, there is a lot of work here that we are kind of blowing through really quickly. You know, there was -- and this is a good thing -- I mean, there were attempts on the part of CMS to encourage the use of this benefit and there are decidedly broader conditions and diagnoses that are being brought into the hospice benefit, and that is probably all a good thing.

But then you also found among the medical directors discussions about -- and this is always an art and it is very difficult, and we have had several conversations with people in the field about this -- in determining the eligibility and the notion of predicting the last six months of life. And again, given the payment issues and some of the growth issues and the saturation in markets, were the definitions of sort of defining people as eligible for the benefit becoming more lax, and that some assertion that some people entered markets and took a little bit more of a

liberal view on sort of who could qualify.

MR. HACKBARTH: And we had people in the hospice field who were saying that you're raising legitimate concerns. There are issues that are of concern to at least some people within the field, so a number of different things came together.

Peter?

MR. BUTLER: Well, I think you are on the right path here with the U-shaped curve and you have done a lot of good additional work. My question relates to performance. Most of the other services, we're increasingly injecting pay-for-performance kinds of standards along with the payment. Obviously, when the clinical outcome is expected to be death, it's not quite the same. Nevertheless, there's pain management or access to support when you need it or communication with family. Have we begun to think about how we would evaluate the job that hospices are doing in a systematic way?

MS. NEUMAN: There are currently several different kinds of surveys that are out there among various hospice associations to survey family members of patients to find out about the experience, so there are survey kinds of

instruments that are out there. They are not across the board, every hospice, and they are not -- it is not publicly-reported data. But there are things like that that are out there that have sort of been the beginnings of quality measurement.

You know, there are some issues with surveys, as you know, as far as quality measurement in terms of, one, sort of a family member's perspective may not fully reflect the experience of the person going through it, and also there's the subjective nature and generalist surveys. So there's been a desire to try to look at some administrative data, if possible, and so we've been thinking about if there are administrative data measures that we could look at. It's, I think, a little bit more difficult with hospice than other kinds of services, but we have been doing some thinking there and we can come back to you on that.

DR. KANE: Yes. I'm just curious to know, since you have Medicare claims data for six months, whether you looked at geographic variability in the patterns of visits over length of stay and maybe even able to -- were you able to take a look at whether the patterns varied by the degree of market concentration? I know that's a tall order, but

even just a geographic variation. Is there much, or is it pretty consistent in different parts of the country?

MS. NEUMAN: I did not look at the geographic variation, and I might be able to do that with the six months of data at a very high level. If we want to get at sort of the market concentration issue, I think we're going to need to wait until we have at least a full year of data so that we have a bigger sample. I had to limit my analysis to people who entered and exited hospice within this six-month window, so that really makes the size of the sample smaller than it would otherwise be. So I think with more data, we could really get at your question pretty well.

MR. GEORGE MILLER: Were you able to determine, based on this graph and your other slides, if for-profit and not-for-profit had a higher utilization of nursing facility and assisted living facility versus patient's home, or is there any correlation between that issue, and the same thing for rural and urban --

MS. NEUMAN: Between for-profits and not-for-profits, you see not-for-profits having more patients in the home and fewer patients in assisted living and nursing facilities. I have not looked at it for rural versus urban,

but I can do that.

DR. STUART: First of all, Kim, thank you for doing this. I really appreciate your sensitivity towards this subject.

I would like to focus into the palliative care that hospice provides and specifically palliation when using radiation therapy or chemotherapy. I have several questions.

One, who pays the facility fee for, say, radiation therapy for palliation and who pays the professional fee? I already have that answer, but I just wanted to kind of ask you that.

[Laughter.]

MR. HACKBARTH: But you're not going to tell us.

DR. STUART: And the other --

MS. NEUMAN: I believe the hospice is responsible for the --

DR. STUART: For the --

MS. NEUMAN: -- because it's within the -- it's for the palliation of --

DR. STUART: For the facility fee, but if it's not done by a hospice doctor, like the radiation therapist, I

think that comes under Part B, but maybe it doesn't --

DR. MARK MILLER: The doctor -- no, go ahead.

MS. NEUMAN: No, you go ahead. Please.

[Laughter.]

MS. NEUMAN: Why don't I get back to you on that? The general rule is, and this may be an exception, that if it's for the palliation of the terminal condition, that it's within the hospice's payment that it has to be funded out of. There may be some technicality here that I'm not aware of --

DR. STUART: Yes, I'd really like you to look into this --

MS. NEUMAN: Yes. I can find that out for sure.

DR. STUART: And I'd like also to see if there's a difference between the palliation, specifically the radiation and chemotherapy, between for-profit and not-for-profit hospices.

And the fourth question, and it's an ugly one, is if in the opinion of a non-hospice doctor that's treating that patient, i.e., like myself, who feels that the person should get something for palliation and hospice disagrees, what happens then with the payment? That's the issue.

Those are difficult questions.

MS. NEUMAN: I'll come back to you on that. In general, the hospice is responsible for all care associated with the terminal condition. The patient can revoke hospice and go back to traditional Medicare, but those are sort of -- that's the general confines of the benefit. And I'll look into your specific examples of radiation and chemotherapy and see how that --

DR. STUART: For palliation.

MS. NEUMAN: Yes, for palliation. These are people who are in the hospice benefit and who -- this is not to cure their condition, but to provide symptom relief.

DR. STUART: That's correct.

MS. NEUMAN: Got it. Okay.

MR. HACKBARTH: Okay, round two.

MS. BEHROOZI: The data on the different sites of care seems really interesting, and I don't -- I didn't see it when I went back over the slides and I don't remember you mentioning it, but you very well may have mentioned it when you were doing your presentation. In the paper, you note that a higher percentage, almost, I guess, 50 percent more, percentage of beneficiaries in nursing facilities went

beyond 180 days of hospice care, and again, maintaining the focus on the going in side, just in terms of how the assessment is made.

I wonder about the relationship between the issues of payment that we're sort of starting to take a look at, before we even get to the question of the services that are provided. I mean, it's a good thing if they get more visits and things like that. I think that's good. But I just wonder about the incentive to create a hospice patient out of somebody who's not really the right candidate. I hope I said that delicately enough.

MS. NEUMAN: One thing to note in those different rates of stays exceeding 180 days among the nursing facility and non-nursing facility patients is that there is a different diagnosis profile across the two settings so that if we were to control for diagnoses, I believe there would still likely be a higher percentage exceeding 180 days, but it would be mitigated somewhat by those differences. So it is something to keep in mind. It doesn't change the concerns you've raised, but just a qualification of those numbers in the paper.

DR. CHERNEW: I want to thank Mitra for that good

set-up question, and my question is similar in the following sense. If I understand correctly, all the analysis in the chapter is based on people that went into hospice. So the length of stays is if you go into hospice, this is how long you stay. This is how many visits you have if you had a hospice stay. It is all if you had a hospice stay.

And so what I think the -- in the theme of several other comments I have made, I think hospice is obviously extremely important, but it has to be framed, I believe, in the context of the broader question of the difficult issues surrounding end-of-life care. And whatever happens in hospice has to be placed in the context of are we getting the right people in when they -- so you could have things look perfectly the way they do, but find some setting where people aren't being admitted to hospice when they should, or people that are being admitted to hospice when they shouldn't. I'm not even sure I know which way it goes.

But I think this is an example of a silo of where we take a bunch of people out conditional on getting some benefit and think about what's going on with these people who have selected or been self-selected or had others select for them a set of services when I think we really have to

make sure that in this context we provide the appropriate care for all the beneficiaries, those that elect hospice or not, when they reach certain conditions. And I think getting that right is really hard, but something that we have to think about broadly as the patient, not just those that end up in a hospice.

MR. HACKBARTH: I think that is a good point, Mike. Could you take it to the next step? So what does that mean for future analysis that you would like to see Kim do?

DR. CHERNEW: I'm not sure what you can do with this data, because part of the data is set up on just people that went to hospice. But if I had my druthers, I would like to see data on, say, deaths -- of Medicare beneficiaries that passed away, how many of them were going into the hospice? How long were they in the hospice? How many of them were -- you know, so I could have a better sense of whether nursing home patients, for example, were being put in hospices too often, not often enough.

There was this issue that was raised before about the SNF payment. So you might have an incentive not to put someone in the hospice, because if you put them in the

hospice, you might forego some other payment you would get from Medicare. But those types of connections between the programs might not be captured if you look on just the people that went into SNF.

So I would like to begin, maybe not for this analysis, because we have to deal with the payment systems we have, but in the broader policy context, I would like to begin to think about how we deal with payment for people in nursing homes, people not in nursing homes but with serious terminal illnesses, people with serious but maybe not necessarily terminal illnesses, because those patterns of care matter broadly whether they are in or not, in a hospice. That's all.

MS. HANSEN: Thank you. I think we all recognize how important the hospice benefit is, and I think to your point, Mike, making sure that people can avail themselves of this service and just perhaps many people who end up dying in hospitals might have had probably palliation that met in a different way, in a non-hospital environment, we would hope.

The question I have is more of some data, and I don't know that I remember seeing it -- if I did, I must

have missed it -- as to what, Mark, you brought up earlier in terms of a lot of the work that the team has done and just getting some backdrop on it. I am just wondering if we have captured the information of -- there was, like, a rather bloom of growth of hospice, of which I think that's part of the reason it's triggered us to take notice after so many years of great effort by the hospice people to make sure this benefit is known.

But did we follow the trail of just when the ownership aspect, say, of nursing homes, and are we able to kind of track that growth pattern, because it just brings back some potential concerns about self-referral in other areas that we have relative to ownership. So I wondered if the work has been done just to be able to have some text on that. Thank you.

MR. BERTKO: Okay. Kim, quick comment and a question. The first is, excellent work to confirm the findings that we did with that earlier smaller work and now we have a wide database to show this. So given that one of the emphases of our Commission is on accurate pricing, it would seem that going to a U-shaped payment mechanism in whatever form we finally decide is useful to do right away.

So I would say an expeditious movement on it.

The other thing is more in the form of a question. I have inferred from both the background paper and your presentation that the U-shaped pricing is the majority part, or the biggest part of the fix that we would want to make. You mentioned some follow-up studies, but just in trying to listen to you, it seemed like the follow-up work would be good things to do for later on, but they shouldn't impede us. We're not missing any big amount now. Is that assumption correct, that we're not missing anything if we said immediately to go to the U-shaped payment mechanism?

MS. NEUMAN: The U-shaped payment mechanism, I think, would go a long way to resolving the issues in the payment system. There are potentially additional refinements in things like drugs and medical equipment that it would be valuable to look at. But I don't think that that undercuts in any way sort of the general findings.

MR. BERTKO: Thanks. That was my impression.

MR. HACKBARTH: Let me just pick up on John's question. My -- and I'm going to focus on the timing here of this -- my recollection was that we made a recommendation to the Secretary that she ought to look at altering the

payment system to one that more accurately conforms with the U-shaped pattern, but there was a question, I vaguely recall -- correct me if I'm wrong -- about the availability of the data to actually go beyond the conceptual stage, that U-shape is the right shape, but to specifically identify the precise shape of the curve. And in order to do that, CMS was going to have to have more data, new data -- here's where I'm getting foggy. Could you fill me in on that?

MS. NEUMAN: Sure. So CMS is going to be having additional claims data beginning in January of 2010, and that will include visit time information as well as information on a broader set of visits -- therapist visits and also social worker phone calls. So there will be additional data that will be available starting in January 2010.

In addition, there was a desire to improve the reporting on the cost reports --

MR. HACKBARTH: Right.

MS. NEUMAN: -- to be able to better identify costs, and CMS has given indications in their rulemakings and so forth as far as notices that they are working toward that. The 2013 time line that we had suggested was one that

we had thought could accommodate the incorporation of both pieces.

MR. HACKBARTH: Yes, given the normal lags in data reporting. So 2013 still seems like a good target date for actually implementing a new payment system. Okay.

DR. MILSTEIN: I think, as somebody else previously mentioned, if we're trying to get the payment system right, it would be nice if we could, in addition to having the payments more closely approximate the production cost, if we could also make a little bit more progress on the quality.

I wanted to suggest that we may want to rethink the view that you had articulated earlier in the discussion that we want to move away from subjective patient-reported or family-reported evaluations of their experience of care as the primary quality indicator. In some ways, I have no problem, given the nature of this program, with that being the primary quality indicator, and I'm not sure that, if I begin to sort of run in my mind through what would be good quality of care measures, quote-unquote, "objective," based on administrative data, that you would remotely be able to come up with a set of measures that would be anywhere near

as important or important to the beneficiaries as their survey-based experience of care, including timeliness, responsiveness, kindness, et cetera.

MR. HACKBARTH: As a non-physician, it would seem to me that probably for palliation, it's in the eyes of the patient, how well has their pain been managed, as opposed to there being some objective measure of that.

DR. MILSTEIN: A second comment, and I won't even look at Mark because I know he'll roll his eyes when he hears this, but, I mean, if you sort of think about --

[Laughter.]

DR. MILSTEIN: It's sort of, Mark doesn't like mission creep, right? He hates mission creep. I understand. If I were in his role, I would hate mission creep, as well.

[Laughter.]

DR. MARK MILLER: [Off microphone.] Thanks.

[Laughter.]

DR. MILSTEIN: But I sort of -- you know, one way of conceptualizing hospice is sort of a first generation look at what a Medicare benefit plan would look like that was sort of better customized to -- if you're trying to

customize a patient's Medicare benefit to their personal preferences, as to what they did and did not want from medical care, you can think of hospice as kind of a first shot at that and say, well, how about end-of-life?

But I think for me, as I listen to people in my family who are reaching this stage, there's quite a few who want something -- who would really love to have the option of a Medicare benefit that wasn't limited to end-of-life care, but essentially gave them a benefit plan that really focused on quality of life rather than length of life at the end of their life.

For example, I have family members who say, isn't there some way I could have a Medicare benefit that would -- they wish -- protect them from either being involuntarily picked up by an ambulance and taken to a hospital, which many of them, that's the last thing they want, given their age. Maybe for a -- this has nothing to do with giving them hospice benefit plan, but this is a moment for us to at least reflect on whether or not in some future initiative we may want to say, look, hospice was a first attempt to come up with a customized benefit plan for preferences of Medicare beneficiaries.

Does it suggest -- this conversation, does it suggest you may want to think about the broader opportunity to think about a new Medicare benefit plan that would be customized to patients whose primary interest is quality of life rather than curative intervention, and then use our experience with the hospice program as input to conceptualizing such a benefit plan.

DR. CROSSON: Just briefly, I just wanted to -- I was going to make the same point that Arnie made on his first point, and that is it seems to me the critical pathway here, if there is one, is to go ahead and reaffirm, perhaps, our recommendation based on the new data that we made in March. But as I was looking and listening to the conversation, the question was, what else could we do, and it has struck me here for some time that, unlike most but not all other areas that Medicare pays for, there is very little information about what Medicare actually is paying for and whether or not the patients are happy with what they are receiving and where they are happy and where they are not happy.

And I agree with Arnie that I think simply asking people, you know, in a formalized way with a set of

questions would go a long way. If we are going to be reforming payment, then it would seem to me that some part of it might be as we have done in other areas, consideration of, in fact, paying more for outstanding results than we pay for less-than-outstanding results, and that would require some sort of assessment tool. And so I would support us thinking a little bit more about that.

MR. HACKBARTH: Kim, have there been any efforts within the hospice field to develop standardized tools for assessing patient satisfaction?

MS. NEUMAN: There are several standardized tools. They're not universally used, but there are several tools. For example, the State of Florida has a report card on hospices that uses one of these tools. So they do exist, and it is something that if there was consensus about, we could explore sort of which tool or a tool plus some administrative data, or, you know, there's a number of options.

MR. HACKBARTH: Okay. Karen, on this point?

DR. BORMAN: Just, Kim, when you look at these, I know in a lot of hospice functions that there is a post-patient death activity with family members in terms of grief

counseling and some of those kinds of things that really bring to closure the episode. Does this length of stay just stop with the actual death of the patient in hospice or does it capture that, and then that activity to me seems to be something that would be important in this scalar assessment, and typically our assessments don't really ask about the family or others of a Medicare beneficiary, but in this case, it would seem to me that that would be an important source of assessment, and as we think about or look at those tools, we might want to make sure that's included.

MS. NEUMAN: This length of stay is the -- it does end with the patient's death or discharge. But to comment on your point, we have heard from hospices the idea that the amount of bereavement support that a hospice provides to family members is an indication of the quality of the care.

MR. HACKBARTH: Any other round two comments?

DR. STUART: Like much else that we do here, we start on what we think is a pretty narrow topic -- this U-shaped visit function is pretty easy to grasp -- and then we spread out. And I wanted to pick up on something that Mike said, and Arnie, I think it reflects on some of your comments, as well, and that is that I'm not sure what we

know about people who are tentatively eligible for hospice and choose to go in or choose not to go in, or the hospice chooses that they go in or not go in. Mike was suggesting that the end-of-life issue was broader than just hospice, and so it would be interesting to know what kinds of services are provided for people that don't go in.

Unfortunately, you can't just look at death and then go backwards in some kind of a database. Really, what you want to do is you want to look at people who had an equal propensity to be admitted to hospice and then look at what happens to those groups of people as they go through.

Now, there's one other thing that I'd like to add to that, and this broadens it in a slightly different way. In the readings that we had, the first table was actually one of the most interesting because it showed not only this U-shaped function, but it also showed -- it broke it down by people who were discharged deceased, and we presume that this is -- obviously, this is what the benefit is designed to do, but there's then that other panel of patients that were discharged alive, and you indicated in your comments that this could be either because the patient decided to remove himself or herself from the hospice benefit or it

could be because the standards for being in a hospice were no longer there.

Do you have any statistics on the number of people that are discharged alive and then the reason why they are discharged alive, because that might have an indication on quality. Clearly --

MS. NEUMAN: People have talked about the discharged alive percentages as being a potential quality measure, and I don't have the statistics right here with me, but I can get you overall figures on the percentages discharged alive. I don't believe I have the reason information, but I'll double-check on that and we can get back to you.

DR. CASTELLANOS: Just to pick up on the quality issue, I think there's a big difference between surveys and measuring quality. Again, I would like to see some instrument where we can measure some form of quality, perhaps palliation of pain, perhaps access, perhaps responsiveness. I think that's a big difference between a survey and a quality measure.

MR. GEORGE MILLER: Yes, I want to chime in where John said that the U-shaped payment is a way we should go,

to move very, very quickly, so I want to add that. But Arnie's discussion started me to thinking here, and that may be a little dangerous, but to pick up on his thought, along with the hospice benefit and just thinking a little bit out of the box, there may be a way to incentivize instead of the provider but the beneficiary, if they had voluntarily selected options to choose instead of going to the ED or using the ambulance, if they choose palliative care and the hospice, maybe a payment difference -- excuse me, a difference would be in their copay or deductible to lower the overall cost as you look at the whole system, because they wouldn't be using the resources if they chose to do that. Again, very voluntarily. Very voluntarily. Be careful about your earlier --

MR. HACKBARTH: Of course, that's the tricky part --

MR. GEORGE MILLER: Yes, I realize that, but he started me thinking. That may be something that is unique and different than either box, if they make choices early -- enough folks make choices. My dad was one of those persons. He didn't want to go to the hospital for anything, for any reason, any place, any time, period. He said, we're all

going to die. Just don't do all that stuff. But very voluntarily. I want to emphasize that.

MR. HACKBARTH: Thank you very much, Kim. I'm sure we'll be back to this.

Okay. Next on our agenda is "Aligning Medical Education with Health System Needs," and Cristina and Craig are going to lead this discussion.

Let me just say a word about the context for this. At our last meeting -- in fact, let me go back even one step further to our June chapter on graduate medical education, sort of a high-level survey of issues in graduate medical education, and we had identified issues around the number and type of people who are being trained by the system and whether it is an appropriate mix in terms of specialty, in terms of ethnic background and race, origins, et cetera.

Then there was a second bucket of issues about just how were they being trained, what were they being taught, what were the settings like in which the training was being done, what was the curriculum.

And then there was a third set of issues about how all this is paid for, both how the money flows out and what the sources of financing are for graduate medical education.

In our last discussion, in October, we mostly focused on the first two of my buckets. Are we training the right number and mix of people and are they being taught the right things in the right places? And I think we started to make some progress towards finding some areas of consensus about that. Much still to be done, but I thought we made some progress.

We didn't really talk, though, about the funding issues and how we should best raise the money to fund what is a very important enterprise for society.

So the purpose of today's discussion is to focus on that third bucket, the funding of graduate medical education and different alternatives for thinking about that, and with that, let me turn it over to Cristina. Are you going first?

MS. BOCCUTI: Sure. Then I can dispense with describing that at the beginning and just say that we are continuing this discussion from the last several meetings. So we are going to cover the following issues:

First, in response to some questions from the last meeting, Craig is going to be giving some background information on medical education and training in the VA

system. So that is background, a few background slides. And then we are going to review goals of medical education and training and discuss current financing mechanisms, sort of the status of what we see today, and then go into a medical education trust fund concept and describe that.

So Craig is going to go on.

MR. LISK: At the last meeting, Nancy and Jay both mentioned the VA and how it serves an important role in graduate medical education, so we wanted to just take a moment to review what the VA does in regard to graduate medical education.

The VA currently funds about 9,800 full-time residency positions. The VA, however, is usually not the prime sponsor of residency training programs. The prime sponsor of the programs that rotate to the VA usually are IPPS hospitals or medical schools. About 35,000 residents and fellows, though, rotate through the VA every year, so the VA touches about a third of all residents, so it is very important in terms of touching a large portion of residents.

The VA provides two forms of support for residency training programs to its institutions. They provide direct support for residents' salary and benefits, which average

about $58,000 per resident, per FTE. They also provide support through what is called the VERA Educational Support Adjustment, which amounts to about $71,000 per FTE. And this is distributed to the VA facilities where the residents train to cover costs associated with the time and structures used to prepare and deliver didactic training and supervision of residents.

This adjustment kind of melds both the faculty component of direct GME if we think about Medicare payments and patient care inefficiencies that are also associated with the Medicare IME adjustment that might result in higher costs to the institution.

The VERA Educational Support Adjustment, however, is a broad-based educational adjustment in the VA training system as it is also used to help support other educational endeavors that may be going on in those institutions, such as training costs associated with training physical therapists and occupational therapists or nurses, for instance. So the count of residents is just a proxy for this, but it is distributed on a per resident basis to these institutions.

The VA also has some important features that

provide a good educational environment for residency training. The VA uses a comprehensive electronic medical record which includes support for a lab and radiological test results. It helps reduce duplication of services and is available across the system.

The VA also provides training in an integrated health care system, and they are launching a major effort for patient-centered medical home as well.

The VA also pays for non-clinical time, so resident time spent in medical conferences or in non-patient care activities are fully supported. And the VA also pays for GME regardless of the site of care or the training takes place.

The VA is also concerned about improving the educational environment, and it has a series of initiatives funded through RPFs, referred to as GME enhancement projects, which I have listed here. The Critical Needs and Emerging Specialties Project is intended to address workforce shortages by expanding positions in specialties of greatest need to veterans and the nation. The New Affiliations and New VA Site of Care Project is meant to address the uneven geographic distribution of residents and

improve access to care in different sites. And the Educational Innovations Project is meant to foster innovative models of education, including programs that will provide opportunities for faculty development, and those programs are focused in programs that have outstanding accreditation records.

The Rural Health Training Initiative is designed to expand residency training in patient care services in the VA for rural sites of care.

Now, a lot of these projects are funding additional GME positions in the VA, and they are expanding, potentially expanding by about 2,000 FTE residents, about $250 million in additional funding. And a lot of this expansion is also allowing more time for residents to take an opportunity to take time for some of these educational endeavors that may take away time for clinical time. So the residents' time is -- so the net resident time in the facility is about the same in terms of the labor and productivity that comes out of the total residents. So it gives them time for those residents.

So Cristina is now going to go on and talk about desired goals for medical education and training.

MS. BOCCUTI: So these are a little bit adapted from what we showed last time, but I just want to put them up because we will keep running with these through work that we do in the future, so I want to make sure that these are the kinds of goals that are shaping our work.

The first there is to ensure that students possess the knowledge, skills, and values necessary to provide high-quality health care, and I think here is where we do recognize that many hospitals and residency programs are doing a tremendous job teaching their residents how to become good doctors for their patients.

Then the other two goals: to produce the workforce that best serves the needs of our society, and to train and educate health professionals to become leaders in forming high-value health systems.

So here is an extremely simplified, almost embarrassingly so, diagram of current medical education financing, so I am going to take you through it, starting with the top two boxes on the left.

Medicare, as you know, receives its Part A financing from the HI trust fund which is funded through a payroll tax on firms and employees. So Medicare's GME and

IME comes mostly from Part A, so that's what we've depicted here on the slide. There is some from Part B, but to keep things simple, we do not have that on here.

Medicare's medical education financing goes predominantly, so following the arrows down, to teaching hospitals to support residency training and higher patient care costs. Most of the hospitals are regular PPS hospitals, but others include cancer and psychiatric hospitals.

So moving back to the top, most states also contribute to medical education through Medicaid and medical schools, which is shown, the medical schools on that gray box down at the bottom. And as you know, the federal government matches state Medicaid payments through established formulas, so we've drawn a dotted line from the general revenues on the far right to Medicaid to represent the matched federal payments. And similar to Medicare, Medicaid payments for medical education are generally made to teaching hospitals. So that is the arrow going down there.

Financing for medical education also comes from general revenues, appropriations from general revenues, so

here, for example, we have got the HRSA, green box, VA and DOD, and as discussed in the last meeting, HRSA supports many targeted programs related to pipeline recruitment at the medical school, and even high school and college programs.

Several of HRSA's programs target potential students from rural, low-income, African American, Native American, and Hispanic backgrounds.

Financing for children's hospitals -- that's the CHGME that is in the HRSA box -- is also appropriated through HRSA. So there is an arrow going from general revenues, HRSA, to the teaching hospitals.

So there's also a lot which is not this slide. So, for example, there are research grants, foundation supports, some health insurer rates, but we hope this diagram is helpful for just laying the basics out.

So now thinking only about the Medicare piece, here is the graphic we discussed at the last meeting, and I will just review this very briefly.

Medicare's payment to teaching hospitals consists of the direct GME and IME. The direct GME -- shown in the light-green box on the bottom -- is for resident stipends,

benefits, faculty salaries, and administrative overhead. Then the two yellow boxes on the top represent Medicare's IME payments. Those are intended to cover the higher inpatient costs that are associated with hosting a residency program.

So the box on the right, the yellow box on the right, represents the dollars Medicare pays above the costs that are derived from calculating higher patient care costs. Each of these boxes totals roughly $3 billion -- summing to a little over $9 billion for the year 2008.

Last meeting we discussed options for redirecting some of the dollars from the "extra" box, so those are the white bubbles on the right, to support other priorities. These included going back to institutions that had environments with greater attention to delivery system reforms. We talked about ACOs last time. We also discussed advantages and disadvantages of supporting residency programs. And then, third, at the bottom, back through the treasury to other federal programs, such as those in HRSA, that focus on pipeline issues.

So then looking back at the current situation, the first issue -- it brings about some issues that we have

discussed that we want to lay out here, and there are concerns and advantages here.

The first concern is that hospitals have a strong financial incentive to maintain residents on their campus throughout their residencies. Second is that hospital decisions to house residency programs may be a function of their staffing needs. And, third, it is the residency programs that are accredited based on quality, so Medicare's payments to teaching hospitals are not really going to the entity that is accountable for educational standards and learning experience.

Of course, there are advantages. Hospitals may be the best entity to supply a stable infrastructure and administrative overhead across all the affiliated residency programs rather than having this function repeated at every residency program level. Also, hospitals are in a position to assume greater accountability for the programs, for their affiliated programs that they house.

The second issue here is that current medical education payments are linked to inpatient admissions. This circumstance highlights two concerns:

It concentrates federal support to hospitals with

high Medicare utilization. Teaching hospitals that serve communities with lower Medicare populations, therefore, get considerably less funding.

Basing payments on inpatient admissions follows some of the volume-based incentives that the Commission has found problematic. So it does not match with incentives for preventing avoidable hospital admissions through improved ambulatory care.

And then on the plus side, linking payments to inpatient admissions does simplify the reimbursement of higher patient care costs, which, of course, is the purpose of IME. So these payments are tied to a major source of clinical care that occurs in the teaching environment.

The third issue is that Medicare is the largest payer of graduate medical education, and this raises the following concerns:

Philosophically, our entire society benefits from medical education, so the case for Medicare's disproportionate contribution can be seen as problematic.

In fact, originating legislation called for Medicare to support its share until the community determined other means.

Also, with disparate funding streams for education, we have no organized system for medical education and workforce planning in the U.S.

Also, another problem is that Medicare's fiscal situation does raise some concerns about affordability for this subsidy year after year.

And finally, even with current funding, Medicare is not really geared to use it to affect the pipeline of health professionals we have in the U.S. because it is focused mostly on physician residency programs.

So this brings us to the concept of a national medical education trust fund. This is not a new idea. The IOM, Pew, and other panels and experts have suggested it, although, of course, each has different versions of it.

In general, such a trust fund would aggregate medical education resources into an entity that can assess U.S. needs and allocate funds accordingly.

Objectives for such a fund generally consider the following: supporting high-quality education and training in a variety of health care settings; workforce issues such as producing health professionals in regions where they are needed; encouraging innovation in medical education and

training; and establishing accountability for these objectives among the entities that receive funds.

So drawing from the previous flow chart you saw of the current financing, this one includes a medical education trust fund, which is in the orange box.

The main points here for you to discuss are that the medical education trust fund gets resources from Medicare, states, and general revenues, and then the trust fund distributes the dollars to recipients that could be one or more of the green boxes.

Now, I am going to pause for just a minute and say that many trust fund proposals I had mentioned include an all-payer concept that imposes a surcharge on all health insurers, the proceeds of which would also go into the medical education trust fund. But this diagram, however, contemplates a medical education trust fund that is financed through existing revenue sources.

The arrows show the flows of dollars here, but, of course, they don't reflect amounts, and we are not talking about amounts and levels here, so we could say that these arrows are here to show flow, but they are not, you know, to scale in terms of dollars.

So then going back to the green boxes at the bottom, from the left side we have providers. These could be hospitals or even other settings, like ambulatory sites. There could also be residency programs which you've already discussed. Then there is HRSA could receive funding through the trust fund rather than through the annual appropriations process.

Other entities such as state councils could also be recipients, particularly if they oversaw workforce at regional levels. And, finally, we have VA here and DOD because their roles should certainly be considered as so many residents do rotate through the VA, as Craig was discussing. And then, again, we have the gray box at the bottom where pipeline issues could continue to be addressed at the federal level through HRSA programs.

Although, of course, there are many issues to discuss with a trust fund, I just want to draw a few to your attention.

First, the stability of the funding from general revenues would need to be secure in order to maintain education and training goals. This could be achieved through mandatory allocations in statute over multiple

years, and we can discuss other ways. Additionally, it would be important that the fund be allowed to keep any unspent funds for use in future years.

Another issue is the mechanism for distributing the funding could take on a formulaic approach, much like Medicare does now, but instead it could be linked to other items, such as a straight per resident amount that is not necessarily linked to Medicare admissions. Or it could include a more reflective approach and address evolving national needs. Perhaps a stakeholder board could become involved in decisionmaking on topics, such as disparities in patient access, pipeline needs by specialty, efficient use of mid-level professionals, which we have discussed here, and training in high-value environments

So here we have on our last slide, we are very interested in your discussion today to give us guidance on areas for future work. ne consideration that you may want to discuss is whether any adjustments to current GME and IME payment policies would be stand-alone modifications to the current system or would be part of a transition towards a trust fund policy. So, for example, changes to IME payments could take place within Medicare as an interim adjustment,

but then would become part of the overall trust fund implementation.

And, finally, we have heard a lot of interest for training in high-value environments, but it would help us enormously if you could identify specific reforms or outcomes that you would want to consider.

Thank you.

MR. HACKBARTH: Thank you. Thought-provoking.

Let me see hands for first-round clarifying questions. We will start with Karen and then Ron.

DR. BORMAN: Just one clarifying question. Cristina, very nice presentation. Do you envision that the disbursements or potentially the target funding on the up-front end, the allocations or appropriations, would be driven by some kind of estimated cost of educating a resident? Because I think we are in an era where we don't know the answer to that question.

MS. BOCCUTI: Well, I think that it depends on how much planning goes on -- and you are talking about the trust fund model, right?

DR. BORMAN: Yes.

MS. BOCCUTI: You know, it sort of goes to the

formulaic and/or more reflective approach in terms of whether you would take some sort of cost analysis and dump that into a formula or you start to add on top of that priorities that then wouldn't necessarily be, you know, penny for penny related to costs.

So I understand that you are saying that it has been hard to quantify total costs per resident because not only do they vary in net costs by specialty, but, you know, by area, by types. So I think that is up for discussion.

DR. BORMAN: So there would be the opportunity in that model to potentially try to get at that question as a basis for allocation with potentially other factors --

MS. BOCCUTI: Overlooking some --

DR. BORMAN: -- but it could start as part of the basis.

MR. HACKBARTH: We have two estimates already, and I know you are skeptical, and probably appropriately so, Karen, about whether they are complete. But we have the direct costs, and then we have a method of assessing the indirect costs. And that is sort of a first-order approximation of, you know, how much it costs to train a resident.

Now, as I said, I know you think that in some ways those are incomplete, but it's not like we're starting with no information whatsoever about what it costs.

DR. CASTELLANOS: A couple of questions directed towards you, and specifically with the VA. I know that's not our main focus here, but I don't think I'm going to get a chance to bring this up otherwise.

We have a VA clinic in our community, and like most places, they have it. And as you said, their EMR is very comprehensive across the VA system, but it's not available outside the system at all. There's no interoperability --

MR. BERTKO: [Off microphone] It is available --

DR. CASTELLANOS: It is not available in my community outside. I can't get the data. I can't get x-ray results. We have tremendous duplication, and I have addressed this locally, and they say they don't have the ability to be able to provide that for us.

Well, I can only say maybe it's just an isolated problem, but it's a significant problem because the duplication of services, the unnecessary testing and procedures, and, you know, we work 24/7, the clinics don't.

They're not open at night. They're not open on holidays. They're not open weekends. I am a surgeon, and I get involved in the acute process, and we end up with total duplication. Maybe it is available some places, but it's not uniform. You know, perhaps you can help us get that uniform.

The other is there is very little, if any, care coordination outside of the VA system. They don't communicate with the community doctors. In fact, you know, that is the system I have, unfortunately.

Thank you.

MR. HACKBARTH: We can maybe do a little fact finding about the availability of the information, but going into how the VA system works and whether it works appropriately with people in the community is probably beyond the charge of our group.

DR. CASTELLANOS: [Off microphone] teaching hospital, you want to be able to embellish the idea of care communication across all borders.

MR. HACKBARTH: Yes, but trying to direct the VA on how it ought to run its operations in relationship with the community I think is probably beyond the scope of what

we can take on.

MR. BUTLER: Two questions, Cristina. Go back to the one with the -- your first chart there that shows the current -- 6. Okay. You don't need to answer here today, but it would be kind of interesting to see the dollars on some of these buckets, most particularly, the HRSA one down below, the VA one, and then also on the Medicaid piece. I have unfortunately been in states that didn't pay for that, but I'd be kind of curious of the total dollars that Medicaid is supporting versus Medicare.

MS. BOCCUTI: I have some numbers here. I thought somebody might ask. But these haven't been updated in a while.

With Medicaid, I'm going to say it's about $3 billion, and with HRSA -- actually, I want to get that more clear before I say what the numbers are.

MR. BUTLER: It could be an important companion.

MS. BOCCUTI: Because there are a lot of different programs, and I don't want to misstate that number. And there are, I believe, five states that do not contribute for graduate medical education specifically, Illinois being one of them, like you said.

MR. BUTLER: But I'm certain that they almost all do it in very different ways with different amounts and different methodologies. So we wouldn't --

MS. BOCCUTI: They do it differently.

MR. BUTLER: It's not, certainly, replicating the Medicare system. That doesn't mean that some of them aren't very large dollars. They just do it in different ways in different states. It would be interesting to know a little bit more about that.

MR. LISK: There is a paper that we can, if you'd like, share with you, too, that has been -- it's a couple years old -- that looks at the VA -- I mean, not the VA, I'm sorry, the Medicaid programs in terms of what the States individually do. And on the VA, the VA is about $1.5 billion, for example.

MR. BUTLER: I'm just thinking ahead to our chapter report. It would be good to kind of show the whole landscape. I think it would be helpful for us to educate our --

MR. LISK: Right. And the children's hospital medical education fund is $300 million.

MR. BUTLER: So my question second is very

different. It's kind of a follow-up to Karen's and that is on kind of the direct graduate medical education side, if you will. So let me understand what numbers we have and what we don't.

The amount that gets paid out goes way back to the base year, 25 years ago, and then it was updated by something less than -- well, it was updated for inflation, and then there were caps put in and so forth. So there's some percentage of the actual costs on the cost report that are not paid for because of either caps or inflation hasn't kept up with the cost.

Now, that is exclusive, I think, of Karen's point that she said there are mandates and costs that aren't even captured on the cost report, I think you are saying. I am not talking about those. I am talking about the ones we formally still capture in the cost report that, in effect, aren't included in the payment just because either inflation hasn't kept up with the actual costs or we have put caps. It would just be good to know that number. I don't think the Commissioners are going to ask and recommend, you know, billions of new dollars for this, but it would be good to know what that number is.

DR. BERENSON: Could you go to slide 12, please? I just want to clarify. Maybe I didn't hear it. But the Medicare piece of that, theoretically, I guess, or the logic of all of this is that the IME portion that goes for inadequate or for higher inpatient costs could or should go directly to the hospitals and not go through this mechanism. And so this would be the direct GME which is supporting residents, or -- I mean, anything is up for grabs, but isn't the logic that the portion that's not really -- that is there to really pay for the inadequate payments would not be in this scheme at all.

MR. HACKBARTH: Well, you could distinguished between the extra, what we've labeled as the extra, and the portion of IME that reflects the empirical amount.

DR. BERENSON: I mean, that theoretically should go directly to those hospitals and not even go through this mechanism, right?

MS. BOCCUTI: Well, a couple things that I'd mention. I would say that, as I am interpreting this, it wasn't that there would be a line from Medicare to go to providers being IME and another line to the trust fund. It was for all of it to be there in the trust fund and then

that be distributed accordingly.

You should note that the IME payments now are meant for the higher inpatient costs, but even when a resident leaves the hospital for training outside the hospital, the hospital continues to get the IME money. So there is some debate about, you know, if for some reason the money were to more follow the resident, it would be a different construction if you are talking about the total monies, because right now it stays within the hospital. But there are people that are discussing other ways, and so the portion of IME isn't so much attached to the resident as it stands now. The resident can leave the hospital.

DR. BERENSON: My point is only that -- maybe I do not have this right -- that as we get better at doing case mix adjustment in the basic payment system and find that there is an excess in IME because we are paying more accurately, that would be money that theoretically shouldn't continue to be paid for that purpose. And so to sort of lock it into this mechanism doesn't seem to make sense to me if we are thinking sort of a new structure.

MR. HACKBARTH: I think I followed you all the way to the last point. So, for example, when we recommended

doing MS-DRGs or what became MS-DRGs, severity adjusted DRGs, we said that you ought to reduce the IME, the indirect IME by some increment to reflect that now we have directly addressed one of the problems that the indirect IME was originally designed to pay for. And so now those dollars would flow, would be distributed based on severity of Medicare cases and taken out of the medical education flow.

DR. BERENSON: But aren't we then saying but we still have identified a remaining portion for which we are still not good enough at paying so we are going to keep that going?

MR. HACKBARTH: Well, yes. So there is the portion that is under the empirical amount, which is the amount that we estimate the costs of the hospital go up in order to train residents. But then there is this additional increment of roughly equal size that is not supported empirically that we have labeled the "extra."

DR. BERENSON: All right.

MR. HACKBARTH: And the construct that we have been talking about is you could keep that money potentially in the training system, but if we're going to keep it in the training system, let's make sure it's deployed in a way that

supports our societal goals, like the ones that were on Slide 5 as opposed to just sloshing around as free money.

DR. BERENSON: There are still issues, but you have answers my question.

DR. MARK MILLER: In that exchange, there is still the question that that could also come off the table, potentially.

MR. HACKBARTH: It could, right.

DR. MARK MILLER: Just to be clear on that. And then to your initial question, I think -- and I think Cristina was trying to say this, and just to make sure that everybody follows it, it could be that whatever is left in Medicare goes -- or comes from Medicare, goes into the trust fund, and is allocated to providers, not directly to the hospital but on the basis of where the resident goes. And I think that's what Cristina was trying to get across. But that is a question that we're putting in front of you.

DR. CROSSON: Just a small point on the same slide. You explained this very clearly, but I just want to make sure -- because sometimes slides have a life of their own -- that where you use the abbreviation "ex," that doesn't mean "except," it means "example."

MS. BOCCUTI: Yes, it was shorter than writing "e.g." So I used "ex" for "example."

DR. MILSTEIN: A couple of questions. If I look at the math, it looks like you are essentially saying we have some residents in the U.S. who are being trained in an organized system of care called the VA system, and it is costing us about $129,000 a year per resident, adding up those two numbers. Is that right? Great. Okay.

MR. LISK: Yes, I mean, for the most part, except for there are certain underlying costs, because they're not the direct sponsor of the program, that they're not incurring that's incurred somewhere else.

DR. MILSTEIN: I realize it's a benchmark. So my question is: What's the equivalent number outside? If you take the $9 billion and divide it by the number of residents, is it above or below $129,000 a year? that is my first question.

MR. LISK: That currently is below that amount from a Medicare perspective. Medicare is paying about $100,000 per resident.

DR. MILSTEIN: Okay. And then my second question is when you -- that diagram you have of a potential future

state, you know, the Medicare -- I wasn't sure how to interpret the labeling, medical education trust fund versus, let's say, health professional education trust fund. Is our discussion to be circumscribed and only talk about use of Medicare funds to train physicians? Or is the notion use of Medicare trust funds to train health care professionals? What is the scope of --

MS. BOCCUTI: I think from our discussions one of the issues about Medicare that we were talking about is that it is focused on residents, you know, physician residents. Having a medical education trust fund or health professional trust fund opens that opportunity, but this is something for everyone to discuss.

MR. HACKBARTH: If you look at the bottom row or the next to the last row, HRSA Title VIII, Public Health Service Act, Title VIII, is non-physician professional training.

MS. BOCCUTI: Right. Title VIII has more nursing and other programs in that.

DR. DEAN: First of all, does Medicare money go to support osteopathic programs? It does.

MS. BOCCUTI: Yes.

DR. DEAN: I wasn't sure about that. The IME part has been controversial for a long time. What has happened with that over the last years? Has that actually changed the amounts that goes to IME?

MR. LISK: The IME adjustment has been -- well, since 2008, it has been approximately 5.5 percent. It has come down from what it was in 1997 slowly, but it has been around -- for the last few years, it has been around 5.5 percent.

I wanted to also correct one thing I said about Medicare paying about $100,000 per resident. That is Medicare paying for about 98,000 residents, but that's not FTE residents. So on a per FTE basis, Medicare is actually paying more than what the VA is paying. So I just wanted to get that point --

DR. MILSTEIN: Roughly, how much more? That was my question.

MR. LISK: Medicare is about 40 percent of these facilities in terms of these facility costs, so -- I'd have to make a calculation for you.

DR. MILSTEIN: Thank you.

MR. HACKBARTH: Just a clarification on that.

When you say on an FTE basis, in that FTE calculation you are taking into account Medicare's share of the --

MR. LISK: I'm not counting -- I mean, there is 90 -- in Medicare IPPS hospitals, there are about 93,000 residents. Okay? So you would have Medicare is paying roughly $9 billion for those 93,000 residents, but Medicare is only a share of those hospitals' patients.

MR. HACKBARTH: Right. Okay.

MR. LISK: So a lot of that is the extra IME in terms of what Medicare is paying. The direct GME Medicare theoretically probably, as people said, because of the inflation factor is probably paying less on average than what the direct GME share would be when you look at it in other ways, kind of for the caps and the inflation factors that have happened over time.

DR. DEAN: Just a quick comment in response to Bob's concern. I think if there is a justification for IME payments, that same argument can be made outside of the hospital. If residents are in a clinic setting, an ambulatory setting, I think the same arguments apply. So I would think it would make sense that it should go through this trust fund. But, you know, I don't know.

DR. CHERNEW: I have a question about actually this trust fund, and maybe I missed it. Is this trust fund just collecting the money the way that this picture looks and then distributing the money out in some way? Or does it have broader -- in the proposal, broader policy authority to make decisions to answer some of these questions? Are we supposed to talk about that now?

MS. BOCCUTI: As a clarifying question, this is for discussion. We put this as a model, and not as a model in the sense of best-case scenario. Simply, we put it up there as a simple diagram.

The authority with which the medical education trust fund operates I think would be something that would be within statute.

MR. HACKBARTH: It might be helpful for our next discussion on this if the IOM, for example, has, you know, put some meat on the bones. To hear what they have proposed might be a stimulus to our thinking.

Okay. Round two --

MR. BUTLER: I have one quick clarifying question. We introduced this as kind of a potential all-payer kind of system, too, and there are no other payers on there. Is

that right? Just as a model. Is there a reason that --

MR. HACKBARTH: I wanted to pick up on this, to get back to something that John had said earlier. There are different models about how you can bring other payers into the financing. One that has been mentioned in the past -- and I think Cristina mentioned this -- was to levy an excise tax on private insurers that would then in this model go into the trust fund.

Another model would be to say, you know, this is a societal activity, and we have a way to raise revenues from all payers for societal activities, and that is the general income tax system. And, you know, there are pros and cons of each of those tax systems, if you will. The model of levying an excise tax, you know, makes it feel sort of more analogous to the Medicare HI tax. You know, it's sort of the major payers each being assessed. But, on the other hand, there are real questions about the ultimate incidence of the tax, who bears that tax if you levy an excise on insurers. I think a lot of economists would say ultimately it will be borne by the premium payers, and it will be basically a head tax, a flat amount per person covered, and there were those who would question whether that is good tax

policy. It is a regressive sort of tax system as opposed to the income tax system.

So I think what Cristina and Craig meant to do was just say the one model would be to have the general revenues funded by the income tax flow into this, but there are other tax systems you could devise.

Round two comments?

DR. KANE: To get back to the question of the role of the private sector, it would be helpful to even know now what differential the private sector pays to teaching hospitals versus non-teaching hospitals for the same service to see if there is already, you know, some differential in there that we could think about.

And then to get to your argument about, you know, the general revenue would be the best, most equitable way, if that is true, why wouldn't we also take out firms and employees and just have the whole thing be general revenue and let the Medicare trust fund go where the Medicare trust fund should go, which is -- so I guess, you know, I would keep on going on the equity end a little bit further.

I think it is definitely worth thinking more about what that trust fund could do, but I do like the idea that

we free up this institution-based method of paying which does not produce what society needs. And the reason I was talking about the VA before, which I think just to elaborate, because I'm not sure it came out clearly, is the VA -- we had talked about the fact that there is a set of competencies that we think the future doctors should know around care integration and electronic medical record, and that the VA was an ideal place to ensure that that happened. I know it was a third a year, but it could well be that many more than a third of all residents go through the VA over the course of their training and that that might be a point, a leverage point for ensuring that certain competencies are both trained and then even tested. We might want to pay the VA to set up those competencies and test them to be sure that these competencies are taught in one kind of national setting.

So that was why the VA was in there. It wasn't just sort of a random -- they do provide education, but they are also a unique site for ensuring that certain competencies are taught rather than having Medicare try to tell a bunch of medical schools and hospitals, you know, how to run their residency program.

MR. HACKBARTH: Let me just pick up on your first comment because it sort of highlights another dimension of this. You know, one model would be to say that Medicare per se does not pay into this trust fund; it is totally finance through general revenues, as you describe. Then one of the next questions that you would face is, okay, how do the funds get from the trust fund to the programs? Does that go through the appropriations process, you know, subject to annual re-appropriation? And I think the people involved in graduate medical education have been concerned about that sort of a payout mechanism because of the uncertainty inherent in having to get annual appropriations as opposed to entitlement funding. So that is sort of a whole other level of issues at stake here.

MR. BUTLER: My comments will be a little bit with the June chapter in mind because I think we are probably going to abandon discussion among us for a while now. So I am trying to think through in a constructive way where we are at a little bit.

I think there are at least three things that we agree on. One is that we don't want to have somebody inject themselves directly into the curriculum. It is not an

unimportant point.

The second is that I think we believe that the number and types of slots and where they are is important, but Medicare as a payment mechanism has some limitations in doing that. We can make some differences at the margin, but in the end the payment environment for the physician who is ultimately in practice, what that environment is like, what the compensation is still is probably a bigger lever than these medical education payments. It doesn't mean we should ignore the issue, but I don't think it is as big an opportunity.

The third, where I think we have some agreement, is that training environment bucket is one that should be our sweet spot where we are aligning that with our health reform. So I still think our biggest contribution is trying to define that and making the graduate medical education programs accountable for producing those individuals who are at the top of their game when they come out and perform again. So I think from just a substantive standpoint, that is where we can make the biggest contribution.

So I think we kind of have -- I would suggest we kind of have agreement on those. Where we don't have

agreement is who pays, how much, who gets the money. But let me just talk about that for a second.

The who should pay, we don't have full disagreement. I'm not sure any of us even have the answers. I think this is a good thing to explore the trust fund, and I'm all for having other payers involved. I just don't see it as a realistic thing where we can make a very solid recommendation in June around this. Even though conceptually we could get sucked into going this route, I'm not sure we are going to make a big early contribution in this one in terms of looking for alternative sites or alternative sources of money.

In terms of how much, again, there will be differences among us from keep the money exactly what it is now, just redirect it towards a training environment, or whatever it is we want as a product down to 2.2, right, or something like that. And we'll just have that debate and decide and think about what is the right way to approach this.

You know, of course, I would advocate more that it is better to incentivize, and if you were to take away a significant amount of that, now you don't have much to --

you don't have any leverage either. You've given -- in fact, they may abandon advancing things at all because you haven't given much incentive for reform. But we'll have that discussion on another day.

The third thing is who receives the money is up for debate as well, and I still advocate more of an institutional approach, Nancy. It's just a question of what qualifies you as an institution to be a recipient. I think that is the key issue. I do think that the program approach is a difficult one because I do think it fragments and is not consistent with delivery reform.

MR. HACKBARTH: Thanks, Peter. One of the things you said was going to be my concluding comment on this, and the way I would phrase it is, broadly speaking, we have got a couple paths we can go down. One would entail sort of a major rewrite, restructuring of this whole apparatus, how the money flows in, how it flows out. And you can make a good case that that is needed.

The political timing for that may not be right, and if we put all of our eggs in that basket, we could spend a lot of time coming up with an elegant new structure that would be terrific, but nothing happens.

Another path is to say, well, let's take into account the environment and maybe we would be more successful if we propose more incremental changes that are not an overhaul of the whole structure but would be at least consistent with the direction, long-term direction we think the system ought to go. We would have more narrowly focused recommendations, a little less dramatic, but maybe greater likelihood of them having an impact.

I don't think we need to make that decision right now, but I think that is going to be part of our calculus on how we proceed with this issue.

DR. BERENSON: The reason I had asked those questions, splitting up Medicare, was to go where Nancy was going, which is sort of the logic around if this is a social good, why is Medicare uniquely sort of paying for it? And I think, frankly, the whole discussion of whether to do a surtax or something on private payers seems to me, at a time when there is -- whether it is technically cost shifting or not cost shifting, they're paying a premium to what everybody else is paying to cover uninsured. To sort of stick another tax on those premiums that will be passed through to employers and employees just doesn't make sense.

So I am very intrigued by the general revenue source of funding for this, but I think we fairly early need to know whether -- you know, your first bullet on other issues, stability of general revenues, of allocation, if we don't have a fairly good mechanism where we could assure that this money would be flowing, the uncertainty for teaching programs I think would suggest we shouldn't go very aggressively down this road, if you know what I mean. I mean, we would have to have a pretty good idea that we could guarantee some continuing flow of funds before we would want to go in what theoretically is the right direction. I just don't know whether we should go aggressively there.

DR. CROSSON: If you would turn to Slide 14, I just want to try to address each one of those points.

In terms of the first one, I really think I end up in the same place that Peter and Bob were, and I think perhaps where Glenn was suggesting, and that is that there is a certain seductive simplicity to this, and it's nice to have a diagram like that. On the other hand, there are some tough nuts in there. You know, just simply the question of whether we are talking about a maintenance of dollars from the Medicare program, which would then imply that the total

amount of funding would be a good deal larger than what it is now -- and some would argue for that, some would question the need for that -- or whether we're actually suggesting that the Medicare program's responsibility in absolute terms would be reduced. And I think we would have to resolve what we think about that.

And then the question of if we go with this model, would we, in fact, be disrupting the medical education training program environment at a time when we're hoping for the opposite -- that is, to get a better product out of that? So I have the same sort of concerns there.

With respect to the second one, what adjustments might be made, I still think that the issue that we talked about before of trying to work for relaxation of the rules and regulations about the site of care and what's paid for and what could be paid for is kind of a slam dunk, and perhaps we could spend more time on that and reiterate some of our previous thoughts.

With respect to the third one, this notion that Peter described as a sweet spot -- and I would agree with that -- in my mind it sounds something like this: you know, that we would be looking for training programs to produce

residents who are prepared for 21st century medicine, and specifically it would include things like experience with a sustainable adult primary care practice. And I don't think many residents are getting that. At least the outcome of choices that medical students -- rather, residents are making and medical students are making would suggest that.

Something in there about team-based care, which is taught in some programs and not in others, that is closely tied to issues of patient safety and experience with working across disciplines in a systematic way to reduce errors and to improve quality. Again, I'm not suggesting that's all missing from all training programs, but I don't know that it's present either.

And then the issue of accountability, individual and collective accountability for quality, and existing in a goldfish bowl of transparency, which I think is not necessarily taught, it's a shock, quite frankly, to some physicians who come out of training and realize that that's an environment in which they're going to need to practice.

And then the issue of cost-conscious decisionmaking and the understanding among young physicians that there is a consequence to the pattern of decisionmaking

with respect to the cost of care on the ultimate affordability for patients and people.

And then, finally, you know, facility with the modern tools of medicine, including information technology systems and office practice, and particularly the use of decision support tools and a familiarity with that and a comfortableness with that, which would enable residents to fit easily into a system that uses those kinds of tools. And we see in our system some residents who are fully capable of doing that and others who are not.

So you were looking for a few specifics, and those are a few.

DR. MILSTEIN: I think the point there, the question that Glenn raised is really I think in some ways the most important question to decide. So many things we do, you know, particularly at the end of the year, we reflect back on we have regrets that -- at least I do and some of us have expressed similar regrets, you know, we have an intuition as to what the right answer is, but instead we have come up with something that we think is the politically digestible answer. And, you know, I guess the further you get into your MedPAC term, the more you wish you hadn't

taken the compromise road.

So I guess my intuition here is I hope we don't have to choose between what we think is the right answer and what we think is a politically digestible answer. Maybe we can combine those and sort of lay out what we think the right answer is, even though it may be a very major departure and make a lot of people uncomfortable, but then maybe indicate, you know, kind of a -- as Glenn would say, the glide path, sort of how we get there with the least amount of disruption and pain for those who currently are not doing the job, you know, frankly. And I like Jay's formulation. The only changes I would make in it is to move it away from physicians and focus on health professionals as our target.

Jay was partly addressed that through his emphasis on teams, and then, secondly, you know, it's this notion of what we want is we want to turn out health professionals who basically lead the way in discovering how to produce more health with fewer dollars. That's maybe the simplified version of exactly what Jay said. And then just work backwards from that vision, but stick with that vision and lay out the path.

MR. HACKBARTH: Just one other thought about this choice between the major redesign or a more incremental path. My recollection is that the health reform legislation addresses some of the issues that we have raised here. I think it was the House bill that I read most recently, but, you know, there are provisions trying to address the problems. They're telling the Secretary to address problems in Medicare rules inappropriately restricting the training locations. There are provisions for Medicare education dollars to go to non-hospital locations, the so-called teaching health centers. There are provisions in the House bill about at least some of the money going to programs as opposed to hospitals. And, of course, there are provisions about basically increasing funding for Title VII and Title VIII.

So, you know, if some or all of those things make it into the final legislation, they may at least tick off some of the items on sort of an incremental checklist, which would then free us up to think more about, you know, the more dramatic longer-term reforms.

So my list may not be complete or accurate, and I need Cristina and Craig to --

MS. BOCCUTI: Well, I will just mention a couple things, and, you know, once there's multiple versions, they start swimming in my head unless I have a cheat sheet in front of me. But I would mention that some of what you described are in some or both. Some take the form of demos, and so when you say provisions, I often think that means, you know, throughout Medicare, and some of them are not.

Some of the rules issues that you discussed, which I think Jay just brought up, that we highlighted in the last chapter have been discussed very much, and that is about redefining all and substantially all language to see who's paying and other non-hospital issues.

MR. HACKBARTH: It might be helpful for our next discussion on this to have a sheet saying, you know, here are issues that we've raised and here are ones that are addressed to some degree or another in the bills.

MS. BOCCUTI: Sure.

MR. HACKBARTH: Okay.

MS. HANSEN: Yes, my comments are brief, but I do want to go on record relative to especially the comments most recently about the different items that some of which may be appearing in the proposed legislation. But I don't

want to lose sight of kind of this larger effort, you know, in terms of whether it is called the pipe dream or the idealized version, because at some point -- and I know, again, all the hazards that we have to identify in terms of not only the money but who is affected by all this. So I think we have to understand that.

But I think the directionality of looking at where things should go, we can still accomplish some of the elements that are described. Some of these elements have been described for literally, I think we know, about 20 years, but perhaps the ability to, you know, coalesce our efforts with where IOM is coming from to all of this, at least the direction is there. So I think the low-hanging fruit possibility, as Jay was saying, you know, even the site of care, and given the future direction of where people are going to go, and oftentimes in environments that are less costly than the facility of any kind, whether we are talking about a nursing home or a special surgical center or an acute care. We have to really think about this in terms of the directionality, because even right now I think the figures -- and perhaps this would be one area if we could have that cited. Right now, of all the discharges that do

come out of hospitals, I think is it just on average about 50 percent or so in that given range that are Medicare beneficiaries? In that vicinity, so --

MS. BOCCUTI: I just was reading that Medicare or Medicaid, I think, so the public patients are --

MS. HANSEN: Right, the public dollars.

MS. BOCCUTI: -- disproportionately shared in teaching hospitals. Would you think that is fair to say, Craig?

MR. LISK: Actually, I mean, in terms of Medicaid has usually been a little bit higher; Medicare is usually a little bit lower in major teaching hospitals, relatively speaking.

MS. HANSEN: So I think, again, thinking about where people who are even of those categories are getting their care, so in some ways the flow of funds of where people have been and will be getting care more should be followed there. So rather than -- again, this is maybe where it's facility or institution vis-a-vis program. You know, there is, as I cited before, more in the chronic-care/long-term care side. You know, money flows with the person in some ways rather than the bricks and mortar. But

I know the bricks and mortar, you know, have that need.

So I just wanted to really go on record that it is about where people will get care, who is going to provide it, which goes beyond one profession, and then the ability to build in those structures that use the measures of quality, process change, understanding accountability and transparency. If a VA system, you know, is in some ways another low-hanging fruit, maybe some aspect of understanding how do we do that to get that momentum going while we try to influence all graduates who come out of these programs.

DR. DEAN: I guess, first of all, I would certainly push or support, encourage that we really look for ways to broaden the base of funding. I mean, obviously, we have talked about that, just to say we need to go in that direction.

I think currently the idea that if we are focused on Medicare contributions, the idea of tying it to Medicare admissions really, I think, is outdated, obviously. And we need to look for other parameters to use.

I guess I am a little conflicted. I understand the needs of the program to have some consistency and some

predictability in terms of the funding that they are going to get. At the same time, I think there needs to be some accountability as to how they are using those funds, and it would seem to me -- you know, I would totally support all of the things that Jay said, but I wonder. I also get nervous about programs like Medicare getting too specific because the environment changes so rapidly. And I wonder if it would not be appropriate to somehow put some portion of those funds at risk and ask each program on some sort of periodic basis to justify, you tell us how well -- you tell us how your programs are training professionals to respond to the needs of 21st century medicine, or something in that regard. In other words, have each one say is your specialty mix, your training environments, are your technical -- the things you are technically teaching residents, how do they fit where they're going to be now and, you know, ten years from now, or something to that effect, so to put them on notice that we really are interested to make sure that they're not doing things just because that's the way it's always been done and that's the number of residents they've had, but we are responding -- if we're using public money, we need to respond to a public need, basically.

DR. CHERNEW: I'm not tremendously familiar with this area. Almost everything I know about it I've learned here. But I listened to the discussion --

DR. MARK MILLER: [Off microphone.]

DR. CHERNEW: Exactly, but I teach. I don't teach good.

[Laughter.]

DR. CHERNEW: By "good," I meant "well."

In any case, I see three different levels of this discussion as I observe it. One of them is sort of change the system, and I actually think medical education trust is too narrow if we go that route. I'm not sure yet it's worth the work, but if we go that way. What it sounds like you're really talking about is something that's closer to the more ambitious health professionals education governing board because you want to allow it to have a potentially wide -- it might end up just being a trust fund, but certainly in this discussion there is a lot more authority than just taking a bunch of money in and paying it out. And I think that is a real major system design. It's a real heavy lift. I do not know if it is desirable or not, but I think it would require a lot of work to outline a little bit what it

was before we knew if it was desirable. But I think it's certainly the most ambitious way to do a lot of stuff. And I'm a little hesitant about it, but as I said, I could be convinced.

The second approach I see is sort of the same system but new tools, so in a very Arnie-esque kind of way, you could envision sort of setting us up, in terms of your work, on a path towards medical education pay for performance where we begin to define outcome measures, and using the same basic system and levels that we have now, but try and move it around so we can say we want to pay for this and not that, but it is not the huge, big change necessarily in everything.

And then the third option I see is more tweak the rates and the barriers at the margin administratively to say, well, we are going to let more people qualify for the money, we are going to change the way we pay for different types of professionals. We basically use the same tools and system we have now; we just see a problem, and we patch the problem with some particular -- you know, we're paying too much for specialists or not enough, we have too many slots here and not enough slots there, and we try and, you know,

basically stay within the same system.

And it might be that all three of these things have to happen in some sort of sequence, and I think that the more aspirational amongst us would say that.

I'm not so sure. I think at the end of the day I have to say I am probably where Peter sounded like he was, which is there's a lot of really big issues that we're trying to solve with the education part being an important but only small tool. And so until -- I think getting this right, if we had nothing else to do, would be the exact right thing to do. Getting it right with a lot of other things to do is just going to depend on the amount of time and resources we have to do it, because I believe there's so many other organizations that are working in this area that it might be a completely rational thing to let them sort through how aspirational they want and have us comment about how that would be.

I think the general -- setting out principles, I think the principle having Medicare pay for all of medical education, at least in a direct sense, and have everything else be implicit, as Bob alluded to, is sort of a difficult place to be in, and a comment about that is useful. I think

there's a lot of sort of principled things we can do. I'm not sure how much of our time we want to spend being another voice in a big field about how medical education should be reformed, but you could convince me otherwise.

MS. BEHROOZI: I think that actually what Mike ended with is why I think that it -- I'm not sure that this really is a place for incrementalism because I feel like different people have a different set of little steps in mind when they're talking about incrementalism. And I'm not sure that they're all available to us, that any set of them or combination of them are available to us. I feel like the one thing that we all kind of end up agreeing on is, well, you know, we don't want to be too prescriptive and, you know, we don't run medical education.

And the way the funding flows through Medicare for medical education, as a number of people have pointed out, you know, that it's attached to inpatient admissions, doesn't necessarily get you the lever to apply to the outcome of medical education if it's in connection with an inpatient admission.

So it seems to me that aggregating the purchasing power of the different public sources -- Medicare, Medicaid,

and the general Treasury -- into the body, whatever the name was that you gave it, Mike, I liked it, but it was too long for me to remember, so --

DR. CHERNEW: [Off microphone.]

MS. BEHROOZI: Yes, okay, you'll do the acronym, but, you know, about health professional -- or not just professionals but, you know, health education and letting that body really be able to be prescriptive and set outcome targets and things like that. While I get it that, you know, such a tremendous change is not low-hanging fruit, I think that it's not necessarily a lot easier to really achieve the things that some people are thinking of as incremental.

Even Slide 7, which is what we were talking about last time, you know, stripping away $3 billion of the $9 billion that's currently going to institutions and deciding where else it should go to, there are a lot of current recipients of that one-third of the medical education money that would say, "This is not incremental," you know?

And then I would like to echo actually the point that Bob made in round one, which is that in order for this to work politically and structurally, we do have to make

sure that we are paying institutions adequately for their costs of care, whether it's associated with teaching, whether it's associated with all the factors that truly drive -- or that legitimately drive higher costs. I guess Jeff and David are going to be working on some of what those things might be.

And just as a final comment, I had been talking about, you know, well, let's talk about all payers, since I am in the one all-payer state, and if I have to pay, all the other private payers should have to pay, too. But I think your comment is absolutely right, Glenn, that really private payers just end up being passthroughs, and it is a different kind of tax, and it is not as equitable as a general treasury payment would be.

DR. BORMAN: Just a couple of hopefully fairly quick closing comments. First, I think if we sort of do the reverse Chernew and come from details up, okay? And borrowing on some other people's things.

Number one, I think we've all agreed that the ambulatory regulatory barriers, you know, it's detailed, it's low-hanging fruit, we should address it. Coincident with that, there will be some things like there are costs at

the parent program even when the resident is somewhere else that we need to not lose sight of, and that we need to make sure that those physicians that they spend time with are not put under undue burden by virtue of welcoming those trainees into their offices, so that they're not necessarily required to report with the GC modifier to identify themselves as a teaching physician, which triggers potentially some special audit things, and a variety -- there's a couple of things we can attack on the ambulatory barrier side.

Also, I personally would welcome seeing some good quality data about this assumption about that there's higher rates being paid to all teaching hospitals. I would just like to know what the magnitude of that is and see some current data related --

MR. HACKBARTH: [Off microphone] By private insurers.

DR. BORMAN: Exactly, by private insurers, because it's one of those four or five assumptions that are out there about all this, that in today's market I'm not sure is necessarily the case in a predominantly ambulatory care delivered environment, et cetera, et cetera. I think we do owe it to ourselves to just try and check that box that

we've investigated that particular piece as part of this discussion.

Then sort of moving to the next level, I think that in terms of Jay's list of things of potential ways to go, I personally see that probably the two biggest ones relate to IT and to faculty. If we truly expose people to an electronic medical record, that is a thing that almost takes on a life of its own, frankly, whether it's with practicing physicians or trainees, whether they're medical students or residents or nursing students or whoever they are. Because once you become secure that you have the information at the moment -- Ron earlier alluded to the duplications -- kind of that duplication cost goes away. And I think we underestimate just how huge that duplication cost is. And so I think those are the two things that could be a source of some direct focus, you know, as part of Jay's list, as sort of the second-level kinds of things.

And then, finally, I think there are some bigger questions about -- for example, we've talked about just general tax revenues that come from all different kinds of places. But, for example, although we keep tacking things on to tobacco costs for everything we want to fund, quite

frankly it leads to a burden of disease. And maybe that's the kind of place where funding for some of these things could come from, or from an excise tax related to alcohol. You could almost argue to some degree from gasoline costs because of people who don't wear seat belts and trauma, or whatever. I think there's a variety of directions you could go, not all of which are sensible and logical, but there are some other things, and that's certainly not -- that's probably way outside our purview. But it says to me that we aren't ready to tackle just the biggest level of this issue.

Another piece of it that I think we should come out in favor of, although, again, not ours to fix, is the notion about debt and the influence that that has. You know, we saw the National Health Service Corps numbers previously. Whatever it is we are writing off, it's not enough. It's not enough to get people to go meet the needs that we want them to meet as health care providers. And so the bottom line is they voted with their feet and we need to advocate to have systems that get to them.

You know, kids that are graduating with $250,000 in debt from residency, there ought to be some hooks you can send them by debt forgiveness. And we need to encourage

that that happens, tie it to some of these goals that we want to get to, and really utilize that, because we are not going to change all the other reasons that people get attracted to specialties or do other things, but if we make the faculty better, if we make IT work, if we work on debt forgiveness, then we go a long ways toward the things that get us in a bigger way where we want to go.

So that would be my reverse, you know, sort of from little to big issues.

MR. HACKBARTH: Okay. Actually, we've got some residents here, I think, in the audience, don't we? Raise your hands. These are people with AAMC, fellows or something? Oh, way past residents, okay, but recent.

MS. BOCCUTI: They're Peter Butlers, administrators to be.

MR. HACKBARTH: Thank you all for --

MR. BUTLER: Strike that from the record.

[Laughter.]

MR. HACKBARTH: What's that? I didn't hear that.

MR. BUTLER: Strike that from the record.

MR. HACKBARTH: Just one concluding process point. As Peter alluded to, we've got sort of an awkward transition

here because for the next couple months most of our time, indeed, virtually all of our time will be devoted the update analysis in December and then voting on the recommendations in January. So what that means is our next conversation on this will be in March. And so I think it's going to be important for us to try to capture where we left things here so we don't have to sort of pick up completely anew in March.

So, with help from Mark and Cristina and Craig, what I'll try to do is put together sort of a summary of, you know, where I think we stand in terms of the process and the issues on the table so that we can have hopefully a smooth pick-up when we come back to the issue in March.

You know, it's one of those topics. It's really important, but at the same time it's almost overwhelming in terms of the different avenues that you might take. And I think it's going to be real important for us to, before that March conversation, sort of make a technical decision, if you will, about what we can reasonably produce for this cycle and how that might fit into a larger vision and with help from Craig, Cristina, and Mark, try to make a suggestion about that direction and get feedback from you

folks offline so we can have a good start when we pick it up.

Thank you, Cristina and Craig.

So our next topic is the dual eligible beneficiaries and trying to address the sometimes conflicting incentives in Medicare and Medicaid. Whenever you are ready, Carol.

MS. CARTER: I'm ready. Good afternoon. This afternoon, we're going to be talking about the Medicaid and Medicare programs and how they often work at cross-purposes regarding the care furnished to beneficiaries who are enrolled in both Medicaid and Medicare.

Today, I'll be presenting information on the conflicting incentives between the two programs and how these can lower the quality of care for beneficiaries enrolled in both of them and can increase total Federal spending. Then I'll outline how care coordination could be improved by enrolling dual eligible beneficiaries in integrated managed care initiatives. Then I present preliminary information on the variation in spending on dual eligible beneficiaries and the implications for the design of managed care initiatives. We plan to report this

information in a future chapter.

Medicare is the primary payer for dual eligible beneficiaries, with Medicaid paying for services, copayments, and deductibles not covered by Medicare. Yet the two programs create multiple conflicting incentives at the program and provider level. Providers have incentives to transfer dual eligible beneficiaries to other settings that lower their own costs. These transfers can also benefit the program paying for that care by lowering its own spending by raising the spending for the other program. Neither program has an incentive to consider the other in terms of cost, service provision, or care coordination, and investments by one program that might improve the situation, if you will, are unlikely to be undertaken if the benefits largely accrue to the other program.

Let me walk through an example to make this a little more concrete, the example of transferring dual eligible beneficiaries from nursing homes to hospitals. A nursing home benefits from the transfer in two ways. First, it avoids the high costs associated with care it could not or elected not to furnish, and second, when the beneficiary is discharged from the hospital back to the facility, the

beneficiary may now qualify for a higher-paying Medicare-covered skilled nursing facility stay. A State also benefits as its financial responsibility shifts from covering its portion of a nursing home stay to now only being liable for only the copayments and deductibles associated with Medicare covered services.

Fee-for-service payment methods encourage cost shifting. Medicaid and Medicare payment methods typically pay for services on a per unit basis, you know, per stay or per day or per episode. Providers have no incentive to consider how their practices affect the costs of other providers or programs. In the previous example, a nursing home has an incentive to hospitalize patients with above-average costs rather than invest in the resources to manage the resident in-house. Unlike the hospital setting, post-acute care settings do not have financial penalties to discourage unnecessary transfers. Although bundling Medicare payments for hospitals and post-acute services would encourage more efficient use of Medicare resources, it would not address the conflicting incentives between the two programs and total higher spending might result.

The conflicting incentives also may lower quality

of care. When patients are shifted from one setting to the other for financial rather than clinical reasons, this can lead to sub-optimal care. Multiple transitions between settings increase the likelihood that a patient will experience fragmented care, medical errors, medication mismanagement, and poor follow-up care. Unnecessary hospitalizations expose patients to hospital-acquired illness that can delay a patient's recovery or erode their health status. In addition, multiple sources of coverage for dual eligible beneficiaries may result in no one coordinating their care.

Enrolling dual eligible beneficiaries in integrated managed care initiatives could reduce or eliminate conflicting incentives between Medicare and Medicaid and improve the coordination of care. A managed care entity would contract with Medicaid and Medicare and would be at risk for total spending. This entity would have an incentive to manage and coordinate care across all providers, avoid unnecessary hospitalizations, and prevent or delay institution-based care. Beneficiaries would have a single membership card, a combined set of benefits. Their care would be actively coordinated, and they would have a

single point of contact for answering questions about their coverage and benefits.

Several issues would need to be resolved for managed care to successfully coordinate care for duals. First would be having an adequate number of managed care entities for dual eligibles to access. Accurate risk adjustment will help ensure that entities do not selectively enroll beneficiaries.

Second, voluntary enrollment may not yield sufficient numbers of enrollees to make care coordination services financially viable. Initiatives would need to help overcome beneficiary reluctance to enroll in managed care and comply with its rules, such as accepting a network of providers.

Another issue to resolve is how to counter the incentives to stint on services furnished. Rewarding entities that provide good quality of care would make it in their financial interest to furnish it. Quality measures that are relevant to the dual eligible population are key to rewarding the right providers.

Many managed care entities will be challenged to effectively coordinate the care of dual eligible

beneficiaries. Many Medicare Advantage plans do not have experience with the services funded by Medicaid, in particular long-term care. Conversely, any Medicaid managed care plans do not have experience with Medicare benefits. Managing the care of dual eligible beneficiaries will require managed care entities to develop expertise in services, staff roles, and tasks that their staffs may not have much experience with.

Now let's look at the variation in spending, because it could shape the initiatives to coordinate beneficiary care. As a group, dual eligible beneficiaries differ considerably from their non-dual counterparts. They are more likely to be young and disabled, have three or more limitations in their activities of daily living, to be living in an institution, have less education, and be mentally impaired. These characteristics shape the amount of services dual beneficiaries require, the mix of providers serving them, and beneficiaries' inclination and ability to seek timely care.

Using MCBS data, we characterized dual eligible beneficiaries into the groups on this slide. First, we sorted beneficiaries into disabled and aged groups based on

their eligibility for the program, and then we used a hierarchy to design beneficiaries first into mental impairment groups and then into physical impairment groups.

Looking at some spending variation, there are two main points to take away from the analysis of the variation in spending, and there's more in the paper, but I'll illustrate by comparing four different groups. The first main point is that there's about a four-fold variation in combined Medicaid and Medicare per capita spending across the subgroups. You can see this by comparing the height of the bars on the far left with the far right.

The second take-away is that high-cost groups for Medicare and Medicaid are different. Starting from the left, comparing the first and second subgroups, the aged not physically impaired and the developmentally disabled, while the combined per capita spending for the second group is higher than the first group, the Medicare spending is actually lower. If we were to select subgroups to focus on based on Medicare spending, the second group might not get identified, even though it has higher combined spending.

Now, let's compare the second and the third groups, the developmentally disabled and mentally aged

groups. While the combined per capita spending for the third group is much higher, this is mostly due to higher Medicare spending. The Medicaid spending is about the same. This group has the highest per capita Medicare spending, but modest Medicaid spending.

The last bar, the aged with dementia, has the highest combined per capita spending, driven by very high Medicaid spending and high, but not the highest, Medicare spending.

There was also considerable variation in the mix of services furnished to beneficiaries in the different groups. Here, we see spending as a percent of the total per capita spending. The group on the left, the aged and the not physically disabled, had relatively low combined spending, and that spending was concentrated in hospital, physician, and prescription drug services -- that is the blue, the green, and the gray areas -- most likely reflecting community-based care with acute and chronic conditions that required hospitalization.

In contrast, high-cost groups tended to have a high share of their spending in facility-based care -- nursing homes, intermediate care facilities, and skilled

nursing facilities. For example, the middle group, 64 percent of its spending was on nursing homes, ICF, and SNF care. That is the yellow bar.

Another high-cost group, the aged mentally ill, shown on the right, had a lower share of facility-based spending, but one-quarter of its spending was on hospitals.

As we consider possible approaches to coordinate care, we will want to target policy options and program initiatives to different subgroups of dual eligible beneficiaries. We may also decide to focus on select subgroups, such as those with the highest per capita Medicare, Medicaid, or combined spending. We may want to focus on groups with the largest number of beneficiaries.

Alternatively, we may want to look at other metrics, such as where potentially avoidable rehospitalizations occur, and select initiatives that have the greatest potential to lower them.

The wide variation in spending and service mix will warrant different approaches to care coordination. Clearly, different strategies should be used for subgroups whose care is essentially facility-based compared with those whose care is community-based. For dual eligible

beneficiaries who are typically institutionalized, care coordination would likely be based at the facility, but we might want to consider whether having an outside practitioner act as a care coordinator would ensure access to needed services.

For beneficiaries with mental impairments, strategies will need to accommodate a limited ability to understand instructions and adhere to them. Institutionalized or cognitively impaired beneficiaries may benefit from different provider arrangements than those established for dual eligible beneficiaries who are not impaired and living in the community. Managing care for dual eligibles whose care is community-based will require coordinating care across a wide array of providers, which will present its own challenges.

Over the next several months we will examine Medicare and Medicaid spending for dual eligible beneficiaries using claims data from both programs. These data will include information about chronic conditions for dual eligibles and allow us to report spending by various clinical groups. These analyses will further refine the beneficiary characteristics that may be important in

designing integrated programs to manage the care for these beneficiaries.

A second strand of work will review several initiatives that have attempted to manage the care for dual eligible beneficiaries. These include the PACE, Special Needs Plans that target specific subgroups of beneficiaries, and demonstration programs that capitate Medicaid and Medicare, such as the one in Minnesota and Wisconsin. This review will consider if these programs' features are well suited to managing the care for specific subgroups of dual eligible beneficiaries.

We would like to get your input on the following questions. First, should we focus on certain subgroups of dual eligible beneficiaries, and if so, which ones? And second, and related to that, how should we select the subgroups? Then the next area we'd like your input on is if there are programs or plans that you would like us to specifically look at as we look at initiatives that have tried to manage the care for duals.

And with that, I'd look forward to your discussion.

MR. HACKBARTH: Okay. Thank you, Carol.

Can I see hands for round one clarifying questions? Mike, and then Jennie.

DR. CHERNEW: I have two quick questions. The first one is on Slide 11 -- it could have been Slide 12. Are the dollar numbers you are showing us here and throughout inclusive of dual eligibles in Medicare Advantage plans, or are they just dual eligibles in traditional Medicare?

MS. CARTER: I think they are just traditional Medicare, because the way -- their claims-based spending.

DR. CHERNEW: All right, so --

MS. CARTER: Yes.

DR. CHERNEW: Do you know what fraction of the dual eligibles are in Medicare Advantage plans already, like --

MS. CARTER: I think it's about -- is it six?

DR. CHERNEW: And is that because -- is the reason you get such a small enrollment because they're dual eligible, the Medicaid program is essentially paying for a lot of the deductibles and other benefit holes, so there's not an incentive for you to join the Medicare Advantage plan if you're a dual eligible now?

MS. CARTER: That's my understanding, right. Would you agree with that?

MR. BERTKO: That's part of it. The other part is the cost to them, and if it's not contracted with the State, the money from Medicare alone is not enough, so in some places it's enough and then they'll just put them in. In others, there's a dual contract. But those are more rare, and then there are only certain plans which specialize in Medicaid managed care which might have that kind of dual eligibility. So there's a subset of Medicare Advantage plans that can really deliver this kind of care across both programs.

MS: BEHROOZI: Or it's directly related. In the paper, there's a chart that shows the per capita spending. It's on page 14 of the paper. And for dual beneficiaries, I guess it's the average per capita spending is a little over $25,000, and it breaks it down by Medicare, Medicaid, and other, and the "other" is nearly $4,000. Given what you said about Medicaid covering the holes, I just wondered what the "other" was.

MS. CARTER: It includes -- most -- the biggest portion of it is out-of-pocket, and there is some private,

but -- it varied a little bit by the subgroups, but it's out-of-pocket, mostly out-of-pocket.

MR. BUTLER: Just quickly, remind me again -- I couldn't find it in here -- the total number of dual eligibles and the aggregate dollars as a percentage of Medicare spending of dual eligibles.

MS. CARTER: It's about 16 percent of the program is enrolled in -- are dual eligibles, and I think they account for --

MR. BUTLER: It must be 30 or something, if they're spending twice as much per capita --

MS. CARTER: Yes. I think it's actually higher than that. I think it was 40. Let me look. I think I have it right here.

MR. BUTLER: I wanted to look at the size of the problem or opportunity, depending on how you look at it.

MS. CARTER: It's 24 percent of Medicare spending.

MR. BUTLER: Okay.

DR. KANE: Yes, Carol, this is great. One thing I just am curious about is how did you find the data, because that was one of the hardest things, as I recall, was getting Medicare and Medicaid data linked up. Do we now have a

national data set?

MS. CARTER: We do have a national data set, but we are in the process of processing it. So these actually use survey data from MCBS, which surveys beneficiaries and then the claims get pulled for those beneficiaries.

DR. KANE: So what size sample -- so the survey, would that tend to favor the beneficiaries who are able to deal with surveys? I am just --

MR. BERTKO: No, this is the panel survey. So I believe, what, 70,000 people total, but across all types of people. So I'm guessing it's the 12 percent or so that are Medicare that are in the MCBS, because it's statistically valid and then it's a subset of that. So it's one-eighth, nine, ten thousand beneficiaries, of which this dual eligible subset has got to be that smaller subset of that. I don't know what your "n" was on that, Carol.

MS. CARTER: I'd have to look it up and get back to you. I don't have it right here.

DR. KANE: So this is just the claims on the people who have responded who are dual eligible --

MR. BERTKO: No, they're not claims. They're actually services, because it's the MCBS --

DR. KANE: It's the survey. It's what they remember using --

MR. BERTKO: It's actually they go in and they reach in and they talk to doctors and say, what did you charge? I mean, it's a very complete survey. I mean, it's incredibly rich.

DR. KANE: But do we have a good sense that it's pretty representative of the dual eligibles in these different subclasses, or -- I'm just curious. This is excellent, but I know it's really, really hard to get that kind of data, so I was just kind of trying to find out how --

MS. CARTER: I don't know how representative it is of the subgroups that we then categorize people into. We'll have a better sense of that when we actually use the Medicaid and Medicare claims data, which we should have in the spring.

DR. STUART: One question that might come up on this point is the aged mentally ill and if they're responding to the survey. Well, the answer to that is that MCBS takes a lot of effort once they select an individual to be in the survey to actually make sure that that person's

information is collected. So if the person is unable to respond, then they will seek to find a proxy who can make that information available. That doesn't affect these numbers, which are claims-based, as I understand it, for A and B, and that's just taking the claims that were incurred on behalf of that group and then just displaying them by their characteristics.

MR. BERTKO: Carol, I think I misspoke, because I was mixing the MEPS with the MCBS, and the MCBS is, what, 12,000 or so in the panel? My fault.

DR. MARK MILLER: So I think, just to connect these sets of conversations, MCBS goes out and surveys Medicare and picks up some of this population, too. Then, as Bruce described, it is a significant effort to keep track of what has gone on with the patient either directly or through proxies, and then says for the people in this panel, extract all of their claims and put them in a file. So it's a way to think about it --

MR. BERTKO: [Off microphone.]

DR. MARK MILLER: Yes. But what we're trying to build now is actually more what you started with, which is is there a national data set of combined Medicare and

Medicaid claims, and that's what we're trying to do now, and there will -- probably not for this conversation -- there will be some caveats attached to that, I believe.

And just to push this broadly, there is going to be caveats, like in this instance where we're using MCBS and then using it to disaggregate or to look at small populations, which it's not specifically designed to over-sample on, even when we construct a national data set, we're going to have to be very clear with you guys about what the caveats are going to be because this is a very difficult exercise and I think there will be some limitations in what we end up with. Is that right?

MS. CARTER: Right, and --

DR. KANE: It has prescription drug in it, so I knew it couldn't be Medicare alone.

MS. CARTER: Well, the prescription drug information was survey information that then gets adjusted for sort of the systematic underreporting.

MR. HACKBARTH: Clarifying questions?

MR. GEORGE MILLER: If I remember correctly, and I don't know if you address it or if it applies, but if I recall correctly, Medicare will -- one of the two, Medicare

or Medicaid, will not allow a patient to be in observation status. It wouldn't pay for that. But the opposite, either Medicare or Medicaid would. Is that taken into consideration in any of this analysis, or is that a statutory issue or a regulatory issue that we have got to deal with in trying to solve some of these problems, or is that --

MS. CARTER: You're talking about a patient that's in a hospital but in an observation bed?

MR. GEORGE MILLER: Right. If they're in an observation bed, either -- I can't remember which, I apologize -- but Medicare or Medicaid wouldn't pay for it for one program, but would pay for it in the other program. I apologize for not remembering which one. But did you run into that issue in dealing with this? And there are some other examples. I know my CFO would always tell me there are examples of conflicts between what Medicare would pay for and Medicaid wouldn't, or vice-versa.

MS. CARTER: Well, this spending would include whatever the respective programs paid for that, and so if one program doesn't cover it but another did, then the spending will include that.

MR. GEORGE MILLER: Because they're dual eligibles.

MS. CARTER: Right.

MR. GEORGE MILLER: So that's not a factor? That was really my question, if that's a factor.

MS. CARTER: Well, the spending's included in here. If there's a conflicting incentive in terms of sort of which program is --

MR. GEORGE MILLER: Just overall captured. Okay.

MS. CARTER: Yes. If there's sort of a gap there, then that's a separate issue, then, the spending.

MR. HACKBARTH: Other clarifying questions?

MR. BUTLER: I'm still struggling a little bit with the profile. On Chart 10 -- let's see -- can you put up 10 there? There we go. In the text, it says that half are mentally impaired, you know, with a third being mental illness and 11 percent having dementia. This is less than this.

MS. CARTER: Well, the dementia --

MR. BUTLER: How do you get to the --

MS. CARTER: -- is one plus ten, so across the two broad groups. Under disabled, there's one percent, and then

there's --

MR. BUTLER: Oh, I see. You add both, then, the columns?

MS. CARTER: Yes. Yes.

MR. BUTLER: Okay.

MS. CARTER: Yes. And so then mentally impaired, I think I included the dementia, the mentally ill, sort of adding all of that up, those four -- maybe all six. I can't remember.

MR. BUTLER: And then over 45 percent, it says, have three or more chronic conditions. That's not on this one --

MS. CARTER: That's not on this one.

MR. BUTLER: But it does suggest the care coordination, or you couldn't begin to do an episode of illness. You'd have to manage at a capitated level, I think, to coordinate the care of this kind of population.

MS. CARTER: I'll be curious when we start looking at it, because the data that we're getting have condition flags for, I think, about 20 or 25 conditions, and I'll be curious to see how many flags and then sort of if there's a neat typology that we can develop to really get at that,

because I think there's going to be many beneficiaries with multiples, and sort of how do you think about that.

MR. HACKBARTH: Other clarifying questions?

DR. CHERNEW: Can I ask about this chart?

MR. HACKBARTH: No.

[Laughter.]

DR. CHERNEW: [Off microphone.] If you're under 65, not physically impaired, and you're not in one of the mentally ill bins, if you're disabled under 65, what is your impairment if it's not physical impairment and you're not in the mental --

MS. CARTER: I don't know. I mean, I know how each of those categories was created, so it's possible that somehow in the coding we didn't pick up exactly how somebody became eligible for the program. So they somehow became disabled for the program, became eligible for Medicare through disability.

DR. CHERNEW: Right.

MS. CARTER: Now, why they didn't sort of group into a higher bucket, I don't know.

DR. STUART: I think the answer is the way you classify people as being physically impaired, and that does

not link up to the reasons for entitlement for disability insurance. And actually, you can do it, and I'd encourage you to do it. The MCBS is linked to administrative records for the disabled that will indicate the reason for the disability. And so that information is available to you. Now, that's not going to help in terms of trying to find people who were not physically impaired aged because they're duals because of age, and so you're going to have a disconnect. I think you're right. You want the same measure of physical impairment for both the disabled and the aged. But it does kind of hang out there -- I noticed this when I first read it -- of saying, okay, well, if you're not impaired either mentally or physically, then what are you doing on the disability list?

MR. HACKBARTH: Other clarifying questions? I've got sort of a round one-and-a-half question. I'm struggling to get my arms around this. So our core problem is that for this population, we've got money coming out of two pockets and that creates weird incentives to shift costs and those incentives, in turn, may be destructive in terms of getting the patients' needs met and getting them met efficiently.

So it seems to me if that's a core problem, there

are two general directions that you can go. One is just for the whole population, say let's do away with two pockets and have it funded out of one. And then the other general direction is that -- and this is one we've tried in various ways in the past -- is to say, well, we can create special programs that the beneficiaries can opt into that will then integrate whether it's a PACE program or it's a SNP program for dual eligibles or a social HMO. But that second path of special program, it seems like we've tried that path a lot and there are issues about getting everybody into that and the incentives may not be strong for people to opt into it.

I'm just not sure why we keep reinventing the wheel here and trying to come up with ways to create special programs to deal with this incentive problem. Why haven't those other approaches worked, and some of them have worked well at the ground level, but they haven't spread widely through the program. It sort of makes me wonder whether the other track isn't the track that you need to think about, which is for all of these patients, get rid of the bifurcated funding. So that's an issue that I'm just struggling with.

MS. CARTER: And I'm sure you know -- no, I don't

know the answer, but people have thought about that for about 15 years, whether it's federalizing or moving the funding under one umbrella, either under Federal or State. I mean, people have talked about that.

MR. HACKBARTH: You know, obviously, federalizing the funding for these patients raises difficult issues in terms of, you know, finance and political feasibility, et cetera, and I don't mean to give light to that at all. I guess my real question is, why are we going to be any more successful this time in developing a new programmatic response with a new name that overcomes the core problem? Am I missing something, or am I --

MS. CARTER: No, I think you -- I mean, without mandatory enrollment, it's tough to get enrollees, and I don't know how you -- I mean, it's possible that you could do more to facilitate enrollment at the State level so that when beneficiaries enroll in Medicare, if they're eligible for Medicaid, you could make that an easier process. But that still doesn't mean you'd have entities to manage their care. You could, I guess, make -- I think beneficiaries undervalue care coordination services, so if they became more aware of what that really would mean for them, maybe it

would be more attractive. But this is a recurring problem with voluntary enrollment.

MR. HACKBARTH: Okay. Round two questions, comments.

MS. BEHROOZI: I'm still surprised by that chart that shows that the average dual beneficiary is spending $4,000 out of pocket and the non-dual beneficiary is spending $6,000. So $4,000 on a Medicaid-eligible level income is quite a lot of money out the door for that person. I mean, that's quite a high percentage of their income, and it seems that it wouldn't be a bad thing, maybe, to do it on an opt-out basis, as you said, you know, make it mandatory, and then have the Medicaid dollars used to really cover everything for that beneficiary so that they can really receive all of the benefits and, yes, have programs accessible everywhere. I mean, this kind of indicates that maybe programs aren't accessible everywhere, because I just can't imagine that people would, quote-unquote, "choose" to spend $4,000 if they were really aware of what was going on.

So I think -- I understand what you're saying, Glenn, about creating new problems, but it just seems like there hasn't been enough of a push, a thrust, behind really

getting folks into these programs, not just about how the dollars are best spent, but these people are getting -- they're getting financially messed up. Their care is messed up. It just really seems like a good time to say that options are limited here. We've got to require people to be in programs.

But then you have to make sure that the programs are carefully selected and contracted, obviously, with the State and Medicare or whatever. It's not a free-for-all that you're going to just shove people into any willing provider kind of thing.

DR. CHERNEW: I agree with Mitra, and I was going to say that in order to do that -- to keep it voluntary, it's going to be hard. To make it mandatory requires you to have real comfort in the quality and the performance, and that's really an important issue. So I think we need to move quickly along with measurement in some of these areas. And the question in part is what do we do in the interim, because I don't think it is a feasible policy option now to recommend that everyone be forced into a dual managed care -- I just don't see that as happening. We have a way to go with measurements.

And I think one of the challenges we have here is the States, and maybe the Federal Government, I think more so the States are playing a game to get as much from Medicare as they can, and it's this difference in rates and difference in rules that allow them to game. And so I think the question, which I don't know the answer, is are there easy fixes that one might be able to put into the system to prevent some of the -- it's bad care in many cases, but it's also a cost shift to get more Medicare money coming out.

So that suggests in some ways -- I could think of ways, I'm not sure if they're good, of sort of having minimum Medicaid payment rates for Medicare beneficiaries so you keep that gap within some bounds so you avoid the incentive to churn people through, because I think what's happening is Medicaid setting low payment rates, paying sort of very much on the margin and relying on somewhat more generous Medicare payment rates to kind of make up the difference. And in order to make that work, given the rules, they have to do some of this churning and the other things you've talked about.

So I think if we could find administrative rules that might minimize some of that short-term inefficiency,

that might be a way to go, because I don't see the other system working in the near term as well as I would like. Maybe someone can figure out a way to do it.

MS. CARTER: And when you -- I just have a point of clarification on my end. When you talk about measurement, do you mean like performance measures or what do you -- okay.

DR. CHERNEW: [Off microphone.] -- put everyone into a Medicare -- if you want to put everyone in a dual eligible SNP-type plan and force them in -- see, the problem is forcing. Now, you can have an opt-out situation, but if you were going to try and really force them in, because otherwise you don't have strong incentives, you really have to worry that they get into something that they just really don't like or they can't force them into something that's really not providing good care. So you have to have good enough safeguards, I think, before you could go that route.

MS. CARTER: Mm-hmm.

MS. HANSEN: Yes, thank you. First of all, Carol, thank you so much for doing this. This focus, as you know, has been an area of not only both interest and history for me, but I just think that this population is going to grow

quite astronomically over time, just because of people's lowered income status and they fall into the category of being a dual primarily because of income more than anything else.

And thanks, Glenn, also to your forbearance on this. You know that I've brought this up probably from the time that I came on, because these are the same people. And the tough part is our statutory focus is on Medicare, but it's the same individual who happens to qualify for two programs and then this bouncing back and forth occurs.

I guess the questions, one is specific to, Carol, the ability to take a look at the current population. Since we have done readmission work in terms of the cycling back of people into hospitals, you know, every 30 days or 90 days, have we ever looked at the particular cut on people who are dual eligibles as a subset of that churn?

MS. CARTER: No, but we have the data to do that. I did look at the share -- and I don't remember the numbers, but I remember that I looked at the share of the repeat, and I think we -- I forget, did we use three or more SNF hospitalizations within a two-year period, and duals were disproportionately represented in that, but I don't know

that I looked at sort of what was their pattern of readmissions.

MS. HANSEN: Right, because I'm thinking if we're going to narrow it for the time being to Mike's point, is are there kind of tighter things that we can do in the meantime while this is a very complex issue, as Mitra points out, and there are not always a lot of good, capable resources to handle this, what do you do in focusing and targeting in the meantime.

The other trend question I have is we talk about the level of people in institutional care that goes on. This now relates back to our work in nursing facilities, licensed facilities and other kinds of facilities where people go to, especially where it's the mentally ill or the people who use custodial institutional settings. Is there -- I forget now what the growth pattern, capital growth pattern in those facilities are, because that itself becomes a factor of resources down the pike, that these non-institutional options for this growing population is going to have to be dealt with because these people are still coming down the track, how we take a look at existing metrics based on the data that you've looked at, but then

projectively, what are some of the issues that we're going to face.

MS. CARTER: So you're asking about sort of the supply of ICFs and nursing homes?

MS. HANSEN: ICFs and SNFs, yes, because I thought that there has been, at least from looking at it for us, we see that there's not a whole lot of new building going on.

MS. CARTER: Yes. That's what I would say, also.

MS. HANSEN: So if that's the case, the compelling urgency of making sure some systems are in place, programs in any form are ready to receive this population, because otherwise they will churn that much more into the hospital environment. So that's something to anticipate.

MS. CARTER: And, of course, you know better than I that some States have been much more aggressive about home and community-based service provision to try to at least not initially institutionalize folks that maybe don't quite need it, probably delaying institutionalization.

MS. HANSEN: Right. So it would be great to -- I know this is not the focus of our work, but just those are the ways that this Medicare population is going to be dealing with it in the future.

And then finally, just as a resource, possibly you already know about it, but AARP just came out with a report focusing on three States, New York, I think Minnesota, and New Mexico --

MS. CARTER: Yes.

MS. HANSEN: -- as to how States are beginning themselves to look at it. And so it's really about their incentives, and my understanding is if they were paid a little bit more, to Mike's example, they would have some greater incentives in some ways to kind of keep the system appropriately whole rather than this bounce back. So certainly I just want to make sure that everybody was aware that we're looking at this on the State level right now.

DR. MARK MILLER: Jennie, when you said paid a little bit more, to whom, by whom?

MS. HANSEN: Possibly some -- the States -- let's see. The note I have is that they would like to be paid up front for avoidance of nursing facility costs. So they just -- so in other words, since their pay is so low right now, there seems to be kind of -- not by aggressive intention, but the ability to have the safety, the valve released by having people go back into Medicare for a while. So if they

had an incentive to kind of keep it steady state, covering their costs on the front side, they would not be -- their incentives to be more aggressive of keeping them in a constant state in the facility might be enhanced.

DR. MARK MILLER: [Off microphone.] And it's a Medicaid rate?

MS. HANSEN: Correct. Thank you.

MR. HACKBARTH: Okay, round two?

MR. BERTKO: This is just a question, Glenn. Since I think your first door of federalizing in any way or shape is not only closed, locked, and painted shut, we might want to focus our own thinking on only the second door, and as several people have said here, I think that we need to face up and say whether -- just forget about voluntary. Have an opt-out rather than an opt-in kind of mechanism, and there needs to be some choice along there. It seems to have worked to some degree. If you look at the LIS in Part D, even with the complex problems they had, most LIS members are covered for Part D.

Secondly, access in Arizona for Medicaid managed care seems to work on a mandatory basis. I think we have some lessons learned there. I would point out, though, that

design and management of these programs, of where they go, is really important. There are about five or six Medicaid managed care plans that I know of that work pretty well, and I think there are others, I think a couple of them in Boston that I don't know much about probably work well. The SNPs are too loosely allowed to qualify, in my mind, for what's done there, not that they couldn't become some, but they should. Jennie, your On Lok program as well as Evercare, I think, are other good models.

But we might need to have an assortment of models by State, because from my limited background on this, these populations are very, very heterogeneous, and so we might need to have four kinds of programs per State to get in there. And with some opt out, allowing you to have a remnant maybe back in this uncoordinated system, but with the vast majority opting in -- not opting in, enrolled in with only the ability to get out. To me, that seems a more productive approach rather than for us to meet -- this is at least the fourth time in five years or six years that we've talked about this and kind of wrung our hands as opposed to make stronger recommendations.

MR. HACKBARTH: I agree with much of what you say,

1 although an opt-in model for Medicare beneficiaries is a
2 radical change in the 40-year philosophy of the program.
3 MR. BERTKO: It's time, though. If Jennie is
4 correct on saying the growth in this is going to be large --
5 MR. HACKBARTH: I think I incorrectly said opt in
6 when I meant opt out.
7 MR. BERTKO: Yes.
8 MR. HACKBARTH: It's an opt out model that would
9 be a radical change.
10 MR. BERTKO: That's right. But if the growth is
11 large and these people are very high-cost, maybe double --
12 not double, but 50 percent more than the average Medicare
13 beneficiary, we've got to think about more radical
14 solutions.
15 DR. CROSSON: Just two comments. Carol, you were
16 looking for places to look, and you may or may not know
17 we've had for 40 years or so a social HMO in our Oregon
18 region, which I think is the longest running if not the
19 biggest one and has been successful, although difficult for
20 all the reasons you talk about in terms of enrollment and
21 then the mix of capabilities that are required. But it has
22 continued to work and folks up there like it, both from the

perspective of the caregivers, the plan, and the enrollees. So you might take a look at that.

The second question is -- it sort of goes back to the previous topic discussion and, you know, do we want to soar like eagles or peck around in the barnyard for --

[Laughter.]

MR. HACKBARTH: That's an image that's going to --

[Laughter.]

DR. CROSSON: So I figured if we're going to take on reforming graduate medical education, why can't we batter down the locked door of at least raising and discussing the issues about federalizing, if that's the term, but sort of unifying the payment stream here and figuring out what would be required?

Now, I mean, some of the more politically astute and experienced here may be laughing either inside or overtly at me, like Bob is --

[Laughter.]

MR. HACKBARTH: The people who are really expert at pecking around.

[Laughter.]

DR. CROSSON: But I think at least since we have

had visions of soaring here today, I'd have to raise the question of why, in this particular case, we are not going to do it.

DR. BERENSON: I'm not answering that question. No, I'm going to -- I think there's -- I'm struck by sort of a disconnect in the discussion. Glenn, I think, correctly laid out the two doors and then pointed to the fact that we haven't been very successful in the second door, even though that seems the one that's politically available to us, so what are we going to do this time.

And then we had a discussion about how the problem is we need to develop an opt out so that we assign people. But what are we assigning them to, is my problem. I mean, I'd like to have four models in each State available, but what we have is PACE, which, what is it, we're up in the tens of thousands now, up to 30,000 or something total in a decade in which PACE has been proved. We had hundreds of thousands in SNPs, but we don't think that that works very well.

So I just don't think that we've got the models yet, I guess is my problem. I'd like, I guess, if we're going to do fruitful work in this area, because I -- you

know, your slide that lays out the rationale for why a managed care plan receiving capitation makes perfect sense to me, and yet it hasn't worked, or these are so tough that I think we need to really understand what the models would be and some reason to believe they'd be successful before we would go anywhere near sort of saying, now we're ready to restrict the choices of beneficiaries because we know what's good for them.

So that's my problem here, is understanding a little more why doesn't SNP work and can that just be tightened up in some ways so that it would, or are we really dealing with just such difficult issues that it's just really hard.

DR. KANE: I want to go back to something that Arnie brought up about the hospice benefit, that perhaps there's a time when we need to open up a third option or a gray area. So there's a zone where people are non-duals, but they're one acute episode away from becoming a dual, or one chronic condition exacerbation away from being a dual, and I'm wondering if we can't use this new data -- which I am delighted to hear we were trying to -- use this new data to say, okay, let's back up on the people who become duals

and see if there's some pattern of care or pattern of illness or pattern of utilization that puts them at a high risk of becoming a dual zone, but they're not yet there, and see if we can't open up the benefit package to be more like the Medicaid community-based, trying to prevent them from becoming a dual.

I mean, some of the stuff going on in Boston is around that, is trying to reach people before they actually hit the spend-down and trying to keep them in the community, and they're often identifiable. I mean, they're frail elders who are just barely hanging on and suddenly they become dual in a year and then you can see what they're spending. But I think there's a lot of people who are not quite duals who would really benefit from having community-based coverage and some of the types of services that they can't get under Medicare and they can only get once they're in Medicaid.

So that may be one way to get at this issue, is try to prevent the dual rather than manage the duals, because I agree. We have tried. I mean, it's very hard to get people to willingly go into a managed care program, but they might like to say, well, if you look like this profile,

we will open up the benefit package to you.

MR. HACKBARTH: In a funny sort of way, that's federalization for people in advance. The Federal Government's going to offer a benefit package that includes the Medicaid element.

DR. KANE: It would save Medicaid money, because people would never become dual. But it also is much better care for the beneficiary. So it's really -- I know. I mean, it's -- but it's not total federalization. It's just partial.

MR. HACKBARTH: Right. Right.

MR. GEORGE MILLER: Just a quick question. We have expert panels all the time and they've been very beneficial. Have we convened a panel with dual eligibles to ask them what would work and if we could -- if they would redesign a good system for them, what would work? Get their feedback, what works and what doesn't work for those who could participate?

MR. HACKBARTH: Well, we have not. In fact, we've not done a patient panel for any issue. To the extent that the issues here are financing issues, obviously, that wouldn't be their vantage point on it. So what they would

speak to is models. But the core problem is a paucity of models for them to relate to. Oh, I tried this one and it was really good compared to that one. You know, it's sort of like a catch-22.

DR. CASTELLANOS: I guess what bothered me on this in reading this is that this food fight that's going on between Medicare and Medicaid, it really bothers me. You know, I don't have a good answer, but I think, Glenn, you brought it up, and Chernew, you really talked about pecking and so on. I think if we could just form a safety net for these type of patients and then do a means test to make sure they do really qualify and then consider for that group of patients looking into maybe federalizing their Medicaid benefits. You know, somehow we have to address that, and I would hope -- I think we should look into it, at least.

DR. STUART: This is in response in part to points that were raised by Michael and Nancy, but also yours, Ron, and it's more in the way of problems and adding more to the rationale for why this has been an issue for so long, and I'll be brief.

The first part is that when you talk about people coming into the program, almost half of the aged duals are

duals who aged into the aged part. In other words, they started out as disabled beneficiaries and then they become aged. There is no disability above 65. You're suddenly cured. You're just aged. So there isn't very much of that, but there is a lot of movement back and forth in terms of entitlement for Medicaid.

It's not just once you get -- you're one acute condition away from eligibility. It has to do with if you're in States that have medically needy programs. In my State, you have to be certified four times a year, and so what you'll have is that you will have some people who will have, for whatever reasons, will be eligible for three months, will be off, and then will come back on. So you've got a lot of this churning that's going on within that population.

The other part, and this gets back to Mike's issue in terms of raising price, one of the reasons that the Medicaid programs traditionally had -- well, maybe now, too -- have low reimbursement is that they get out of covering Medicare cost sharing. So if a State pays below 80 percent of Medicare then it doesn't pay the 20 percent cost sharing for physician and other Part B services. So if you're

talking about raising the price, it's not just raising it for the Medicaid services. It's also raising it for the cost share part.

I hate to end on such a note of kind of despair, but the more you know about these, the tougher it gets, which I think gets back to Bob's point about what kind of a model do we have here, because the model has got to adjust to all of these things.

DR. CHERNEW: I agree with that completely and want to point out in addition, one of the problems of, say, like federalizing this to get rid of some of the efficiencies, which is appealing in many ways, is, for whatever we don't like about what the Medicaid programs are doing, they're spending less because they pay a lot less. The budget implications of bringing it all into the higher-paying system are non-trivial for reasons that you read, but even just the straight reason that we just pay more. And so if we put at the higher rate, it might smooth things out, solving one problem, but it creates other problems.

DR. MILSTEIN: I think it would be helpful to make a distinction between federalizing the program and coming up with a coherent program that jointly manages the Federal and

State contributions. I think that's an important distinction.

I spent a lot of -- for ten years when I was in practice having a disproportionate fraction of patients in this group. I would say even if they didn't cost the Medicare program a dime more, they are hugely more vulnerable. Many of them are relying on county welfare workers to figure out all the administrivia. It is very challenging. Often their care does suffer due to the fact that you've got two uncoordinated payers.

So purely based on the fact that these patients are much more vulnerable than any other class of beneficiaries that we try to do well for, I would say on that basis and on the basis of opportunities to prevent health crises through more coherent management, I think there is a case to be made for a single coherent benefit plan, separate and apart from whether it's fully Federally funded or funded through a combination of current -- some pro rate distribution based on State and Federal contribution. But I think there's a quality of care case to be made here separate and apart from improving efficiency of the program.

MR. HACKBARTH: Okay. I'm feeling really bad for Carol here.

[Laughter.]

MR. HACKBARTH: We've dealt her a difficult hand. Why don't you put up your questions slide.

MS. CARTER: They are easier than the issues you raised.

MR. HACKBARTH: Right, they are. But that's why I'm putting them up, because I'm hoping that maybe we can at least give you a little guidance on your narrower --

DR. MARK MILLER: I mean, the kind of things I could come away from with this conversation is I think we probably should, just like anything else that we do, we should continue to make sure that we understand these populations at some level of detail. We tend to speak of dual eligibles, but they aren't all the same. There are some very different -- so I think it's probably worth continuing down that road.

Another way to take comments here about where, well, we seem to have tried these models, these mixed models and have failed. Why aren't we talking about the federalization approach? And that's really the point of

this conversation, is to ask you guys what you want to do. We could go through the history of -- or some of the history, not in detail -- what people have proposed on the federalization side or the State versus federalization side and at least acquaint ourselves and yourselves with some of the ideas that have been talked about in the past.

It's probably important to keep in mind when we talk about those models of understanding what the impacts are at a budgetary level and that type of thing because you'd have to get into things like clawback from the State and that type of thing, which are always really pleasant conversations to have. But at least we could work both sides of the street, these models, and also review again -- because you guys already went to it and immediately brought this back up. So this means that the Medicare issue of kind of freedom of choice for this population would have to be compromised if you go with one of these models. And so we could crank through all of that and have somewhat more of a precise conversation of what each of these conversations involve and supplement that with building this data set and trying to figure out what this population looks like, because it also may be that you might want to target which

way you go with these populations as opposed to just saying it's everybody, although maybe in the end it is everybody, but just understanding.

That's a couple of things that we can do, and that's how I was telling Carol she'd be spending her weekends.

[Laughter.]

MR. HACKBARTH: And just to pick up on that, if we end up rolling out the federalization door and saying that we're going to develop new models, and then whether it's opt in or opt out, another question that would interest me is in more successful programs where we've had some organizations that have done a good job organizing the care in an efficient way, high-quality way, why haven't more patients opted into those models? What does it look like? And maybe this is sort of George's question. You know, what does it look like from the patient's perspective? Why aren't they clamoring to enroll? I think we have had a few successful experiments, and why haven't they drawn more patients? Is there something that we could do to make it more enticing for the patients to elect that model?

I think that the opt out is a real tough road

politically, and so maybe we can figure out how to make opt in more attractive from a patient perspective.

DR. BERENSON: Just to modify your question a little bit, is the problem that patients don't want to enroll or that we don't have an infrastructure out of a few specific places because it's tough to manage these programs? So if they were available, it might be that people would choose them, but they're not available. I don't know that. I think it would be helpful to sort that out.

MR. HACKBARTH: Okay, Carol -- Bruce, last comment.

DR. STUART: I'd just like to add something on the other end of the spectrum. I mean, we were talking about capitated programs, coordinated care within those programs, all the problems associated with it. At the other end of the spectrum is something that Medicaid programs actually have been doing for 40 years, and that's case management. Now, they may not do it very well, but one could think of a benefit that would be case management that would, in fact, require that some of the coordination problems that we talked about would actually be part of that benefit. You'd pay to have somebody do that on an individual basis. I'm

not advocating that, but I think that if we're looking at a spectrum of alternatives, that deserves to be there because there is some history with that.

MR. HACKBARTH: Thank you, Carol.

Okay. We are to our last topic for today, and that is looking at the variation in home health agency margins.

MR. CHRISTMAN: Hello. Really, today, we're going to cover two separate topics. The first is to give you an overview of the factors affecting the financial performance of high and low margin home health agencies. The second is related but separate topic regarding the accuracy and payment integrity issues raised by the way Medicare pays for home health outlier episodes.

For some time, the Commission has reported variations in the margins of home health agencies. The question for the Commission is how much of this variation is due to differences in cost or provider efficiency and how much is due to inaccuracies or problematic incentives in the payment system. Examining the characteristics of high and low margin agencies will allow us to begin to answer this question and possibly identify areas of the payment system

that need further analysis or refinement.

Briefly, let me review the variation we have reported.

For the last 4 years or so, there has been a consistent spread of about 23 percentage points between the agencies at the 25th and 75th percentile of the Medicare margin distribution, as reflected in the data you see here for 2007.

Now we see this variation in other payment systems. For example, there was about a 26 percentage point spread between the 25th and 75th hospital in the IPPS in 2007. So the magnitude of the variation in home health is not unusual, but it is still a useful tool for examining the payment system.

We divided our agencies into quintiles based on their Medicare margins, and here you see the margins and characteristics of the top and bottom quintiles. The agencies in the low margin group had an average margin of about negative 9 percent while those in the highest margin group had an average margin of about 37 percent.

There was little difference in quality when measured using our composite measure of about two dozen

performance measures from the OASIS. The urban and rural shares of episodes provided were about equal among the high and low margin providers.

Now, it's not on this table, but the most significant difference in service area was within the types of urban areas that providers served. Low margin providers delivered more episodes in the urban areas with populations greater than one million while high margin providers delivered relatively more episodes in urban areas with populations of less than one million.

Next, we compared the ownership and cost characteristics of high and low margin agencies. If you look at the second line on this table, nonprofit agencies tended to be a greater share of the low margin group and a smaller share of the high margin group.

Now, if you look down at the next line, high margin agencies delivered about 25 percent more total visits in a year, and high margin agencies averaged about 28,000 visits compared to 22,400 for the low margin agencies.

This combination of high margins and larger size suggests economies of scales, and the trends in agency cost support this, if you look at the next set of lines down.

High margin agencies had a cost per episode that was 40 percent lower than low margin agencies, and they had this lower episode cost for two reasons. They had lower cost per visit and fewer visits per episode. Of these two factors, lower cost per visit appears to be most significant. High margin agencies had a cost per visit that was 34 percent lower than low margin agencies, and high margin agencies provided about 2 visits fewer, or 10 percent less visits, per episode.

Finally, the average payment did not vary much between high and low margin providers.

Overall, this table suggests that high margin agencies have lower costs because they are larger and can achieve economies of scale that reduce their costs.

Next, we compared the patient severity and services used for high and low margin agencies on a number of metrics. This table is a little busy, so let me point out the main conclusions and then say a little bit more about a few of the metrics.

If you look at the first and fourth lines, the ones in yellow, this is home health case-mix and HCC risk score. The latter is the factor used to risk-adjust MA

payments. On these two measures, the high margin providers have higher values, indicating that they serve more severe patients than low margin providers.

However, if you look at the fifth and six lines in orange, you can see that on two measures, functional impairment and chronic conditions, we did not find any difference between these two groups.

So, in total, across the four measures, we get a mixed picture: Two, including the case-mix, suggest higher severity for high margin agencies, and two suggest no difference. Specifically, the home health case-mix alone suggests that high margin agencies serve more severe patients, but two other measures disagree with it. These inconsistent findings make it hard for us to conclude whether the difference in severity suggested by the case-mix is accurate.

Further, the findings on case-mix and margins suggest that agencies with better margins had higher case-mix. Higher margin agencies have higher case-mix because they provide more of two types of episodes with higher values. They provide more episodes that had 10 or more therapy visits, which qualified for extra payments, and they

provide more episodes that are in the 2 highest categories of clinical severity as measured by the PPS.

The correlation between high case-mix and high profitability suggests a bias in the payment system where the high case-mix episodes appear to be more profitable. To understand this further, we analyzed the relationship between case-mix and episode cost in a multivariate regression. The regression had a result that was consistent with the trends on this table for case-mix. It found that it tended to overpay for episodes with high values.

These results lead us to two conclusions generally about the home health case-mix. First, it appears that the case-mix may not be accurately measuring severity. The inconsistent results across our four measures do not depict a consistent trend, and more analysis is needed to understand why. Second, while there may be issues with the case-mix's sensitivity to severity, the correlation between higher case-mix and higher margins suggest that, as constructed, the system overpays for high case-mix episodes.

So, based on this data, we have a few preliminary findings and some plans for further work:

First, size appears to be an important factor in

margins. Agencies that are larger have lower cost per episode and better Medicare margins. The difference in cost per episode is greater than the difference in average payment, case-mix or any other factor we examined.

There is no significant difference in the share of urban and rural service areas of high and low margin agencies, and there is no difference in quality based on our composite measure.

The results on our patient severity measures are mixed. It is not clear how accurately the case-mix is capturing severity.

That said, whatever limitations it may have, the case-mix in effect in 2007 appears to overpay for episodes with higher case-mix values.

Based on these findings, there are some areas we plan to pursue. First, CMS implemented refinements in 2008 that changed the case-mix significantly. We will need to look at the new case-mix to determine the impact. We also may examine additional patient characteristics such as home health diagnosis, additional facility characteristics such as specific quality measures like hospitalization or ER use, and beneficiary characteristics such as dual enrollee status

or the availability of informal care.

We are also interested in any additional areas that you believe are appropriate.

That completes the discussion of the variation in home health margins, and next I want to brief you on a second topic, issues with the accuracy and integrity of home health outlier payments.

Differences in outlier costs could affect an agency's financial performance, but that difference appears to be small in practice. In our examination of agency financial performance, we found that outliers equaled about 3 percent of episodes for high margin agencies and 5 percent for the low margin agencies.

The difference is not large, but because of the way Medicare pays for home health outliers it may be undercompensating agencies with high outlier costs and overpaying those with low outlier costs. Let me explain why.

In the home health PPS, costs are measured using standardized cost factors based on 1997 cost reports. These standardized factors are used to estimate the cost of the visits in an outlier episode.

These standardized costs are used even if the provider's costs vary from them significantly. Providers with costs above these amounts are underpaid, and, in the case of agencies with costs significantly lower than what Medicare assumes, outlier episodes could even become profitable.

This became evident in 2007 when an aberrant level of outlier payments were made to agencies in Miami-Dade County. Agencies in this area accounted for about 60 percent of outlier payments for the nation, and the number of visits in an outlier episode in Dade was about double the average for the rest of the country. The high proportion of cases was obviously suspicious and suggests that some agencies were pursuing outlier episodes because they were profitable. This can occur when agencies either do not provide the services they bill or, again, have lower costs than the benchmarks Medicare uses when it computes payments.

CMS took some steps to address the fraud issue but did not change how it pays for outliers. Most importantly, they continued to use the standardized cost factors to compute outlier payments.

This example shows the problem the current system

creates: If a provider delivers 157 visits in a 60-day episode -- again, this was the average for Dade in 2007 -- Medicare would assume the episode costs about $12,700 based on its standardized factors and would make a payment of about $9,500 to cover both the base payment and the extra outlier payment that the episode qualifies for. Based on Medicare's calculations, the provider would have lost about $3,800 on the episode.

If the provider had costs that were lower than what Medicare assumed, the lower example in this case -- 30 percent lower is what I've used for this example -- Medicare would have made the same payment of about $9,500. But because the costs are lower than what Medicare assumes, the provider would have made a profit instead of a loss.

As long as Medicare does not use providers' actual costs to set outlier payments, low cost providers could use the system to make these episodes profitable. In addition, high cost providers get a smaller payment than they would get if actual costs were used.

This brings me to an option the Commission may wish to consider. Other PPSes use actual costs when computing outlier payments, and home health is an exception.

Using actual costs would raise payments for high cost agencies and lower them for low cost agencies. The payments would more closely match providers' actual costs.

The changes CMS has proposed for 2010 do not address this issue, so these inaccuracies remain. For these reasons, the Commission may wish to consider a recommendation for the Secretary that would change outlier payments to use actual costs when calculating payments.

This completes my presentation. Please let me know if you have any questions on outliers or the variation in margins work.

MR. HACKBARTH: Thanks, Evan.

Let me ask a question about the first part. One of the things that you found we have heard before, and that's larger agencies tend to do better, tend to be more profitable, which has always puzzled me. I associate economies of scale with industries that have high fixed costs, and so you're able to spread your fixed costs over a larger base, and that reduces your average cost per unit of service.

Home health is not an industry that I associate with high fixed costs. Any idea what's going on there?

MR. CHRISTMAN: I mean I guess one thing when we've looked at their costs generally, the break between sort of direct and indirect costs -- and generally thinking more of indirect costs as being those back-end things -- has been around 35, 40 percent and not terribly different from other providers. So they do have some home office costs that they do incur, and there are some things that home health agencies invest in, such as IT systems, that may offer some economies.

I guess I'd say that's something we could probably get a better handle on.

MR. HACKBARTH: Okay, further clarifying questions, we'll start on this side.

DR. CASTELLANOS: Can you turn to Slide 9, please? This is for clarification. I do not live in Miami-Dade County. Thank you.

MR. GEORGE MILLER: I just want to understand on 10, what you talked about, the payment for low providers versus high providers. Are you suggesting this only for low cost agencies or would it be a policy change for everyone, that you go to the providers' actual costs?

MR. CHRISTMAN: The way we've done it is for all

agencies. So the payments, this example shows a lower cost provider. Again, this is just an option.

MR. GEORGE MILLER: I understand.

MR. CHRISTMAN: We would look at the providers' actual costs, and those with higher costs would get an outlier payment based on that, and those with lower costs would get an outlier payment based on that. So you can kind of see how they're payments would change.

MR. GEORGE MILLER: I'm a little surprised because wouldn't that benefit the more profitable agencies much more, if you change?

MR. CHRISTMAN: I don't believe it would, I think, because what would happen is that if you look at the information we showed earlier the low cost agencies are the higher profit agencies. So what this would effectively do is it would lower payments, outlier payments for low cost agencies and raise them for high cost agencies, which in this case would more or less be consistent with saying that we would be lower them for highly profitable agencies and raising them for less profitable agencies.

MR. GEORGE MILLER: Okay. Thank you. I got it.

MS. KANE: Yes, I have a couple questions. In

keeping with Glenn's question about why there might be economies or why higher, it's not that much higher, actually. I'm wondering, is there a difference between the free-standing and chained agencies, where they're sharing overhead more, or do we know anything about that?

MR. CHRISTMAN: We haven't looked at chain, and that's an option that we could pursue. The difficulty with that is that the chain data that is available is notoriously inaccurate. So that's definitely something we could look at, though.

MS. KANE: My other question is on the written document where you talk about quality scores being the same, but these are composites on 24 items which could cancel each other out. I'm just wondering, within the individual 24, are there any noticeable quality differences that might not show up when you do a composite so that everybody looks the same?

MR. CHRISTMAN: I think that's sort of a next lap we wanted to take on this. This composite score was based on a methodology the Commission developed about three years ago when we looked at approaches for examining home health pay for performance.

MS. KANE: So you can break that out from the 24? It would be useful to see that.

MR. CHRISTMAN: Yes. I'm sorry. Yes, I want to be clear. I think we see that as a next step. The two things we definitely think are kind of on our list are hospitalizations and ER use and looking at those rates specifically, and the other stuff. I think the adverse events stuff is at the top of our list.

MR. BUTLER: So, sometimes we soar like eagles and do things like the Medicare Advantage recommendation. Sometimes we peck in the farm yard.

This outlier thing, like Dade County, is almost like pecking below the farm yard level. When you get 60 percent of the outlier payments in 1 county and we're handling what looks like a very technical thing, somebody fix it.

Is this partly because -- and I'm just kind of curious. Do these things fly under the radar because it's home health, and CMS only has so many resources, and these things just kind of get lost in the shuffle or am I missing something? We're entering this discussion at a pretty detailed lower level.

MR. CHRISTMAN: There are parts of your question I can't really answer. But I think just to put some perspective on this, I believe the number I saw was that Medicare does prepayment review of like half a percent of all home health claims. So the kind of work that might have uncovered the outlier stuff was not really possible until Medicare had paid. It's not necessarily ideal, but that's the way things have been.

MR. HACKBARTH: I would point out that some of our best work has been in the barn yard. Yes, we've made some really specific, but important, recommendations on issues like this. So it's detailed, but it can be significant in its impact.

The thing that strikes me about the outlier is that the system was set up from the beginning different than all the other PPS systems. I wonder what the history was behind that and why they would opt for a different model that, incidentally, would have pretty predictable consequences. It's not like this is a surprising result. It's what you would expect.

MR. CHRISTMAN: Anecdotally, the only thing I'm really aware of is that I believe in moving to PPS Medicare

has tried to use approaches that minimize its reliance on the home health cost report. They don't audit these cost reports. So I'm not entirely sure that that's exactly why they did it, but it's definitely consistent with that motive.

DR. BERENSON: That was one of my questions. I have two left, one on Slide 6 and 5, on trying to reconcile. You emphasized on Slide 6 the different case-mix with the high margin which looked fairly substantial. On Page 5, though, you show a payment per episode differential of only 4 percent. Are those consistent, that that kind of case-mix difference and more therapy episodes, et cetera, only get you that small amount of payment difference?

MR. CHRISTMAN: The payment per episode is a payment for all episode types, and so it includes episodes that are paid outside the case-mix. For example, episodes with fewer than five visits are paid on a per visit basis, and outlier payments obviously will have an extra on top of the standard case-mix payment, the case-mix adjusted payment.

DR. BERENSON: The last question is, and others probably know the answer to this, do we have a number for

what percentage of revenues for home health agencies come from Medicare?

MR. CHRISTMAN: It varies, and I can get that. The last time I tried to pull it off the top of my head, I did it wrong. So let me get back to you on that.

DR. BERENSON: Okay.

MR. HACKBARTH: Clarifying questions?

DR. DEAN: The case-mix calculation, as I read this, it seemed to me it's drawn directly from, almost from the amount of service that's provided. Is that so you can sort of generate your own case-mix severity by how many visits you decide to make? Is that accurate? I mean it didn't quite make sense to me.

MR. CHRISTMAN: Let me clarify. Maybe I overdid it, but one of the points we wanted to make in the paper is that when it comes to episodes with therapy visits, the number of visits you provide can drive your payment.

Now, remember there's three commonly provided types of visits -- nursing, therapy and home health aide -- but it's only the therapy visits that if you do more you get a higher payment.

The system in effect until 2008 had 1 therapy

threshold. If you hit 10 or more, it basically doubled your case-mix. You can think of that as doubling your payment. Less than 10, obviously, you can see the effect.

So the new system that went into effect in 2008 has a more gradual series of thresholds. We're just starting to get data to see how that works out, but I want to be clear that even under the new system it operates in some respects like a fee schedule -- the more visits you provide, the more your payment will go up.

DR. CHERNEW: Can you describe how a current outlier payment system works and how responsive to more or less visits, or more or less intense visits.

MR. CHRISTMAN: Okay. I guess what I would say is remember that the outliers decide to pay for high cost episodes. They lay aside 5 percent of total payments, and they set a threshold of cost based on their estimates of how much, what the distribution of cost looks like, so that the amount of payments that they'll pay out will be equal to the 5 percent pool. That's the way they sort of ration the payments.

For an episode that exceeds that threshold, they pay 80 percent of those costs.

Again, remember, all of these costs are computed using the standardized factors that CMS uses, and not the providers' actual costs.

DR. CHERNEW: So, if I have an outlier in my agency in the current formula, and I give an extra visit, or five, I don't get any more money.

MR. CHRISTMAN: After you've exceeded this threshold, you will get 80 percent of the cost of those extra visits.

DR. CHERNEW: Of my costs?

MR. CHRISTMAN: No, using the standardized formula. Right. So they take those five visits, and say they're nursing, and say the standardized visit says they're $100. You do 5 visits, you get $500. They only pay 80 percent of that, so that you get a payment of $400.

DR. CHERNEW: The reason I'm asking, the problem I have with all actual cost payment systems is they tend to give incentives to do more of the particular things, and I'm trying to figure out how this compares to the existing.

MR. CHRISTMAN: Let me point out two features that get at what we're talking about. One is remember we're not paying. In theory, we're not paying all of the additional

costs when we make an outlier payment. It only includes the 80 percent of the costs above the threshold CMS has set. So, in a marginal sense, they're not supposed to be getting the full cost of the additional service they're providing.

A second place they're supposed to lose money is that this threshold is greater than the base payment, and Medicare makes no payment between the base payment and the threshold. So there are two places they're supposed to be losing money.

So that was what was most striking about the experience of Dade.

These outliers would balance the incentives for efficiency, which you mentioned, and selection, and these outliers are only supposed to pay a portion of the incremental costs of these episodes.

When we saw a lot of agencies pulling down these payments, it raises the issues that I tried to sort of underline on this slide, which is that if you have costs, you can do this two ways. You cannot provide the visit and just be outright fraudulent. But, legitimately, if you have costs that are lower than what Medicare assumes --

DR. CHERNEW: [off microphone] Eighty percent of

what Medicare assumes.

MR. CHRISTMAN: Right.

DR. CHERNEW: [off microphone] Now I understand.

MR. HACKBARTH: [off microphone] Round two.

DR. CASTELLANOS: I'd like to focus in a little bit on therapy. I fully recognize that physicians order the therapy. Somebody has to have the power of the pen. I also recognize that this is in the same bailiwick as any fee for service -- the more you do, the more you get.

I guess what I'm asking is, and I'll tell you where I'm going with that, what's the criteria for these visits, for the different forms of therapy -- physical therapy, occupational therapy, speech therapy -- and what's the appropriateness?

I guess where I'm going on this is, like what we did in hospice, we kind of tightened down on who would recertify that. Is there any mechanism we have that we can perhaps look at the appropriateness of therapy and how it's ordered?

MR. CHRISTMAN: I guess I would just briefly say that, one, the patient -- and this is not a small thing -- the patient has to be eligible for home health. So they're

only going to be getting these services in the home if they're homebound and if they have a need for therapy or nursing.

Now, among the types of the services, it's simply going to be a joint discussion between the physician ordering the service and generally whoever is doing the assessment, looking at the patient's needs. I would say in this area I don't know that there's a lot of agreement right now on any sorts of best practices or clinical protocols that people follow very widely.

I guess another way of answering that question is that under the old system, remember we made these extra payments at 10 visits. It was surprising when we looked at one run that showed Medicare episodes by their sequence -- the first episode in a spell, the second, the third, the fourth. When you looked at those episodes that just had one or more therapy visits, the mean number of visits was 10. It didn't matter if you were in the first episode of your home health spell or the seventh. By some measure of chance, it came out to about 10 visits.

Definitely, it appears that some folks have reacted to what's gone on in the payment system.

DR. MARK MILLER: And, of course, it's not chance. It's where we set the threshold that drove it.

I think the way I'm hearing your point, Ron, or I'm going to ask you, am I hearing you say that as we think about this issue perhaps we should adopt some of the strategies that we adopted in hospice, about looking at some of the high end and asking for a medical record review or some additional amount of certification on the part of the physician or whoever else is making this, in order to see if we can't drive some of the tail?

DR. CASTELLANOS: Exactly.

DR. MARK MILLER: Yes, that's what I thought I was hearing.

MR. HACKBARTH: Other round two questions, comments?

DR. BERENSON: Yes, on this outlier issue, I sort of share Peter's view that we're into the weeds on this one, but I guess my question would be if we think that what's going on here is there's an opportunity for gaming the system.

I guess my concern is there's an opportunity also for gaming cost reports. If we do not have a history of

auditable cost reports that have ever been used, sort of assuming that we can just get that up and going and that some creative person in Miami, who is not Ron, would not see that avenue for gaming us as opposed to doing unnecessary visits. I mean I'm not sure where we're going, but I would certainly be looking at the infrastructure required and the oversight needed to start moving to auditable cost reports, I guess.

DR. CROSSON: Well, sort of the other side of that is I would assume if we were going to do cost reporting for outliers, a home health agency would have to do cost accounting for all their patients because they wouldn't know who is going to be an outlier, right?

If what we already have is a situation where the very largest organizations, presumably with the most assets, have the highest margins, they would be the organizations more likely to be able to absorb the cost of doing the cost accounting, whereas the smaller organizations would not. So it would seem to me in addition to determining what resources CMS might have to put to this and whether it's doable and auditable, we also might want to think about, try to understand what the burden would be and whether that

would have a magnifying impact on the relative margins that we've looked at.

MR. HACKBARTH: So just to pick up on this theme, if you're really concerned about abuse of the outlier payment system, there are two paths that you can go down, and they're not mutually exclusive.

One, you can alter the payment formula which may add some burden to the system, may create a new vulnerability.

Another approach, to pick up on Ron's comment, is to say this is what we have an IG for. Let's just flag the people who have these very suspicious patterns and say go get them.

It may be that the latter is the most practical solution, at least worth thinking about. Of course, we have to fund enough IG people for the scale of the problem.

Other round two comments?

DR. DEAN: As Evan knows, I've been concerned about this issue and it's been very troubling because I've gotten a lot of complaints from people in our area that the small rural home health agencies are closing. In fact, just before I came to this meeting, I got a report from the

hospital association saying there were three more in our area that have closed, and yet it doesn't show up in these data. I'm struggling to figure out where the disconnect is.

One of the things, and I think it may respond a little bit, Glenn, to your questions about economies of scale, one of the economies of scale is the reporting of this OASIS instrument, which is apparently a very demanding thing. Several of them have told me that unless the nurses are doing this very frequently it's going to take them a long time, and then they probably still won't get it right.

I know the home health agency in my hometown was pulled out because they said the staff simply were not being accurate or complete or whatever it is, in completing that instrument, and they needed to have people. They were willing to send people from a central agency 50 miles away to do the visit simply to make sure that this got filled out completely.

So, like I say, I'm not quite sure if that's a fair comment or not. But for some reason we seem to be seeing a decline in access to Medicare home health coverage, and yet I realize it doesn't show up in these data. So I'm not quite sure where the problem is, but that may be one of

them.

MR. HACKBARTH: Yes, to me, this is one of the more important, more urgent questions on the table. In the past, we've tried to look and see if by cutting the data various ways, urban/rural, et cetera, whether there is a group that looks to be really suffering, and we've never been able to find that. Now, with more analysis, we still can't find it.

Yet, on the other hand, I know people on the Hill are hearing what you say, that there is some group of agencies that is really suffering. Obviously, this is important in the context of our recommendation, which the Hill has been interested in, to cut the home health base payment.

If there's some way, something that we might be missing, if there's some specially defined group of home health agencies that truly is greatly disadvantaged, boy, I'd like to know because what I'd like to do is suggest a solution that's appropriate to that problem, not the alternative which is well, let's keep the rates high for everybody across the board.

DR. DEAN: That makes perfect sense.

One of the issues, and maybe it's impossible to do, but part of it is how you define rural because the ones that are having the most trouble in South Dakota are the ones we call the West River area, which is western South Dakota where these agencies are probably going to be 100 miles apart. Their average travel time is huge. So they have progressively reduced their area they're willing to cover simply because the amount of travel time, in addition to being very small volume and having these administrative challenges of getting the questionnaires filled out appropriately. I think it's some combination of those issues that is causing the problem.

Yet, if you define rural as just non-metro, you've got a fairly large contribution of places where the population is still fairly dense as opposed to western South Dakota where you've got probably less than one person per square mile, probably way less than one person per square mile in parts of it. So I suspect it's somewhere in there that the problem is.

DR. MARK MILLER: Can I just ask a couple things before we jump on, either to Jim or Evan? So, when we cut the data by urban and rural, didn't we use the more detailed

urban and rural breakout?

MR. CHRISTMAN: We did. We used what are called the rural/urban continuum codes, and it has nine steps. It takes the rural areas and splits them into five steps.

And I looked this up. Wessington Springs, it's in the very, it's in the least populous bucket that this system has.

DR. DEAN: [off microphone] Where I live is densely populated [inaudible] --

MR. CHRISTMAN: I guess what I would say is that we appreciate that these splits between urban and rural may be too big to get at some of these issues. So we did make an effort to look at it with a more granular set, and we didn't find anything.

DR. DEAN: [off microphone]

MR. HACKBARTH: To be more specific, what do you mean by we didn't find anything?

MR. CHRISTMAN: I'm sorry, when we looked at the share of episodes provided by high and low margin providers in those very rural areas, the share was not that different between. The share of episodes provided in those areas was not that different between high and low margin providers.

So you could be a high margin provider and serve people in the most rural areas or a low margin provider appeared to be equally possible.

DR. DEAN: [off microphone] [inaudible].

MR. HACKBARTH: What I'm told, it may be important.

DR. DEAN: [off microphone] That was a key thing.

DR. MARK MILLER: Tom, when you were saying that you got notice of some more agencies that had closed, does this mean that there's now no one in the area that takes beneficiaries for home health or does this mean that there's fewer home health agencies in your area? Do you have any sense?

DR. DEAN: I should go back and check, but I think they were probably the only providers in the area. I don't know that for certain.

DR. MARK MILLER: Because I mean remember there was, and I don't know your area although apparently Evan does, there was an uptick in numbers of agencies in the last few years. There has been very aggressive growth in number of agencies. So the question is sort of are you coming down and there's no one there to serve or is that now instead of

five, there's two? I think that's the question.

DR. DEAN: Well, I'd have to go back and check, but I don't believe that that's the case.

DR. MARK MILLER: We can check as well, but I think this is the question.

DR. DEAN: Because we have essentially no for-profit providers. In fact, I can't think of any in our area. They're all agencies that are run out of small rural hospitals, and they've just somehow made this decision they can't afford to do this anymore because outside of the two population centers, Sioux Falls and Rapid City, I don't think there are any for-profit agencies anywhere else in the state. I don't believe. Again, I'm not 100 percent sure.

DR. MARK MILLER: Once everybody has finished their comments, I have sort of a sense of where we might look next and how it might circle back around to some of this, but I've talked enough.

MR. HACKBARTH: I think we're close to the end.

MS. BEHROOZI: The yin to Tom's yang, I get the same kind of complaints from providers in New York City.

You talked, Evan, about in terms of areas for further analysis, looking at facility and beneficiary

characteristics. You mentioned looking at dual status beneficiaries. One of the things that they've raised is could you look at it by zip codes and socioeconomic status by zip codes.

Some of the different services, completely different services that they feel like they have to provide that are not compensated, that are not accounted for in the payment system, put them at a disadvantage when it comes to margins.

I wish Bill were here because I think he would say something along the lines of just looking at the claims data, the numbers, isn't informative enough, I think in this context because we don't really know enough about what the benefit is supposed to be.

I wonder if we're kind of getting to the point where you're looking for all these different ways to slice and dice the data, and you can't really come up with the truly explanatory factors. Is it time to do a focus group among agencies to interview the high margin, the low margin, the urban, the rural high margin and low margin?

MR. HACKBARTH: I think we want to be sensitive to paying fairly for agencies in all circumstances, but let me

draw a distinction between New York City and South Dakota. It's important. We shouldn't be trying to set up a payment system where every single agency is profitable across the board. The issue would be are we paying adequately to assure adequate access to care for Medicare beneficiaries in all parts of the country.

If a particular agency goes out of business in New York, there may be alternatives. Now, if it's VNS and Carol Raphael, that would have obviously broader implications, but I don't think Carol is going out of business.

MS. BEHROOZI: But I think it's about what the benefit is. I mean they think that providing a quality benefit requires them to put resources in that they're not being compensated for, and they think that the quality of the benefit will ultimately suffer if they are forced to operate at a negative margin all the time.

MR. HACKBARTH: Yes.

MS. BEHROOZI: I didn't say we were the same. It was just sort of like opposite arguments on the continuum.

It is troubling that we can't explain the variation, and I just wonder if it's time to look beyond the numbers and talk to --

MR. HACKBARTH: When Carol was on MedPAC, which has been a number of years now, as you know, the issue was a little bit different. In fact, it was more akin to the SNF issue.

Carol said, yes, we make money on Medicare. We do reasonably well, but we need that to offset the poor payment that we get from Medicaid, et cetera.

You know what my response was on that.

Now again, just for the record and for people, that was a number of years ago, and we're talking about a different payment recommendation here. We're talking about potentially cutting the rates, and so I don't want to pretend that Carol would say the same thing to this.

Okay. I don't know about anybody else, but I'm running out of steam here.

DR. MARK MILLER: Just a couple things on this, and I'll be brief. The model I would carry in my head, or I'm carrying in my head -- you guys can do that if you want -- is we had something of this same discussion on SNF, and we spent some time trolling around and ended up finding out that there was some cost that we didn't think the system was particularly capturing well. When you started to adjust

that, it started to back into things like redistributing money to hospital-based SNFs.

So one of the things that I took away from this, looking at the case-mix measures and particularly the case-mix for certain non-therapy episodes, is that if our case-mix is overcompensating at a certain level and there are providers who have figured that out, that may be the source of what we need to look at.

Now the other things I was going to say, you already said. We're going to continue to look at the other things, dual eligibles, services that are offered.

And to your point on focus groups, we've had some real focus groups. We have gone to their meetings, and they have come to us, and we have had some extensive conversations with the industry. I don't know if you want to rest assured, but you should be assured that we have talked to them, and they keep pointing. Each time we say the data doesn't show us this, they say well, then please look here. That's really what we've been trying to do for the last several months.

MR. HACKBARTH: Okay. Thank you, Evan.

Let's see. Before we do the public comment

period, let me just let the commissioners know that C-SPAN will be here tomorrow. So wear your best clothes, your bright tie or whatever.

Now we'll have our public comment period.

Hearing none, we're adjourned until 8:30 tomorrow morning.

[Whereupon, at 5:23 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, November 6, 2009.]

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 6, 2009
8:30 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, J.D., Chair
FRANCIS J. CROSSON, M.D., Vice Chair
MITRA BEHROOZI, J.D.
ROBERT A. BERENSON, M.D.
JOHN M. BERTKO, F.S.A., M.A.A.A.
KAREN R. BORMAN, M.D.
PETER W. BUTLER, M.H.S.A.
RONALD D. CASTELLANOS, M.D.
MICHAEL CHERNEW, Ph.D.
THOMAS M. DEAN, M.D.
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
NANCY M. KANE, D.B.A.
HERB B. KUHN
GEORGE N. MILLER, JR., M.H.S.A.
ARNOLD MILSTEIN, M.D., M.P.H.
BRUCE STUART, Ph.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: Good morning. We are going to go ahead and start.

For the benefit of the C-SPAN audience, this is the Medicare Payment Advisory Commission, and we are an Advisory Commission to the U.S. Congress, a nonpartisan Commission that advises the Congress on an array of Medicare issues, payment policy in particular. And we make recommendations periodically, publish two reports -- a report in March and one in June -- and then, in addition to that, special reports as requested by the Congress.

Our first topic this morning is, in fact, a report specifically requested by the Congress and will include votes on recommendations. John?

MR. RICHARDSON: Thank you, and good morning, everyone. Carlos and I are here to discuss the congressionally mandated report on how to improve comparisons of the quality of care between Medicare Advantage and fee-for-service Medicare and among MA plans. Today we will present a set of eight draft recommendations for the Commission's consideration and voting.

As a reminder of the provisions of the mandate,

Section 168 of the Medicare Improvements for Patients and Providers Act of 2008 directed the Commission to study and submit a report to the Congress on how quality measures can be collected and reported starting in 2011 to allow comparisons of the quality of care between Medicare Advantage and fee-for-service Medicare and among MA plans.

The MIPPA provision directs the Commission to address technical issues such as potential new data requirements and benchmarking measures. The report is to include any recommendations for legislative or administrative changes as the Commission finds appropriate.

Before we go through each of the recommendations one by one, we think it will be helpful to provide a road map of all the recommendations together. As you can see on this table, the eight draft recommendations are arranged chronologically from top to bottom in terms of when the proposed recommendation action would feasibly be implemented. The two columns, headed "MA-to-MA Comparison" and "MA-to-FFS Comparison," indicate which of the two types of comparisons the draft recommendation applies to. As you can see, two of the draft recommendations -- the first and the last -- are cross-cutting and would affect both types of

comparisons.

Also note that some of the draft recommendations have been revised and reordered somewhat to reflect Commissioners' feedback at and after our October meeting.

The first draft recommendation would call on the Secretary to define the forthcoming criteria for the meaningful use of electronic health records, or EHRs, to support the storage and reporting of the data elements specifically required for the computation of a comprehensive set of quality measures with robust risk adjustment. The ready availability of clinical record data will significantly improve the quality of the quality comparisons that Medicare can use. This draft recommendation is presented first because, while the Medicare subsidies for EHR adoption by physicians and hospitals will not start until 2011, CMS is planning to publish draft meaningful use definitions by the end of next month and issue final regulations in early 2010.

The second draft recommendation addresses the issue of the appropriate geographic unit for reporting and benchmarking all types of quality measures. The draft recommends that the geographic unit for quality comparisons

should be the same as the geographic unit that MedPAC has recommended for MA payment areas, which generally are smaller geographic areas than currently used in quality comparisons. This draft recommendation could be implemented by 2011, and by that date would allow for MA-to-MA plan quality comparisons using current Healthcare Effectiveness Data and Information Set, or HEDIS, measures and the current Consumer Assessment of Health Care Providers and Systems, or CAHPS, patient experience survey instrument. For MA-to-FFS Medicare comparisons, it should be feasible to measure and report CAHPS results for the proposed smaller geographic units by 2011.

The third draft recommendation would apply only to MA-to-MA plan comparisons and require that data collection and reporting underlying certain quality measures be consistent across all types of MA plans -- HMOs, PPOs, and private fee-for-service plans -- which currently is not the case. This draft recommendation could be implemented to improve quality comparisons among all MA plan types by 2011.

The next three draft recommendations form a set of additional quality measurement improvements that would come online in 2013.

Draft recommendation 4 would require the Secretary to develop for fee-for-service Medicare a version of a quality measurement tool that is already in use in MA called the Health Outcomes Survey, or HOS if the Secretary determines that this instrument can be used to meaningfully differentiate health outcomes between MA and fee-for-service.

Draft recommendation 5 would direct the Secretary to add a set of outcome measures to the quality comparison toolbox for both MA-to-MA and MA-to-FFS quality comparisons. These measures can be calculated using administrative data such as fee-for-service claims or health plan encounter data -- data that the draft recommendation would require the Secretary to obtain from MA plans in sufficient detail for the calculation of these outcome measures.

Draft recommendation 6 would direct the Secretary to use a limited subset of HEDIS administrative-only measures for MA-to-FFS comparisons if the Secretary determines that such measures can be used to make valid comparisons between the two sectors.

So to briefly recap the big picture thus far, draft recommendations 4, 5, and 6 together, along with draft

recommendation 2, would require Medicare by 2013 to begin using patient experience outcomes and some process-of-care measures to compare quality between MA and fee-for-service and among MA plans and to do so in most areas at a smaller geographic level.

Then draft recommendation 7 would recognize that the clinical process and outcome measures in use today need to be further developed to cover more segments of the Medicare population, such as beneficiaries over age 75 and under age 65, and to measure quality of care for clinical conditions, such as mental illness and geriatric conditions, for which there are currently few quality measures.

Draft recommendation 8 recognizes concerns about the potential budget implications for CMS of the draft recommendations and whether the Congress should dedicate funding for the implementation of these activities to ensure that any quality comparisons between MA and fee-for-service and among MA plans are executed with sufficient resources to be as accurate as possible.

Now I will go on to the individual recommendations.

Most of the quality measures used today in all

public and private health insurance programs rely on administrative data services, such as medical claims or encounter data, and in some instances, also medical record review samples. However, for many providers engaged in clinical care, the validity and actionability of quality measures today is fundamentally limited by the absence of detailed medical record information in calculating these measures. This information could be used to accurately compute the measures and to appropriately risk-adjust the results to reflect the relative probabilities of achieving the desired outcome given clinical factors such as municipality co-morbidities and contraindications that often are not captured in administrative data.

Many quality measurement experts today believe that electronic health records hold significant promise to provide detailed clinical data for quality measurement and risk adjustment much more efficiently than is currently possible. New Medicare payment incentives authorized by the American Recovery and Reinvestment Act of 2009 are expected to accelerate the adoption and use of EHRs by hospitals, physicians, and integrated delivery systems starting in 2011. The central policy question in this process will be

the definition of what constitutes the meaningful use of an EHR to qualify it for the Medicare subsidies.

Earlier this year, an HHS Federal Advisory Committee developed an initial set of recommendations for defining the meaningful use criteria, but the final definition of "meaningful use" will be set forth by CMS through regulations expected to be issued by the end of December 2009 and finalized in early 2010.

In our October discussion with you, several Commissioners supported an initial draft recommendation that the forthcoming meaningful use criteria should require qualifying EHRs to have the technical capacity to efficient store and report the data elements needed to allow comprehensive quality measurement with robust risk adjustment for both MA-to-MA and MA-to-FFS quality comparisons.

We also discussed the importance of EHRs being able to contain and report patient demographic data, such as race and ethnicity, which would allow quality measurement reporting to examine disparities. As Bill and other Commissioners noted in our previous discussion, the source of the demographic data in an EHR may most appropriately be

seen as administrative records. We have revised the previous draft recommendation to allow for this flexibility in the meaningful use criteria while also recognizing that some relevant demographic information, such as finer distinction in race and ethnicity, may be more feasibly collected during patient encounters and included in EHRs.

So the current draft recommendation reads: "The Secretary should define EHR meaningful use criteria such that all qualifying EHRs can collect and report the data needed to compute a comprehensive set of process and outcome measures consistent with these recommendations. Qualifying EHRs should have the capacity to include and report patient demographic data, such as race, ethnicity, and language preference."

To be clear, the intent of the second sentence in the recommendation is not to require that patient demographic data necessarily should be collected by providers during patient encounters, only that any EHR that qualifies for the Medicare subsidy payments should have the capability of storing demographic data and reporting it as needed to compute quality measures for specified patient populations.

The implications of draft recommendation 1 are as follows: For CMS administrative spending, we do not anticipate any additional costs for the agency beyond the administrative costs already assumed in the agency's budget for developing and implementing the EHR meaningful use criteria. I should note here that we are not providing ranges of estimated budget impacts for the draft recommendations throughout the report because MedPAC typically does not make estimates of the impact of draft recommendations on Medicare administrative costs.

The implications of draft recommendation 1 for beneficiaries, and also for policymakers, is that more comprehensive information on the quality of care would be available with the capability of more feasibly reporting on quality by race and ethnicity, gender, and age group. For providers, we estimate that there would be no additional costs as a result of implementing this draft recommendation beyond any net costs that providers are already projecting for the acquisition and deployment of the HR systems that meet the meaningful use criteria.

Carlos will now go through draft recommendations 2, 3, and 4.

MR. ZARABOZO: The second draft recommendation is relevant for both the MA-to-MA and MA-to-FFS comparisons. The current collection and reporting of most quality measures in MA occurs at the level of the MA contract. Some MA contracts cover very wide geographic areas. For example, plans in California that cover much of the state, the entire state, report one set of statewide HEDIS results even though different parts of California have very different health care markets and the provider characteristics in each geographic area can be very different in both fee-for-service and MA.

For the purpose of informing beneficiaries about the relative quality of MA plans and the quality of MA plans as compared to fee-for-service, quality comparisons should pertain to a specific geographic area in which beneficiaries are making choices among different plan options and between plans and fee-for-service. This will enable beneficiaries to know which plans are better than others and how fee-for-service compares to available MA plans.

For CMS in its role as the entity monitoring the quality of plans and seeking improvements in plan quality, it is also important to evaluate the care that each plan

provides in different geographic areas in which the organization operates and how each MA plan compares to fee-for-service in its market area.

The Commission has already recommended changing MA payment areas from the current county-based payment system to one based on metropolitan statistical areas and health service areas. Consistent with that recommendation, draft recommendation 2, therefore, reads: "The Secretary should collect, calculate, and report quality measurement results in MA at the level of the geographic units that the Commission has recommended for MA payments and calculate fee-for-service quality results for purposes of comparing MA and fee-for-service using the same geographic units."

This recommendation affects both the MA-to-MA and MA-to-FFS comparisons as of 2011. HEDIS measures that MA plans report can be aggregated and reported at the appropriate geographic level as of 2011. And CAHPS results for both MA and fee-for-service Medicare can be determined for smaller geographic areas if there is an expansion of the sample sizes for this beneficiary survey.

The implications of this recommendation are that CMS will require significant additional resources to collect

the necessary information and report it for each of the smaller geographic areas. This would require a significant level of resources because systemwide reporting is not currently done for the Medicare fee-for-service sector, and there would be more detailed reporting for MA results.

For beneficiaries, the change would allow better comparability of quality measures. However, the number of beneficiaries being asked to participate in surveys will increase. Many plans would face additional burden and costs because of the increased number of reporting units that reflect the recommended geographic areas.

The particular draft recommendation also has a number of consequences affecting the reporting of data on quality. For example, if a measure for a given reporting unit is based on a review of a sample of medical records, expanding the number of reporting units would require more medical record review.

As we have mentioned in the past, there is also a small numbers issue. In going to smaller geographic areas, you are dealing with fewer enrollees and sometimes too few to yield valid results. The Secretary would have to develop alternative ways of evaluating reporting on quality in such

cases, for example, by using three-year rolling averages.

Draft recommendation 3 pertains to the MA-to-MA comparisons. Currently, not all MA plans report their results on the same basis. HMO plans can include information from medical records when they report their performance on some of the HEDIS measures, while PPO plans and private fee-for-service plans are permitted to use only administrative data for reporting on the same measures. In addition, a statutory provision provides that PPOs and private fee-for-service plans need only report on the care rendered through network providers, even though beneficiaries in such plans are free to use non-network providers. This results in a lack of comparability of measures across different plan types within MA.

Having all plans report on the same basis would enable a valid plan-to-plan comparison across all HEDIS measures, including for important measures such as intermediate outcome measures. The plan should also report on all the care that its enrollees receive whether or not providers are under contract.

Draft recommendation 3, therefore, reads: "The Secretary should have all health plan types in MA report on

the same basis, including reporting measures based on medical record review, and the Congress should remove the statutory exceptions for PPOs and private fee-for-service plans with respect to such reporting."

The additional reporting that we are talking about can begin by 2011. This particular recommendation only affects the inter-plan comparisons of HEDIS results in Medicare Advantage, that is, the MA-to-MA comparison, as we are calling it.

The spending implications of draft recommendation 3 are that CMS would incur costs in processing more data than would otherwise be reported. For beneficiaries and providers, this recommendation would improve beneficiaries' ability to compare plans and systems. Non-HMO plans would incur additional costs in reporting on measures requiring medical record review and for reporting on non-contracted providers.

One of the sources of information on the outcomes of care for Medicare beneficiaries enrolled in MA plans is the Health Outcomes Survey. Currently, this kind of survey is only conducted among MA enrollees. We have discussed issues regarding its use in MA and whether CMS is able to

report results in a way that shows more distinction among MA plans. In your mailing material, we discussed how the public reporting through the Medicare.gov website differs from other reporting of HOS results. The Medicare.gov website shows more distinctions among plans. In the mailing material, we also noted that CMS is examining the HOS methodology, and one of the factors the agency will look at is the degree of differentiation reported across plans.

At last month's meeting, part of the proposed draft recommendation called for CMS to undertake the equivalent of the HOS survey in the fee-for-service sector. The Commission discussed how the HOS information could be collected in fee-for-service Medicare and whether it would be reasonable to undertake a survey effort in fee-for-service if the results cannot show meaningful distinctions between the fee-for-service sector and MA.

Based on that discussion, we are suggesting that the Secretary examine the utility of a fee-for-service Health Outcomes Survey and undertake such a survey if it is found to be useful in making distinctions between MA and fee-for-service.

Draft recommendation 4, therefore, reads: "The

Secretary should collect and report the same survey-based data that are collected in MA through the Health Outcomes Survey for the Medicare fee-for-service population if the Secretary determines that such data can meaningfully differentiate quality among MA plans and between fee-for-service and Medicare Advantage. For this particular recommendation, results of the MA-to-FFS comparison would not be available before 2013.

The spending implications of this recommendation are that it could require substantial CMS administrative resources if the Health Outcomes Survey is expanded to accommodate reporting for smaller geographic units and if fee-for-service beneficiaries are also surveyed. For beneficiaries, it would improve their ability to compare plans and systems, but the number of beneficiaries being asked to participate in surveys will increase. Plans would face additional costs for expanded member surveys.

John will now discuss further steps that can be taken to improve the measurement of quality in MA and fee-for-service for inter-plan and inter-sector comparisons.

MR. RICHARDSON: Draft recommendation 5 concerns adding outcome measures to the array of quality indicators

that Medicare can use to compare quality between MA and fee-for-service and among MA plans. Outcome measures provide an integrated assessment of quality because they reflect the result of multiple care processes provided by all the health care providers involved in a patient's care. In contrast, process measures, such as HEDIS, often focus on a single dimension of care for one specific condition. Outcome measures focus attention on system-level performance because achieving the best patient outcomes often requires carefully designed care processes, effective teamwork, and coordinated action on the part of many care providers.

To this end, outcome measures may be key indicators of the value-added functions such as coordinating care for beneficiaries with chronic conditions that a health plan can perform to improve the quality of care for its enrollees.

In our study, we examined four types of outcome measures that can be calculated for fee-for-service Medicare using existing claims data and that could be calculated for MA plans using encounter data if those data are specified to include the necessary data fields. These outcome measures are: hospital admissions for ambulatory care-sensitive

conditions, which are an indicator of the quality of ambulatory care in a health plan or geographic area; hospital readmissions for conditions where clinical evidence suggests that appropriate discharge planning and post-discharge follow-up can prevent unplanned readmissions; potentially avoidable emergency department visits; and mortality within 30 days of a hospital stay for patients diagnosed with conditions such as a heart attack, heart failure, or pneumonia.

We anticipate that CMS will begin collecting encounter data from MA plans beginning in 2011. CMS has specifically stated that the encounter data to be collected would be used for quality monitoring and that the agency plans to specify the exact data submissions requirements for MA plans.

This leads us to draft recommendation 5, which reads: "The Secretary should expeditiously publish specifications for forthcoming MA plan encounter data submissions to obtain the data needed to calculate patient outcome measures. If CMS obtains encounter data with the requisite data fields for MA plan members in 2011 and 2012, it should be feasible to calculate the four types of outcome

measures we have described by 2013 and use the results to compare MA to fee-for-service and MA plans to one another on these dimensions of quality."

The implications of draft recommendation 5 are as follows: For CMS administrative spending, we anticipate that there could be some additional costs for the agency beyond what is already assumed in the agency's budget if the proposed encounter data specification and collection is significantly greater than what CMS is already planning to do. CMS would also incur costs from calculating and reporting the outcome measure results themselves, but we will get to that in a moment under draft recommendation 7.

For beneficiaries, information on important care outcomes would be available as indicators of the quality of care provided under their MA plan or by fee-for-service providers in the aggregate in a local geographic area.

Implications for providers and plans are that they would incur costs above whatever costs they have already assumed for the planned 2011 encounter data collection. That potential cost increase depends on how much more extensive the collection of inpatient claims data that are needed for the specified outcome measures is relative to

what plans are already assuming about the scope of CMS' collection effort.

Draft recommendation 6 concerns the feasibility of using a limited subset of HEDIS process-of-care measures along with the outcome measures we just discussed and CAHPS patient experience measures. The key technical issue we have discussed in previous meetings and mailing materials is whether it is possible to make valid comparisons between MA and fee-for-service using a limited set of HEDIS measures that relies solely on administrative data.

The administrative data available for fee-for-service Medicare -- that is, medical and pharmacy claims data -- is not as rich a source of information on patients' diagnoses and treatments as the broader variety of administrative data available from MA, which includes claims data, encounter data, and in some plans, EHR data. These qualitative data differences do not necessarily affect all of the potential administrative-only HEDIS measures, and in some cases, such as monitoring plan enrollees who are using certain kinds of medications, we've found that fee-for-service Medicare appeared to have better results, perhaps due to more complete reporting of pharmacy data through Part

D.

In the end, we conclude that there may be a subset of HEDIS measures that potentially could be used to compare MA and fee-for-service using administrative data only, but each measure should be carefully scrutinized to ensure that any resulting comparisons are valid and reflect actual differences in the quality of care, not differences in the quality of the data used to calculate the measures.

Therefore, draft recommendation 6 reads: "The Secretary should calculate fee-for-service results for HEDIS administrative-only measures for those measures that the Secretary determines can provide a valid comparison of the two sectors."

The implications of draft recommendation 6 are that CMS would incur administrative costs in computing and reporting the selected HEDIS measures for fee-for-service Medicare in each of the geographic areas specified by draft recommendation 2. Beneficiaries, as well as policymakers, would have a limited but still relevant set of HEDIS measures, adding another dimension of quality comparison to go along with the outcome measures discussed earlier and CAHPS patient experience measures.

This total package of measures should improve beneficiaries' and other stakeholders' ability to compare quality between MA and fee-for-service. As for providers and plans, there should be no additional costs to them since they already submit to CMS the data that would be used for these HEDIS measure computations.

Draft recommendation 7 addresses the issue we have discussed in prior meetings about whether the current set of available quality measures, specifically focusing on HEDIS and outcome measures, are sufficiently comprehensive. Among the HEDIS measures currently in use for MA plans, few measures other than those related to medication use apply to Medicare beneficiaries over age 75, those with geriatric medical conditions, or beneficiaries under age 65. Some existing measures of the quality of treatment for certain clinical conditions, such as mental illness, typically are captured for such small numbers of beneficiaries that they do not lend themselves to public reporting. There also is a need to develop measures for special categories of providers, such as those serving rural areas.

A few minutes ago, I presented four types of outcome measures that could be used to compare quality among

MA plans and between the two sectors, but each of them has limitations as well. Other types of outcome measures, such as changes in patients' functional status or the ability to perform activities of daily living, also may be appropriate for use in quality comparison, as long as they are valid, reliable, and feasible to implement.

Outcome measures are of particular interest to the Commission because they are important indicators of health care delivery system performance and indicators of the potential value-added effects of MA plan activities.

Therefore, the next draft recommendation, 7, reads: "The Secretary should develop and report on additional quality measures for MA plan and MA-to-fee-for-service comparisons that address gaps in current quality measures."

We anticipate that the Secretary would assess the technical feasibility and costs of using or adapting existing quality measures, including those used in fee-for-service Medicare, such as those used for Hospital Compare or the Physician Quality Reporting Initiative; the measures of the care for persons with disabilities used in State Medicaid programs; and measures developed by health services

researchers, such as the Assessing Care of the Vulnerable Elderly, or ACOVE, measures developed at RAND.

The implications of draft recommendation 7 are increased administrative costs to CMS for the research, development, and implementation of new quality measures; improved quality of information available to beneficiaries -- that is, more and more relevant measures of the quality of care received by a greater portion of the Medicare population; and increased provider and plan costs for collecting and reporting data needed to compute any new measures.

The final draft recommendation relates to the importance of making sure there would be sufficient funding for CMS to administer the other recommendations in the report. At our October meeting, several Commissioners agreed that CMS must be provided with and devote a sufficient amount of resources to executing the quality comparisons among MA plans and between MA and fee-for-service.

The result of trying to implement the recommendations we have just presented without additional administrative funding for CMS likely would be inaccurate

and unreliable quality comparisons, which would not only waste resources but be detrimental to the interests and needs of beneficiaries, plans and providers, and policymakers.

In light of these concerns, the Commission agreed with taking the unusual step of considering a draft recommendation to the Congress that would dedicate administrative funding to CMS specifically for the implementation of the other recommendations in this report. This draft recommendation, number 8, reads: "The Congress should provide the Secretary with sufficient resources to implement the Commission's recommendations in this report."

The rationale that I just went through underlying the recommendation is also on this slide, with the additional proviso that the Commission would expect the Secretary to submit a detailed budget proposal for the use of the funds that are dedicated to support implementation of the recommendations in the final report.

The implications of this recommendation are that any additional CMS administrative resources appropriated by the Congress would increase Federal discretionary spending unless the additional spending is offset by spending

reductions elsewhere in the budget. Beneficiaries, providers, and policymakers would have significantly improved ability to compare the quality of care among MA plans and between MA and fee-for-service.

That concludes our presentation of the draft recommendations. Thank you.

MR. HACKBARTH: Thanks, John and Carlos.

So this is the culmination of over a year's worth of work and discussions in the Commission. I think that John and Carlos have done a very good job of capturing the suggestions that we have made, answering the questions we have raised. And, of course, you have all seen these recommendations once already. We discussed them at the October meeting, and they're essentially the same, albeit reordered in the way that John and Carlos described.

So I think we are at the very end of this process, and rather than having our usual rounds of discussion, what I would suggest we do here is just go through recommendation by recommendation and give people an opportunity to make a statement or ask any clarifying question on each as we go through. And then once we have gone through the entire package, we will go through and vote on each other in turn.

Okay?

So why don't you put recommendation 1 up? In fact, maybe before I do that, why don't you put the table up that sort of presents the whole package, and let me just invite any questions about how we've reformatted the recommendations and the way we've structured it. People feel comfortable with that? Any clarifications needed?

[No response.]

MR. HACKBARTH: Okay. Put up recommendation 1.

DR. BORMAN: I am going to interpret this, and I think I heard you, John, use the word "interoperable." And I just can't stress how important that particular characteristic is. And I just wonder whether we say that enough here, whether we need to explicitly use the word "interoperable."

In reading this, I hope that is what it means. I am going to choose to assume that's what it means. But I see Dr. Dean shaking his head, and on the provider end of this, we are constantly confronted with a myriad of products, most of which will not speak to each other, whether it is in the offices, hospitals, or whatever. And I just really wonder, because the information technology is so

key to this process, whether or not the "interoperable" word should get added in here somewhere. Otherwise, it is very well stated.

MR. HACKBARTH: Maybe what I'd suggest, Karen, is that in the text explaining this we include that as a key concept. Keep in mind what we're doing here. We are making a recommendation pertaining to a particular aspect of the EHR implementation, the definition of "meaningful use," which qualifies physicians and hospitals for the federal subsidies. And so there is a whole big operation to define what medical records will qualify for federal subsidies, and we are just sort of looking at a sliver of that.

So I think that it would be appropriate to have a contextual statement that sort of describes the overall effort, a key element of which is to move towards an interoperable system. Does that address your concern?

DR. BORMAN: [Off microphone.]

MR. HACKBARTH: Okay. Also on number 1, Tom.

DR. DEAN: Karen took the words right out of my mouth because that was the first thing I was going to say, too. It is a huge problem, and anything we can do to promote interoperability on a broader scale is important. I

realize that that is not the direct intention of this part of it, but anything we can do to emphasize the importance of that move, we need to do, often and loudly.

DR. MARK MILLER: John, you have been tracking this process. I assume that this has been a subject of conversation and there has been comment on this and --

MR. RICHARDSON: Yes, the HHS IT Policy Committee that has put forth some draft recommendations for CMS' consideration for the definition of "meaningful use" contemplates that for a part of what defines "meaningful use" is the ability of the systems to be interoperable. But for this specific purpose, I would say it's more implicit in the fact that since these measures -- the data that go into the calculation of the quality measures are going to have to be rolled up at some level that we have put before you for consideration a certain geographic level, there is going to have to be some standards and interoperability between the different EHR products that would qualify for the subsidies.

DR. DEAN: [Off microphone] So it's definitely a step in the right direction.

MR. RICHARDSON: Yes, and we can make that, as Glenn said, clearer in the contextual text around the

recommendation.

DR. MARK MILLER: The only other thing I would say is when we comment, you know, through comment letter on EHRs, we can make sure to reinforce this point each time we do that as well.

MR. BERTKO: My comment is probably, Glenn, to you and Mark and maybe following up on Mark's statement there is the timing of all this. I'm assuming this would typically come out as a recommendation in our March report, which might be after the close period on the comment letter. So do we envision as MedPAC releasing a statement or something that supports this recommendation within the appropriate time period?

MR. HACKBARTH: Well, my recollection, Mark, is that we've already provided a letter of comments consistent with this message. Now, what they publish in December will also be open to comments, will it not?

MR. RICHARDSON: That is correct.

MR. HACKBARTH: So that will be a second opportunity for us to comment. So I think rest assured that we've been sending this message and will send it multiple times before it gets to final publication.

Mark, anything you want to add on that?

DR. MARK MILLER: That's it.

DR. CROSSON: John and Carlos, I'd like to compliment you also. This, as you know from our multiple previous discussions, is a pretty complicated area, and what you have done here is to make it understandable -- probably not simple but understandable and clear.

I also like the chart that brings all the recommendations together, not just simply because we can see them all in one place, because it implies something that I think is important, and that is that all these recommendations work together. In other words, this is a coherent whole. It is not just eight separate recommendations. And I would point out that there are interrelationships among them.

For example, the one we are discussing now, number 1, with respect to EHR use, at least in my mind is closely related to a number of them, particularly number 7, where we will talk later about the need for the Secretary to develop new measures.

When we looked some years ago in Kaiser Permanente at the ACOVE measures that you mentioned, when they first

came out, it looked to us -- we didn't do a thorough analysis, but it looked to us that about 50 percent of them could potentially be acquired over time for electronic medical records.

And so I think one of the fertile areas for the development of new measures will, in fact, be an analysis of what can be extracted or could be extracted over time for electronic medical records leading to the construction of much better quality measures.

MR. HACKBARTH: Any other questions or comments on recommendation 1?

[No response.]

MR. HACKBARTH: Okay. Let's move on to 2. Questions and comments on 2?

MS. BEHROOZI: Yes, thanks. Ditto on all the compliments on making this comprehensive and comprehensible.

In the paper, you had noted that an alternative approach to prescribing smaller geographic units for reporting would be to have CMS use the actual beneficiary-level data that the plans currently collect or that CMS currently collects through CAHPS. So I wonder if you could comment on why that didn't make it into the recommendation,

because I just -- you know, I mean, you're the data guys. You know how much more fun you can have when you have all the raw data available. Or would it not really provide any meaningful ability to sort of reorder the data in useful ways?

MR. ZARABOZO: The issue with CAHPS is, Is there a large enough sample size for the units that we are talking about? So that would be the change in CAHPS. I think the answer is no, right now there is not; based on talking to the people that know more about CAHPS, the researchers, you do need to add more people to the survey to have an appropriate result for the smaller geographic units.

The HEDIS measures, also you can -- the current HEDIS measures are reported on a person-level basis to CMS and, therefore, you can use that information to report in a different manner, you know, aggregate differently.

MS. BEHROOZI: Yes, I think my question really goes -- assuming that there is a broader and deeper basis of data, you know, a larger sample size, whether it needs to be sort of pre-aggregated in these reporting units before it gets to CMS. Or should you not necessarily be prescribing the reporting unit, just say give us more data but give it

to us raw? Since we are talking about CMS needing lots more resources to do all of this, anyway. Or does that not give you meaningfully more ability to analyze it?

MR. ZARABOZO: Well, I think on the CAHPS data, it is primarily a CMS function -- that is, the aggregation. So I think it is -- what your saying should happen is probably what's going to happen and probably is what happens now with the CAHPS data.

DR. CHERNEW: First, let me join the number of people complimenting you on the work you have done, and I think the report is very thoughtful and very good. I want to make one comment about the interpretation of some of the data that is related to this recommendation, but I am supportive of this recommendation, and that comment is that often when we think about things like comparing MA and fee-for-service plans, we treat them as if they are distinct entities where you have MA plans often someplace treating patients and fee-for-service plans somewhere else treating patients, when in reality the norm is that providers are serving both the patients in the fee-for-service system and patients in the MA system.

I think the most important implication of that for

policymakers and for people who are interpreting the data that comes out of this is that the observed differences between the MA plans and the fee-for-service plans are not the appropriate metric for measuring the value of the MA plans, because anything that the MA plan does to try to improve any of the measures that we're going to talk about later, existing ones that exist that we have talked about, anything the MA plans do to improve those measures for MA beneficiaries will almost surely spill over into improving the quality of care for the fee-for-service beneficiaries.

So if we, for example, got rid of all of the MA plans, we wouldn't expect the fee-for-service performance to be what it was when the MA plans were doing all the things that the MA plans may or may not have been doing.

And so I think while I support this recommendation and the recommendations that follow, I think in the report it is important to be clear about what we can or can't learn from a comparison of the MA and the fee-for-service plans. From the point of views of the beneficiaries, it might give you a good idea of what's going on, but, again, it's telling you about the plans in general, not necessarily your provider and things like that. I think that type of

language is important to help the interpretation underlying this recommendation.

MR. HACKBARTH: I think your point about spillover effects is a valid one. There may be spillovers the other direction as well. It is not all one way.

MS. HANSEN: Again, just the opportunity first to say thank you very much. Always reading it from more a vernacular standpoint, it still makes coherence and sense, even though it is complex.

I am just struck really by the recommendations. I really am supportive of all of this, and I appreciate kind of the added commentary about the impact to beneficiaries as a whole. But I'm struck by not only our chapter here, but some of the other chapters that relate to how beneficiaries will look at information and use information. And given the kind of general track record in other parts of the Medicare program as to how much people use this information to change plans and make decisions as such, it seems like -- and I would love for future work -- because it is cross-cutting as to how choice architecture or use of information, the Hospital Compare, all these things that are really geared for beneficiaries, and yet the net result is there is very

little, sometimes, change. And when we talk about prescription drugs later, even though things are more expensive or not necessarily best quality, people don't necessarily take the information and use it.

So I just don't -- so it's more of a question of how do we have things framed that become truly useful or are designed in a way that people can be guided toward probably their quality best decisions or their price best decisions.

So it is a broader issue that cross-cuts everything, but I just would appreciate that, but it struck me in reading the recommendations here as well as some of the other chapters.

Thank you.

MR. HACKBARTH: Okay. Other questions or comments about 2?

DR. MILSTEIN: This is really a comment related to the prior comment on, you know, can we really -- you know, when a physician who is serving both the fee-for-service and the Medicare Advantage population makes changes, doesn't it equally benefit the fee-for-service population? And it goes in both directions, as Glenn pointed out.

I think over the last five or six years, one of

the things we have seen in the MA industry is the use by health plans, but not Medicare fee-for-service, of these so-called gaps in care alert, where they basically say this patient is missing this and you need to order this if you want to bring them up to snuff with respect to quality standards. And I think for that reason the spillover effect is real, but it's by no means 100 percent. And I think that is one of the ways in which plans add value relative to fee-for-service. And so I think the fact that there is some spillover effect is still not -- it's not clear that that would nullify all the advantages that some of the plans that are more quality conscious have begun to apply.

DR. CHERNEW: I agree with what Arnie said, and, in fact, what I would think would generally be true, although I recognize spillovers go both ways, my general belief would be the Advantage MA plans would be bigger than the observed differences that you see, because you are going to see some differences because of what the MA plans do that directly touch their beneficiaries or touch the providers related to their beneficiaries. That is part of the difference. But you'll see another value of the MA plans that are spilling over.

So for whatever value might -- now, I understand they could go both ways, Glenn, so I admit that that is true. But I think if you were to ask me for my intuition as to what you're going to see, the general value of MA is going to be bigger, because every time the MA plan causes the provider groups to put in a program to prevent readmissions, to get people in for mammograms, that will often spill over one way or another to others. That's my sense.

MR. HACKBARTH: What we'll do, as Mike and I had discussed, is we'll include a passage in the text that addresses this issue. There are, I think, spillover effects both ways, and I would also agree with Arnie's point that some of the things that the plans do that add the most value may not be as inclined to spill over because they are building a unique infrastructure that doesn't apply on the fee-for-service side.

So it is a complicated issue. I think it is a valid point. We will include discussion in the text.

DR. STUART: I think it's also important to note that there is considerable difference in MA penetration across service areas in the country, and so in a sense, this

would provide the information as a test of this hypothesis, because in areas in which there is very low MA penetration, Mike's hypothesis would be the quality would be lower than in cases where it is higher. And this would be the first time that we would really have information to be able to make that conclusion.

MR. HACKBARTH: Other questions or comments on 2?

MR. BUTLER: So this is an interesting one to me because it's the first Congress asked for that is fairly technical, so I suspect we have a greater chance of having an impact of actually following through with some of these recommendations.

We also have had them out there for a month, so what I am curious about, this particular recommendation and others say there is a spending impact, for example, on plans, and we have opened up now to the public our website to say provide comments and issues, and so these recommendations that have been out there, it's almost like proposed regs effect if you will.

So I am just curious. Have we gotten anything -- I know we got one letter, but it wasn't on the -- have we learned anything in the last month now that this has been

out here that would guide this at all? And one other comment and then I will let you answer.

This particular one says increased spending, although, John, I think you were the one that said last month reporting at this level, breaking it up, is not a real big deal for most plans. So when we say increased spending, we don't have a dollar, but I suspect this one isn't a real big deal.

MR. ZARABOZO: The biggest expense, what John was talking about, for example, as I mentioned, is with the HEDIS data. You can just reaggregate it in a different way. It is coming in on a person-level basis, so a plan that's reporting a statewide number, you can just report by county or whatever unit you want to report on. The problem is with medical record review, because let's say for the State of California, you are a plan and you cover the entire state, you use sample medical records, 411 medical records to report for that unit. If we say that California should be divided into eight markets, then you probably have to do 411 medical record reviews for each of the eight markets. So that is the big expense from a plan point of view.

And in talking to the trade associations and to

plans, that cost can be large. We've got a range of from $12 to $70 per record for the review. So that would be the major cost associated with this kind of -- with this range.

MR. BUTLER: Well, my question, though, was, among others: Did anybody use our new tool to express, you know, their --

MR. ZARABOZO: Yes. Yes, we have received comments about the --

MR. BUTLER: Three? Five? Ten? I am just kind of curious.

MR. ZARABOZO: One comment, one commenter.

DR. BERENSON: I was going to ask this in the next one, but it's relevant to the conversation we just had, which is that in the discussion you've emphasized it would apply to all plans, and then say HMOs, PPOs, private fee-for-service. But are we also talking about SNPs, PSOs, HSAs that are out there, Legacy Cost Plans? I mean, does this apply to everybody? And the relevance to the recent discussion is that SNPs, for example, are a small-volume plan with the -- I mean, they don't have lots of people, but the idea is that they're going to have a great impact on them. Would there be any different kind of cost

implications for small plans or HSA-type plans that we haven't thought through?

MR. ZARABOZO: Well, actually, in the case of SNPs, there are two kinds of SNPs. Of course, there is a SNP that is part of a larger plan, but the SNPs are currently being asked to report additional data, so they already have an additional burden. And so an organization that has SNPs within the larger organization is reporting for the entire organization for the HEDIS measures, and then they also have to report for the SNP plans those numbers.

But, yes, this affects all plans, essentially, all kinds of plans, including cost plans, for example, that appear at the Medicare.gov website. So, you know, small plans would be affected.

DR. KANE: The SNP is reporting -- are they supposed to have a fee-for-service comparison? And if so, do we have some plan to pull a comparable fee-for-service beneficiary pool and segregate them out so that they can be compared appropriately to the SNP? Say it's a dual-eligible SNP or if it's got a specific purpose, is there going to be some fee-for-service comparable population that they get compared to? Because that would, I think, add quite a bit

of work to CMS, anyway.

MR. ZARABOZO: That is a good point. I think one way to answer that is with the person-level data, you can cut it a number of ways, and one of the ways to look at it is, for example, people with certain conditions, if it's a SNP serving people with these conditions, you can do that kind of comparison. You may not want to do it on a plan basis to the fee-for-service people in that area. You may want to do it on a certain more aggregate basis. But those kinds of comparisons can be done.

MR. HACKBARTH: I think that it may make sense to add a sentence or two to the text saying that SNP comparisons raise some special issues that need to be thought through and that we have not thought through.

Okay. Any other questions or comments on number 2?

[No response.]

MR. HACKBARTH: Hearing none, let's move on to number 3. Questions or comments on number 3.

MS. BEHROOZI: On the same basis sounds fair; you know, it sounds like a level playing field. But I think when it comes to a PPO plan in particular, we might not be

getting accurate or full information if we have them report on all of their providers regardless of whether or not they're in network, because some of the tools that they have to improve care they might only really be able to exercise with respect to their in-network providers. So rather than saying they should be exempt in a special way, perhaps we could add a layer for them to also be able to report separately on their in-network providers so that, you know, beneficiaries really have an understanding, particularly if there is a difference for any given plan, whether you're in network or out of network, that, you know, perhaps they really could have a better quality experience if they stay within the network within that PPO.

MR. HACKBARTH: I think that that may make a lot of sense. We need the raw material, the information, the data, and then this is an important display issue that I think may add value to the Medicare beneficiary trying to make a decision; here is the in-network score versus --

DR. BERENSON: Can I just pick up on that, though?

MR. HACKBARTH: Yes, sure.

DR. BERENSON: I had thought of that myself, but there will be -- just like the outcome measures around

readmissions or admissions for ambulatory care sensitive conditions, the care might have been provided in and out of network, and that's where the breakdown is occurring.

So I don't think that -- I mean, I think it's another sort of we need to work through those issues and should say something, but that it's not just a lay-up that you can report your in-network experience. It just won't work that way.

DR. CHERNEW: I was just going to say what Bob said.

MR. HACKBARTH: Any other questions or comments about number 3?

[No response.]

MR. HACKBARTH: Okay. Let's move on to 4.

DR. MILSTEIN: This one was the only thing on the list that I kept coming back to, and let me articulate the basis of my concern.

My concern really relates to this idea that implicit in our recommendation is there is a need for an additional review as to whether or not, you know, comparisons with fee-for-service, you know, would be useful or meaningful. And I wonder if you could just elaborate on

that a little. I read the text in the chapter, but, you know, from my perspective, this comparison has already been done. It was done for the Medicare Plus Choice plan. It wasn't done, you know, relative to geography by geography. It was done relative to, you know, a fee-for-service characterization nationally.

But, in essence, through that comparison the feasibility of making the comparison I thought was reasonably well demonstrated. So, you know, there obviously is a cost in further delaying for reconsideration given the fact that such a comparison was shown to be feasible. We actually used it in our deliberations to, you know, draw some initial conclusions about how the different MA plans across the U.S., I guess Medicare Plus Choice plans in the U.S., as they existed before MA, how they were performing relative to a national fee-for-service standard. I personally found the results useful, revealing. I think many other Commissioners did.

So could you elaborate further on the need to incur another delay while the Secretary reappraises the meaningfulness of the comparison between fee-for-service and MA. It seems to me -- I wasn't sure that that delay was

justified, and if it was justified, I couldn't from reading the text, again, understand what the basis of the justification was.

MR. ZARABOZO: Well, I think it reflects the discussion at the Commission meeting last time where people were concerned that, given what is happening in MA, you don't see many distinctions among plans, in some years no outliers, as they call them. Would that be the case if you brought in fee-for-service also?

And on your question, one of the questions might be, well, can you do it at a small geographic level? Is it appropriate to do it in that way versus doing sort of a broader fee-for-service HOS kind of study and being able to do it at that level as opposed to going to the effort of saying for each geographic area we will, in fact, do a Health Outcomes Survey for the fee-for-service population, which may show that there are meaningful distinctions between MA here and fee-for-service in this area.

DR. MILSTEIN: I would ask that maybe we would want to reconsider this, because unless we think that conceptually, you know, there is some reason that a comparison that's more locally grounded would face some

major technical barrier, you know, I would say in some ways on the face of it, it would be a lot more meaningful because if I'm a Medicare beneficiary choosing between a plan or fee-for-service, it's the performance of the fee-for-service community in the location in which I would be, you know, making a selection other than Medicare Advantage that I think would be relevant. And so it seems to me that if validity is our concern, then this recommendation would only strengthen the likely value of the comparison.

MR. HACKBARTH: For my money, the issue that I thought was at stake here was the power of HOS as currently used to discriminate performance among plans. So it's the first issue that Carlos referred to that the vast majority of plans perform as expected and only small members better or worse. And so when I look at this recommendation, I think what we're doing is asking the Secretary to look at the tool and see if it can be adjusted so that it more effectively discriminates among plans in terms of their performance while retaining its validity as a tool for assessing value.

You know, we have got to balance those two things. We could say instead of using a 95-percent confidence

interval, we're going to use a much lower threshold, but then we need to consider whether, in fact, it is a true measure of performance.

And so rather than trying to answer that question, we're saying to the Secretary please explore that, and if you think it can be altered to be more discriminating and still valid, go with it.

DR. MARK MILLER: Yes, I would even go further. I felt like what we were trying to do -- and you guys should speak up, you know, if this is getting off track. I thought what we were trying to do is accommodate two of your concerns, one being that this tool wasn't, just as Glenn went through, distinguishing and could we drive the policy process to think about what those confidence levels were; and, two, to build it up on the fee-for-service side so that it could be done across fee-for-service and managed care.

So I thought we were actually addressing the issues you raised and drove through the Commission.

DR. MILSTEIN: I like what you just said, but I don't think that's --

DR. MARK MILLER: Am I missing something? That is what the reg is --

DR. MILSTEIN: An example, a way of putting the words that I think might better accomplish that objective would be rather than determines whether it can meaningfully differentiate but how the comparisons could be adjusted to better differentiate both plan to plan and plan to fee-for-service. That way it's not a question of, you know, should we go forward with this. It is we want to go forward with it, and we're directing the Secretary to focus on how the comparisons could be adjusted to create more differentiation, more distinctions. As worded now, it is framed as determining whether it is useful in differentiating.

MR. HACKBARTH: Let me ask Mike for his comment, but while I'm doing that, think of exactly what word change you would propose, Arnie.

DR. CHERNEW: My comment was going to relate to this, because I think Arnie's comment implicitly raises a bigger issue and assumption which I think is worth making explicit, which is in almost all of the recommendations, including this one, there is the cost portion that says this will require more resources, culminating in the last recommendation about the more resources to do that.

I believe and I think the Commission generally believes, although people could speak for themselves, that there is the presumption that the value of the information will vastly outweigh the costs of collecting it in ways that we might know, but even in ways that we don't know. And while I won't put words into Arnie's mouth, I think in October he said very explicitly that measurement is sort of the first step to this pathway of getting the whole system better, which I think, in general, at least I agree with that point.

What I had heard in October about this particular one is that specs of the measurement tool were such that we weren't sure of that assumption; we weren't sure that the tool, as currently devised, would pass that implicit cost-effectiveness threshold that we were assuming in all of the other cases. So our goal was before going out and imposing the costs of doing this, we were going to try and make sure that we would pass that cost-effectiveness threshold. And I think that for most of the other cases, we believe that we're sufficiently above that, although I haven't seen the numbers. This is a bit of faith. But I believe we're sufficiently above that not to worry. And this one I

thought we were, and I think it's useful to make sure that we don't seem like we're willing to spend anything to get any amount of information, that we are sensitive to the costs that are being imposed on the system. And I think this is good.

MR. HACKBARTH: And so you are making an argument, if I understand it, that is in support of conditional, "if the Secretary determines."

DR. CHERNEW: [Off microphone] Yes, I am.

DR. MILSTEIN: My comment here is that that point I completely agree with, but in no way is specific to this particular measure. If one begins to think about how one might conceivably define, for example, meaningful use of EHRs in order to know that they maximally populate all the quality performance measures we believe might be useful, you could get into equivalent questions about incremental cost-effectiveness of some of the -- I know Jay mentioned that using the system they're using at KP, you can get about half of the ACOVE measures. Well, if we want to -- do we want to go -- do we want all of the ACOVE measures? Implicitly, there is -- you know, Jay is, I think, making the point that it may not be cost-effective.

So this point that Michael is making I completely agree with, but from my perspective, it is not uniquely a hurdle that we ought to hold up explicitly for this particular measures.

MR. HACKBARTH: Well, what I would like to do is get to specific language, an alternative proposal and language. While Arnie is working on that, I think Jay may have some thoughts on how to do it. Let me invite any other questions or comments on recommendation 4.

DR. CROSSON: Well, yes, I just thought that we could maybe move a little bit in that direction by changing the wording to say, rather than "if," to say "unless the Secretary determines that such data cannot meaningfully differentiate quality among MA plans." And/or you could add to that, "meaningfully and efficiently differentiate."

DR. MILSTEIN: The first one I think is very good. If we're going to introduce the issue of cost-effectiveness, then we ought to apply it to the whole list.

MR. HACKBARTH: I'd like to avoid trying to do it item by item, and, you know, I'd be happy to add that as a broad consideration when we talk about cost. But let's not try to amend each one to include "efficiently." So read it

again.

DR. CROSSON: So then it would say, "The Secretary should collect and report the same survey-based data that are collected in MA through the Health Outcomes Survey for the Medicare fee-for-service population, unless the Secretary determines that such data cannot meaningfully differentiate quality among MA plans and between fee-for-service and MA."

DR. KANE: Just the word "meaningfully," I'm happy with the way Jay has rephrased this, but the word "meaningfully," I think the reason we didn't like the HOS originally was that it was statistically not helping us differentiate among plans. But there is another set of meaningful that I think Jenny brought up, which is do people act on that information if you present it to them. And I'm wondering if we shouldn't somewhere in the text somewhere describe what we mean by "meaningfully" to include not only a statistical significance at some meaningful cut-off point, but also whether there shouldn't be some exploration of whether it's meaningful to the users. If we are going to start getting into meaningful, I think we might need to have some kind of definition somewhere what "meaningful" -- what

the attributes of "meaningful" are, because the statistics may not be relevant.

MR. HACKBARTH: I'm not a statistician, but maybe a more statistical term would be "validly distinguish" or something like --

DR. KANE: [Off microphone] higher than that and bring in what Jennie was saying, which is do people really use this data.

MR. HACKBARTH: Again, we will try in the text to address more broadly the issue of meaningful comparisons. I think that spans a number of recommendations, so I'd like to try to not do it in individual recommendations.

So would you prefer to stick with "meaningfully" here or would you like an alternative word like "validly"?

DR. KANE: No, I'm happy with the word "meaningfully" there. I just meant we need to define "meaningfully somewhere in the text.

DR. MARK MILLER: For the text, statistically and the use of the beneficiary. We can get that wording for you.

MR. HACKBARTH: Okay. So when we come back to vote, we will once again read the Crosson amendment.

Let's move on now to recommendation 5. Questions or comments on 5?

[No response.]

MR. HACKBARTH: Seeing none, let's move on to 6. Questions or comments on 6?

[No response.]

MR. HACKBARTH: Okay. Let's do number 7.

MS. HANSEN: Well, I really appreciate this one just because we're really covering two populations, I think, in your parentheses of the description of -- actually more on page 22 when you indicated the kind of beneficiaries that oftentimes aren't as well covered traditionally with HEDIS measures, coupled with Jay's comments about the ACOVE measures. So one is that I really do support that.

My question is also about knowing that some of these measures right now are covered, say, in the special needs plans. But given the fact that MA plans and certainly, of course, fee-for-service, but other MA plans will have some of these populations who might age in place in their plans, I just wonder whether or not there was an intention that ultimately some of these measures be nested in all MA plans and collection for fee-for-service.

MR. RICHARDSON: In some of our earlier mailing materials, we had contemplated that very question, and we will bring that back into the text of the report, because a number of those measures seem logical to apply to any plan serving a Medicare population.

MS. HANSEN: Great. I appreciate that. Thank you.

DR. KANE: Just to follow up on our previous conversation, perhaps the word "meaningful" should be put in before "MA plan" so that we could refer that back to what we -- you know, in the text, the definition. So, "The Secretary should develop quality measures for meaningful plan to fee-for-service comparisons." Just to keep incorporating the standard that we would use.

MR. HACKBARTH: I suspect if we went back all the way to number 1, we could find additional places to insert "meaningfully." Again, what I would prefer to do is have, early in the discussion in the text, language about what we want as meaningful comparisons, even some language that's not as easy as it sounds to come up with meaningful comparisons for a beneficiary trying to make decisions. I prefer to handle it that way as opposed to try to go through

and insert "meaningfully" in all of the individual recommendations.

Other questions or comments?

DR. CASTELLANOS: Just a general comment, not specifically on that but on that.

First of all, I want to congratulate you. I thought it was great work that you've done, and it's been fun watching you over the year developing this, and I congratulate you. I think you did an excellent job.

I guess my point is, somewhat like Jennie's, that we need to make sure this information is somehow provided to the beneficiary in some meaningful way so the beneficiary has the benefit of this analysis. And it seems that we do such good work here, but it doesn't seem to filter down all the way sometimes.

The other point I would really like to make is that, first of all, I support these programs. There is a definite increased cost to the provider, to the medical profession, to the doctor, and this needs to be recognized.

Now, I understand and I think it's worth the cost of doing it, but I think we need to recognize that this puts a tremendous burden on a one- or two-man practice. They

have to gather this information either by hand if they don't have electronic records. That needs to be acknowledged, perhaps not in the text but hopefully all of us recognize that this is a burden to the provider, too.

MR. HACKBARTH: Other questions or comments on number 7?

[No response.]

MR. HACKBARTH: And let's move then to the final recommendation, number 8.

DR. BERENSON: Yes, first just a wordsmithing thing, and then a substantive concern.

In the second bullet, where you have the word "costly," in context it looks like it's the figurative use of the word "costly," not a literal word. And since this is all about resources and spending and funding, I think we can say the same thing with throw an adjective before "detrimental," like "extremely" or -- in other words, I would suggest taking the "costly" out unless you mean literally costly. That is a small point.

The more general point I have here is -- and it picks up a little bit what Jay was saying way back in number 1, which is, are we viewing this as a coherent whole? I

mean, the language we have now, which is basically if you do this, dedicated resources are necessary, you need a sufficient budget. Do we even want to go further and say you really shouldn't proceed -- my concern is the budget will be whittled down, you get half of what you want and you go do half of this. Do we think that is acceptable? Do we want to say something about the importance of the coherence of this whole package?

My own view is that the most important thing we're doing here is number 5, which is introducing new quality outcome measures. But I don't know if we want to get into a process of deciding which have to hang together and which don't.

I guess I would like to see language -- but you've got more experience in how the Congress might receive it -- about being even stronger on don't go forward if you're not prepared to support this adequately, or something like that.

MR. HACKBARTH: Let me just get a clarification. The four bullets would not be part of the formal bold-faced recommendation that we included in here because we thought that they were such essential elements of the text that goes along that we wanted to highlight --

MR. RICHARDSON: Exactly right

MR. HACKBARTH: All right. And so I think Bob's editorial suggestion is a good one. We'll just delete "costly and" and use "detrimental."

As to the broader suggestion, what I'd ask, Bob, is that you submit us some language for the text, and let me just check in with the other Commissioners. I share Bob's concern that it won't be half the money, it'll be less than half the money, and the expectation will be that all of it be done. And I do think that it's important to maintain some coherence here and that should be part of our textual message.

Now, whether we should take the additional step that you propose of saying, you know, this is the most important piece, I think that would be further than we have discussed --

DR. BERENSON: [Off microphone.]

MR. HACKBARTH: Yes, yes. Bruce, did you have a comment on this?

DR. STUART: I agree. I think that if we start getting in the business of prioritizing these, we are actually going to get to the point where somebody is going

to say, well, if it's only the eighth priority, then, you know, cut it off.

So I think I would argue that the cohesiveness of this is really what we're after.

DR. MARK MILLER: And just on that point, the Congress asked how should we do certain things, and this package is designed to address their request. So in some ways, I'm just trying to say that I think your comment is consistent with coming back to them and saying, "You asked us how to do this. This is how you do the thing you asked us to comment on."

MR. GEORGE MILLER: Yes, as a general comment kind of in support of what Ron was just mentioning, and I also want to add my congratulations for the work that has been done and very well done. But in the chapter, a comment was made, "No provider costs beyond baseline spending to acquire and use EHR systems that meets CMS meaningful use criteria." Like Ron, small and rural hospitals, I would say that the additional cost for support of EHR, so for staffing and for interpretation of data, it will be also costly, it is just not buying the EHR and plugging it in and pushing a button and letting it run. There are support staff and ongoing

maintenance that is beyond the initial cost. I just want to bring that point up as well for providers.

DR. DEAN: Just a quick comment. I would want to reinforce what Jennie and Ron have said about -- I think it would be useful to follow up on this, and I'm not sure how, but we are very much driven by data and consider factual information to be the defining determinant of how we make decisions. That doesn't happen in much of the general population, and I think we need to -- clearly, we need to do this, but I think it would be useful somehow to follow up and to see, you know, how is it received and how much impact does it have on the general public. Because my experience is that what a relative's experience is or some story in the newspaper or something tends to have a lot more influence than some of these nicely laid out charts or how many stars they get.

MR. HACKBARTH: Well, I think that's unquestionably true. I think what the Congress is trying -- well, for those who are inclined to look for more objective sources of data -- actually, that's probably not a good characterization. Additional sources of information to complement what they can get from the relative or a

neighbor. Right now it's very difficult to get that sort of information. We are trying to fill a void for those beneficiaries who want it.

DR. DEAN: I'm not happy with that situation.

MR. HACKBARTH: Right

DR. DEAN: Because I think we need to definitely move in this direction so there is some objective data and try to familiarize and make our population comfortable with dealing with more objective criteria. But the reality is that that is a tough sell.

MR. HACKBARTH: Absolutely.

MS. HANSEN: Well, I appreciate the other Commissioners' support of this theme, and it seems to have some resonance. And one possibility is to go back to thinking about draft recommendation number 4 where it's looking at the Health Outcomes Survey. Since it's collected from the beneficiaries -- and I know it's the discipline of the rigor that we're trying to still get, but whether or not the meaningfulness to beneficiaries could be a part of that language up to the Secretary, in other words, having the -- unless the Secretary determines that such data cannot meaningfully differentiate quality among MA plans and

between fee-for-service and MA, inclusive of beneficiaries.

MR. HACKBARTH: What I would like to do is have language in the text that discusses "meaningfully," and I think there are two distinct components to that. One is the statistical sense that you want valid comparisons, but the other sense, which you and other Commissioners are highlighting is that the ultimate goal of this effort is to provide information to beneficiaries that is useful, or at least one ultimate goal. As we've discussed in previous meetings, there are other potential uses of this information -- payment bonuses and the like. But one potential benefit could be to help guide beneficiary choice. Achieving that aspect of this is maybe the most difficult piece, and we need to recognize that in the text, and people will have an opportunity to review the chapter if they want.

DR. CHERNEW: I agree with that, and I just wanted to note there actually is an existing and somewhat growing literature on how individuals use information like there. There are empirical estimates. There are people that worry about how it affects plan behavior. I think there is a whole sequelae of benefits from the information. I wouldn't change any of the recommendations, although I do think that

it's useful to note in the report that whatever support can be given, to not just generate the information but to not only support its effective use by beneficiaries, but to support research to understand the factors that influence the performance. There's a whole bunch of reasons why we want to know how these plans are doing that extend beyond helping beneficiaries choose. And the more research we can support to understand it once the data exists, I think the better the system will be.

MR. HACKBARTH: Said like a researcher.

[Laughter.]

DR. CHERNEW: I held off. I held off for almost the entire discussion, and only waited until Jennie said the opening.

MR. HACKBARTH: Right. Okay. I am ready to vote. How about you folks? So let's put up Recommendation 1. All in favor of Recommendation 1, raise your hands, please? All in favor of Recommendation 1? I'm not sure I've got everybody's attention. We've got votes. All. Okay. Thank you. All opposed? Abstentions?

Okay. Number 2. All in favor of Recommendation 2? Okay. Thank you. Opposed? Abstentions?

Okay. And, Jay, bump me when we get to the one where we have the amendment. It is 4, okay.

Recommendation 3, all in favor? Opposed? Abstentions?

Recommendation 4, and, Jay, will you read the amended language.

DR. CROSSON: So Recommendation 4 as amended would read: "The Secretary should collect and report the same survey-based data that are collected in MA through the Health Outcomes Survey for the Medicare fee-for-service population unless the Secretary determines that such data cannot meaningfully differentiate quality among MA plans and between fee-for-service and MA."

MR. HACKBARTH: Okay. You're jumping the gun. Okay. All in favor of Recommendation 4 as amended? Thank you. Opposed? Abstentions?

Recommendation 5. All in favor of Recommendation 5? Opposed? Abstentions?

Recommendation 6. All in favor of Recommendation 6, raise your hands. Opposed? Abstentions?

And Recommendation 7. All in favor of number 7? Opposed? Abstentions?

And, finally, Recommendation 8. All in favor of number 8? Thank you. Opposed? Abstentions?

Okay. Well done. John and Carlos, thanks for your work on this project.

The next item on our agenda is a status report on Part D.

Rachel, will you be leading or Shinobu?

MS. SUZUKI: Good morning. Part D is about to start its fifth year with nearly 27 million enrollees and over 50 billion in spending accounting for a big chunk of Medicare spending.

In this presentation, we're going to walk you through what we've learned from looking at Part D enrollment data, what plan sponsors are offering for 2010, and what the cost implications are for enrollees and Medicare program. Remember, the open enrollment season for Part D runs from November 15th through December 31st, so now's the time of the year when beneficiaries have the opportunity to switch plans if they choose to do so.

According to CMS, in 2009 about 90 percent of Medicare beneficiaries had Part D or another source of drug coverage that's at least as generous as Part D. At the

start of the year, nearly 27 million or 59 percent of all Medicare beneficiaries were enrolled in Part D. Of the 59 percent, 39 percent were in stand-alone prescription drug plans that provide drug only benefit -- that's the green piece -- and the remaining 20 percent were in Medicare Advantage Drug Plan, where enrollees get both medical and drug benefits through a single private plan.

Focusing just on PDP enrollees, there are about 17 and a half million beneficiaries enrolled in PDP, and 46 percent, or nearly half, received Part D's low-income subsidy, which provides extra help with premiums and cost sharing to people with low income and low assets. That's the dark green piece. This is an important point to note because LIS enrollees tend to be sicker and tend to use more drugs.

In contrast, a little over 9 million beneficiaries are enrolled in MA-PD plans, and 19 percent of those in MA-PD plans receive low income subsidy; that's the dark blue piece. So about 1 in 5 MA-PD enrollees receive LIS, which is a much smaller share compared to PDP enrollees.

Data from 2007 show that demographic characteristics of Part D enrollees differ from overall

Medicare population. For example, Part D enrollees are more likely to be female and more likely to be minority compared to overall Medicare population. And there are also differences between PDP and MA-PD enrollees and between those who receive the low income subsidy and those who don't. Compared to PDP enrollees, those in MA-PDs were more likely to be Hispanic and less likely to be disabled beneficiaries under 65. This might be a reflection of the areas in which MA-PD plans are located. LIS enrollees are more likely to be female and are more likely to be minorities and disabled beneficiaries under 65.

Part D enrollment also varied across the country. In 2007, Part D enrollment ranged from 40 percent in Alaska to 68 percent in California. And remember, when MMA created the Part D program, it also set up a subsidy program for employers who continue to provide drug coverage to their retirees. So in the regions with high take-up rates of retiree drug subsidy, Part D enrollment tended to be lower, for example, in Michigan and Ohio.

MA-PD share Part D enrollment also varied across regions, ranging from 2 percent in Alaska to 56 percent in Arizona. This pattern was generally consistent with the

Medicare Advantage enrollment.

Finally, we looked up the share of Part D enrollees receiving low income subsidy, and also found that it varies from region to region, ranging from 28 percent in upper Midwest to 64 percent in Alaska. And participation in Part D's low in come subsidy program, of course, can be affected by region-specific factors, such as poverty rates and health status.

So we've been following beneficiaries' choice of plans since the start of the program. There hasn't been a dramatic shift from year to year, but there are some notable trends. We have two charts here. The one on the left is for PDPs and the one on the right is for MA-PDs. Green and orange represent those paying deductibles. You can see that a much larger share of PDP enrollees pay a deductible compared to MA-PD enrollees.

In 2009, about half of PDP enrollees paid no deductible -- that's the light blue piece -- compared to over 90 percent of MA-PD enrollees paying no deductible. Many sponsors of MA-PD plans use some of the financing from the Part C payment system called Medicare Advantage Rebate Dollars to lower Part D premiums or to enhance the drug

benefits, and eliminating the deductible is a very common strategy used by MA-PD sponsors to enhance the drug benefit.

Another common way MA-PD enhance the drug benefit is by coverage on drugs during the coverage gap. Here, green represents those in plans with no gap coverage, while orange and blue represent those with gap coverage. Looking left to right, you can see that a much larger share of MA-PD enrollees are in plans but cover some drugs in the gap.

In 2009, only 7 percent of PDP enrollees were in plans that provided some benefit during the gap, while over 60 percent of MA-PD enrollees were in plans that covered some drugs during the gap. But as you saw in the earlier slide, nearly half of PDP enrollees get extra help with premiums and cost sharing through low income subsidy, and this low income subsidy essentially fills in the coverage gap. So even though most LIS enrollees are auto assigned to basic stand-alone PDP with a gap in coverage, they have a more complete benefit because of this subsidy.

So the open enrollment season is about to start in just over a week, and here are some of the main changes in plan offerings for 2010. Unlike in the previous few slides, now, I'm talking about percentages of plans and not

percentages of people.

You can compare the PDP and MA-PD offerings down the two columns. There would be fewer plans available in 2010, a 7 percent drop for PDPs and a 10 percent drop for MA-PDs. And some of the reductions were due to consolidations among plan sponsors as well as CMS' effort to reduce low enrollment in duplicative plans. But beneficiaries will still have access to many plans. In any given region, beneficiaries will have access to between 39 and 53 PDPs and many MA-PD plans.

A big change I wanted to call your attention to is the drop in the number of PDPs with zero deductible. In 2010, only 40 percent of PDPs have a zero deductible compared to 55 percent last year. A larger share of MA-PDs will continue to offer plans that have no deductible.

Finally, a smaller share of PDPs will be offering coverage in the gap; 20 percent in 2010 compared to 25 percent last year. And slightly over half of MA-PDs will offer plans with some coverage in the gap, which is about the same as last year. And over 40 percent of those MA-PDs offering gap coverage will cover both brands and generic drugs.

DR. SCHMIDT: Part D premiums are up again, but the premium increases are smaller for 2010 than they were for 2009. On the far left, the average enrollee in a PDP paid about $35 per month in 2009. If they remain in the same plan for 2010, enrollees can expect to pay $39 or over $4 more.

MA-PD enrollees pay a combined premium that covers both Part D benefits and their regular Part A and Part B -- and other medical benefits. If we just look at the portion of that combined premium for their drug coverage, the average MA-PD enrollee will pay about 14.50 per month in 2010, and that's just slightly under what they've been paying in 2009.

You can see that the MA-PD premiums are a lot lower than the PDP premiums. On average, MA plans have lower bids for providing basic benefits, and some of them are doing a very good job of managing benefits. However, the difference you see also reflects the fact that MA-PDs can use rebate dollars from the MA payment system to lower their premiums.

Overall, the average enrollee pays about $29 per month for Part D in 2009. And if they stay in the same plan

next year, their premium will increase by about $3 or about 10 percent.

Now, we know for certain that some beneficiaries will switch plans, particularly some low income subsidy enrollees will be reassigned to different plans. Last year, reassignments and voluntary switching led to an average premium that was about $2 lower than if beneficiaries had stayed in the same plan, and this mostly affected the PDP average.

Part D's payment system relies on competitive bidding, and it's the risk to plan sponsors that enrollees might switch plans that you give them incentive to bid low. But over the past several years, we've only seen about 6 percent of enrollees switching voluntarily from one plan to another.

Right now, it looks as though most PDP enrollees will see their premiums go up again for 2010. But once again, there's this open question of whether the premium increases for 2010 have reached the point that they will motivate more enrollees to switch plans.

The year-to-year changes in Part D premiums also affect enrollees who receive the low income subsidy. That's

because Medicare sets a maximum amount in each region on what it will pay for the premium for low income subsidy enrollees. So each year, there is some turnover in the plans that have zero premiums to LIS enrollees. If an LIS enrollee is in a plan with a premium higher than this threshold, and they haven't picked a plan themselves, then CMS reassigns them to a lower premium plan.

For 2009 and 2010, CMS changed the method for setting these thresholds in a way that they hoped would reduce the numbers of beneficiaries to be reassigned. After receiving bids for 2010, CMS estimated that even with this new method, there would be about 2 million reassignments. So they've decided to use general demonstration authority to set thresholds in a different way, omitting the Part C rebate dollars from MA-PD premiums before setting the thresholds. This change especially affects parts of the country where a larger share of LIS enrollees are in MA-PDs. The Office of the Actuary estimates that this demonstration will cost about $110 million in 2010.

With this demonstration in place, nearly the same number of PDPs have premiums below the thresholds of last year, 307 compared to 308. CMS expects to reassign just

over a million beneficiaries. That's moving beneficiaries into a plan offered by a different sponsor with a different formulary. Another 100,000 enrollees would be reassigned to a plan offered by the same sponsor, and that usually means the same formulary.

CMS does not reassign beneficiaries who have ever picked a plan on their own, which now number about 2 and a half million people or about a quarter of all LIS enrollees. We're not yet sure how many of these beneficiaries are paying a premium, but it's likely that many, or perhaps most, are, and the most common amounts are in the 8 to $10 a month range.

I mentioned that Part D's payment system uses competitive bidding, and in this chart, let's take a look at the year-to-year changes in average bids from plan sponsors for providing basic benefits. I want to call your attention to the red circle, the overall increase of 5 percent for 2010 bids. That's better than last year's situation when the average bid increased by 11 percent. And 5 percent is roughly what drug trends are looking like for other private sector payers.

Another difference from last year is that, this

year, each of the components of the bid, individual reinsurance, the base beneficiary premium, and Medicare's directly subsidy or its monthly payments to plan, grew at close to the same rate.

Last year, I came to you and told you about a big jump in the reinsurance component of the bids or what plans we're expecting in the way of catastrophic spending by their higher cost enrollees. Remember that drugs to treat certain conditions, like for rheumatoid arthritis and multiple sclerosis, can be very high cost, and patients who use those therapies tend to move quickly through the coverage gap and into the catastrophic phase of the benefit, where Medicare pays for most of the cost through individual reinsurance.

This year, the increase in the average bid for that reinsurance piece was closer to the increases for the other parts of the bid. Although that's good news, we still need to keep our eye on that component of Part D spending because it's precisely those kinds of high cost drugs where plans are less able to negotiate with manufacturers for rebates on price.

Now, let's jump from how much it cost to provide basic benefits per enrollee to the bigger picture,

Medicare's aggregate spending for Part D.

Incurred benefits have grown from about $43 billion in 2006 to 49 billion in 2008, and CMS expects spending to reach about 53 billion for 2009. That's an overall average growth rate -- annual average growth rate of about 8 percent.

There are a couple of things about this slide I'd like to call to your attention. First, the low income subsidy piece, the extra help with premiums and cost sharing, has grown to become the single largest piece of Part D spending. It's now bigger than the direct subsidy or Medicare's monthly payments to plans to subsidize the cost of basic benefits for all enrollees.

Second, reinsurance has been the fastest growing component of Part D spending, with an average annual growth rate of about 22 percent. Reinsurance covers most of the catastrophic costs for beneficiaries who have very high drug spending. And this second point reinforces what I just talked about on the previous slide, our concern about how to control spending for very high cost drugs and biologics.

MR. YANG: Every year, CMS collects data from a variety of sources to measure the performance of its Part D

plans. In this section, I'll describe those performance measures that it makes public on its plan finder tool on the medicare.gov website to enhance beneficiaries choice.

There are currently 19 measures available, divided into four categories: customer service, member complaints, member experience, and the last group combining drug pricing and patient safety. CMS rates sponsor performance for each of these 19 measures and then assigns star ratings for each of the four categories. Finally, it assigns a summary score to measure overall performance.

In February 2008, the Commission convened an expert panel on Part D performance that highlighted the importance of the development of measures that accurately measure cost, access, quality and customer service.

In comparison to these expectations, we find that the current set of metrics still focus largely on customer service and enrollee satisfaction, and still does not offer a direct measure of timely access to need and medication.

As for measures of clinical quality, in 2009, there was one measure available on the plan finder; that is, the percentage of elderly beneficiaries who are prescribed medication with the high risk of side effects when there may

be safer alternatives available.

For the 2010 benefit year, CMS has expanded the section to include one more measure; that is, the percentage of drug plan members with diabetes who also have high blood pressure were given a type of blood pressure that is suitable for people with diabetes. In addition, it also plans to put out two measures, one on drug-drug interaction and diabetes medication dosing on its website.

Next, we took a look at the distribution of summary score for Part D beneficiaries enrolled in stand-alone PDP plans. In this graph, the blue bar shows the percentage of non-LIS enrollees' need summary score, and the yellow bar shows the percentage of LIs enrollees.

If we take a look at the contrast between the blue and yellow bars in the lower score categories, that is 3 and below, we see that a higher percentage of LIS enrollees are with sponsors with lower summary scores. Half of LIS enrollees enroll with sponsors with ratings 3 and under as opposed to a third of the non-LIS population.

We're not sure what to make of this; that LIS enrollees are in lower rated plans does not necessarily mean that they receive a lower quality of clinical care. Because

the 2009 metrics focus largely on customer service and enrollee satisfaction, this difference may mean that they're in a lower premium plan that may dedicate less resources to customer call centers and other elements of customer service. We'll leave that up for discussion.

DR. SCHMIDT: So we'll leave you with a few issues to discuss. First, we pointed out that the low income subsidy is now the biggest component of Part D, and Medicare's payments for reinsurance are the fastest growing component.

Second, there's the role that plan switching plays in Part D. The prospect of enrollees changing plans and premiums that grow too high is supposed to give sponsors incentive to bid low. And likewise, the prospect of getting or keeping LIS enrollees is supposed to give sponsors incentive to bid low enough to keep their premium under the regional premium thresholds.

But we seem to have some ambiguous feelings about plan switching. Some analysts would like to see less of it because there are transition issues that come up for beneficiaries and providers when they change plans, but others might want to see more switching to make the

incentives to bid low more credible to plan sponsors.

Finally, there's the continued need for better quality measures in Part D. CMS has introduced some new measures on the plan finder for 2010 and has plans for other measures for the future. But there's still considerable room for new measures that reflect timely access to medications and clinical quality.

We'll take your questions now.

MR. HACKBARTH: Thank you. Nice job, some provocative questions I think.

We will use our usual procedure of multiple rounds, the first round being strictly clarifying questions.

DR. STUART: Thank you very much. This is one of those reports that could easily have been four times the size. And I think you've done a really good job in taking a lot of information and putting it together in a very usable fashion. So I want to thank you for that.

I have a question and then a comment. The question relates to slide number 2 or the comment relates to slide number 2. And I'll simply note that that orange bar on the top that says "No creditable coverage, 10 percent," now that has been stubbornly 10 percent since 2006. And so

my question is, what's happened between 2006 and 2009, or projections for 2010, in terms of who's in that group?

One of the disadvantages of having a report that's a snapshot of each year is that it doesn't focus on changes within the population. And there are actually three groups that I'm interested in to think about. This will go in to part two, but I think it's important to put them on the record.

The first is LIS and the extent to what proportion of those people would be punitively eligible for LIs based on income and assets but simply don't enroll.

The second part that I'd wonder about would be individuals who are covered under RDS, the Retiree Drug Subsidy, and that spending seems to be flat over time, which might imply that, in fact, there are actually fewer people that are in that. So there's a question of whether there might be people who are actually not getting employer coverage.

Then the third part that I'm really interested in, because I've never seen it come up anywhere, which is the number of people that have enrolled in Part D in one year and then disenroll later on. So three dynamic population

questions.

MR. HACKBARTH: I think the rule book says somewhere that round one questions can never have three parts.

DR. SCHMIDT: Did you want me to give it a try?

MR. HACKBARTH: Yes. We'll give Bruce a waiver, this time.

DR. SCHMIDT: I think the short answer is we don't have a very good sense, frankly, of who all is in that 10 percent. I think CMS comes up with these numbers each year after kind of looking at new versions of SIPP and CPS and other data sources that might be available to try and get a handle on what types of drug coverage people have.

In terms of how many of these people might be LIS, I think that CMS has been making some effort to try and reach out to the LIS population, providing more region-specific information about who is likely to be in this no coverage category or in a category of may be in the Part D plan now, but not aware that they're eligible for LIS. So that they have been making more detailed information available to SHIPs and other organizations to try and reach out to that population. But you're absolutely

correct. It's been a very stubborn 10 percent.

On the RDS, I think the numbers have declined slightly for that, so it's possible that some of those people are falling into that category, but I also think there may be some movement from employers into MA-PDs.

MR. HACKBARTH: Okay. Other round one clarifying questions?

MR. GEORGE MILLER: The way you looked at me, I can't ask a three-part question. I'll just make it one part.

I'm curious about our conversation yesterday about the dual eligibles, and if there's a link, and which block on this same slide would dual eligibles fall in.

Are they in any one of these three areas or do you have a correlation?

MS. SUZUKI: Sure. So, actually, this will be a better picture to look at. So on the right hand, we have the PDP population broken into LIS and non-LIS. And the majority of the LIS are dual eligibles, because a little over 6 million of the 9.3 roughly million LIS enrollees are duals.

So part of that dark green or the majority of that

dark green are duals, and then if you look at the MA-PDs, there are, again, a little over a million, I think, dual MA-PDs. And a big chunk of them we think could be duals, although we haven't analyzed them.

MR. GEORGE MILLER: Well, to follow up on Bruce's question, do any of them fall in that 10 percent category of no coverage or do you know?

DR. SCHMIDT: Well, the duals were automatically assigned into Part D in 2006.

MR. GEORGE MILLER: Okay.

DR. SCHMIDT: So it's highly unlikely.

MR. GEORGE MILLER: Okay.

MR. HACKBARTH: Nancy?

DR. KANE: On slide 15 -- I have two questions, but they're not one question two ways.

So are there no plans with a 5.0 or are there no beneficiaries -- I mean, I'm trying to understand.

What's the distribution of plans by rating? Because you've got the beneficiaries, but -- are there no plans with a 5.0?

DR. SCHMIDT: I think that there were extremely few.

DR. KANE: But there are no enrollees --

DR. SCHMIDT: Jae is trying to pull up the numbers.

There are absolutely no plans below 2.5; we know that for certain.

Jae, do you remember there are -- just a handful it looks like.

MR. YANG: Yeah, there are nine plans that were under the five star rating.

DR. KANE: And no enrollees?

MR. YANG: Well, this is looking at -- this is looking at PDP plans.

DR. SCHMIDT: So this is everybody.

MR. YANG: Yeah, this is everybody.

DR. SCHMIDT: I'm sorry. We don't have the numbers of PDPs that had five stars. We know that overall, across MA-PDs and PDPs, there were a handful that had five. But this particular slide is just related to PDP, and we don't have the answer as to whether or not there were any with a five star rating right now.

DR. KANE: Well, let's just say there were no enrollees --

DR. SCHMIDT: There are no enrollees, yes.

DR. KANE: -- in a five star PDP.

MR. HACKBARTH: So the implication would be that all the five stars are MA-PDs.

DR. KANE: Okay. So now I understand that.

Then the other question I had is on slide 9, which is the plans offered for 2010. And you talk about there being 10 percent fewer plans, and private payers, we're talking about one-third.

I'm just trying to -- is that -- the causes

for the drop, is that related at all to what's going on with the MA payment? I mean, what's going on with the drop, and how many people are affected by the fact that we're actually losing MA-PD plans? What do they do instead?

MS. SUZUKI: So I don't know exactly why the numbers are dropping, but a couple of things. There are consolidations among the plan sponsors. CMS has been trying to reduce the number of plans because they were very low enrollment plans and they were also duplicative plans. So if you wanted to offer multiple plans, you had to make sure that they're different, meaningfully different.

MR. BERTKO: Can I add, Nancy, there is also a new

network requirement starting, I believe, in 2011, which means that certain kinds of sponsors, I think -- and I'm inferring this from public reports -- have determined they're not going to be in that business anymore. And so the -- I won't say the consolidation, but their exit from a market that they can't serve seems to be beginning.

DR. KANE: And you're referring to the private fee-for-service plans, which is the second bullet on the right-hand side.

DR. SCHMIDT: By one-third.

DR. MARK MILLER: Which are in markets where there are other plans available for people to go to.

DR. KANE: Do we know how many enrollees are affected when we lose plans?

DR. SCHMIDT: I think a CMS official put out a number recently. It was on the order of 600,000, thereabouts; 6 to 700,000 beneficiaries in predominantly private fee-for-service plans will need to move to another plan or reenter original Medicare and pick a PDP.

DR. KANE: I guess what I'm trying to get is, is this just a one time thing or is this a -- how unstable is the MA-PD option, I guess, is what I really want to -- maybe

I should get at.

MR. HACKBARTH: That will depend on the health reform legislation and the specific provisions included on payment for MA. And then even once that's settled, presumably, it will take some period of time for plans to make judgments and for it to have its ultimate impact. So we'd be several years, I would think, away from the stable situation that you described.

Peter?

MR. BUTLER: My question, I want to confirm something in writing, in your written material, not in this. And that is we said yesterday we don't typically do focus groups with beneficiaries or patients directly, but this is an example where you did. You did 12 focus groups with eight in a focus group, three on LIS, three on non-LIS.

What really struck me is on the non-LIS, you reported that there was only out of -- which means of about 50 people involved, there's only one, you said, that did not change their behavior when they reached the gap. Everyone else reported that they changed from going to generics or asking for drug samples. You have a whole list of things.

Is that right?

DR. SCHMIDT: Yes, that's correct. And, actually, Joan and Shinobu presented on that back in September, a more lengthy discussion of it. But, yes, there is a lot of change in behavior in anticipation of the coverage gap.

DR. BERENSON: I want to pursue Bruce's question to one more group, if you could go back to number 2. And that is the distribution of beneficiaries in MA only versus MA-PD.

If you've got 20 percent on MA-PD and there's about 24 and a half or 25 percent total in MA, can I assume that about 5 percent are in MA only? Do we know that? Not necessarily?

I'm also interested, and Bruce, in sort of trends and sort of anticipating what might happen if there's a payment cutback or a bench mark cutback so that benefits are less generous. Is there a population that would essentially revert back to MA only? I'm interested in the dynamics between the two, if you know.

DR. SCHMIDT: I'm not sure I can get you a precise answer, but I think that there are some private fee-for-service plans that do not offer a drug benefit as part of their package. So some of those people would be

enrolled in PDPs.

DR. BERENSON: My understanding, and I may have this wrong, is that an MA has to offer a PD, but they also can offer non-PD products.

DR. SCHMIDT: Yes, that's correct.

DR. BERENSON: And so --

DR. SCHMIDT: Why don't I come back to you with a more precise number of the percent in MA only plans.

DR. BERENSON: And the trends in recent years, if you could.

MR. HACKBARTH: Additional round one clarifying questions?

DR. CROSSON: Yes, and I'll word this very carefully; there's a consequence.

I'm sort of trying to figure out with respect to the LIS population who's better off. The non-choosers who have somebody watching out for them from the perspective of how much they have to pay in premiums, but they have this problem of being disrupted in terms of the plan and then the formulary, potentially changing medicines, or the choosers, who in fact have the opposite situation. They have a stable formulary, but on the other hand they might be paying more.

So my specific clarifying questions are, on slide 11, where it says at the bottom, many of the choosers are enrolled in plans with premiums above the LIS threshold, do we have an idea, on the average, how many more dollars a month those folks are paying, in other words, for the stability -- let's say for the stability of the formulary?

DR. SCHMIDT: I think our rough guess -- but we need to do some further calculations on this -- is an 8 to $10 a month range.

DR. BERENSON: Eight to ten dollars. Okay.

DR. SCHMIDT: Another piece to this puzzle is that CMS has done some early work trying to look at the effects of reassignment in your calculus of who's worst off or better off; what happens to reassignees.

A study that looked just for the year 2007, comparing LIS enrollees, who stayed in the same plan versus reassignees, found no difference in health outcomes as measured by mortality, ER use and hospitalizations. So that's one piece of data out there about reassignments. But, again, that's just for one year, so it's perhaps not as complete a picture as we might like.

DR. BERENSON: So that, perhaps, is an answer to

the second part of the question, which relates to slide 15. And the question is, the different distributions there that you have, the distributions of the LIS enrollees, how does that compare to the distribution of the star ratings? In other words, are they, in fact --

Oh, did Nancy already ask that? I'm sorry. Sort of asked it, so I'm really asking it.

[Laughter.]

DR. SCHMIDT: So it if were not weighted by enrollment, you mean, what does the distribution of the plans look like?

DR. BERENSON: Yes.

MR. YANG: We don't have that right now.

DR. SCHMIDT: We don't have it for the PDPs here, I'm sorry to say. But it's, you know -- you'd see probably a bit more spread to it, but it's not that dissimilar.

DR. CHERNEW: I don't understand how you could have a 5 if you had no -- if you had a plan that was a 5, you have to have some enrollees in it; otherwise, you wouldn't know it was a 5.

DR. SCHMIDT: I'm sorry. It would not be more spread out. It's still within the range of a 2 to 4 and a

half.

DR. KANE: There's only MA-PD with 5's. That was what the answer was.

DR. MILSTEIN: Obviously, we have a program here that's founded on this notion of consumers disciplining the vendors and the vendors raising value as a result. My question is this.

It works a lot better for consumers if the burden associated with disciplining the vendors is low rather than high. Can you just update us -- because so far, I didn't see anything that addressed this -- update us on what, if anything, CMS has done over the past year to reduce the burden on beneficiaries of a) even knowing when there's a plan that would be a better value for them, given the drugs they're on, better value meaning you can get the drugs you're on, but in your total spending per month, but estimated out of pocket plus premium, would be lower.

So that's called the burden of ascertainment -- what has CMS done to reduce the burden of ascertainment for enrollees? And then secondly, what has CMS done to reduce the burden of actually making a switch? So it's a seamless switch, kind of analogous to what the FCC

did in asking the cell phone companies to allow you to keep your cell phone number in order to reduce the switching costs associated with switching cell phone carriers.

So in the last year, what progress has CMS made, if any, on reducing these two facets of burden, that, if reduced, could make a big difference in consumers' ability to discipline the vendors?

MR. HACKBARTH: Let me just add on this. I consider this a round two issue. But since Arnie mentioned it, I think this is a critical, conceptual point about the program. And I'd just add that here we have a model that is premised on consumers disciplining the marketplace. The choices are quite complex, and we're talking about relatively small premiums. So the dollar gain for going through the effort may be relatively small, which puts a real premium on simplifying the decision making in the switching or the whole house of cards falls down.

DR. SCHMIDT: I'm not sure I have a very complete answer for you, and I may need to return with a bit more information. But I do know that there's been some academic work looking at if you notify beneficiaries that there may be lower cost options available to them, does that affect

their behavior, and there's some indication that it could. And I think that CMS has been taking a look at this literature. It was taken in the form of letters to beneficiaries and that sort of thing.

DR. MILSTEIN: So it sounds like there has been no material progress other than investigating relevant research.

DR. SCHMIDT: There is each year an effort to say to beneficiaries, it really behooves you to get out there and look at your options, but I would say that's -- that's what I know of the extent to it, but let me research that further and update you.

MR. BERTKO: This is a related question about future work. If you go to slide 13, I think some of you mentioned in the presentation about the concern about the growth and the reinsurance portion, which, again, is inferred by me to be mostly -- partly driven by the really high-class drugs, the biologics and such.

With the Part D data that I think we're getting access to, will be able to disaggregate the difference between growth and unit classed utilization and intensity in terms of new drugs, more people having drugs? I mean, is

that in your future work plan?

DR. SCHMIDT: Ideally, yes, depending on what all you have for us to do. We are able to look at utilization, and we have 2006 data now. We're hoping to get 2008 data perhaps later this year or early next year. But, yes, I see that as something that should be part of our agenda.

MR. BERTKO: My editorial comment is I think parts of healthcare reform legislation do have that pathway to biologic types of drugs that might be in here, and we might as a commission want to be on top of that.

MS. HANSEN: This is also on the same slide. It's just a question about the employer subsidy. If you could just refresh my mind about was this a temporary piece of subsidy in the legislation and will go away? And if so, will that have, obviously then, some impact on the distribution of the total spending for Part D?

MS. SUZUKI: It's not a temporary thing; it's a permanent subsidy that's available to employers who are offering actually equivalent coverage to Part D or more generous.

DR. DEAN: On page 14, slide 14, I was interested in the measures of clinical quality. You mentioned that

there was one drug they were concerned about, then they planned to release some more requirements.

Do you have any more specifics about what those are?

DR. SCHMIDT: Well, the one measure that was available for the 2009 benefit year was a measure of the percent of elderly members in each plan that were taking high risk medicine. So something --

DR. DEAN: The famous Beers list.

DR. SCHMIDT: I don't know if it's precisely the Beers list, but it's something equivalent.

DR. DEAN: I mean, that's a very controversial area --

DR. SCHMIDT: Right.

DR. DEAN: -- and some of us have great skepticism about the Beers list.

DR. SCHMIDT: Right.

DR. DEAN: That's why I wondered if that's what they were using.

DR. SCHMIDT: I will come back to you with more detail on that.

DR. DEAN: Okay, thank you.

Well, I just was going to say, just to Bruce's point -- because I was interested in the group that are not covered. The reality is that there are a certain number of people that just simply don't take drugs and don't perceive a need. And I suspect that that's a part of the group. I'd be interested to know how big it is.

DR. KANE: So when you look at the LIS population, does CMS make an effort when they reassign? If they have LIS enrollees who are going to blow right through the coverage gap and into the catastrophic, to put them in plans that will minimize their catastrophic crisis, or do they just say, well, if it's -- so there's no effort by CMS to protect Medicare from the rather substantial what they call reinsurance piece of this for the LIS -- I mean, CMS is reassigning LIS people at times, but they're not saying, well, you look like you blow through the coverage gap regularly or you hit the coverage gap. But there's no effort to minimize Medicare's ultimate cost because of the reassignment.

MS. SUZUKI: That's correct. It is randomly assigned.

DR. SCHMIDT: And a sense of whether there are

opportunities to protect Medicare a little bit, if the reassignment did incorporate the cost profile of the LIS.

MR. HACKBARTH: The implication I'm hearing is that there are some plans that would be better at preventing people from going into the reinsurance category.

DR. KANE: Or may have better prices so that the overall total is lower or some way manages that cost.

MR. HACKBARTH: For the expensive drugs. Okay.

DR. MARK MILLER: Actually, Rachel, I think you should pull in pretty fast here. We went through this discussion, I want to say, a year ago --

DR. SCHMIDT: A couple of years ago and continued to work last year, too. That was the perspective of the issue of beneficiary centered assignment. So you remember -- I think you raised this issue before, Nancy, which was a related issue of can you try to think about whether there are opportunities to put people into plans more intelligently, based on their past utilization of drugs and trying to minimize either the beneficiaries' cost sharing, or their formulary coverage, or those kinds of things.

NORC in Georgetown did some work for us on that

issue. It seems like there is a bit of a trade off between minimizing government costs versus minimizing beneficiaries' cost sharing or coverage of drugs on a formulary.

DR. KANE: For LIS people, it's actually just Medicare that you'd worry about.

DR. SCHMIDT: Well, except that there is the breadth of a formulary to consider as well because if a drug is not covered on it, then a person may be stuck paying for the entire thing themselves and may stop taking that certain therapy. And we I think decided or commissioners --

DR. MARK MILLER: I mean, the punchline -- we got pretty -- I mean, for analysts, we got pretty jazzed up about this and thought that there was something here that we thought we could come away with. But when we got deeper into it, the trade off was less clear cut, and exactly how to execute it I think got somewhat difficult.

DR. SCHMIDT: I think also, some of you commissioners raised some dynamic issues over time that there could be some unintended consequences if we were to do that; that certain plans might get the majority of LIS enrollees that take certain drugs, which might affect their bidding for a subsequent year. It might raise their -- it

might have the result of raising their premium and might actually lead to further reassignment. So that was one point of view that I think Bob Reischauer had, for example.

MR. HACKBARTH: Is there any way of knowing to what extent the beneficiaries who go into the reinsurance are there because they're using single source drugs, where there would be no price variability; it's basically the drug maker's name and the price?

DR. SCHMIDT: It's possible to do that through claims analysis, but it's not a trivial thing to do.

MR. HACKBARTH: Yes, okay.

Bruce?

DR. STUART: I take this as an incredibly important area that requires that we examine it holistically. And the reason I say that is that there are at least four dimensions that I can think of in terms of how you'd want to evaluate particularly the random assignment.

I mean, one came up in terms of what Jae's comment was on slide number 15, is that if the LIS population is predominantly in low star plans, and there is an annual reassignment that is truly random, that means that they're going to look like -- that may actually help them

out or it may not. So, I mean, that could go both ways.

As far as trying to map the choices of individuals according to what the prices are on the drugs that they use makes a very, very strong assumption that they're on the right drugs to begin with. And I think that is probably something that would not hold up if you were to look at it. And so, I think that's a second thing.

The third is about reassignment in terms of the reinsurance rate. You're right. It could be because of a single source drug, and that would be worth looking at, but just because the product is single source and doesn't have a competitor doesn't mean that there aren't therapeutically equivalent products that would be arguably as good if not better.

So I guess what I would suggest is if we're going to go along this route, we really should have some criteria about how we're going to make judgments about what's good or bad for assignment of enrollees that would include cost of the program as well as benefits to beneficiaries across a variety of areas, including satisfaction as well as drug quality.

MR. HACKBARTH: Ron?

DR. CASTELLANOS: In your final comment, you questioned about the better quality measurements. From a practical viewpoint and from a physician viewpoint, compliance on the patient's part is so important. I know we've talked about it before.

Is there any new data on that or are there any studies that we could do? It's going to impact on the cost of the Medicare system, especially with readmissions, et cetera.

DR. SCHMIDT: Patient adherence to their medications is a perennial problem. And, actually, the Pharmacy Quality Alliance has been developing some measures of medication use that focus predominantly on adherence. And I think over the longer term, CMS is hoping to introduce some of those measures into the ones that it uses for clinical quality.

That is really at the stage right now of -- the PQA's been road testing some of those measures. They're just now getting some of the results in from that. So it's a little bit farther down the road. One issue is that you could argue, from the standpoint of being a PDP sponsor, look, I'm running just the drug benefit; why should I care

about adherence?

Our past expert panels that we've had internally at the Commission, the thought has been, well, maybe you should hold PDPs to some of those measures, even though there are problems with patient compliance and even though it's not running an entire medical benefit as perhaps a pay-for-performance type of measure.

DR. CASTELLANOS: Thank you.

MR. BUTLER: So we typically look at these things. And then aggregate Medicare spending is 53 billion or a little over 10 percent, I guess of the Medicare budget, but its collateral impact on other spending is probably really. really important, and growing. So I think this is really important.

I had a thought. We typically in the Commission look so much at this aggregate spending from the Medicare point of view versus the beneficiary point of view, and we've increasingly looked at the impact of not only out-of-pocket spending here, but in Medigap and what happens to downstream Medicare spending as a result of these implications.

I'm wondering, maybe it doesn't belong in here,

but even in a context chapter, if we look at the typical Medicare beneficiary through his or her eyes and say the annual out of pocket is X dollars for the Part B premium, X dollars for the Medigap, X dollars for out-of-pocket drug expenditures, something like that would help us understanding, through their eyes, the levers that they're looking at annually in terms of the choices they're making. And if we had that and say, what does it look like to them, and recognize not everybody is average, I think it'd help us a little bit more on some of these trade offs and choices and where we might start to impact the benefits side versus just the expense side, and how do we contain $53 billion in spending.

DR. BERENSON: Just a couple of thoughts about quality measures. On the issue of drug adherence, it does seem to me there's a theoretical advantage of an MA-PD, which has the delivery system as part of it, or at least it's closer to the delivery system than a PDP. So it does seem to me it's an area that we should be able to see some differences across MA-PDs and a difference with PDPs.

I'm particularly interested in the polypharmacy issue. And if the Beers list is no good, we need to make a

good one because I think, for the most part, we do have unique issues with the Medicare, the old, old population that Medicare has, which has gotten little attention in most of the FDA and other kinds of evaluations of drugs. So I think something -- I would like to work in that area and improve what is out there in terms of medications that are problematic in seniors and then on the polypharmacy issue.

DR. MILSTEIN: A couple of suggestions. One is just a direct consequence of my prior round one question, which is, I think a very useful area in which we could potentially be very useful would be to include within this topic as we proceed, an examination of what's being done elsewhere by what we consider exemplary within the health industry to help connect consumers with "better", whether it's a better plan, better provider. For example, some of the real strides that have been made in connecting patients who need organ transplants with the highest value, quality, outcome and cost organ transplant provider and an individual drug selection.

Obviously, our unit of selection here is PDP plan, but I think many of the lessons that the exemplary organizations that have made progress on reducing switching

burden and enabling switching to be highly discerning would be relevant. And if we mobilized it and put it into a finding, I think it might be very useful to either CMS or Congress.

There's been progress in applying, I call it choice burden reduction, good choice burden reduction, as it pertains to health care. And I think to the degree we have the resources to summarize it, mobilize it, and think about how it might be applicable to this particular program, which is very much formulated on optimizing consumer decisions, I think we could make a real contribution.

MR. HACKBARTH: And as I said earlier, I agree with that.

Have we, in previous reports or previous presentations that you've done, looked at the literature on switching behavior and health plans outside the Medicare Part D area, how much price difference is required? I'd be particularly interested in the switching behavior of seniors. My assumption would be -- I don't know if it's valid or not -- is that there's a bit more inertia and a little bit more reluctance to switch.

DR. SCHMIDT: We have not really reported on that,

but I know that the academic literature bears that out, the studies I'm familiar with, that they are more reluctant to switch.

MR. HACKBARTH: There are two sides to this. One, how strong are the signals motivating switching, and then how easy do we make it for beneficiaries to choose new options. As Arnie says, they're fundamental to the design of this program.

DR. SCHMIDT: Another piece of data that may be interesting is that the proportion of switching that's occurring voluntarily in D is about the same as in FEHBP, which is kind of interesting. There are some younger people in that population.

MR. HACKBARTH: That's important information, and if we could just do a little bit more context so we can put these numbers in a broader context, that would be good.

John?

MR. BERTKO: I'm going to open up a can of worms here, which is do drugs indeed reduce cost in A and B. And when Bill Scanlon and I were on the panel, Americare's trustees' technical panel in '04, we asked that very question. And my recollection is that the people from OACT

and CBO said can't find any evidence either way.

We have here potentially a natural experiment of turning on drugs in '06-07, and I'm not sure I'm ready to assign that to our team, that is MedPAC staff. But is there a possibility that we could monitor and work with some variety of people that would study that thoroughly, and then I'd go down to Mike's direction of a value-based insurance, which is to be able to know the subsets of drugs that really work and encourage those in one form or another.

So not a big thing, but I'm just saying can we throw that on our agenda?

DR. CHERNEW: The best site on this is a site by Yuting Zhang in the New England Journal of Medicine. So they've done it in one plan.

I think -- my take on the literature is it is undoubtedly true that drugs reduce spending in Part A and B. It is unclear whether they reduce spending in Part A and B as much as you spent on the drugs. I believe that in some cases, for some drugs and for some patients, they do. In fact, in some cases, for some patients, they more than pay for themselves. In other cases, as your question alluded to, there's great heterogeneity in that.

I want to go strongly on record as saying, saving money should not be the purpose of the Part D drug program, and we have to be careful that we don't set up this bar that we should only do it if it saves money. But it is true that the overall cost of Part D is somewhat less than the 53 whatever it is; how much less remains to be seen. And I'm sure it will be a lot more work quantifying that, and I do think we could do a better job in evaluating the plans if we took into account some of the heterogeneity issues and the benefit design things that you said.

I was going to make a part two comment on this point, but maybe I'll wait until it's my turn.

DR. KANE: [off microphone] -- have to ask whether it's better than having had Medigap.

MR. BERTKO: And here is the natural result. I mean, we've seen the benefits of the switch from brand to generic, which has happened rapidly over this. I think there's another switch that Mike only alluded to, but I would describe more explicitly as saying, some drugs obviously work. Those are the high value drugs. Other drugs would seem to be wasted and, one way or another, emptied into toilets later as people take them but never has

any impact. And knowing more about that should serve us because who else is better to look at this particular question. There are other parts of the industry that have, if no incentive, even perverse incentives to keep this information unknown.

MS. HANSEN: Yes. My comments really amplified that of what Bob's already brought up relative to that population, and I've oftentimes also brought up in the past. Since older individuals tend to oftentimes take as many as anywhere from 15 to 20 drugs. That set up right there is just ripe for understanding that.

The second point that relates to that, that, again, we've done other work in the past, too, is to just look at the Medication Therapy Management Program that's nested into the Part D and how we can kind of put this together.

I know that there are changes in 2010 in terms of making sure that this will be perhaps a little stronger, but I would like to just see if we can kind of look at this in a composite way relative to MTM and the polypharmacy as it relates to the MA vis a vis PDPs, because I know that PDPs, again -- as you point out, the incentive, but does that have

meaning. And to Arnie's point, are there some best practices where it is used that are shown to be somewhat effective, hopefully, in the effective use of that MTM.

The last thing is on the quality issues of drugs -- excuse me, not the quality issues of drugs, but just the quality issues that need to be looked at. And if the Beers method is understandably not widely accepted but there are some, already I'm sure, research on sentinel kinds of drugs that have such dangerous impact -- many older people take blood thinners, for example, and that's high risk in the hospital and very high risk outpatient. So if there's some way to really focus on those things that oftentimes are the prompter for hospitalizations, and if that could be really looked at a little bit more carefully from the clinicians who would identify that.

MR. HACKBARTH: Okay. We're down to our last few minutes here.

Tom?

DR. DEAN: I just wanted to comment on the Beers list again. The Beers list, for the people that are not familiar with it, is a list of drugs that was published a few years ago under the heading of Drugs That Should Never

Be Used in the Elderly.

The dilemma for us as clinicians is that I would absolutely agree that everyone of those drugs has major complications and major problems. On the other hand, there are certain situations where we don't have any other alternative, and there are situations where the use of drugs on that list are extremely beneficial. They have to be monitored, they have to be used carefully, but to say they should be never used really produces harm because I've got a list of people that are on those drugs because we didn't have alternatives, and who tolerate them, and who are getting benefit from them.

So that's the dilemma. I mean, they're high risk drugs. I mean, I don't argue with that. But, unfortunately, they usually are published under a heading that says "should never be used," and that's just way too simplistic.

DR. SCHMIDT: I think in CMS' defense, they're not using that heading, and I'm not even sure that's the exact measure that they're using. They label this as high risk of side effects in the elderly.

DR. DEAN: And they are.

DR. CHERNEW: I just want to finish up briefly where I think John was going, which is, first let me say, I do think it's important to hold PDPs accountable for the adherence to the certain types of medications that their beneficiaries are taking. I agree with Bob's point that they have less of an incentive to do that than a MA-PD plan, although when we begin to look into this, I think what we'll find, I'm not sure, is that it's actually -- they're more similar to MA-PD plans than not because many of them are using similar formularies from the same organization. So you might find more connection than you otherwise would expect if you were just looking at pure incentives. But in any case, that's neither here nor there; it's an empirical question, and conceptually, we should hold them accountable.

I think one of the challenges here, when you look at some of the measures that you look at on reports like this is we see that people pay a deductible. We see that they have coverage or not coverage in the gap. But we have to ask ourselves is that good or bad. On one hand, you want them to have to pay something because you worry about the inefficiencies and you want there to be efficient use of medications in a whole bunch of ways. On the other hand, we

realize that we want to worry about their financial burden, and more importantly, the incentives they face to take the medications that are important, because they're important, and in fact there may be some spill over savings down the road.

But in any case, the problem is that cost sharing is both good or bad. So I think to the extent that we can, to the extent that CMS can, to the extent that other groups -- and I don't know what the Pharmacy Quality Alliance is doing -- can have more nuance benefits to recognize that there are some of these medications -- I think that blood pressure medication for diabetes is one of the classic ones that I use, which is clearly a high value medication, then I think -- we want to be able to develop those metrics and evaluate plans good or bad, based on a little more clinical sophistication and nuance than simply, oh, there's a doughnut hole, that's bad, or, oh, there's a doughnut hole, that's good.

There is some way in which we have to encourage the good but try and get efficiency within that. And that I think is hard, and I commend you for beginning to work on this. And the more we can bring in other work that you're

doing and others, I think the better.

MR. BEHROOZI: It might be a little related to what Mike said, but I think, too, what a number people have said, the extent to which -- and I know that you have been doing focus group work. The extent to which we can really get at the beneficiary's perspective, as Peter said, but remember the beneficiary's perspective is a prospective one when they're choosing plans. They're not looking back over how much they had spent. You know, it's not all totaled up yet.

So in terms of Arnie's comment about choice burden reduction or Glenn's comment about sort of what's the tipping point in terms of price difference, it might not just be a number. It might be where it hits them. It might be that it's the premium that's the most important thing because that's the first thing they're going to have to pay. Or it might be that it's the deductible because that looms large before they get to anything else. But then they are given the information about the fact that over the course of a year they will spend less in premiums, deductibles, and whatever because of the drugs that they're using.

Is it just that number or will they say, yeah, but

I can't even imagine how I'm going to pay the next three months' bills much less can I worry about what the total cost is going to be for the year. The immediacy of the cost or the immediate choice that they have just might not be capturable kind of by looking at retrospective data.

Like I said, you have started this work, and I would really encourage you to get into the head of a beneficiary, looking prospectively, and probably choice burden reduction I think is going to loom larger than just the dollars and the ultimate best choice that you might be able to make at the end of a period looking back.

MR. HACKBARTH: Okay. Thank you all. Well done, as always.

And our last session is on access to hospital services, and this will be sort of an initial step toward our hospital payment adequacy analysis. Much more will follow at the December meeting. Hannah, are you leading, or Jeff, or Zach?

MR. GAUMER: Good morning. Before we get started, I want to thank Jaeyoung Yang and Jeff Stensland for their contributions to this work. Hannah and I will present most of the material here.

In December, we will present the Commission with a variety of hospital payment cost and margin data to help you arrive at the annual hospital update recommendation. But we've decided to carve out the access component of the hospital update this year and talk to you about it this month because our analysis includes two measures, industry employment trends and the willingness of hospitals to accept patients with Medicare Select plans. Specifically, we view employment trend data as an indicator of capacity, and hospitals accepting Medicare Select patients as an indicator of hospitals' willingness to provide access to Medicare beneficiaries.

This presentation has two broad components. The first concerns hospital capacity to provide care, and the second concerns hospitals that accept Medicare Select patients who pay a discounted rate. Overall, we find that facility volume has grown, the scope of services has expanded, employment has grown, capital is available, and some hospitals are accepting patients in Medicare Select plans.

I will begin by talking about the capacity portion of the presentation and then Hannah will talk to you about

the Medicare Select analysis. Finally, at the end of the presentation, all three of us will be available to take your questions.

The number of hospitals participating in the Medicare program increased in 2008, in part because of the number of hospitals that left the program slightly decreased. This marks the seventh consecutive year in which the number of hospitals that opened have outnumbered the number of hospitals that have closed. Specifically this year, or in 2008, 52 acute care hospitals opened and eight closed. Those that opened were relatively small, and among those that closed, most were urban. Overall, approximately 3,500 short-term acute care hospitals participated in the Medicare program in 2008. And it is important to note that hospital occupancy rates have remained relatively stable in recent years, at about 65 percent across all hospitals.

In addition to capacity growth, hospitals have expanded the services they offer in recent years.

DR. CROSSON: Just one moment. We've lost the slides.

[Pause.]

DR. MARK MILLER: [Off microphone.] We've got a

technical person coming. Everybody has handouts in front of them, the audience --

MR. GAUMER: Okay. So we'll continue with the beginning of Slide 4, if you want to flip to your hard copies.

In addition to capacity growth, hospitals have expanded the services they offer in recent years. Our analysis of hospital services reveals that from 2004 to 2007, the share of hospitals and their affiliates providing most specialized services increased. For example, on the top row of the table you're looking at on your hard copies, we see that the share of hospitals offering palliative care programs increased more than any other service, at approximately seven percentage points. As a result, 42 percent of hospitals offered palliative care programs in 2007.

In contrast, there were only two types of services that were not offered by a larger share of hospitals from 2004 to 2007, and on the bottom two rows of this table, you can see that trauma center services remained even at about 42 percent and the share of hospitals offering urgent care centers declined two percentage points, to 33 percent. And

the five other services included on the table were included because they were among the fastest-growing services offered by hospitals from 2004 to 2007.

Service expansion occurred for both urban and rural hospitals from both 2004 to 2007, but was more rapid for urban hospitals. Services such as cardiac catheterization and open heart surgery, which are both more common in urban settings, continued to grow faster in urban settings. Rural hospitals also experienced service expansions, but generally at a slower rate.

The only notable departure from this trend was MRI services, which expanded twice as rapidly at urban hospitals. In 2007 overall, we can see that MRI services are catching up in rural settings, are catching up with the urban settings, where 79 percent of rural hospitals have MRIs and 92 percent of urban hospitals offered MRIs.

Slide 5 -- Bureau of Labor Statistics data reveal that as of August 2009, general hospitals employed over 4.4 million individuals. Within the 24-month period that we're displaying on this slide, we see that general hospitals added approximately 170,000 jobs, growing approximately four percent from September 2007 to August 2009. Overall, this

growth rate is on par with the industry's ten-year average growth rate. However, you will note that hospital employment stagnated from roughly December 2008 to May 2009. And following this period of stagnation, the hospital industry appears to have resumed its longstanding employment growth trend.

Now, placing hospital employment trends in broader context, we see that hospital employment has increased at a relatively average rate for the health care sector. The hospital industry's four percent increase over the last 24 months is displayed on the chart in yellow. Employment for the rest of the health care sector grew by five percent, which is represented by the red line, and it's important to note that that five percent line does not include hospitals. We've removed hospitals from there. However, the health care sector's trend line does include offices of physicians, which experienced an employment increase of about 5.5 percent, more than any other health care provider during this 24-month period.

The green line on the slide represents employment for the economy overall during the last 24 months, and economy-wide employment inclusive of hospitals and inclusive

of the rest of the health care sector declined 4.7 percent, from September 2007 to August 2009.

The trend in spending on hospital construction suggests that access to capital remains adequate. Overall, the Census Bureau projects that over $33 billion will be spent on hospital construction in 2009. Therefore, it appears that hospital construction will remain at levels comparable to 2007 and 2008. But as we look back, we see that construction spending steadily increased from 1999 to 2007, culminating in over a ten percent annual increase in both 2006 and 2007. However, from 2007 to 2009, construction spending slowed, increasing just 1.5 percent per year.

Two additional indicators of hospital access to capital are, first, the trend in hospital tax-exempt municipal bond offerings, and also interest rates for hospital bonds. Based on data for the first nine months of 2009, we see that the average monthly dollar value of bond issuances for 2009 were equal to the average monthly dollar value of bond issuances for 2007, at approximately $3.4 billion per month. Based on data from previous years, we do not anticipate a surge in bond issuances in the last three

months of 2009, which would bring those 2009 bond issuances up to levels observed in 2008.

Interest rates on tax-exempt debt have declined from one year ago. As of October 2009, the average interest rate on AA tax-exempt 30-year hospital bonds was 5.1 percent, significantly lower than the 7.3 percent interest rate documented for similarly-classified bonds in 2008. This suggests that capital is more available to nonprofit hospitals than it was one year ago.

Hannah will now walk you through our Medicare Select analysis.

MS. NEPRASH: New to this year's analysis of access to hospital care is a discussion of Medicare Select plans. We could include this in the access to care discussion because it's one more piece of information on the relationship between payment rates and Medicare beneficiaries' access to care.

A Medicare Select plan is a type of Medigap plan in that it must provide beneficiaries with standardized benefits, identified by a letter A through L. What separates Medicare Select plans from other Medigap plans is that the Select plan charges a lower premium than the

identical Medigap policy, provided that the beneficiary uses in-network hospitals for non-emergency care. And for a hospital to be included in a Medicare Select carrier's network, that hospital agrees to waive all or part of the Part A inpatient deductible.

So how common are Medicare Select plans? According to the National Association of Insurance Commissioners, there were 106 Medicare Select carriers in 2008. These carriers offered Select plans in 45 States, but participation rates varied tremendously. Medicare Select is common in some States, like Florida, Alabama, Louisiana, and Illinois, and rare or nonexistent in others. Select plans represented roughly ten percent of all Medigap policies sold in 2008 and covered slightly over one million Medicare beneficiaries.

We analyzed the hospital networks of Medicare Select carriers in California and the five States with the highest reported Medicare Select enrollment. Focusing on the largest Select plans, we constructed a database of hospitals that participated in at least one Medicare Select network. We found that the share of the States' IPPS hospitals participating in Medicare Select networks varied

widely across States, ranging from only 14 percent of total hospitals in California to 97 percent of total hospitals in Alabama. On average, hospitals that participated in Medicare Select networks tended to have lower standardized costs per discharge compared to that of non-network hospitals. The lower costs resulted in higher Medicare inpatient margins at Medicare Select hospitals than the other hospitals.

Comparing quality of care at participating Medicare Select network hospitals and non-network hospitals, we found that the two groups of providers performed at roughly the same level. Likewise, the breadth of services at the average Medicare Select hospital appears to be at least equivalent to that of non-Select hospitals.

It's important to keep in mind that we examined all IPPS hospitals in six States where Medicare Select enrollment was sizeable and our information comes from plans that willingly shared their in-network hospitals with us. These are States where Medicare Select is relatively popular and not a representative sample of the United States.

With that caveat, the willingness of these hospitals to take lower rates for their Medicare patients

suggests that in the areas we examined, hospitals continue to see increases in Medicare patient volumes as desirable, and this is a positive sign for patients' access to care, at least in those markets.

So this concludes our presentation and we're happy to take questions, but two issues for the Commission to weigh in on include hospital capacity measures, as Zach discussed, and also if Medicare Select is a useful indicator of patient access to care.

MR. HACKBARTH: Okay. Why don't we start on this side, round one clarifying questions. Mitra and then Mike.

MS. BEHROOZI: When you were talking about the, I think it was the growth in specialized services, Zach, you referred to the difference between urban and rural experience. I wonder if, in general -- and I know that we do these analyses and we do the payment update and everything on a national basis, but I just wonder if you looked at regional differences, whether it was for growth of specialty care or any of the other issues, employment, and obviously it is an issue with respect to Medicare Select, but did you see regional variation? Did you look for it?

MR. GAUMER: We typically go down to the urban and

rural level and don't go further for that services analysis, but we can look into doing that.

MS. BEHROOZI: How about for employment or any of the other measures?

MR. GAUMER: Employment, we didn't go any further down because what we were trying to do was get a very broad assessment of employment trends.

DR. MARK MILLER: Does the data have the capability of doing that?

MR. GAUMER: Umm --

DR. MARK MILLER: Because this is the stuff that comes out of the BLS, right?

MR. GAUMER: Yes, exactly. So this is BLS data. I'm not exactly sure if we can go down. Usually, it goes down to the occupational level using a different data set. I can look into it. I don't think so, but I can look into it.

DR. STENSLAND: We can do regions on the overall employment.

DR. MARK MILLER: It's the region stuff. It's the big giant regions, right?

MR. GAUMER: Right.

DR. MARK MILLER: It may not be as -- that's what I was worried about, is how far down that data could go. We'll look at it. My sense is that it won't be as satisfactory as you might have been looking for there.

DR. CHERNEW: I just want to make sure I understand the Medicare Select market and what's going on. The hospitals that accept Medicare Select plans are in Medicare Select networks. They get paid the same amount as they otherwise would have gotten paid. The DRG payment is what the DRG payment is.

DR. STENSLAND: Well, they get the same amount from the government.

DR. CHERNEW: Right.

DR. STENSLAND: But then there is the patient's deductible.

DR. CHERNEW: Yes, right. No, exactly. So they get paid -- the government DRG rate is the same and they agree to waive the deductible from the patient, suggesting that they had a lower cost and they want to attract more patients.

DR. STENSLAND: Yes. Sometimes they waive the whole thing. Sometimes they just waive part of it. They

may say, okay, we will waive $500 of the deductible for all the patients that come here from your Medigap plan.

MR. HACKBARTH: The inference -- I was going to ask about this, also. Are you finished, Mike?

DR. CHERNEW: No --

MR. HACKBARTH: I don't mean to interrupt.

DR. CHERNEW: Well, I -- so the insurer now, the Medigap plan was sort of only paying for the deductible. So now the premium is lower because now the insurer is not paying that. So basically what's happening is they get a very low premium because the hospital has agreed not to charge, and that's the --

DR. STENSLAND: So it kind of -- basically, the -- from sort of the beneficiary's perspective, they talk to the Medigap plan and the Medigap plan says, maybe we'll give you $500 off a year on your Medigap premium, okay, and they say, I like that. What do I have to do in exchange for that? Well, they say, you've got to be limited to this network of providers. So then the insurer goes to the providers and says, we're going to steer volume to you if you're willing to give us a waiver of the deductible or a reduced deductible, and then that's kind of the trade-off.

DR. CHERNEW: And so this only works -- follow the logic -- this only works if the hospitals themselves are low-cost and therefore have a high margin with which to pay. They don't need --

MR. HACKBARTH: Well, that's what I wanted to ask. So I think the inference that I would draw from this is that for a hospital that elects to participate, they believe that their net revenue per case is higher than their marginal cost of treating the additional patient, and they want additional patients because they've got unused capacity. So it wouldn't necessarily say that they're profitable. It's that the marginal revenue exceeds the marginal cost.

DR. STENSLAND: Right. Yes. So that marginal revenue might not exceed the total cost, but it exceeds the marginal cost, so they want those additional patients to fill a bed. It's better than an empty bed.

MR. HACKBARTH: And what is the conventional wisdom in the academic community and the literature about what proportion of hospital costs are fixed versus variable? I know that's a harder question --

DR. STENSLAND: There's a lot of disagreement on that.

MR. HACKBARTH: Right.

DR. STENSLAND: I think a lot of people would think at least a substantial portion are going to be fixed, at least somewhere on the order of 20 percent or something like that. Some people may say more, but there's kind of, like --

DR. CHERNEW: There's a long-run/short-run issue --

MR. HACKBARTH: Exactly. You consider --

DR. CHERNEW: -- costs and --

MR. HACKBARTH: Yes. What's your time horizon for assessing what's fixed and variable, yes.

Okay. I've led us into non-round one questions, so I have Tom and then John.

DR. DEAN: On page seven, is there any measure, or do you have any data about how much of that spending is replacement and how much of it is really new beds or -- is the bed capacity changing, going up that rapidly? I assume not, but --

MR. GAUMER: In terms of bed capacity specifically, we've looked at some of the most current survey data out there and it seems like bed capacity itself

is staying relatively constant at about 800,000 beds across the country.

DR. DEAN: So the construction is replacement or outpatient stuff and --

MR. GAUMER: Umm -- yes --

DR. DEAN: Diagnostics --

MR. GAUMER: Yes. We believe so, yes.

DR. BERENSON: Clarification. On Slide 3, which is the number of hospitals opening each year, and maybe I wasn't listening carefully enough, but this looks like it's the number of hospitals open. Are all these hospitals, as far as you know, taking Medicare patients, as well?

MR. GAUMER: Yes. These are all participants in the Medicare program, right, or those that are no longer participating in the program.

DR. MILSTEIN: Do we know anything about what I'll call sort of effective availability of a hospital to a Medicare beneficiary with respect to whether or not some of the hospital-based physicians do or do not take Medicare assignment? I mean, some of the anesthesiology groups now or pathology groups that are the only -- the sole provider of the hospital, some of them are not offering -- that don't

take Medicare assignment, and so we have this new category of hospitals that are not effectively available to Medicare beneficiaries unless they have got a generous Med Supp plan. So do we track that? Do we have any information on that, because it certainly does affect the availability -- the de facto availability of these hospitals to less-affluent Medicare beneficiaries.

DR. STENSLAND: I don't think we've tracked that. Maybe that's something we could come back to you on when we talk about physician availability and how many are accepting Medicare patients next month.

DR. BERENSON: Yes, I just wanted to follow up on Tom. I think this is very useful information and I just think we should include the bed capacity trends that are happening because of the work we're going to want to be doing related to Paul Ginsburg's presentation last time about one of the strategies hospitals using of not expanding beds to have strategy. It puts this in some context. And by the same token, on the table that has the specialized services, I mean, there are others that I think are declining that you don't have, like mental health, substance abuse, maybe inpatient rehab, I don't know. I think it

would be very useful to get a real comprehensive list of specialized services, which helps us identify where the winners are and where the losers are. But it's very useful.

MR. BUTLER: Quickly, on construction costs. What gets you in that hopper, because somebody might do minor construction to meet code versus a big construction project. I see the source. I'm just curious what the definition is for construction costs.

DR. STENSLAND: My recollection is I think they look at the construction permits, and correct me if I'm wrong, Hannah. So you have -- both are in there. Like they'll have some, and they'll break it down into, okay, new buildings, major renovations, and they might also just have renovations within the hospital.

MR. GEORGE MILLER: On the four percent growth in unemployment, I want to come back to Mitra's point and try to flesh that out. I already heard the answer, but you don't know if there's been a shift to higher positions as an example of mid-level providers or the previous contract ED positions, as an example, or to Arnie's point that if the anesthesiologist no longer will accept Medicare, they either put the anesthesiologist on payroll and/or they subsidize

the anesthesiologist so they will take Medicare patients? So you don't have that bifurcation of that segment, because that could be part of the four percent growth in employment of hospitals.

MR. GAUMER: We did a little searching into the occupational changes that are taking place in employment --

MR. GEORGE MILLER: Right.

MR. GAUMER: -- and I don't think this exactly gets to your question, but we do see some changes in terms of RNs seem to be growing fast, imaging professionals seem to be growing fast. But we need to dig deeper into that issue about contracted versus employed physicians, if that answers your question.

MR. HACKBARTH: So what I hear you saying, George, is that --

MR. GEORGE MILLER: Do we know --

MR. HACKBARTH: -- growth in employment doesn't necessarily reflect a growth in capacity, but rather could just reflect a change in the relationship from a contract to an employment relationship and --

MR. GEORGE MILLER: Yes. Yes. And then on the Medicare Select, could it be, or did you do enough analysis

to determine if some hospitals may be choosing to accept those patients because -- or if your analysis determined if they're not collecting the copay or the deductible and their bad debt is high and this is a strategy to offset that.

DR. STENSLAND: Umm --

MR. GEORGE MILLER: If you're not collecting the copay and deductible --

DR. STENSLAND: Right. We didn't look specifically into that, but I could imagine something to that effect. The hospital could say, all right, there are certain people in my community that have a tough time affording their Medigap premiums, so I'm going to offer this Medigap Select policy to come to my hospital so they can afford a premium, so then at least they'll have a Medigap policy --

MR. GEORGE MILLER: Correct.

DR. STENSLAND: -- and maybe I'll at least get something from them. And if they didn't have a Medigap policy, maybe they wouldn't pay their deductible. It would be bad debt. And Medicare pays a portion of the bad debt, but they don't pay all of it. So I could see a conceivable story where that might flow into the decision making of

whether you'd want to accept Medigap Select patients.

MR. GEORGE MILLER: Okay. Thank you.

DR. MARK MILLER: When he was asking the question about the contractor to employee, you looked like you were almost going to say something. Did you have something to say on that?

DR. STENSLAND: Well, they also have contract employees that are going to show up as hospital employees, like if you're a hospital employee in that area contracting with somebody, they try to track that down, that they work in the hospital industry. So it's not so much that you are employed by the hospital, but you work in the hospital industry. So if I'm Manpower, Inc., and I contract with a certain hospital in Houston, BLS tries to count those Manpower, Inc. employees that are working in Houston as hospital employees in Houston.

DR. CASTELLANOS: I'd like to drill down on the employment issue, too. I think you need to really look at that. I don't think by hiring a whole bunch of doctors, and hospitals are doing that, it doesn't indicate an increased capacity.

The other point that Arnie made -- I think it was

Arnie -- about some of the doctors now not participating, it really has a significant effect on the beneficiary, because a lot of these doctors now are balance billing and the patients are getting surprised with an additional billing and that needs to be looked at.

And the other point that George made earlier and I made earlier is a lot of these patients -- I know I am hiring a lot more people, but to cover the regulatory side and not the capacity side. These unfunded mandates, and I hate to use that word, it's requiring myself, and I'm sure a lot of the rural hospitals and big hospitals, to hire people, not because they have increased capacity, but because of regulatory needs.

MR. HACKBARTH: I'm still thinking about this employment issue. But even if it didn't necessarily reflect an increase in capacity, it could have other implications. It could reflect a sign of financial health, that they feel that they can bring people onto the payroll that previously maybe were not on the payroll. That can play into market dynamics, as we discussed with Paul Ginsburg and Marty Gaynor. If a previously independent physician is brought into the hospital as an employee, that could alter the

competitive position of other hospitals who previously got referrals from that physician. I'm not saying that we know any of those things, but in looking at -- thinking about employment is an interesting way to look at this. It's a little tricky to figure out what conclusions to draw from the changes in employment, I think it's fair to say.

DR. BORMAN: I tried to think about this sort of at a rather high level and then a more detailed level. And so at the high level, I think the question that you've in part brought to us is that you've got two more potential measures of access, and are these helpful to us? Should we continue to look at them? And as I think about the other measures of access that we use, these certainly have their warts, but all those other ones do, too, so I personally find that having these additional measures is of some benefit, recognizing that they're imperfect, as are the other measures that we use. And so I would welcome continuing to use these and then the other payment adequacy assessments, potentially looking for other supplementary information that may be of equivalent value to us. And so I think that's helpful.

I think on the more detailed level, it sounds, if

I heard you correctly, that this Select group is relatively small and is somewhat geographically concentrated, and I would wonder -- one of the things we've not explored in that is are the relationships between these hospitals and post-acute settings different in this rather smaller group because could you potentially take a hit economically on the acute inpatient care with the expectation that you are more likely and more quickly going to some post-acute setting that may, in fact, balance your bottom line. And having remembered some of the maps we've seen about the non-random distribution of certain kinds of post-acute care, it does raise that question in my mind. So that if we were going to drill down on the meaning of and importance of the caveats, then that would be my question. Again, I'm not sure that that's the point of this exercise. It seems to me that perhaps more important is the notion that these are two more things that have some value and we just deal them into our composite measure.

MR. HACKBARTH: Okay. Round two. Arnie?

DR. MILSTEIN: This, you probably anticipated, based on my question. I think, on a going forward basis, or analysis of availability or access, we should think about

building this second measure in that uses the data that's in the Medicare claims database to identify hospitals whose hospital-based physicians predominately do not accept Medicare assignment. This could be -- I will defer to you in terms of -- but the obvious are predominant ER group, predominant anesthesiology group, predominant pathology group -- radiology, thank you, radiology group. So we could begin to have a sense, at least for non-affluent beneficiaries, have sort of a second measure of access that might be highly germane.

The third thing, and maybe someone -- maybe Mark or somebody knows the answer to this, but last month's presentation from Paul Ginsburg was obviously a very nice potential qualitative source for us, because they do this community tracking study where they're just continuously talking to providers. One of the things I think it might be good to get early readings on is whether or not that community tracking study is detecting any -- because they interview everybody in the community -- as to whether any hospitals are actually actively contemplating not participating in the Medicare program. That's something that we would be very well advised to get an early read on,

rather than have it explode two weeks before our December and January meetings and then we would be in a state of crisis.

So I think as long as we have that national asset, I think it might be helpful to use that as an information source for kind of -- like that early warning thing, you know, radar over the horizon to essentially detect that, because I think that would be something that if it were to spring on us unexpected might result in a level of panic that we'd prefer to avoid.

DR. BERENSON: Let me just comment, because the new round of site visits is going to be beginning in the very near future. Their initial meeting is in December. The problem is that we go to 12 communities and go to the large hospital systems in the 12 communities. So that only picks up, then -- I mean, I think it's unlikely that we're going to pick up what you're trying to pick up through that method. I think it's real important to do early sort of sentinel stuff, but it's a limited snapshot of hospitals who are not going to not see Medicare beneficiaries. They're not in the position to do that for -- I would be very surprised if the ones we go to would be the ones you'd be

picking this up on.

MR. HACKBARTH: You know, I would think, given the basic economics of hospital care, that this would be a lagging indicator, not a leading indicator, because so long -- they have fixed costs, and so long as the payment is exceeding their marginal cost, there's a reason for them to stay in if they've got excess capacity. But they could be at extreme levels of financial distress with inability to replace staff and equipment long before they get to the point where, oh, I'm going to drop out altogether. So I think of this dropping out of hospitals is probably more a lagging than a leading indicator. I'll let an economist address that.

DR. CHERNEW: Well, I think I'm going to say something slightly different, which is per our earlier discussion, a lot of different measures are all useful, but I think it's the primary measure for doing our primary task, understanding access from the beneficiary perspective is most important. And what I would worry about doing is setting up a set of measures that lead to a paradigm that makes us think that our updates have to be such that every beneficiary has access to every hospital in every setting.

I think that the more important thing is that every beneficiary have access to appropriate hospitals and appropriate care, even if some they can't go to.

So, for example, in the Medicare Select world, I don't mind using Medicare Select, or having it developed by the market, I might even add, to steer patients to hospitals that seem to be, based on your presentation, about comparable quality but likely cheaper. So I think that we run into a real risk of developing measures that identify one group of physicians or one group of hospitals or one group of something that are no longer in Medicare and thinking, oh no, access is reduced. We had better pay more. Because as long as we have the beneficiary perspective, I'm fine with some hospitals dropping out, some doctors dropping out, some -- particularly the ones that I think are high cost and not better quality. So that's --

DR. MILSTEIN: I agree with Michael. I think I was trying -- I wasn't addressing policy implications. I was simply saying, can we enlarge and enrich the dashboard that we build with respect to access measures, especially access measures affecting people who are not affluent enough to buy Med Supp. In terms of policy implications, I'm

probably with Michael in terms of how I would respond to it. But I think it improves the -- I think it gives us the ability to triangulate, and I think diversity of access measures would only benefit us.

DR. MARK MILLER: Just a very fundamental point. I mean, we do consult each year with Paul and HSC when we come up to our access analysis. However, again, to your point, it has mostly been focused on the physician side of things and what they're hearing there, and we can certainly cast the net more wide. But we talk to them each time -- every year at this time of the year.

MR. BUTLER: Now we're in round two, right?

MR. HACKBARTH: Yes.

MR. BUTLER: Okay. First, the narrower question. You're looking for guidance specifically on information to help guide our update factor for next month. So on the Medicare Select, I'm not -- that's not my favorite and I'll tell you why. First, it is people that -- I'm not sure what -- it's a very small number right now, and I think people would forego the deductible primarily for increase in volume. That's not to say they'd do it for all Medicare, but more importantly, we already know in the Medicare

Advantage plans, where it's voluntary to contract, that hospitals are not doing it for the Medicare rate.

So if you want to use it for the Medicare Select argument, then you would have to use it for the Medicare Advantage, which we know is one of the reasons why Medicare Advantage in certain markets are high, because hospitals are not -- they're saying Medicare is not enough. I'm not going to participate at Medicare rates. So I think you'd have to look at that side, as well, if you want to look at an indicator of what hospitals would be willing to do, because they've already spoken on Medicare Advantage and they've said, I'm willing to walk away from the Medicare Advantage plan at Medicare rates.

Now, back to the bigger kind of picture. I agree with Glenn that employment is a good thing to have on the table. I don't think we want to draw too many quick conclusions, but it informs more just than the financial health of the institution, and let me just paint a little picture of kind of a barbell, the haves and have-nots, and what I think these numbers are telling us. Then I look at our own market ourselves.

There are those that are spending money on

capital, and by the way, knowing the IT piece would be an interesting piece of tracking capital because it's something we want. People are -- there are a certain set of institutions that are anticipating stimulus dollars. They are the same ones that the physicians are lining up who's going to win in my market, whether it's lining up for Kaiser, maybe, in a market, as easier to employ than before, or lining up with hospitals, those institutions that are going to have the IT support, the environment, the success. And so it is not just individual doctors. It is their staffs with them that are flipping into employment relationships. And it's not just hospitalists and ER doctors. It's physicians that are really, as we pointed out last month, that are lining up.

I know in our own numbers, that's where you would see the biggest increase of all. But it's also in the quality infrastructure in anticipation of whether it's readmission rates or -- I know our quality staff, that's a growth area. Our IT staff has grown. And so some of where you want growth -- in fact, some of these areas are things that you want hospitals to invest in in order to perform so that actually they can take costs out of the system. So if

I look at our own numbers, that's where the increase is. It's not the number of nurses at the bedside, that we're sloppy on productivity. It's in these other areas.

But contrast that to the other set of hospitals in our market that may look efficient, and, in fact, are efficient, but their capital spending is low. They're not putting money into IT. They're not putting money into the quality infrastructure. And yes, they may be able to do pretty well right now compared to Medicare, compared to others, but they're falling rapidly behind and they're kind of one stimulus dollar away from it. So when it comes December of next year, these are the same institutions largely that have been helped a bit by the stimulus dollars in the short run, but when that -- and has sped up some of the Medicaid payments that have lagged behind -- some of those have caught up in States, and in December of next year, you face another threshold.

So I don't know what all that is saying, but it is kind of reflective of what is happening in markets, I think, overall.

MR. HACKBARTH: I'd like to pick up on a couple of things that you said, Peter. First of all, what do we know

about the relationship between the rates that private plans pay versus Medicare? Is there any systematic information about that? We do that for physician services using a sample of private insurers. So that would be one question.

And then on this issue of the haves and the have-nots, so to speak, we've gone through our analysis that showed that institutions that don't have the luxury of a lot of high private payers can, in fact, lower their costs, but that's a static look at the issue. So long as the money keeps flowing into their competitor institutions that allows those institutions to do more stuff, their competitive position can erode even if they are profitable on the Medicare business, especially if the purchaser community is not really focused on buying value but people are just going to who's got the nicest atrium and the most whiz-bang programs.

So I wouldn't draw the conclusion that although those institutions that are constrained can break even or make a little money on Medicare, that this is a sustainable situation so long as all this money is flowing in from the private side.

MR. BUTLER: Some of your conclusions, I agree

with. I guess I'd probably state it in a different way. But there's fallouts in the market that could occur that are not necessarily in the places that you want it to have happen, and how we reflect that or get that into the pricing is a -- we all do these across-the-board things and, frankly, we'll be arguing about whether it's -- there's not a lot of money to hand out anyway, but it is an important question, if we could get around those leading indicators, as well.

And I mentioned IT spending. It would be very interesting to see on some of these places that we call efficient, are they advancing the IT agenda, for example, because if you don't have that, as we pointed out even in the previous sessions, you are going to be out of luck.

MR. HACKBARTH: On the issue of database, a way of more systematically comparing private and Medicare rates --

DR. STENSLAND: I think we can come back to you next month and have a little more breakdown on what the margins are for private payers between the private pay non-Medicare business that they get and then the margins that they get on their Medicare Advantage payments. I think we can do that on an aggregate basis. I think we can look into

last year's data, at least, and come up with that. But we don't have individual, by person, or even by hospital breakdown of that. It would have to be at a national level.

MR. HACKBARTH: Yes, I sort of suspected that that was the answer. So at the highest level, we have the aggregate information on private payment-to-cost ratios, but we have little ability to dig beneath that and say that the rates paid by Medicare Advantage plans or plans that have negotiating leverage because they have closed networks are these and they compare to Medicare.

DR. STENSLAND: I think we can look at Medicare Advantage plans as one big group, but we can't break it down to say Medicare Advantage plans in Chicago or what they're paying them.

MR. HACKBARTH: Yes, or closed HMO versus --

DR. STENSLAND: Right.

DR. MARK MILLER: Yes. Jeff, I was kind of surprised by that answer, the MA piece of it. We're pulling this off the cost report?

DR. STENSLAND: This is from the AHA survey, so AHA annually does a survey and they share some aggregate data with us. They kindly do that. So we don't get the

data directly. They get the data, they aggregate the data, and then we see the aggregate numbers. So we don't see any individual numbers from any individual insurer or individual hospital. We just get the national numbers from AHA.

DR. MARK MILLER: Okay. So this would be very different than Medicare allowable cost or anything like that?

DR. STENSLAND: Yes.

DR. MARK MILLER: All right. So we can take a look at this. There may be some caveats that will travel along with this.

DR. CHERNEW: There are databases, like the HCUP database is the most widely known database of hospital discharges. I just don't know -- in many cases we've been trying to get in other settings, it's considered proprietary what Plan X pays Hospital Y, and so in many of these databases, they will give you a cost number that is not actually what was paid but what is sort of a standard number. So I don't know what that is.

There are other places you might actually really get what was paid, although there might be some other issues. For example, Medstat has a database that includes a

lot of Medicare beneficiaries and actually does have in it paid claims amounts. So pending confidentiality issues, like you wouldn't release this was from one health plan or another, you might be able to access the actual payment rates from large claims databases like the Medstat database.

MR. HACKBARTH: Okay. We're down to our last little bit here.

DR. KANE: I mean, actually, there are some States that have all-payer data sets now that you can look at them, at the State level, anyway, differences in the payment-to-cost ratios by pretty specific payer types.

But I guess, just to react to the idea of how to measure access and adequacy of payment, it seems that the measures of employment and medical participation in Medicare Select, they just really seem like proxies that are much better measured more directly. So certainly, I mean -- I agree with the comment, I think it was Mike's comment, that don't we survey beneficiaries as to whether they have long wait times or can't get in for elective surgery? We do survey beneficiaries a lot, but don't we have some of the direct measures of beneficiary access, or even patient complaints? Given all the measuring we are doing about

plans and all these other things, there should be some good ways to measure beneficiary access. So that's one comment, that I think I'd rather see the direct measures than these indirect ones.

I do have a concern with the availability of trauma care, from what I've heard, that there's a lot of markets where there isn't adequate trauma capacity and that some places are still on divert and people wait for a long time. And I'm wondering if those might be better -- something to consider for quality metrics, is what's the wait time from when you arrive with an emergency and when you get seen or get admitted. And I know that data is available. I know my State collects those kinds of things and maybe we should be looking at those metrics in terms of service capability and adequacy rather than these kind of very broad, it's available but is it open all the time? Can you get in?

And then, finally, on financial measures, I mean, that's what I do for a lot of States, is I do financial analysis. You know, we're looking at the tiniest piece of information we can, Medicare margins and total margins. There's much better, broader data sets out there around

financial measures, and including capital spending over a five- to seven-year period relative to the depreciation and age of plant and balance sheet stability for ability to invest in the future. I mean, there's many, many better measures out there that we all know how to use, but you just can't get it off the Medicare cost report because the balance sheet data there is pretty bad.

I did a report on this before I joined the Commission, but I do think if we really do care about how well hospitals are going to survive this big round of investment in infrastructure, it might be worth at least picking a few sentinel markets and going in depth and trying to see if the hospitals that are big Medicare beneficiary hospitals are likely to be able to be competitive with ones that may have much more commercial or a different payer mix. No, it doesn't have to be on everybody, but you could definitely develop some -- sort of like what the Ginsburg study does, but with more financial measures. That data is available. It's public, actually. Increasingly, you can download it off the municipal repositories for free.

I would just encourage you to try to think about a broader set of financial measures, because there's much more

useful stuff out there than margins.

DR. STUART: Just responding to the question about access to care, the Medicare Current Beneficiary Survey actually has two components, and you know this. The component that's relevant to Nancy's question is the access to care, and there are a battery of questions about various sources of care, primarily ambulatory, but it also covers outpatient hospital and it includes such things as how difficult is it to get an appointment, how much time it took to wait in the office, and there are some other kinds of things that could be correlated, at least with the outpatient side of hospitalization if not the inpatient side.

MR. GEORGE MILLER: Thank you. To the questions, I agree with Peter's comments and Nancy concerning these measures being a direct method. I believe they are indirect.

I want to deal with the Medicare Select issue. I have a concern with the graph and the numbers because three of those States are small, poorer States. They have a high percentage of low-income people, and three of them, Alabama, Kentucky, and Louisiana, have a higher percentage of rural

hospitals in those States. And some of those may be sole community providers, sole community hospitals, and therefore they, as I said earlier, may choose to waive the copay and the deductible. And in those States, I wonder about the wage index issue, if that doesn't factor into the reason why they may be willing to take Medicare Select, because they would get a better reimbursement thinking or figuring they're not going to get the copay -- not a better reimbursement, I'm saying, but thinking they would get a reimbursement, because again, they're not getting the copay and the deductible.

I don't know with six States you can draw a conclusion for the entire nation. I think there's about a million people in the plan. So I don't know if you plan to interpolate that for the entire nation, but I'd have a problem with that. It may be indirect measure. It may be a way to select it. But I think we need to peel back the onion and dig into it more for the reasons of the conclusions from this report. But I don't think you can interpolate for all hospitals across America based on that.

To the point about capital, Nancy mentioned about the balance sheet. Moody's, for example, downgraded more

hospitals this last quarter, which is another indication of the strength of hospitals, unfortunately, than they upgraded.

And to Peter's point about part of that capital being health information technology, not only do you have that capital cost, but you have got to hire more staff and that may relate to some of the growth capacity. So again, I'm not sure increase in hiring is an appropriate measure. It may be one tool, but an appropriate measure for capacity. I think there's others, as Nancy indicated.

DR. CASTELLANOS: Just hitting some of the things that have already been said, I agree. Hospital openings, closures, service, construction, these are proxies for payment adequacies. But the subject really is access to hospital services and I don't think we're addressing that.

It was somewhat addressed by Mike and Nancy and Bruce just recently on the patient side, and I think that's extremely important. We need to get that. But I think you need to also address it on the physician side. I want to know what services are available, ancillaries that are available, whether the hospital has IT available, the quality of the hospital I participate in, and the

infrastructure.

Now, I know on the physician side, you go out and do surveys. I don't know why we can't -- not for this section or this time period, but I think it would be important to go out and get some surveys, just like we do on the physician side, to the patient and to the physician to see where we stand. I think we're going to be surprised.

MR. HACKBARTH: Okay. We are at 12 o'clock. Thank you, and we'll look forward to hearing much more about payment adequacy for hospitals next month.

We'll now have our public comment period for anybody wishing to make a comment.

[No response.]

MR. HACKBARTH: Seeing nobody approaching the microphone, we are adjourned. We'll see you in December.

[Whereupon, at 12:01 p.m., the meeting was adjourned.]