MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: Good morning everyone. Our first session this morning is a panel of guests -- welcome to all of you -- on medical education, and Craig is going to do the introductions.

MR. LISK: Yes. I am going to start off. We're going to have a panel this morning on the session entitled, "Is Medical Education Training Our Physicians for Health Care Delivery in the 21st Century?" We have a distinguished panel in front of you who I will introduce in just a moment.

This session will be the Commission's first foray on this topic, which comes up frequently in some of your discussions. As you know, Medicare provides close to $9 billion in support for graduate medical education at teaching hospitals, so it has a substantial stake in the education process.

I'm going to start this session, though, by giving some brief overview of the process of becoming a physician and some basic data on medical school and residency training and information on Medicare support, and review some of the Commission's stated concerns we've made in past reports.

So I'm going to have a series of slides here that

talks about the path to becoming a physician. Of course, it starts off at undergraduate education, where students have to decide to take pre-med course work in order to be able to get into medical school. And then they go into medical school where the first two years are largely spent on classroom type of instruction in basic sciences, where they might get some introduction to clinical interviewing techniques and things like that, to where in the last two years they do their clinical clerkships where they get more practical experience with patients and such.

Of course, in the last year they also have to decide what residency training programs they are most interested in and what specialty they may want to pursue. Then they participate in the resident match at that point in time. The resident match ends up assigning them to, based on joint preferences, what residency training program they go into. So medical school four years, then residency training.

The residency training lasts from three to five years, depending upon the specialty, or a little more in certain surgical specialties -- three years, for instance, for primary care specialties of internal medicine and family

practice, five years for general surgery, six years for neurosurgery, for example.

When a resident has completed a certain number of years of residency training--and this depends upon the State -- they can seek licensure to become a licensed physician to be able to practice independently, and that's in our green boxes. And to continue on with their licensure, they have to fulfill certain continuing medical education credits over time.

Also, after residency training, though, residents can seek board certification. Now, board certification is not mandatory, but most residents do pursue board certification in their specialty they pursue, and to keep that certification in many specialties you need to also get recertified after a number of years.

But residents can also choose after finishing residency training, they can seek their board certification. They can also choose to subspecialize in fellowship training programs. So these would, like, say, for internal medicine, someone who goes and continues on in cardiology will take an additional three years, or someone who chooses to go into nephrology. For general surgery, someone might choose the

subspecialty of hand surgery, for instance, or in orthopedic surgery, back surgery, and this will take additional years of training, depending upon what specialty that might be, one to four additional years of training. And then again, they can get subspecialty certification and they would enter practice after -- at that point, after completing their subspecialization in that subspecialty.

Now, as you see here too, though, in terms of who accredits these different bodies, the Liaison Committee on Medical Education accredits medical schools. The ACGME, the Accreditation Council for Graduate Medical Education, accredits residency training programs. The different members of the American Board of Medical Specialties handle the board certification process. And then the States handle the licensure process. So there's different groups involved in each of these accreditations.

Currently we have over 150 accredited allopathic and osteopathic medical schools in this country with almost 86,000 students. In the most recent year, there were about 21,800 first-year students entering those programs. New medical schools are opening and class sizes are also growing, so these numbers will be starting to grow.

In graduate medical education, there are over 9,000 ACGME and AOA accredited approved residency training programs with more than 110,000 residents. If we think about those and about 25,000 -- a little more than 25,000 residents entering training each year in terms of for the first time in the United States. More than a quarter of all residents end up being graduates of schools outside of the United States or Canada, called international medical school graduates. So that's where they come into the process.

Medicare, though, provides substantial support for graduate medical education. There are over 1,100 hospitals receiving Medicare payments in support of GME. Direct GME payments, which cover Medicare's share of hospitals' direct costs of approved residency training programs -- that's the residency stipends and benefits, supervisory physician costs and program overhead expenses -- Medicare paid roughly $2.8 billion for these in 2006. Then we have indirect medical education costs, which cover higher patient care costs associated with teaching activities. These payments totaled $5.8 billion in 2006.

The Commission has stated a number of concerns over the years. One, we have recognized IME payments are

set more than twice what can be empirically justified in terms of the relationship of what Medicare payments are relative to the higher patient care costs of teaching hospitals. We also find that payments are provided to hospitals without accountability for how they are used or without targeting policy objectives consistent with what Medicare's goals are. And the Commission has also had concerns whether we are adequately treating physicians to be leaders in shaping and implementing needed changes in health care delivery.

So with that, I want to introduce our panel. So we have this panel that our first look here is to focus on graduate medical education and the education process. First, we're going to have Dr. Thomas Nasca, who is a board certified internist and nephrologist who is Executive Director and Chief Operating Officer of the Accreditation Council for Graduate Medical Education, or the ACGME.

Next then will be Dr. Michael Whitcomb, an internist and pulmonologist by training. He retired from the AAMC in 2006 as Senior Vice President for Medical Education and Director of the Division of Medical Education, where he also directed AAMC's Institute for Improving

Medical Education. Up until December of last year, Dr. Whitcomb was Editor-in-Chief of the Journal of Academic Medicine.

And finally, we will have Dr. Benjamin Chu, a trained primary care internist who is President of Kaiser Permanente's Southern California Region, where he directs health plan and hospital operations.

More detail bios on the panelists are included your briefing books, they have extensive resumes, and we'll start off here with the Dr. Nasca after I get his slides up here.

MR. HACKBARTH: Well, thank you all for coming. We really appreciate your spending the time with us. As Craig indicated, this is a topic that we have often come back to. Dr. Nasca?

DR. NASCA: Thank you very much, and it's a pleasure to be here. I've been asked to answer two questions. First is the ACGME, who are we and where are we going? And then the second is, is medical education training our physicians for health care delivery in the 21st century

And I will cut to the chase right off the bat so

that there is not anticipatory anxiety. For the first question, I think we would give ourselves a grade of C and reasons to follow, and let me address the second question then for a few minutes so that you can frame my comments and from whence I come.

The ACGME is a not-for-profit 501(c)(3) corporation whose mission is to improve the health care of the public through enhancement of the education of the next generation of physicians. It is governed by a Board of Directors who are nominated by five member organizations, and you can see that they represent the broad spectrum of those organizations that are interested in medical education. And indeed, the individuals who are nominated to our board are experts in graduate medical education. So the ACGME is really a convening location for experts in graduate medical education. We also have public members, we have resident members, and we have the chair of the Council of Review Committee Chairs who sit on our board.

The ACGME is the accrediting authority for residency programs in the United States. It delegates that authority to one of each of the 28 individual specialty review committees whose members are nominated by a subset of

those organizations representing each specialty. So, for instance, in internal medicine, my discipline, the American College of Physicians nominates members, the AMA nominates members, and the American Board of Internal Medicine nominates members to that committee and that committee then evaluates -- first of all, sets standards for the programs in that discipline, internal medicine, and then evaluates programs' compliance with those standards.

Now, we periodically review each set of standards and each program. The standards are reviewed approximately every five years and modified every five years, and we review each program on a cycle based on their compliance with those program requirements.

The current status is that about 97 percent of programs have continuing accreditation or initial accreditation. There are 3 percent of our programs that are on probation or warning, and about 1 percent right now who are in some process of withdrawal. Withdrawal can either be based on the committee's decision that the program should not be educating at the present time or it can be voluntary withdrawals. So that's a mixture of both voluntary and involuntary withdrawal.

There's a formal appeals process, that is, a group of external specialists, specialists not involved in the ACGME process, who review the recommendations for withdrawal or adverse decisions and make a recommendation to the Board of Directors who ultimately decide the final disposition of the appealed question.

Now, we accredit about 8,500 of that roughly 9,000 programs that you heard about. We have over 650 accredited institutional sponsors and they are in all 50 states. We oversee the training of approximately 107 of that roughly 110,000 resident number that you heard, and the pipeline for residency positions is approximately 25,500. That's the number of entry-level positions that continue and produce net output. Much of the growth in the ACGME accredited programs over the last five years has been in subspecialty programs which lengthen training but do not increase the flow of physicians through the pipeline.

We have about 300 new programs accredited each year and the success rate on initial accreditation is about 75 to 90 percent, and we have 90 to 100 withdrawn per year, and the majority of those are voluntarily withdrawn. The institution or the program ceases to desire to train or they

lack the resources to train and they recognize that and they voluntarily withdraw.

Now, we have about 1,100 new program directors per year, which is about a 15 percent turnover rate in our program director cohort, and those are the individuals who are responsible at the programmatic level for the training of individuals in that program in that specialty.

Now, to understand the role of the ACGME, you need to understand the philosophic setpoint for accreditation. And this is something that is continuously debated both outside the ACGME and inside the ACGME. When one thinks of accreditation -- and the old position of the ACGME was minimum standards and with accreditation standards that were trailing edge. By that I mean that the general consensus was that the vast majority of programs provided that type of education and therefore that should be the minimum standard. So it's a trailing edge phenomenon. It is driven by what happens in the field first.

And over the last 10 years under the leadership of David Leach, the accreditation setpoint was moved more towards the right, towards active fostering of change and innovation through the standards and moving more towards a

leading edge phenomenon. An example of that and an important example which we will talk about a little bit more is introduction of the physician competencies and configuration of residency programs around outcomes as opposed to process.

Now, what I predict will happen is over the next five years, we will continue to inch a little bit more to the right, more towards active fostering of change and innovation through our standards. Now what do we mean by that and why is that important?

Well, right now, if you were to start a new residency program, you would start with a concept of a curriculum, which is a listing of educational experiences that most residents in that discipline undertake. It would be time-based and it would usually be based on some external conception of what the curriculum could be. For instance -- and I use internal medicine because that's what I know best -- the Federated Council of Internal Medicine created a curriculum back in the 1990s.

You would then choose educational experiences that exist within the sponsoring institution and faculty who exist within the sponsoring institution and then identify

and develop evaluation tools that are formative and summative and attract the clinical experience of the individual trainees and you would educate the residents.

The key to recognize is that the drivers in this design would be that the patient care needs of the sponsoring institution at the time. And this gets to the issue of current versus forward thinking education. In other words, you would design the program to meet the immediate needs of the public you were serving, not necessarily the future needs of the public you were serving. You would also be designing to meet the patient care and research needs and interests of the faculty that are unique to that institution.

You would be re-duplicating or duplicating the tradition of program structure that exists within the discipline because that's the safe way to get a program accredited. The minimum standards of the ACGME's program requirements would be an underlying driver and the only measurable outcome that we have now systematically is medical knowledge, and that is the ABMS certification examination process. And so you would see the curriculum dominated by knowledge accumulation, not necessarily skill

sets.

Now, the ACGME along with ABMS, really following the lead of the medical schools in the 1990s, because the medical schools actually created an outcomes project prior to the ACGME core physician competency concept -- it is designed a little bit differently, but this is the conceptual framework that we are working with in graduate medical education, six domains of clinical competency, and in the parentheses there you'll see that I've added technical skills and surgical competence. There is a discussion now between ACGME and ABMS to more formally and overtly recognize the surgical and technical skills competency dimension of those disciplines' practice.

But this construct of sort of the subsets of the domains of physician capabilities was proposed and adopted and given to the field about seven years ago, and we have over the last seven years asked the field to begin to innovate in these areas, especially the last two, which are the main drivers of understanding how to meet the needs, I believe, of the patient population and health care in general for the next 20 years. That's practice-based learning and improvement, learning how to improve one's

practice continuously through active study of one's clinical care at the individual as well as group level, and then systems-based practice, understanding how to function within the system in which you find yourself more efficiently and effectively working as a team member and a team leader in order to bring about positive outcomes in our patients.

Now, in addition, we adopted a conceptual framework about evaluation, in other words, a scale. This was a scale actually developed in a government-funded study of analysis of how the Air Force Academy and the Air Force produces jet fighter pilots. So it's an attempt to begin to quantify the steps in development of mastery.

There's a fair amount of debate in the field around the nuances of this, but it's a convenient conceptual framework and the goal of graduate medical education is to take the advanced beginner and in many phases competent graduate of a medical school and produce an proficient physician who consistently and efficiently performs the tasks and the roles of their discipline, with some of them rising to expert status even during training, and then ultimately a goal of maintaining proficiency but some continuing in expert and some reaching mastery status over

the life of that physician. And this is represented in this graphic here where we attempt to take our graduates who come in as novices in medical school and produce proficient physicians who maintain at least proficiency over the course of their career. Now, we are speaking about the phase of graduate medical education.

It is obviously much more complicated than just a simplistic look, because most of our undergraduate trainees who went through the first year of training would be in the advanced beginner to marginally competent level, and our goal is obviously over the course of three years to produce proficiency.

When we look at systems-based practice, however, though, we usually encounter them at the novice level. The reason for that is they leave one training institution and they come into another that has a different system of care. They rapidly then will move into the range of competent and then into proficiency and then maintain that proficiency.

None of us, however, in graduate medical education, expect to see a novice or an advanced beginner when it comes to professionalism. The point here is that we have different expectations in each discipline around both

the pre-morbid capabilities as judged by the competencies of our trainees and we have a trajectory upward that we need to monitor. And the reason it's important is because when a resident falls off that trajectory, we need to have both data as well as the tools to recognize it and also to remediate it so that when they graduate they are indeed where we expect them to be.

Now, one of the challenges is that we face in American graduate medical education and that we are trying to remedy is that while there is a general understanding of this, there has never been a concrete set of expectations in each specialty around these milestones of training and the milestones upon graduation other than medical knowledge. And so we are now in the process of operationalizing the competencies, and we are driving this through accreditation.

We have created a learning portfolio that will be entering beta testing next July in internal medicine where we have the centralized computer hardware and software infrastructure to create specialty specific common evaluation systems around the competencies. We have received the report and approved the report of an assessment committee that is evaluating evaluation tools in the

competencies so that we can have some reliability around those evaluations. And we are convening groups in specialties, and the groups that have already been convened and are working are internal medicine, general surgery, pediatrics, and family medicine will be the next one to come online, to establish in all six domains of clinical competency the core elements that every one of their graduates must demonstrate at the level of proficiency.

The goal, then, is to accumulate this -- and this is a three- to four-year process to work our way all the way through the 26 specialties -- to produce specialty-specific competency evaluation program requirements for reporting of the outcomes.

There are a number of key pieces of the puzzle that are already in place, and the one that we will be working with our sister organizations with is faculty development on a large scale to both develop the competency to teach some of these competencies, because again, many of us are flying the airplane while we build it, which is a real challenge down at the level of the individual residency program. There are many faculty who don't have some of these competencies, for instance systems-based practice and

practice-based learning and improvement, and to be sure that our observers have appropriate inter-observer reliability and reproducibility.

Now, why would you say would an accrediting organization be doing this? Well, if was U.S. News and World Report and I was asking you which of these three programs, say on a scale of zero to 10, was the best program, I would hazard a guess you would say that program C is the best program. Well, it probably isn't as simple as that. This is an outcome measure, a theoretical outcome measure, and I can give you practical examples of what this might be.

But we need to know much more than that. We need to understand whether that is -- if there are predictive parameters whether a program is really performing as residents would be predicted. We also need to be able to understand whether it's not a linear function but whether it's a plateau kind of a function. In each case, the program would be judged differently based on those particular outcomes. The reason this is important is we want to be able to be sure on an at least every six month basis that every training program in the United States, the

residents are performing as expected in comparison to these milestones.

So this is a graphic example of how one might think about evaluating a residency program in the outcomes. Let's say for the sake of discussion, say in this particular specialty that each of the six domains of clinical competency have six parameters that we will, on an ongoing fashion, monitor, and we are looking at the percentage of residents who have fulfilled or have reached or exceeded the milestones. The shaded area in the center is two standard deviations below the mean. The national means are in red, and you can see that this program appears to have a problem in practice-based learning and improvement. Their residents are not achieving the scores.

To give you a practical example, we might in internal medicine be using a practice improvement module from the maintenance and certification process from the American Board of Internal Medicine, a highly validated tool to use in a residency program. So we may have a valid measurement tool. And this program's residents are performing significantly below the rest of the residents in the United States. Something needs to happen to that

program to get them to address this problem.

We are moving towards an evaluation system for programs, that is an annual evaluation system rather than biopsy every five years, very much the way medical schools' outcomes are judged continuously by the LCME, so that we can intervene and assist so that no resident is left behind in this process.

Now, do we have the capacity to do this? Well, this is actual data from a colon-rectal surgery residency program looking at -- this is procedural performance in comparison to national standards with the dotted lines being two standard deviations from the mean and the solid lines being one standard deviation from the mean. And you can see that this program has some procedures that are slightly above a standard deviation above the mean and slightly below on two of them, but that we can then look at this portfolio and say that this program is performing at appropriate levels.

To give you some idea of the kind of data this comes from, we accumulate in excess of 14 million surgical procedures performed by each resident on an annual basis, so we have the capacity to absorb and to process that kind of

information.

So where is this taking us? Our goal is if we were going to design a residency program five years from now, instead of taking an existing curriculum, a residency program director will take the required outcomes in each domain of clinical competency. They will design educational experiences and rotations in faculty that will produce those outcomes. They will use standardized evaluation tools to measure the outcomes, both formative and summative, to produce proficient physicians at the end with the competencies that the profession has deemed appropriate. Furthermore, we will oversee that by having external accountability not for the process of education alone but also for the outcomes.

Now, what are the barriers to success in this? The first is the relative success of the current model. It is very easy for us to be hypercritical of what we do, but I will tell you, as the head of the accrediting body that oversees this, I am asked constantly by other nations to come to them and produce this system in their country. So from a global perspective, this is the gold standard.

So getting people to change from the gold standard

and to evolve it is difficult. There are tremendous institutional and individual barriers because of the success at the local level in meeting many of the needs of our sponsoring institutions. We have challenges around the newer competencies within the faculty -- you know the analogy of building the airplane while you fly it. And we have a real challenge -- and I think this is the major cultural challenge we have -- we are evolving the traditional sense of professionalism in the individual physician duty to patients in an era that requires us to change those relationships in different ways, and that underlies much of the resistance to some of the changes that we are trying to introduce.

So our grade for training for the current system, I would say, is a B to an A-minus. Our grade for caring for the under- and uninsured is a B-plus to an A in many of our teaching hospitals, which are also most of our safety net hospitals in the United States. But for the future needs of the country, we have got a C, up from a D, and our goal is to reach the promise of the Outcomes Project, which I believe will get us closer to where we would like to be and be a B-plus or an A-minus by 2012. I don't think we will

ever get to an A-plus, but we will always try.

Thank you.

DR. WHITCOMB: Thank you very much. I really appreciate the opportunity to be here, and what I thought I would do in my presentation is to be brief and to actually focus simply on a couple of what I think are very fundamental issues that it is important for you to understand as you begin to try to understand the challenges that Tom has so aptly described that we face before us in trying to make sure that we meet what I think is actually the goal of our educational program, and that is to educate doctors to provide high-quality medical care. And I will comment about why I think it is so important to stay focused on the target in an appropriate way. And I think the challenge of staying focused on the target is one of the problems that we have to overcome as we try to move forward and improve the nature of the educational program.

This is a fundamental issue which I face and have faced for a number of years in my previous role in getting people to understand fully what it is that is important to be aware of as we think about how we improve the performance of physicians once they enter practice. And while it may

seem fairly straightforward for this group, given the jurisdiction that you have with respect to residency training, it is not to many people and it confuses the discussion over and over. And that is, doctors learn how to practice medicine during residency training.

Tom has shown very nicely how we try to improve the skills and to prepare people for practice and that happens during residency training. And the reality is that that is not the function of the medical school educational experience. I have heard many times in settings like this, where people will come out after these sessions and say, well, we need to make changes in the undergraduate medical education program. And the reality is that is not where you make changes if you want to improve the way doctors practice. So the focus clearly has got to be on residency training and the kind of activity that Tom has identified for you as a function of the accrediting body.

So the reality is that residency programs are responsible for preparing doctors to provide high-quality care when they enter practice, and this, I think, the fundamental issue here is to make sure that the kind of outcome measures that Tom is talking about are ones that

reflect the requirements that physicians have in their own discipline to be able to provide high-quality care.

In other words, it is not to reproduce physicians who will look as we look given our training in the past. It is not to stick to the status quo. But it is to look beyond that and ask the fundamental question, are doctors currently providing high-quality care? What do they need to provide high-quality care? And that needs to be the target in the redesign of residency programs. So the focus has clearly got to be on that, and again, it needs to be at the level of residency training.

Where do we stand today? Tom has given you a grade and let me sort of put it into some perspective. There are a number of studies that have been done in recent years, survey research either of physicians who have recently entered practice or residents who were in the process of completing training. These are discipline specific. They don't cover all disciplines, but I think we can generalize and say that if we had such research covering all disciplines, that the results would probably be somewhat similar, and that is that physicians who have entered practice or who are about to enter practice do identify

areas that they are going to face in their practice or they have faced in the practice for which they have not been adequately prepared to deal with.

Right away, you run therefore into the dilemma that we are not producing physicians who are armed with all of the skills and the knowledge and the abilities that they need to provide high-quality care when they enter practice.

And I want to add to this, because even though it may not be appropriate to the jurisdiction today of the group, it is incredibly important to understand that the residency programs prepare physicians to enter practice. Those physicians are then going to practice for about 30 years. Their ability to maintain their clinical competence is highly dependent on the nature of the continuing medical education activity that they are required to participate in and the design of those programs so that they are specifically focused on, in fact, maintaining competence, and our continuing medical education enterprise does not provide that today.

There have been substantial criticisms, most recently by an expert panel convened by the Macy Foundation, which is highly critical of the approach that we take, and I

think once again linking not only residency training but monitoring physicians in practice and providing a system that will assist physicians in practice is critically important in being able to meet this overall goal that we have in terms of providing high-quality care.

The current situation that we have, because of the nature of the design of residency programs in this country, is one in which we are training physicians for what we have done in the past. But the reality is that the nature of medical practice, and in fact the populations that we need to be particularly focused on, have changed rather considerably, certainly during our careers but even so in recent years, and will continue to change.

And just to highlight one, and that is that the major challenge facing American medicine today is to provide high-quality care to patients who have chronic illness, the major challenge. About 130 million Americans who have one or more chronic disease. If you have one chronic disease, there is a good chance you will have more than one. And we know, based on outcome studies that have been done, that those patients do not receive high-quality care as best we can currently measure it. And that's an important caveat by

the way, as best we can currently measure it.

We have a system of educating physicians which is very hospital-based. And yet if you ask what is the challenge of caring for the patient with chronic disease, the reality is that you want doctors to be prepared to deal with the individual problems those patients present with incidentally across specialties. But the reality is that what you really want to be able to do within the system is to provide the care that will keep patients out of the hospital, or if they've been hospitalized to make sure that the care that they get after they've been in the hospital is adequate. And that particular responsibility falls more disproportionately, I guess, on our specialty of internal medicine, family medicine, et cetera. But it is a reality that if you think of the way we currently train and think of the importance of what I have just said, that we are not connected properly in terms of the nature of our training program.

The other thing I think which is extremely important in understanding the results of the survey research is to appreciate that major specialty organizations have acknowledged that we need to change the nature of our

residency programs independent of the accreditation process. And those activities are, in fact, currently underway.

At the present time, there are initiatives underway in family medicine, internal medicine, and surgery, and others, but these are three major specialties. These initiatives have been underway since early in the decade. And I think that the challenges of, in fact, being able to move forward with these initiatives is incredible.

At the present time, they have not yet resulted in what I would consider to be fundamental change. In other words, rather than tinkering around the edge, I'm talking about the kind of fundamental change that would make sure that the graduates of the programs are really going to be able to meet their responsibilities in the evolving system and with the evolving patient populations. And because of the time involved and the sequence of changes that have got to occur, I really have questions about whether these initiatives will lead to fundamental change that is needed at the present time.

I just put up there in Academic Medicine in December of this year, we actually published progress reports of these three initiatives, and I followed up and

there has been very little accomplished since that particular point in time.

Now, why is this? Why do we have this problem? First and foremost, I want to return to a principle that I said before and that is that as we think of the design of our educational programs, while assessing the outcomes of the individual residents as they go through the program is critically important, it is fundamentally essential that before that program design occurs we understand the knowledge and the skills that the individual is going to need to provide high-quality care on entering practice. In other words, the training programs have got to be linked not to performance simply while in the program, but they've got to be linked to performance once that individual has left the program and is now out providing patient care.

A couple of years ago, the Agency for Health Care Research and Quality started an initiative to try to begin to get at how we might do this. Unfortunately, I think that that process is no longer ongoing. But it is critically important to be sure that we know what it is that doctors need to be able to do in order to provide high-quality care, and we then design the programs to make sure that we are

providing the opportunities for residents to acquire the knowledge and skills they need for that purpose. And we then need to monitor as they go through the programs that they are, in fact, meeting the milestones that need to be acquired.

Why is this challenge so great? Here are four fundamental reasons in my mind. Medical education infrastructure is linked to teaching hospitals. When we go about as deans recruiting faculty and those faculty are going to be involved in clinical care in one form or another, for the most part with very few exceptions, when we think about clinical care it is hospital-based care, maybe in the clinic but largely the care responsible for the care of patients in the teaching hospitals that are our major affiliates. And so we immediately have a focus on inpatient care as the purpose for which we are recruiting individuals who are going to be involved in clinical activities.

Our clinical faculty, to be realistic, have a vested interest in retaining resident duty responsibilities. This whole issue around resident duty hours and other activities that relate to the way residents spend their time. I use the analogy of law firms. In many ways,

residents are our associates. And so if they don't do some of what they do, we may have to do that as members of a clinical faculty. And so there is a reality that we've got to be honest about and understand and make sure that we think about how to deal with that.

It's also the case that there is incredible fragmentation of professional oversight and governance. I could have Tom put back up one of his slides and that would be the end of the discussion. You saw how many organizations. And if you think that it's because these are all, and we will say internal medicine organizations, they have a shared view, that's not true at all. There is tremendous differences in the way different organizations in different subspecialties within specialties look upon these issues. And so trying to get a consensus to agree upon the kind of changes, why is has been so difficult in these residency redesign initiatives to move more quickly than has been moved to date and why they are somewhat stalled at the present time, it's a critically, critically important issue.

And then you have the reality that you deal with, and that is that for the most part, the financing of graduate medical education is linked to hospital-based

experiences because hospital revenues are what support, whether it is the revenues derived from the Medicare program or from other patient care revenues, it is the linkage to the hospital source of funding that maintains much of the way that our system is currently organized.

So we have a major, major, major challenge and it is embedded within the realities that I have sort of summarized for you very quickly, and I look forward to the opportunity perhaps to pursue some of these in discussion as we go forward.

Thanks very much.

DR. CHU: Thank you. I just wanted to emphasize a couple of things that Dr. Nasca and Dr. Whitcomb spoke about.

You know, it's interesting because when you think about graduate medical education, you tend to be very myopic about, well, what does this program actually do for individual doctors coming out? And I've always looked at it from a different point of view, because the training of health professionals really is a sort of a dynamic interplay between what we are doing to bring new physicians into the system and what system we want them to practice in. And so

there's got to be a much more dynamic relationship between the two.

In a previous life, actually -- I rarely admit this to people because usually I'm talking to a group of doctors, but I was one of the members of the Bell Commission in New York state where we actually talked about resident hours. But the main point of that commission was really about resident supervision. And that was sort of an attempt at the commission level to really think about graduate medical education as to whether the system of graduated responsibility was actually accomplishing what we wanted to do in terms of the overall health care system.

And I really want to applaud your June report trying to lay out some really bold ideas about health systems change for the express purpose of really trying to drive the health care delivery system to a higher performing level, because there's no point in training doctors for what we're doing unless we're training them to really participate in a very, very high-performing health system.

I just want to very briefly run through this presentation. As you know, I'm actually currently in Southern California running a large region of Kaiser

Permanente, and really the take-home point here is that we're a small player in graduate medical education at Kaiser. We train between 600 and 700 residents and fellows, depending on how you actually count the affiliates that rotate through. But the key take-home point here is that as an organization, we've invested about $4 billion in a health IT system that brings a huge amount of capabilities to our system.

But before that, I spent a real career in New York City in the New York City Health and Hospitals Corporation, where I guess the key take-home point is that as a public hospital, we were involved in the training of over 3,000 residents and fellows at any given time and we were, in fact, an early adopter of electronic health records starting out in the 1950s. And actually subsequent to my leaving, there has been a continuity of activity so that in New York, I think the public hospitals have become a leader in the patient safety movement overall in the City of New York.

I just want to go back to some points that Dr. Whitcomb and Dr. Nasca talked about. The core tenets of medical education really is a professionalism model. As a professionalism model, it's highly reliant on individual

accountability for performance, largely hospital-based, as Dr. Whitcomb pointed out, and acute illness-oriented, very specialty-centric, limited emphasis on coordination and population health, and there's little emphasis on team and system level accountability even though it's one of the six competencies that the ACGME has been espousing for about six or seven years now.

And largely, I think one of the things that that has driven, while we are mired in this system, is that the health care system still functions in the paper world, and in the paper world -- anyone who's been in and operated in that, you just simply didn't know what you didn't know. And so we were sort of, if you really thought about high-performance and trying to get to the next level, it was just virtually impossible to actually gauge the level that you were at and also to get real-time data to improve your overall performance.

There are plenty of new tools, and I think that one of the things that we've discovered at Kaiser Permanente and certainly in the Health and Hospitals Corporation is the digital revolution in health care, converting to a digital format, and not just a digital format by replicating the

paper record but embedding in them population care management tools, care registries, a lot of emphasis on looking at outcome-based measures that you can deliver on a more real-time basis and perhaps even pay-for-performance or outcomes.

Actually the point here is that with that kind of information, you can start to pay for not just adoption of IT, but you can actually start to pay for outcomes, not just processes but outcomes.

And in the inpatient setting, in the last few years, I know that Don Berwick has probably been here to talk to you about the patient safety initiatives and the need for much more team-based accountability. But the public reporting of patient safety, the light that has been shined on some of the errors in health care, have really spurred a whole generation of new effort in trying to address some of the problems that were very easily hidden, quite frankly, in the old days, especially in the paper world.

Again, I applaud MedPAC for looking at payment reform, looking at episodes of care payments, trying to move the system away from the financial incentives that supported

an old system and maybe even moving more towards another. I know that capitation is not a good word for most people because of the sour taste of the 1990s, but at Kaiser Permanente, we really have thrived on capitation. In fact, one of the drivers in New York when I was there as President of the Health and Hospitals Corporation, was a drive to capitate a good deal of the patients that we saw.

So I think you don't have to capitate everyone, but if there's a significant portion of your patients where the financial incentives are really driven towards keeping people as healthy as possible, then there's enough of an incentive to drive the system to pause for a minute and think that maybe doing the best thing for your patients is not as financially deleterious to you as it actually can be.

So in trying to address training gaps, I think that there are key components. Paper to electronic health records, decision support tools, and a whole host of other things expose huge gaps in a system of care, and I'll give you some quick examples.

Also, the drive towards having much more vibrant quality performance measures that are transparent, publicly reported, also highlight gaps in care, and not only gaps but

huge variations in performance of care.

New physicians at Kaiser Permanente that come on board, I think we require a good deal of onboarding and retraining and refocusing on the overall orientation, and that is sort of an indictment of the kinds of activities that are actually going on in training programs, because they're not -- even though we want them to be systems oriented and quality oriented and performance improvement oriented, they're not. They're not coming out that way.

So I actually think very strongly that it's a chicken-and-egg question. Do you reform medical education to produce drivers for systems change, or do you actually try to change systems to pull physicians, to pull the training programs to a point where you're requiring them to train people to function in a high-performance system?

So it's a sort of an interesting dynamic on this push-pull continuum, and I actually almost always fall on the side of needing to pull, not that ACGME and the ROCs and the training programs don't have an active responsibility, but they are never going to be able to produce those kind of individuals unless those residents actually function in high-performing systems where they actually have a -- they

taste the flavor of what can be done and they actually face the gaps in care that the system has in front of them and figure out ways to try to address those gaps.

So it's not just knowledge acquisition, but it's about what do you do with the information that's in front of you, and what do you do particularly with the information that says the system isn't performing a high enough level that we want residents to begin to think about. And if we're successful at that, that the cadre of new doctors coming out will help propel the overall health care system to a much higher performance level.

And the last point here is I guess the light that's been shined on, or shone on -- I guess is probably a better grammatical way of saying it--is on the health systems and how the gaps in the health system's performance really point out the plight of primary care. I'm a primary care internist by training and one of the things that we're finding at Kaiser is that once you have the electronic record and the information flows and all of the gaps in care that are just so glaringly apparent when you start to feed information from good population care registries, decision support tool-types of things, you begin to flow that

information to a poor primary care doctor who can't possibly deal with it in any systematic way.

I read a report that said it just--and it may be an exaggeration, but for a primary care doctor to address all of the screening, do the health preventive maintenance types of activities, would require ten hours of their day. And to address all of the chronic disease issues would probably require another six hours of their day, in order to get us to a high-performing level. Physically impossible in a system where most primary care doctors see their patients four visits a year, 15 minutes, an hour a year to do that. And that shines a light on what health systems need to do in order to get to that higher level of performance that we are all trying to drive to.

I want to give you just some examples of population care management. We actually have built a number of registries that allow you to drill down to the facility level, physician level, group level, and it actually identifies care gaps, protocol, evidence-based-driven gaps in care for each of the patients. We have built registries. There are eight current registries in Southern California. That gives you -- and by the way, they're interrelated with

the population care tools so that you can actually drill down to an individual doctor's panels. You can drill down to the panel of the patients that are coming in on a regular basis to any setting, primary care or specialty setting.

And, of course, these kinds of tools absolutely point out the gaps in care. And in an organization that has prided itself on preventive medicine, when you actually look at it, there were huge gaps. When I first got to Kaiser, I know that in Southern California we were looking at control rates for patients with hypertension on the order of 50 percent. And actually, that was probably better than a lot of other experience, but clearly not adequate when you think about the potential roll-out of the disease burden with not treating that. It's a very simple disease.

So one of the things that the information systems and these tools have allowed us to do is to really target different strategies that are not necessarily on the backs of the doctors. It allows you to reconfigure the practice environment to look at the best ways to get at closing those care gaps from in reach, which is just really giving people the information so that when a patient actually shows up in any setting that they are systematically--their gaps are

systematically addressed in one form or another.

We have a lot of outreach capability, you know, the telephone reminders and mail reminders. And now actually with our electronic web-based interconnectivity with the patients, e-mail exchanges. Who knows, text messaging and social networking, Facebook, all of those things could probably be in the armamentaria.

But the most important thing is that we really have tools that allow people to track. And when you have those tools, then it's just so glaring to the health system, not just the individual doctor, but it's a responsibility to try to address those gaps in care.

And so we've begun to redesign the practice. And this is -- I don't want to go into this slide, but one of the big initiatives that we are trying to do in Southern California is something we call the proactive office encounter. And basically, it's using the data that's available in the population care management tools to bring to bear sort of lists of things to do for every single part of the health care team, from the back-office ancillary staff to the medical assistants to the nurses to the doctors. There's a much more joint accountability to

address important gaps in care for the patients that we have.

Now, we are just at the beginning of this. There are probably many, many other ideas that we could integrate in, especially as new tools come on line, much more vibrant Internet capabilities with patients. But that is the system that we want. That's a system I think that the country wants to get to in order to drive for better outcomes for our patients.

And this is just an example of a checklist that a clerk actually can work on. You know, you have a list of people who are coming in to see an ophthalmologist -- actually, the one thing about -- I should go back and talk about proactive office encounter. It's not putting the burden just on the primary care doctor, because actually when we looked at our patients with the largest number of care gaps, 60 percent of them, even in our system which is very primary care-oriented, 60 percent of our patients actually came to access Kaiser Permanente through one of the specialty clinics and only there. So if you don't take those opportunities to address the gaps in care, you're not going to get to where you want to be at this point.

So now, ophthalmologists, orthopedists, all of the specialty clinics are actively engaged as one of their activities to take a proactive approach to addressing all of the care gaps, whether they are there for that problem or not.

I put this up because in the inpatient side, we are a little slow. We have been -- I hate to say this, but one of the things that we were try to grapple with in the Bell Commission was the see one, do one, teach one mentality, and it's better than see one, d one, teach one. I don't want you to think that we haven't progressed. But the truth is that learning on somebody who's live at a given time without that sort of experience that -- we're relying on having experts and other people with a lot of expertise. And, of course, we don't even know that all of the experts are always expert, right?

So I think that one of the things that we are trying to do, and they know that Health and Hospitals has moved down this path as well, is to do a lot more simulation of really critical activities that go on in a hospital. We just invested millions of dollars in Sim men and Sim baby and Sim whatever, but the idea is that you really need to

bring teams together to actually practice on these kinds of situations so that when the real-life situation happens, you can pretty much be sure that there's a reasonable competency level.

I remember every year or every couple of years, I needed to do ACLS. But I did it and then all of a sudden, you think that that one couple of day training would translate into, you know, I could run a code, I could do all of this, and the truth of the matter is you can't do it all of the time. You need to continually refresh your activities. And the other thing is you are always working with different people. When you call a code, you don't know who the anesthesiologist is, so it's really important sometimes to begin to develop these kinds of tools to allow people to systematically go about doing things the way it actually should be to get to the optimum outcomes.

And then I just talked a little bit about our web portals. And to tell you the truth, I'm in my 50s and I can't get my hands around or my mind around all of the social networking, Web 2.0 type of things, but I am so happy that there are a lot of people who are out there who know all this stuff and actually help us.

Just a couple of quick slides just to show that this kind of a systematic approach can actually yield marked improvements in overall care. And then this is just our way of trying to put a number on it that actually may make a personal connection.

So just to quickly summarize, what can we do in graduate medical education? Well, one way is to really look at much more team-based approaches, maybe even including families. We are actually experimenting with bringing family members in to rounding on the inpatient setting. Integration of patient safety and performance improvement in training. Computerized simulation, I talked a little bit about.

But more importantly, I think the last point, we probably need in graduate medical education programs to move the training to settings where--that are clearly devoted to high-performance, and not just high-performance on the inpatient side, but really high performance for the longitudinal experiences that most doctors will actually be practicing in. And I actually think that those models of care -- you talked about that in your June report with the medical homes concept -- need to have sophisticated IT

infrastructure care management tools, because without them you will just never know what you don't know.

So I think that we need to move towards a new professionalism. I'm never one to say that medical care shouldn't be based on supporting the doctor-patient or patient-provider relationship. Accountability is what's best for our patients, you know, emphasizing that aspect of accountability. Commitment to lifelong learning, I think is very important, but you have to have the proper tools to allow the professionals to continue down that path of lifelong learning. Commitment to the best quality outcomes for patients using available and yet-to-be-developed support tools. Commitment to coordination of care. Teamwork and leadership skills. I think you've heard that the ACGME have emphasized this, but what are the practical things that we need to put in place that demonstrate teamwork and leadership skills? And it's going to be a much more combination of individual team and system accountability that will get us to the high-performing health system that we want.

And I would say that for MedPAC, the three things that I would emphasize is we have got to continue to set

high expectations for transparent and measurable performance outcomes for the health care system to really drive for high-performance. I think we have to do whatever it takes to encourage adoption of key tools, and namely decision support, panel management, those kinds of instruments, not just health IT, because the health IT umbrella embodies so much at this point.

I know that the Commission has talked a little bit about GME funding and I actually think that maybe we should be thinking about setting a timetable for tying continued GME support to having these tools, because I think the tools are so important as an infrastructure for driving performance.

And then, really, I think that it's important to have training programs in environments where a commitment to high-performance on both the inpatient and outpatient side is absolutely paramount.

And then I think that's about it.

MR. HACKBARTH: Great. Three terrific presentations, and I'm sure there are lots of Commissioner questions and comments. We have about 50 minutes, 17 commissioners. That's three minutes each. We've got three

potential respondents to every question. So choose your single best question.

DR. DEAN: Thank you all. That was very helpful. One of the areas that you didn't address that I am concerned about, I am a family doc in a rural area in South Dakota, very isolated area, and certainly our concern about recruiting physicians has always been a problem and continues to be a problem.

I have a long list of questions, but the first one has to do, you didn't really address at all the impact of who actually gets into medical school in the first place. All of the information that I've seen is that we not only need to have effective graduate training programs, but we need to get people into the programs that are most needed in the system that we envision if we're going to be able to staff things like the medical home. We just have to have more primary care physicians and we're clearly not getting those people. The evidence that I've seen, anyway, is that a lot of that choice, or at least the preferences, is determined fairly early on.

So I wonder -- and it's a problem. It's especially a problem for areas like I'm in because we need

to get -- if we're going to get people to go back to rural areas, for instance, as an example -- there are a lot of other examples -- you almost have to recruit people who grew up there in the first place, and there are many barriers that they face in terms of either it's elementary and high school preparation or it's the intimidation of things like the MCAT or a variety of things.

But on the other hand, even in spite of those barriers, it seems to me that unless we address those and figure out some way to deal with those, we're never going to be able to really get the workforce that we need to serve these new models that we're talking about. I'd appreciate your thoughts.

DR. NASCA: I agree with you in many ways. I was the dean of the medical school that has probably the longest experience in a formal program to bring rural medical students into the system who are interested in family medicine. That's the Jefferson experience in Pennsylvania, and it's been published a number of times, Howard Rabinowitz's program.

One of the interesting aspects of this choice about family medicine is that it's one of the most durable

sort of pre-morbid choices. If you look at students who come to medical school and you ask them what specialty they're interested in, more than half of them don't have an answer. But of the ones that do have an answer, family medicine, more than 50 percent of them actually go on to family medicine careers.

And specifically going back to rural areas, if they grew up in a rural area they are highly likely to go back to that environment if they're both interested in family medicine and from that environment.

The challenges, I think, are myriad though. First is our society doesn't reward medical schools for training family physicians, by and large. So if you look at the ranking systems, they would be penalized for taking students that have less than stellar MCATs, for instance, or undergraduate GPAs, and many of them do because of the reasons that you outlined. So it takes a will and so there needs to be an incentive.

Now, in certain States it's a high priority, and South Dakota is of those and I'm sure they have a rural program for that. I think we need to send a clear message that primary care physicians are valued in the United States

and right now they're not.

DR. DEAN: I guess the question is what can we do, what are the mechanisms to respond to that, other than increasing the value, which is something that obviously MedPAC has to address and has already to some degree in the June report. But we haven't gone nearly far enough. What do we do to bring about those changes?

DR. NASCA: I think it's probably above my pay grade. I don't have the answer. Anybody else?

DR. SCANLON: Dr. Chu's presentation raised for me again an issue that I have, which is what for the 21st century is the role of the physician. And that role, I feel -- and this is as a non-clinician but sort of an observer of what has been happening -- that the expansion of knowledge and the ability of the human brain to sort of manage that knowledge is so sort of discrepant these days that the introduction of information technology is critical. But also, it creates sort of an entirely different set of possibilities.

The question of how do -- if you were thinking about sort of an optimal system for the future, how does the mix of personnel sort of change, and what is the role of the

physician versus other clinicians? What's the role of the individual, because some of that -- you mentioned sort of the overwhelming amount of responsibility or tasks that a primary care physician might face in terms of prevention. But how much of that responsibility can actually be shifted to the individual sort of through technology, reminders, et cetera, because physicians can't make everyone compliant for everything.

And so this also, I guess, comes back to something that Dr. Whitcomb raised, which is that we are talking today about residency programs. But I think it also raises questions about undergraduate medical education. What do we want people to be trained as undergraduates and then sort of in their residency programs in this new world where we may be having people function very, very differently?

My feeling in all of this is motivated in part because MedPAC is concerned about how much we spend, and if you look at the numbers that Craig put up in terms of the amount of time that an individual spends to become a physician, and being the economist and saying, well, what is the rate of return to all of that education, this is a precious resource and we need to think about how do we

optimally use it in a system where were worried about the amount of money that we can afford to spend.

DR. CHU: I think that there are a lot of things that we need to put around doctors to make them much more effective. I do think that there is a lot of value to the years of training that doctors go through. This whole professionalism model, the new professionalism, should emphasize some of the real individual accountability and the skills-based acquisition that medical education has.

But also, the point that I would make is that there are a lot of things around getting patients to a better health status or a better health outcome that will require other people to do this. If you just put it on the backs of the doctor, you're wasting a whole set of training around the ability to bring knowledge to bear, to analyze data, you know, because one of the other things that we have is huge observational databases now that can actually monitor what's best for individual patients. And those are the skills that you want to emphasize for physicians, not tracking down Coumadin levels or INR levels if you're putting somebody on Coumadin. You have a lot of other trained professionals that can actually do this, I think,

under the guidance of a health professional.

So it's really about prioritization, because in this world where things are streaming in and you're taking responsibility for 2,000 patients or however many, you can't possibly keep track of it all and then you don't apply the things that you really can bring to bear that add value, and that is the ability to think clearly about what's the best treatment, the kind of interpersonal interactions that can actually get patients to a better place.

DR. MILSTEIN: The Medicare program does not need better clinical outcomes. They Medicare program needs lower cost pathways to better clinical outcomes. When I reflect on the faculty that I come in contact with that are teaching in medical schools or teaching in graduate medical education programs, there's virtually no one who has any enthusiasm for that topic or who has much in the way of skill sets to demonstrate it, let alone teach it.

How can we use the Medicare payment system to responsibly light a fire under this facet of both practice-based learning and systems-based practice?

MR. HACKBARTH: That's an easy question, come on.

[Laughter.]

DR. NASCA: Well, I think one potential way has already been mentioned and that is to somehow use the graduate medical education payment system to foster the development of the information technology base of teaching hospitals, because we really can't begin to address in an effective fashion systems-based practice and practice-based learning and improvement until there is actual data available to analyze the physicians' practice.

At the ACGME, we are very--we recognize that we have limitations to what we can regulate, but we have growing concern that there are institutions in the United States who may not be providing the highest-level care to patients, yet they are training physicians. If they are training physicians in an environment where the highest level of care is not provided, they are training them to provide sub-optimal care and they're not meeting Dr. Whitcomb's expectation around training for excellence.

Until those institutions have the data systems to do what was outlined, as has been done at Kaiser, we don't know the answer to that. We are at the point, though, of going beyond requiring just Joint Commission accreditation as a surrogate for quality of care to beginning to be more

specific around those issues.

So my local legislators when I was a dean asked me what we could do to improve medical education. I said, well, you can have a Hill-Burton plan for computerization of health care because the financial barriers to many of our teaching hospitals to enter this world are absolutely huge. Most of them don't have $4 million to spend, or their proportionate amount of money to spend on information technology to garner the information to demonstrate and to move towards excellence in provision of care. I think that would be one tangible step and I can think of, because we can't teach systems-based practice and practice-based learning improvement in an environment that doesn't have the tools to provided to their faculty, never mind their residents.

DR. CROSSON: Perhaps this is another take on the same question. To go back to the same slide where you lay out the six physician competencies, and then the spiderweb diagram of how those things are theoretically scored, compared with what Dr. Chu laid out as a goal, what is the -- could you be more specific about how that particular area is currently evaluated and scored? In other words, on the

chart, you have got SBP one through six. I know that is just a theoretical diagram. But what actually is being looked at or is the plan for the next few years to look at specifically in this area?

DR. NASCA: Well, the plan is to begin to standardize the evaluation. Right now, for instance, currently, a first-year house officer in internal medicine would be evaluated in system-based practice and there would be a number of questions that the faculty would be asked, all locally generated so that the evaluation form is not standardized in any way. And then they ask. The house officer understands how to attach resources within the system to efficiently provide care to their patients, and you would grade it from one to nine. That is the internal medicine scale, usually. And that would include concepts such as effectively writes orders, effectively interacts with consultants, effectively interacts with the laboratory and x-ray.

The challenge that we face, though, is, as Dr. Whitcomb outlined, it's all designed around working on the inpatient side because that's where the reimbursement is for graduate medical education, and that's where the faculty are

reimbursed. That's what -- the sponsor that receives the reimbursement is the teaching hospital. So it's not functions effectively in the office, for instance, to bring about those kinds of things, works effectively with other members of the team, because in the office-based setting there may not be other members of the team in that hospital-based environment.

Our goal is to move to using -- because we all perform based on our evaluation -- through a standardized evaluation tool to drive the behaviors into the system. That would produce the outcomes that we want.

And as Dr. Whitcomb pointed out, the key is to make sure that the outcomes that we define reflect the needs of the future.

This will take some time to do because it's a constant negotiation because the people we are negotiating with are dealing with the burdens of the present because the residency is the provision of much of the safety net care that occurs in many of our cities. I'll just give you a statistic. It's an old statistic, but in the 1990s, 80 percent of the Medicaid patients in the State of Pennsylvania were cared for in the 20 percent of the

hospitals that are teaching hospitals. There is a huge social burden that is placed on teaching hospitals, and that's now a burden. It's not future, it's now. And they have to function within the system that exists.

And so we measure their function within the system that exists. Our goal is to try and remove some of that service requirement so that we can train people for the system that will exist in the future or should exist in the future. It's a challenge, though.

DR. CHU: I would just make a comment on the safety net's role in training because it's actually--you can get locked into thinking that because of the needs of an underserved population that the residency programs and fellowship programs are the cornerstone of that care. But I think it can be a trap, as well, because -- and that's one of the approaches that we took in New York in the New York City Health and Hospitals Corporation because we were certainly dependent on 3,000 residents and fellows coming through to provide a good deal of that care.

But until you start to take the incremental steps to sort of defining a different world where there is much more attending responsibility, as we did in the 1980s with

sort of the Bell Commission type of activity, and then providing the infrastructure for us to take a transparent look at what our performance was, you don't change. You don't begin to think about changing the structure of the residency programs that, in fact, could be not only a better experience for the residents, but a better model of care to deliver to vulnerable populations.

I think that we have to free ourselves from thinking, well, we're trapped here because residents provide so much uncompensated care and so much care to vulnerable populations, because if we don't free ourselves, then we are locking ourselves into a system where I don't think anybody, if you look at it objectively, can say that it's the best care possible for those populations.

And so I just want to think about it. I'd love the Commission to wrestle with a little bit. I know I've wrestled with it in about ten or 15 years and I have definitely come down on the side of, sure, residents have a role to play, but they don't have the dominant role to play. And even if they play, they have to play in a system that aims for better outcomes and a higher performance.

MR. GEORGE MILLER: Thank you, panel, very

informative. Along the lines of how do we build a better system for the future, in this country we have a changing demographic of population. I haven't heard you talk a lot about cultural competencies in your presentation. Could you address that, particularly with the disparities that we have in this country with vulnerable populations.

I don't know all the specific statistics, but as one example I know that Afro-American men with the same insurance, Medicare, get different type of care if they come to the hospitals or see a physician with cardiac problems. The same thing with Afro-American women with cervical cancer. How are you going to address that in the future, and what do you suggest MedPAC it do to help that change positively? Again, you mentioned how well the country--the health care system we have in the country, but our infant mortality rate in urban areas and Appalachian areas are just atrocious.

DR. CHU: We can spend days talking about this, George, as you know. But I think that one of the key points I want to make is that unless you really know how you're doing, you can compare what the outcomes are for various groups of people, you don't really even begin to think about

the solutions that are out there. So again, I want to really emphasize that it's about getting a system -- the health care delivery system up to a high-performing level with good information, good information technology.

I will say that in New York in particular, and also at Kaiser, we have a huge diversity of our population. Getting access to that information really tells you, it points to the areas of huge gaps. I mean, translation services is a good example. In New York, we actually piloted lots of different translation methodologies. Most hospitals have their translators on call and you get called. There's a language bank. But it's not adequate for a good deal of the sophisticated care, particularly with patients with chronic illnesses. So we had to -- I don't think we had the answers completely, but we developed simultaneous translation capabilities, sort of like what you see at the UN if you go to the General Council.

Those are the kind of things that systems start to push towards in order to address those gaps in care. But you have to see those gaps and it has to be -- and once you see the gaps, then it's hard to ignore them. It's hard to ignore trying to come up with solutions to doing that.

DR. NASCA: I would just add two short points. The first is that a major component of interpersonal and communication skills is cultural competency, specifically enumerated. So we are attempting to address that issue in a formal sense with the competency and outcomes project.

The second is that I would just echo the importance of having data down to the level of the individual physician practice. And the reason for that is, and I believe very strongly the following statement, I've not met a medical student or a resident who wants to provide unfair or unequal care. Most of the time, it's the subtle biases that exist that they're not even aware of. And the only way they're going to be educated to that fact is if data is provided to them for their own practice.

I've not met a malicious physician who wants to provide disparate care. Yet the statistics are absolutely clear. It is being provided. So what we have to do is provide them with their own information so that they can learn. That's what we mean by practice-based learning and improvement. That's one of the essential dimensions.

DR. STUART: I have a question for Dr. Whitcomb. I really enjoyed your presentation, and you give us some

real challenges in terms of impediments to change in the current system. Your first item was that medical education infrastructure is linked to teaching hospitals. Medicare is very much in the line. And so my question is, what recommendations would you have for MedPAC for changing the relationship between Medicare payment and teaching hospitals with respect to residency education?

DR. WHITCOMB: I think it's really hard to answer that question in a very specific way without sort of going back and thinking a little bit about this. First and foremost, you have a hospital that has a responsibility to provide care to the patients that are admitted to that hospital, and so I would say number one is that it is important as we think about the future to make sure that all hospitals, in fact, are beginning to think through and plan for the kinds of changes that need to occur within the hospital for the hospital care of the patient to provide the kind of system of care and the opportunity for physicians to practice within a system of care that would, in fact, meet what we see as future needs.

So I wouldn't sort those out one way or the other. I mean, I think that is an issue for Medicare as a major

payor for services in hospitals across the board to be thinking through what can be done to motivate these kind of changes that need to be made, and that is an incredible challenge because going from the current system to some future what we might even say at the present time idealized approach to care is extraordinarily difficult.

I would say that with respect to the question of the residency programs that then occur within these institutions, I think that the payment for residency programs ought to be -- at least require the programs to meet a standard that represents quality education for the future in terms of the understanding of the residents about the -- or I should say, the understanding of the program about the specific responsibilities that that resident is going to have when they complete their program, and that there are in place approaches not only to monitor whether the training program is meeting those requirements, but also to monitor the performance of the resident after entering practice and to get feedback to make sure that there has been adequate preparation. That is another major challenge.

But I think we've got to begin looking at accountability against measures that are meaningful. I

would just comment about some of the focus of the questions that have been made, is this. I think identifying the system of care and performance within the system of care at all levels is critically important for the future. But as we think about that, it is equally important to understand that within that system, you want to make sure that the internist who is being trained actually knows how to take care of a patient with hypertension.

In other words you can I get so overwhelmed by systems of care and performance using the kind of measures that are currently available without understanding that doctor needs to know how to provide care, because it is the doctor that makes decisions that influence the kind of care that patient is going to get. And I think we've got to keep our eye on that as we go through this.

And I would just make one other comment with respect to some of the issues that have been raised. I do think that there is a fundamental rethinking of undergraduate medical education that needs to occur as a part of this. We continue to have the kind of undergraduate -- approach to the undergraduate education of physicians that existed when I was a medical student, when Tom was a

medical student, when we were all students, which basically was based on a tradition and a tradition of a design that represented the fact that when I got out of medical school in 1965, I got a license to practice medicine about three weeks later with no requirement. Now, I could not have got hospital privileges anywhere, but I could have gone out and practiced medicine. And we continue to sort of think that we are somehow preparing medical students for the practice of medicine. We know are not doing that, but we have to go back and think through some of the questions you have asked.

I've written about this in some of the editorials that I wrote, that I think that almost the theme for the undergraduate experience should really be what does it mean to be a physician in the 21st century? It's framing the question a little bit different than the way you ask them, but what does it mean? And I would say that one of the things which it should mean is that medical students coming out should have an understanding about system performance and should become forces for change as they begin to enter a residency program and began to work towards then their ability to provide care.

But that also is important with regard to cultural

competence. It's important that medical schools learn far more than they currently learn about the nature of our health care system, about the way that care is financed so they can begin to become not only change agents, but there's a reality that it impacts on the ability to provide care.

And the example I like to use in the system as it exists at the present time is this: It doesn't do any good for a resident to sit down on the discharge of a patient and write prescriptions for the patient that's he's going to need for follow-up if the patient leaves the hospital and can't afford to fill the prescriptions. And that happens over and over and over, and because the residents really don't understand what it is going to require for the individual to be able to do that.

So let me just stop there. I think that there are very complex issues that need much more. But I would say that with regard to the core of your question with regard to Medicare payment, I think it's accountability and what are the standards that are going to be applied for accountability as it relates to the education of residents.

MR. HACKBARTH: I want to follow-up on Bruce's question. I think I heard each of you say that Medicare

payment, Medicare's role in financing medical education creates an opportunity to use it as a lever for change. Dr. Chu and Dr. Whitcomb both talked about how training is focused on hospitals and it would probably be a good thing if there was more outpatient training. And Medicare plays a role in reinforcing that pattern, so we could change the rules there. Dr. Chu and Dr. Nasca talked about the importance of infrastructure and somebody mentioned you could make Medicare payment contingent on the institution having 21st century infrastructure in place.

I just want to check whether I'm hearing you correctly, and I don't want to misrepresent your views. Could you just react to that? Could you imagine Medicare being used as a lever in those two specific areas, moving more training to the outpatient and having training done in institutions with 21st century infrastructure?

DR. CHU: I guess it's a good thing I'm out of New York right now so I can actually say these things. I actually think that's true. I think Medicare can play that role. There is a continual argument over the funding of GME. Well, it at least ties some of the GME funding to having core infrastructure and putting our residents in

settings that actually we want them to be, the settings that are 21st century settings are driven towards high-performance, you know, whether it is -- I don't know if you want to split -- whatever the mechanism is.

I know the ACGME requires that most residents now spend a good deal of their time in the outpatient setting, but there's no form to it really. There's a menu of things like ER, block time in the ambulatory care. It doesn't specify what they do in that ambulatory care setting. It does specify in general terms.

But I think in this day and age where we can actually monitor these outcomes a lot more, and we're doing that in the system, we should probably think about a progression, maybe not tomorrow, maybe not two years from now, but sort of a time line over the next five years or ten years to get to a system that we think is really going to be vibrant enough to take care of our population. And that does include having that infrastructure in place, but also the infrastructure to utilize that information to drive for higher performance.

And so the part and parcel of that, of course, is continuing to refine the measures of outcomes that we want

for the Medicare program, but for the country as a whole.

DR. REISCHAUER: Can I just put a footnote on Glenn's question? Can you consider your answers in light of redistributing the existing amount of money as opposed to would it be good to cover these additional things and add money to it?

DR. NASCA: I'm a probably about to get in trouble here.

[Laughter.]

MR. HACKBARTH: That's our goal.

[Laughter.]

DR. NASCA: Thank you very much. You know, certainly from my fiscal prudent standpoint, Medicare is providing a significant amount of money into the medical education system. In case no one has ever said anything to you along those regards, thank you.

[Laughter.]

DR. NASCA: Because it is these dollars that make it possible for us to make changes. You see the major leverage that the ACGME has is that CMS recognizes that accreditation as a stamp that allows institutions to receive Medicare reimbursement. And so the ACGME standards actually

have the power to drive largely based on that linkage, as does the osteopathic accreditation process, so it's not just us.

I think you need to examine exactly how this gets operationalized, though, and understand that many of the payment mechanisms that are sort of downstream impact from a policy standpoint on how payment is made based on location of clinical experience. It needs to be well understood by this group, because many of the limitations and innovation in environment of training are driven by the absence of funding for that, because it's not institutionally sponsored locations.

And that is a -- I tried to elude to that in that slide that I put up about how one would design a program now. It's largely based on the environments that currently or would be able to be receive Medicare funding. And so the entire portfolio of educational opportunities, including many creative ambulatory sites, are usually off the table for most programs because they can't fund it.

And so not only are we grateful for your funding, but we ask that you recognize the limitations of the methodology that is used to distribute those funds on the

options for creativity in educational program design.

DR. CHU: I think there are blunt ways to redistribute money and there are gentler ways, and I have always been a much more gentler way approach because, you know, I know that you all operate in a very political environment and you have to get the Congress to approve. But I would say that some of the things that MedPAC has been doing, tying market basket increases to certain infrastructure improvements, could be used as a mechanism to drive the system to change in a gentler way, especially if you telegraph that a couple of years in advance. You say, well, this is where we're going. The health system has to get to this point. We really want the training programs to train people for the 21st century. So that would be my recommendation if you're going to consider doing that.

DR. WHITCOMB: I would agree with both. I mean, I think that the funding of graduate medical education and the opportunity to make changes that you might see desirable is linked in a way that one has to be very, very cautious, realizing most teaching hospitals, the reality is that the majority of the direct graduate medical education payment, if you look at it in total, is not Medicare funding. And so

it's not as though this is simply the only source of funding.

And what I always like to remind people or sort of suggest to people, I think it is valuable to think about Medicare funding in many cases as the equivalent almost of a matching program. If the institution is not willing to put up their fair share first, you don't get the Medicare funding. And so there has got to be an institutional commitment to maintain funding under the circumstances that they could do that.

And so you don't want to drive a system in which you say, we will give you one-third of your funding or 20 percent or whatever it might be and have the institutions say, we can't afford to do that. We're not going to fund anything. So it has to be done with great care, and I think that the objective performance measures that one wants to use to have accountability in the system need also to be developed in a way that reflects a very real understanding not only of the performance within the system, but as I keep saying, of the individual physician's ability to provide competent high-quality medical care and what those outcome measures ought to be for that purpose.

DR. CHERNEW: Thank you all for your presentations, and I was impressed with the presentation emphasis on measurement and the continued emphasis on measurement in the discourse. My simple question is, outside of medical education, we have a lot of pay-for-performance-type things where there are metrics and payment can vary based on how people perform as opposed to a sort of minimum threshold and then everyone gets the same amount of money if you fill out these check-boxes.

And so my question for you is how you thought a sort of a more nuanced payment system might work where there would be standards that might, for example, force institutions or encourage institutions who might be receiving the payment to, say, contract out to another organization that's not getting the money to meet some performance standards if those performance standards were designed to meet the needs of Medicare or the system more broadly, recognizing the clinical importance in measurement as well.

DR. WHITCOMB: Let me just make a quick comment and then let Tom sort of pick up the specifics, but just to emphasize again what I've alluded to in the past. I think

if you're talking about changing the performance of the institution as an institution, that the Medicare payment that contributes to residency education is not the source of funds to use for that purpose. That was my -- so I am not sure if I understand exactly what you meant by it, but I just want to make that point.

DR. CHERNEW: I was referring to the performance in terms of the educational outcomes. So does the person -- you all had performance measures on your slides, but the payment isn't tied to institutions doing a better or worse job on any of those metrics or other metrics that might be more the spirit of what Arnie was talking about.

DR. WHITCOMB: I'll say what I said before.

I think there should be accountability. I think that there needs to be carefully thought through performance measures. I would tell you that I think that we already have within the system circumstances where one would raise very serious questions about the quality of the educational experience that is being funded through Medicare. There are programs where a significant percentage of the graduates, for instance, do not pass certification boards. So you might say, yes, certification is not required. But if

that's sort of a national audit of performance and you've got 60 or 70 percent of your residents not passing those examinations, shouldn't that raise one question about quality of the program?

So I think you can begin to think about linking payment for education to educational outcome based upon performance measures that are legitimate performance measures and that are crude in some sense, but nonetheless applicable measures.

DR. NASCA: I would agree. Right now, the only validated measure that we have would be in medical knowledge, and that would be the board certification rate. For instance, many of the residency review committees use not only the pass rate but the take rate as a criteria for accreditation. And so we use that already. Most of that information is public, although some boards do not make that information public.

One of the challenges that you face is that in many programs, the N in each is small, and so the statistical variability is really great. And so you need to -- you may need to be less granular than the individual program but have some sort of roll-up statistic at an

institutional level. For instance, about a third of our programs are single-program institutions that have just a family medicine residency, for instance. There might only be three or four trainees per year graduating from that program. Having a statistically valid measure that you could base the determination of sliding scale payment on would be a challenge, but something that could be overcome if we had multiple measures. Once we get having reliable six competency measures, we may be able to get there. We are probably years away from it, though.

MR. HACKBARTH: Okay. It's almost noon.

DR. NASCA: May I just add one more point, though? What you could begin the process with is some sort of distribution of funds tied to successful measurement of outcomes as the first step, introducing the incentive to do it or the disincentive not to do it on top of the ACGME accreditation process, which would accelerate the process of implementation.

MR. HACKBARTH: Could I prevail on you folks for another 15 minutes? I know we were scheduled to end at noon. I would like to give all of the Commissioners an opportunity, if they want one, and we've got seven

Commissioners left. Nancy?

DR. KANE: Thank you. I enjoyed your presentations. I had a question. It seems that education, medical education -- we're sort of specializing most of our time in the delivery system and it seems to me that the medical education world, which is actually -- I'm in the education field myself -- is a completely other set of worlds and issues and measurement issues and competencies than the delivery system. It also seems from what you've said that the people making policy and medical education world and the content decisions and outcome measurement decisions, there's multiple bodies doing that and they don't seem to have a common vision or a common even understanding of what they think the future is going to be.

And I'm wondering in this new world where government is now actually valuable again whether there might be an argument, and what are your thoughts, I guess, on an argument whether there shouldn't be some type of maybe government-based or national body whose concern is simply how we educate physicians and what the future skills and competencies are and then how the payment system should then diffuse those through not just Medicare, but other payers

might also be interested.

Is this going to be doable with this sort of fragmented voluntary sets of bodies being involved in medical education? Or should there be some authoritative Federal or quasi-public agency that works with all the different parties to bring together a consensus on where the education should be going, not just for physicians, but from what I've heard you say and from what Dr. Chu said, for all the nurses and allied health people who need to also be part of this team? If all these different people are doing different things and we are not all sharing that vision, isn't it going to end up being mush, the way it is now?

DR. NASCA: I need to preface this by saying I'm from Philadelphia and Ben Franklin is turning over in his grave as we speak. The concept of not-for-profit entities doing the public good is indeed what this is.

That said, I think that there is a tremendous need for someone to say 20 years from now, this is what the health care delivery system is going to look like, because all you have to do is tell us that and we can design systems to produce those people.

The challenge has been, if you've sat in the

medical education world for any period of time, we've been whipsawed around at least two or three different kinds of delivery systems. The early 1990s was--and you saw it in medical student interest -- there was a huge peak in primary care. Now you have an entire generation of people who are cynical because of the failed promises of the early 1990s. You can watch the medical education system sort of swing back and forth based on where public policy appears to be going, but it's never consistent. So if you could tell us -- I don't think you need to tell us how to educate. All you have to do is tell us what you need. It would be very helpful, and we'll figure out to get there because we are pretty good at that.

And I would just point out to the scientific advances that have taken place over the last 30 years at our medical schools and our teaching hospitals. When someone declares war on cancer, we go to war on cancer. When someone declares it's time to address neurosciences, we are addressing neurosciences. I think the public just needs to give us a clue as to what the health system is going to look like and we can help you get there without forming a government agency to tell us how to do it.

DR. WHITCOMB: If you go back and look in the history of medical education in this country, you will find reference to a number of what were referred to as citizens' commissions in which prestigious people who were thought leaders within society were brought together, sometimes by foundations, sometimes by professional organizations, but fundamentally asked to do what Tom has said, which is as you look at this from outside the profession, what is it that you think would be in the best interest of the public? And you free yourself, therefore, from the constraints that all of us operate under when we are working within organizations within the profession.

And so I have advocated for the need for some sort of body that can at least monitor and make comment on how we are going about our approach, on the one hand, the issues that relate to how the system is developed so that it meets performance standards, but also how the educational system changes in order to begin to prepare doctors to be able to function in a better way not only within the system they're going to find when they going into practice, but hopefully so that they become advocates for change.

I think there is that historical precedent that is

worth going through. What happened as medical education moved forward is that as we got into the 1960s and 1970s, is that the profession itself began to develop its own regulatory bodies and that sort of changed the nature of the discussion and the way that many of these decisions were made so that they were made within the profession.

And while that did serve a very important purpose, and I think performed very well, the fragmentation of the profession has made that process more and more and more cumbersome and difficult to achieve any consensus around even very fundamental issues that we really need to be taking more seriously.

MR. BERTKO: Thank you for your presentations. I have what I hope is a forward-looking question, and Dr. Chu, I'm going to aim it to you because you've done it somewhat inside Kaiser already, that is to say, generously assuming that we have some changes in payment incentives, whether it is bundling or medical home payments or accountable care organizations. You mentioned the word onboarding, which I will translate into additional training perhaps. Given that you've got a unique institution in Kaiser Permanente, how could you do this training? And what would you suggest for

the rest of the country, particularly the middle of the country where there are only small practices? And then that's for new doctors, but more importantly, or as importantly, what kind of continuing medical education would you have for the current cohort of physicians?

DR. CHU: Well, I actually appreciate that question because it's actually is something that I've been grappling with for quite some time. I think that no matter what the setting, we should never think that one setting is incapable of performing at a high level.

I think the key is actually perhaps not a Federal bailout of the education system per se but really setting, as Mike said, very clear expectations of what we think high performance should be, right. And I do think that there's a lot of activity out there that actually can address that.

Because we get this all of the time, and Jay is from Kaiser. You're Kaiser. You have all this money. The truth of the matter is there are a lot of different tools that are out there. We are now actually in the beginning stages of partnering with the Institute for Health Care Improvement, IHI, around -- you know, they have done this Patient Safety Academy. But now they're trying to

establish, which we're helping them fund the establishment of a school for health professionals, which really is targeted at developing skill sets for health professionals from all over, not just doctors, but nurses and other health professionals, on patient safety types of issues and really to give them practical online, virtual -- this is sort of a virtual school that they're going to try to be developing.

And I think actually that we should be thinking about that those kinds of tools that we now have available to us, that -- you know, again, it's hard to get your mind around it, but in the next decade or so, we're going to have tremendous interactive capabilities on a virtual basis so that that rural doctor may actually be able to be linked to certain things, certain systems, and be part of a larger system to try to drive performance.

But the key is setting that expectation for high performance, I think, because I agree with the other panelists that people don't go into health care to do a bad job. Nobody wants to do a bad job. It's just that we would create a system that makes it so hard to do a good job, and maybe that's where we need to concentrate on.

And sure, financial incentives are important, you

know, figuring out how to take the disincentives to doing a good job out of it is an important part of your work. But also thinking forward as to, well, what are the achievable outcomes that we can have for our health care system?

And I actually always am a firm believer that if you actually go after that, some of the dollars that, Arnie, you're talking about will actually fall out because--and in fact, I think there's some evidence that that's true. You get to better care and all of a sudden you can see a pathway for better value.

MS. HANSEN: Thank you very much. I also really appreciated this and would like to build on the segue of all of your comments about the 21st century and where we are right now and having a pathway of where to go. Part of it is just the pure data of the population being older, chronic disease being this soup du jour for a long, long time, and the fact that the subset segment of older people, Medicare population, growing the fastest is the 85-plus population. So I think that's kind of a factoid that is there.

Given that, one of the things I know, besides primary care and internal medicine and family medicine having challenges itself, the next subset of really on that

end point are physicians who choose to specialize in geriatrics, which a chief of medicine told me that they're the ones who cost me the most. And yet the ability to get the outcomes that you're talking about of sometimes really the not planned for iatragenesis that comes about from all the unintended plans of treatments in silos, perhaps good, but in co-morbidity is not good, on polypharmacy.

So one of the things I've been as a Commissioner bringing up on a regular basis is what value do we get, even in the interim for the Medicare spend with both IME and GME currently on the content of geriatric care, because that is body of information. The IOM has weighed in on it recently. I just wonder where the leadership is relative to that, because people say, well, we already do geriatrics. We treat older people, but I'm not sure that we're doing really geriatrics.

So where is the leadership both in the education on the undergraduate level as well as on the residency level thinking about relative to this content? And I offer an opportunity to think about one option, and that is I noticed nursing is having the same issue when they are not drawing geriatric nurse practitioners. But they have chosen in the

educational -- AACN, the American Colleges of Nursing, has chosen to push out geriatric content to all the 70 specialty groups as a requirement in the curriculum. Do you see that possibly happening at all on the educational side?

DR. NASCA: Well, I can start. In most of the disciplines that have direct patient care responsibility, there is a recognized and evolving body of knowledge around the octogenarians and beyond. And that is -- we really consider that part of the core element of those specialties. It's not the kind of thing that is mandated, say, in common program requirements because it doesn't apply to every specialty. You don't demand that pediatricians learn about geriatrics, for instance. But what we are seeing is in each specialty and subspecialty, especially in the subspecialties, for instance, in medicine and in surgery, we're starting to see the recognition of specific curricular element requirements and educational experiences around the unique aspect of the octogenarians and beyond.

This frequently doesn't make its way into the program requirements in a written form, but it's an expectation of the committee when they review the curriculum of the program. So that there is an expectation around

geriatrics that really spans all disciplines.

We've had a sort of a go-around with some of the surgical subspecialties, a group of surgeons who feel very strongly that there needs to be explicit, for instance, geriatric requirements, say in urology or in a couple of the other surgical subspecialties. We've resisted requiring that in the common program requirements, but have directed them to the individual specialty requirements. It's perfectly within their realm of authority to put in specific requirements related to that patient population.

Some disciplines already have fairly extensive -- in internal medicine, there is a required geriatric rotation for all internal medicine residents. So there are core elements in many of the disciplines, similar things in family medicine. So I think we recognize the issue. It is one that in some disciplines has been chosen to be legislated in rules and in others it is an expectation but not a written rule yet. Does that answer your question?

MS. HANSEN: It does, but I think it's not just the octogenarian but what that represents in terms of co-morbidity and polypharmacy. But an example that I think Dr. Whitcomb said is when you send somebody--writing a

prescription by itself is not enough when somebody can't afford it or they're definitely not going to adhere to it. So it's just the whole concept which goes to the process side of management, but it really affects so often now that half the beds in the hospital are really occupied by the 60 and older.

DR. NASCA: And a lot of that gets to the systems of care that that hospital has. It's far beyond the educational system. If there's no database with regard to prescription refills and the like, the trainee is not going to have that opportunity to look at the entire portfolio of medicines. That's a real challenge that we all face.

DR. WHITCOMB: I would just comment, I think this is one of the issues that also needs to fall into my sort of general approach of what does it mean to be a physician in the 21st century and the undergraduate education. And I think that where this applies is that we need to do a much better job in educating medical students about the reality of specific population needs, and the geriatric, over-85 or however you want to characterize it, is one, but there are others. So that no matter what specialty a physician goes into, and there may be applicable aspects of orthopedics

that would apply, but as Ben pointed out, an awful lot of patients end up in the care of a specialist and have problems that don't get recognized because the specialist, it's not in their domain and they haven't been taught to recognize this.

And I would say we deal with this at both ends of the age spectrum in critically important ways. One is the elderly. The other is the adolescent age group. We still spend most of the time in medical school with our students on pediatric services doing what they did when I was a student. The major challenges of pediatrics are adolescent care, and these are kids that walk in and they've got a problem and somebody needs to look at them for why ever they come to the doctor and say, maybe there's something else going on here and what is it? But if you haven't been prepared with that as sort of a fundamental part of your knowledge, you don't think that way.

And so I think this whole focus on population health which is beginning to work its way to the medical school curriculum is critically, critically important, and it obviously implies then across ethnicity and race and other activities in the way you create the populations to

focus on special needs.

DR. CHU: I think the only thing I would like to add is that we went through a period in the 1980s and 1990s where we really wanted to -- we saw the demographic imperative coming on and we really put a lot of effort into trying to train geriatricians, specific groups of people that deal with the elderly. And quite frankly, the more I thought about it, it's never going to work that way.

And I think it's absolutely important to have a broader general understanding across all health professionals about the issues of this, the particular issues of the elderly. But really, it seems to me that, and please don't think that I'm a wonkie or anything like that, because I'm really not. I think it's very important to have individual relationships with patients.

But if you're seriously thinking about getting better outcomes, functional outcomes for our elderly, in some ways it has to be a combination of training of health professions and a systemwide accountability. And that's why having these tools in place that keep reminding people and pointing out, well, this person looks like they're falling through the crack here, let's pull it together because who

can take 15 medications at the same time? So you need to reconcile these things.

Those kinds of systems-level tools will force, I think, force a high-performing health system to deal with some of these issues in ways that are much, much more sound and reliable than thinking that if we just train the geriatrician and assigned these patients to the geriatrician, that it's going to happen.

MS. BEHROOZI: Thanks very much. At the risk of being provocative, I just want to save a little time. I'll jump right to the question about what attention is being paid to the cost of medical education itself, and not only for the Medicare program, which MedPAC has been paying some attention to in terms of the relationship of IME to the actual costs, but for the graduating students themselves, for a doctor starting in practice with a mountain of debt that prevents them from making some of the choices about where they practice geographically or in what specialty they practice. And in terms of looking toward the future, what is the medical education community doing to make it possible for people to practice where we need them to practice?

DR. WHITCOMB: This is one of my favorite topics,

and let me give you my equally provocative view. The reality is that I think we have a very, very, very challenging situation in this country related to the cost of education. This past year, about 70 percent of the entering medical students came from families in the top quintile of family earners. This reflects what's happening in undergraduate education and university-based education in general.

But I personally think that this is a tragic set of circumstances for the profession of medicine because all of us are informed by our own life experiences. And if, in fact, what we're doing is simply making the profession increasingly elitist, it won't be surprising where we will go with this. The Association of American Medical Colleges put together a group that actually made the observation that it won't be too long in the future, and we're sort of on the cusp, where nobody will be able to go to medical school unless they come from a wealthy family.

What can you do to decrease the cost? This has been studied, a recent study done by the Wharton School at Penn, and made an observation, which is the most effective and immediate way to decrease the cost of medical education

for the entire spectrum is to decrease the length of the undergraduate medical education program. Take one year off of the four years. It saves one year of tuition, which is incredibly high. It also saves the living expenses for the year. And it also adds, then, the opportunity of the earning potential for that individual as they go through their career. But most immediate is the reality of the savings that can occur up front.

Is it feasible to do that? The reality is that we used to have three-year medical education programs in this country. The two programs in Canada which are accredited by the accrediting body in the United States, which have the largest number of applicants and which are considered to be leaders in medical education, are three-year medical education programs.

This is a challenge. Most medical schools for years had the fourth year as an entirely elective experience, so we know we don't need it for our current purposes. And the changes that have been occurring in the nature of the undergraduate curriculum have actually freed up even more time to be able to do this.

This very recently -- the Canadian editors of the

Canadian Medical Association Journal recommended that this issue be addressed within Canada, which is to go all the schools to three-year programs. If there are students who want to stay longer for track purposes or research training or whatever, that's one thing. But there ought to be a track that says, you can come here, go three years and enter your residency program.

For about 10 years in this country, we had a series of programs in place which allowed individual medical students in internal medicine and family medicine to go three years to the medical school, going into the residency program at the same institution. The outcome of those was that at the end of the six years, as opposed to seven years, those individuals could not be distinguished from individuals that have done four plus three. Those programs were discontinued by the boards because they couldn't be generalized, but it is a data that we should look at and understand. We can educate medical students, particularly if we think more seriously about what that educational program should be, we can do that in three years.

DR. NASCA: I would just add that one of the discussions that I think we need to have in graduate medical

education is the role of research in the training of the subspecialists, because about 50 percent of the time spent training subspecialists is spent in research and we need to understand clearly what the educational outcomes that are to be derived from that experience are, because that would shorten training as well. So, for instance, in nephrology -- I'm a nephrologist - it would shorten training by a year if there were no research requirement.

So there are points in our existing continuum where we need to critically assess the utility of it in producing the workforce for the United States.

I think the second thing that I've been struck by, I just got back from Singapore. They want us to help them set up our accreditation system in Singapore and move from the British system to the United States system of medical education. They have a five-year service requirement. Included in that five years is their residency training period. But they have a requirement that there be service provided in public hospitals prior to entering practice. And their tuition is subsidized on that basis, on the basis of that commitment.

COGME recently put out a position paper calling

for the opportunity for a service requirement for graduates in medical education. I think if it were coupled with either subsidization of tuition or loan repayment subsequently, I think you would see a lot of takers and we can do a lot of social good with that manpower. So it's another thing to be considered, I think.

DR. CASTELLANOS: Well, first of all, thank you for coming, and I think the three of you have shown us that medical education is a specialty in its own and I congratulate you for the evolution of what's happening in medical education. My question to you is one of the things MedPAC is very concerned about is access to care for the beneficiary. I'm a urologist and I see a lot of workforce problems coming in. I think Tom mentioned something about primary care, Jennie said something about gerontology, but it's not just related to that. Now, you're educating these doctors, but how do we get them in the fields that society needs? Do we do it with health policy? Do we do it with IME, GME? I'd like to hear your comments.

DR. NASCA: We're all going to have our own biases on this one. I had the opportunity to work with the State of Delaware -- we were the medical school for the State of

Delaware -- in trying to bring physicians to the State of Delaware. They started off by providing scholarships and found that that was tremendously ineffective in bringing individuals back to Delaware, first of all, and then choosing primary care fields, which is what they needed at the time.

By the time the first graduates finished college, medical school, and residency and were to go back, they didn't need primary care physicians anymore. They needed specialists. They needed OB/GYN especially. And so we moved to a loan repayment kind of a program and it was much more successful in trying to motivate individuals to come back and provide service in underserved areas, and in particular with the specialty mix that they needed at the moment, and that could change, then, as time moved on.

So my pet program would be loan repayment programs, because there is so much debt burden for medical students, especially after residency training and deferment of debt for a long period of time, and the opportunity to come in and provide a needed service while also having a benefit sets up, I think, a positive reinforcing sense of responsibility to society, and I think those physicians

carry them for the rest of their lives.

DR. CHU: I'm sorry, I thought I understood your question as to how do you get people into the right mix of specialties, right, and --

DR. CASTELLANOS: We have a significant workforce a problem, perceived or real --

DR. CHU: Right.

DR. CASTELLANOS: -- and we have a society obligation for access to care, and that's really my question.

DR. CHU: Yes. Well, I mean, I'm a primary care physicians so--and I've really been grappling with the plight of primary care for the future. One of the things I know that you've been grappling with is payment reform to sort of more equalize. And, you know, of course, it's really a can of worms, you start to talk about that. You have to take it from somebody to give it to somewhere else. But a lot of the access problems, I think, really are tied to finances and quality of life.

I mean, it's not just finances, it's quality of life, because you think about being a primary care doctor now, particularly if you go to a rural area, it appears to

be an impossible job. So there is this issue of trying to figure out systems of care that can actually make it much more a realistic career for people. But there is the issue around financing, and I think the work that you've been talking about doing in terms of rebasing the cognitive versus the procedures, the procedural payments, are actually a very important thing.

Now, I think the other issue that we have to lay out here is, you know, when I applied for medical school, I looked at some of the available literature and the average doctor worked 70 hours a week. I mean, it was just one of those things. They saw 7,000 patients, or some unbelievable number, and it almost discouraged me from going into medicine. But the truth of the matter is the demographic shifts in the mix of medical students coming in and doctors coming out, it's much more gender balanced. In fact, I think it's more women now than men. And quality of life issues are very important. So I think that if we are think seriously about workforce planning and trying to figure out the right mix, we have to factor all of those in there at this point in time.

So there's a reason why dermatology is such a

popular specialty. It's quality of life, it's payment, it's a whole host of things that I think, unfortunately, it's your job to try to figure how to reconfigure the system to help us move there.

DR. WHITCOMB: I hate to come to sort of come to the close of this on a really horrible note, but I think I will do it anyway, and that is this. I was one of the founding members of the Council on Graduate Medical Education, and if you go back to that period of time in the late 1980s and the 1990s, we were absolutely certain that we were right almost with everybody else that we were headed towards a substantial physician oversupply. And the question at that time really was, are we going to have enough of those physicians doing primary care? So there was a focus on primary care. And the second question was, what are we going to do for the unemployed physicians who went to medical school and residency and couldn't get a job?

Of course, we came to the year 2000 when we had these projections of 140,000 too many doctors and everybody knows that's not the case today. People will argue that with that a different system, we could use the physician workforce more efficiently, but getting to that different

system is incredible.

And so if you simply take what seems to be the consensus at the present time, and there are still challenges to this, about the tremendous undersupply of physicians, the reality is that the issue won't be, are individuals going into the right specialty. The usual will be, there would be enough physicians in all of the specialties. There are already huge problems that you can look at in the market, the inability to keep physicians to take coverage for emergency rooms in the hospitals where they have privileges. Community health centers, which can't recruit enough primary care physicians to meet their needs, et cetera, et cetera, et cetera.

I've been working over the past couple of years with universities developing new medical schools and there has been a lot of emphasis on the development of new medical schools and expansion of medical students, but the reality is that all of that work will not lead to one more doctor in this country unless there is a tremendous increase, or let me say a proportionate increase, in PGY1, entry positions in graduate medical education. That's the determinant of outcome. And since that's not changing, we're going to have

more graduates of U.S. medical schools and residency training, but the aggregate supply won't change whatsoever and that's going to be the challenge that may come back to MedPAC at some point, when people start going, we can't get to see a physician and understand you've got to increase residencies if you going to increase the number of doctors. So it's a harbinger of a perfect storm that we are heading into, conceivably.

MR. BUTLER: Moving us along, I'll say two optimistic things. One is that at Rush, we have this course called Health Care in America, where all the students in the College of Health Sciences and College of Nursing are in the same class and the medical students will be in it next fall, and it's a foundation course that teaches them about all the basics, the foundation and the team-based learning. It's very exciting and they're very enthusiastic and they go out in the community and do programs together in an interdisciplinary way.

The second thing is that we spent, I think, a little over a quarter of a century building an industry around how to count and pay for and track your residents. It's a pretty bizarre business, the way we've lined up these

payments, and this is a great opportunity to kind of rethink that. What are we really trying to do? So I'm very much in favor of kind of saying, what is that we've done that we can improve upon? So we can do it better.

And the third is -- but part of my comment is, just shifting to ambulatory, if they're just going into the existing payment system, it doesn't do anything Arnie wants to do. They're just in widget-based systems and so we put them in a different setting. It doesn't make any difference.

I would come back to your comment, then, about the poll -- you use words like poll and capitation and things that aren't popular, yet it's at the heart of being able to line all of this up, the investment in IT, the investment in appropriate technologies, the chronic care. All of it really does require payment system reform and the educational system, frankly, will fall into place. Maybe not rapidly.

So my question for you, because Kaiser hasn't historically had a high percentage of Medicare to begin with, and they haven't had a commitment to education to begin with, and probably because it screws up the ambulatory

setting to some extent, but my question is what would it take for Kaiser to be a -- from Medicare, to be a more integrated, bigger player in education, graduate medical education, particularly where Dr. Whitcomb says is where you really learn to practice?

DR. CHU: We are actually beginning to look at those opportunities. I mean, part of it is, of course, if you have to spend all this time onboarding people coming in, you actually want to spend a little more time training them so that it's a little bit easier. So part of it is self motivated.

But also, the larger issue is, you know, if you think about where we want to go in terms of our health system, and really along a dimension of trying to push us to get to higher performance, it is sort of an obligation to train people in settings that actually try to do that, you know, try to bring all of the factors to bear. So we're actually looking at affiliations with a couple of the new medical schools that are starting out in California. You know, I come from a background where we've done a lot of training so I've sort of been pushing us to do more and more.

Right now, 600 to 700 residents and fellows in a system as large as ours is really actually relatively small. When I was associate dean at NYU, we had over 900 fellows, just to give you a comparison basis. So slowly but surely, I think were going to move down that dimension.

You know, and our Medicare members are actually capitated members, so it's really our own decision to plow some more resources in. The organization is a not-for-profit, so we actually have a board-directed and sort of a mission-directed mandate to use some of our funding for the public good. I think medical education and research are going to be a larger piece of that at this point. But you're right. It does screw up the care.

[Laughter.]

DR. BORMAN: I enjoyed the conversation very much. Just a couple of quick comments and a question.

I appreciate -- I have absolute confidence in your assertion that if we told you what to do, you could devise a system to do it, because I'm an academic surgeon, so I have absolute confidence in that. However, I think they probably have told you some of the pieces that we do want, and I think, in fact, certainly in the competencies-based movement

across medical education we have told you a little bit, and there are some things that do need to -- that could potentially start happening right now across the continuum of medical education.

I think, for example, if we really want to have residents that we can bring to another level of system-based awareness, that we have to go backwards to the foundational pieces in medical school and in pre-med requirements of an economics course, a government course. The ability to take full advantage of what Peter is talking about providing at that level requires the foundations. And there's nothing stopping that from happening right now in terms of a proposal.

So I would put that challenge out there. I know you, too, are aware of that, but just on a general basis. So it's not sort of like waiting for the big dropping. We'll tell you and then you can go do it. There are some things that can go ahead in the interim.

In thinking about coming to the Commission and having looked at the agenda materials, it certainly had occurred to me that analogous to some of our other work, we could consider a bit more aggressive posture about the

expectation or what we get for the Medicare dollars invested. And certainly I would argue there's a lot more government dollars invested, although they don't come under the purview of this Commission, in terms of NIH funding of academic science, you know, medical center-based science. There are a whole bunch of things -- there are a whole bunch of government funding to medical education that is not just in GME. The GME is on our plate.

Since the money goes through the vehicle of the teaching hospitals, it would appear to me that the requirements could, in fact, be somewhat hospital-based as opposed to necessarily all education-based, and it gives me some disquiet as an educator to say that. But that's what the money is going. So I don't see it as unreasonable to hold to some hospital-based standards like things about IT and perhaps some things we've talked about and requiring that those teaching hospitals show us their transition outcomes when they discharge somebody, or some of those kinds of things that would have merit both on the education side and the hospital site. And so I would not craft it quite so narrowly as the educational outcomes because I think we're a ways from having those necessarily.

My question to you would be, one of the problems that I see in talking to people about GME and this whole area is that we really -- I don't think you could answer the question of how much does it cost to train a resident for a year today? Because what we pay has come from a historical accretion, if you will, and been done on a regression basis out. And in terms of sitting down and prospectively saying today, what is the cost of a resident, factoring in modern education things like simulation, the time they're in ambulatory environments, dah, dah, dah, I'm not sure we've got the answer to that question, and I would say that is one thing that absolutely the medical education community could do to help us go down the road of understanding where to go. And do you have any ideas about how we could get to that information?

DR. NASCA: I actually wrote an article about that a few years ago. The challenge is that if you did it on a cost basis, it would be different from hospital to hospital. For a governmental agency to look at it from that perspective, I think is very difficult. We go back to the history, part of TEFRA, I guess, and cost-based reimbursement.

Another way to look at it is what are the minimum costs required to expend on it, using standardized salary scales and the like, in order to satisfy the ACGME accreditation requirements? Because those are what Medicare has set as the threshold for payment. Therefore, it should be reasonable that they be reimbursed for being able to satisfy those requirements.

And you can actually construct -- I've done this with a teaching hospital, constructed on a standardized basis the actual cost to satisfy the requirements that were costs that were not compensated by patient care revenue for the teaching physicians. In other words, when a faculty member is taking a resident on consultation rounds and they see consults, the resident sees the consult first, presents it to the -- and the quid pro quo is the evenness of exchange of information, and there should be no extra payment for that because you recognize that as paying for patient care in the teaching environment. The physician is paid for providing that patient care and there is an equal exchange of time.

In situations where, for instance, in the ambulatory environment, where it's clear that the cost of

educating there slows down patient care, you actually pay a portion of the salary of the physician. You can actually calculate this, program director time, infrastructure time. You can divide up the cost of simulation on an estimated basis, the cost of oversight, and you can come up with a standardized per resident amount, and you can customize it to not only the discipline, but the nature of the discipline -- primary care versus inpatient oriented. There are ways to do that, as opposed to going to an individual hospital and saying, how much does it cost you to educate?

When we actually did that using standardized dollars, it came very close to the average that is paid by Medicare per DME. It was not very far away. So the historical approximation was reasonable. Unfortunately, the range at that time was very large for the DME across the country.

DR. BORMAN: What about the IME, because the DME is a lot easier to put some money behind. But now when you start talking about IME, I would submit to you that most hospitals, or when I've tried to--at the various centers where I've worked -- and tried to trace a dollar that came in, presumably as IME, it's pretty impossible to do.

So the flip-side would be to make our best approximation of what are the things from a sound educational standpoint should comprise IME expense and then work from that. And so I think that's a challenge. I don't expect that there is an easy answer to that, Tom, but I just -- I raise that as that would be a valuable dialogue and data approximation to get to.

DR. NASCA: I think this group knows an awful lot about IME and I wouldn't presuppose to imply that I know any more than the nuances. What I think the group does need to understand, though, is that there is a significant internal--let's put it this way -- discussion that goes on around support of graduate medication costs between the administration of the teaching hospital and the actual educators. And so anything that you can do to assist the educators in actually receiving the funds that are provided by Medicare in order to educate would be helpful, at least it would be considered helpful by the educators.

MR. HACKBARTH: Okay. We could surely go on for another hour, but we've run out of time. Really terrific presentations, and thank you so much for your insight and we will certainly be talking a lot more about it. So thank

you.

Is there anybody in the audience who has a public comment, before I forget about it? I see just one hand, two. We are way behind schedule, so I will let you make the comment, but it will be about one minute before we are moving on to the next one, so please keep that in mind.

DR. DAWSON: Thank you, I came down from Boston just for this.

I want to thank you for the chance to at least speak for a minute.

My name is Steve Dawson. I'm an interventional radiologist at Mass General in Boston. I also used to run the largest interventional radiology fellowship program in the country. So I've seen the education from your side, as well.

What I want to talk to you about today is medical simulation. We have heard a little bit about it mentioned here. I think if we're looking at education for the 21st century, medical simulation for both procedural and team training and communications needs to be a part of that formula.

We have published results now in the literature

that say it's cheaper than using animals. It shows transfer of training from simulation into clinical care. It can be used for procedural knowledge, for skills knowledge, pieces that the boards don't test. The boards are set up to do cognitive testing, not skills testing.

We can add stimulation to do skills testing and broaden the learning base from which physicians and nurses and first responders are trained.

There's a bill currently in Congress called H.R. 4321, The Enhancing Simulation Act of 2007. I would be glad to talk -- I'm the chairman of AIMS, which is the organization that's working on this. I'd be glad to talk with the Commissioners from MedPAC about the legislation, about the possibilities of simulation, and about how that can fit into the 21st century education process.

The last sentence I will say is flight simulation did not make flying safer for pilots, it made flying safer for passengers. Medical simulation can do the same.

Thanks very much.

DR. HSIEH: My name is Joseph Hsieh. I'm the Policy Fellow for the Congress of Neurologic Surgeons but I'm also a resident right now.

One of the things that you guys have been talking about is information systems, information technology that link to graduate medical education.

I think one of the big opportunities that we have right now is to actually sponsor information technology systems that are uniform throughout the country if possible. Because if you're you talking about efficiency, you're talking about a lot of waste of time to have every single hospital try and develop their own legacy IT system that is not interactive, that will waste time when the trauma comes in, and you don't have any medical records on the patient because they come from a different hospital system.

So if we're doing this, if you guys really are talking about this, then some thought should be made for sponsoring some kind of uniform information technology system.

MR. HACKBARTH: Thank you.

We will reconvene at 1:30.

[Whereupon, at 12:46 p.m. the meeting was recessed, to reconvene at 1:30 p.m. this same day.]

AFTERNOON SESSION [1:33 p.m.]

MR. HACKBARTH: We needed to get started.

Our first topic this afternoon is public reporting of physicians' financial relationships. This is a topic that we have discussed three or four times before. And today we will be discussing draft recommendations that I am offering as Chairman. What we've tried to do is develop draft recommendations that reflect the conversation that we've had to this point.

I'm sure, in some ways, we've missed that so that's why we're calling them draft recommendations.

When we get to the discussion piece after the overview, I hope we can have a very focused discussion. We've been over this general terrain several times. What I'd like to do during our discussion is really focus on the draft recommendations.

So we will do three rounds of discussion. First, there will be an opportunity for Commissioners to ask clarifying questions, and I mean strictly clarifying questions, what does this mean and that sort of thing.

Then we'll do a second round and give everybody an opportunity to make a one to two minute comment. When you

do that, what I'd ask is that you say what you like about the recommendations and whatever reservations you have, and then be specific if at all possible about how it might be changed to address your issue. So I want a very focused discussion.

Then once we've gone through that round, I suspect we will have probably several areas that more than one Commissioner has touched on and we can have a little bit more free-flowing discussion of those issues. So that's the plan.

Ariel is going to lead the way.

MR. WINTER: Good afternoon. We will be discussing our draft recommendations on public reporting of physicians' financial relations with drug and device manufacturers, hospitals and ASCs.

We want to first thank Hannah Neprash for her help with this work.

I will be walking through the recommendations related to drug and device manufacturers and Jeff will be handling the recommendations related to ASCs and hospitals.

Before we get to the recommendations, I'm going to quickly highlight some key findings from our June chapter on

this issue. First, that financial relationships between physicians and drug and device manufacturers are pervasive. According to a recent survey, most physicians have interactions with drug manufacturers, examples of which include receiving samples, meals and gifts, speakers' fees, consulting arrangements and research grants.

Second, industry-physician relationships have both benefits and risks. They can lead to technological advances and increased use of beneficial products but they may also undermine physicians' independence and objectivity.

Studies have shown that interactions with the industry are associated with rapid prescribing of newer, more expensive drugs and requests to add drugs to hospital formularies.

There have been efforts by the private sector and government to regulate these relationships. Manufacturer and physician groups have developed voluntary ethical guidelines. But there is no mechanism to track compliance with these guidelines and there is evidence that some inappropriate practices persist. Five states and D.C. require manufacturers to publicly report their payments to physicians but many of these laws have weaknesses. Only the

Massachusetts law covers device manufacturers and the data collected by these laws are often incomplete and not easily accessible.

We've been discussing whether to have the Federal government collect national data on physician industry relationships. On this slide we've listed potential benefits of public reporting. It could discourage inappropriate arrangements. Media and researchers could use the data to shed light on physician-industry relationships and track compliance with ethical guidelines. Payers and plans could use the data to examine whether physicians' practice patterns are influenced by their financial arrangements with the industry. Academic medical centers could verify financial interests of researchers. This is important because clinical investigators who receive federal grants are required to disclose their financial interests to their institutions, which in turn must manage, reduce, or eliminate significant financial interest that could be affected by the research. There have been recent cases in which prominent researchers significantly underreported their consulting fees from drug companies. And finally, hospitals could check on whether physicians who are involved

in purchasing physicians, such as serving on formulary committees, have financial ties to manufacturers.

A national database would also have costs and limitations. There would be compliance costs for manufacturers as well as administrative costs for the government to monitor, to implement, and enforce the reporting law. There is a concern that public reporting might discourage beneficial and legitimate arrangements between physicians and industry. Public reporting would not eliminate conflicts of interest. And the information may be of limited use to patients because patients usually lack medical expertise and tend to trust their physician.

Notwithstanding these concerns, there is a growing consensus that the benefits of a national reporting system outweigh the disadvantages.

I'm now going to walk through the key design issues for a public reporting law and present the draft recommendations. This proposal is based on the June report and your discussion at last month's meeting.

First, we propose that the national reporting system would apply to a broad set of manufacturers and recipients of payment. It's important to note here that

manufacturers would be reporting the information and not the recipients. Companies that make drugs, biologicals, medical devices and medical supplies would have to report their financial relationships regardless of the company's size. We propose to cover their subsidiaries as well to prevent companies from paying physicians through a subsidiary to evade reporting requirements.

We propose that the following recipients of payments would have to be reported by manufacturers: physicians and other prescribers such as physician assistants and nurse practitioners; hospitals and medical schools because academic medical centers receive significant industry support for research and education; professional organizations and patient advocacy groups because they frequently receive grants from manufacturers for research, fellowships, and public education; and finally, organizations that sponsor continuing medical education.

At the last meeting there were some concerns raised about including this category. The reason we've kept it in the proposal is because commercial support accounts for an increasingly large share of total CME dollars, about one-half in 2006, and there are concerns that the support

may result in a disproportionate focus by CME programs on drugs and devices.

Accredited CME organizations are required to disclose industry support to participants in their programs but this information is not available to the general public. Including these organizations in a public reporting system would enable researchers and others to track industry support of CME.

Here's our first draft recommendation. We want to remind you that you will have an opportunity to consider each recommendation twice, both today and at the next meeting, when it will be voted on.

The draft reads the Congress should require all manufacturers of drugs, biologicals, medical devices, and medical supplies, and their subsidiaries, to report to the Secretary their financial relationships with physicians and other prescribers, hospitals, medical schools, organizations that sponsor continuing medical education, patient organizations, and professional organizations."

The specific design issues for a reporting system are described in the text of your paper and I'll review them in the next few slides. For the sake of brevity, we have

left them out of the recommendation itself.

Here are the implications of the first draft recommendation. There will be some administrative costs for the government to implement and enforce a reporting law but it's difficult to estimate these costs precisely. The Medicare spending implications are indeterminate. In terms of beneficiary and provider implications, we foresee no direct impact on beneficiaries. Hospitals, medical centers and health plans should benefit from information on physicians' financial ties. If a Federal system replaces multiple state laws, this should reduce manufacturer's compliance costs. And some physicians, such as those with large financial arrangements, may receive public scrutiny.

The first design issue I will talk about is the dollar threshold for payments that should be reported. Based on your discussion in September, we propose that manufacturers would have to report payments if the total annual value of payments to a recipient exceeds $100. This threshold would be adjusted annually for inflation. Once the threshold is reached, all payments or transfers of value to a recipient would have to be disclosed. We think this strikes a balance between reducing the reporting burden and

maximizing public transparency.

The next design question is what types of relationships should be reported. We've tried to develop a comprehensive list. This would include gifts, food, entertainment, honoraria, research, funding for education and conferences, consulting fees, investment interests, and product royalties.

We propose excluding discounts and rebates because this information is considered very proprietary and public reporting of this could make it difficult for purchasers to negotiate price reductions. We would also exclude free samples for patient use based on your comments in September.

Based on a question that Jay asked at that meeting, we learned that Federal law requires companies to internally track the drug samples they distribute, including details about the drugs and recipients. This information is not reported to the government. One idea to think about is whether this information should be publicly reported so that researchers could examine the impact of samples on prescribing patterns and overall drug costs.

We propose that companies should report the value, type, and date of each payment and the name, specialty,

Medicare billing number if applicable, and address of each recipient. The billing number is important for linking the payment information to claims data.

Next we turn to guidelines for reporting of payments related to new product development. We're trying to balance a trade-off between allowing manufacturers to protect sensitive information and the goal of public transparency. Based on the discussion last month, we're proposing that companies be allowed to delay reporting of payments related to clinical trials until the trial is registered on the NIH website. Registration of clinical trials is currently required for Phase 2 and Phase 3 trials.

And second, that companies be permitted to delay reporting of other payments related to development of a new product until the product is approved by the FDA but no later than two years after a payment is made. This would ensure that payments related to products that are never approved by the FDA are eventually disclosed.

The next key issue is preemption. We propose that a Federal reporting law should preempt equally or less stringent state laws. We're trying to strike a balance between state autonomy and the advantages of having one

national uniform system. State laws that collect data on the same types of financial relationships and recipients as the Federal law would be preempted but states would be allowed to collect information on other categories of payments and recipients such as samples.

Here we cover some other design issues. The government should have the authority to assess civil penalties on manufacturers for noncompliance. The law should require manufacturers to investigate and correct any errors in a timely way that are reported to them by recipients. The information should be reported annually. And finally, companies should be allowed to report additional clarifying information about a payment. For example, they way wish to explain that a payment was made for training other physicians in the proper use of an implantable device.

Finally, we consider some implementation issues. We propose that the Congress should allow the Secretary to choose which agency should administer a reporting law. The possibilities include the FDA because it regulates drugs and devices; CMS because it pays for a significant number of drugs and devices; or the OIG because it has responsibility

for investigating financial relationships that may violate the anti-kickback statute.

As we mentioned earlier, the administrative costs of implementing a reporting system are unclear. According to Minnesota, the cost of collecting and posting data on a website is minimal but Minnesota's program does not yet have a searchable electronic database which might increase the cost. We also lack data on costs incurred by states to monitor and enforce compliance. We would ask Congress to provide sufficient resources to the Secretary to administer a reporting law.

This brings us to the second draft recommendation, the Congress should direct the Secretary to post the information submitted by manufacturers on a public website in a format that is searchable by manufacturer; recipients' name, Medicare billing number if applicable, location and specialty; type of payments, and year. The goal here is to maximize the accessibility and usability of information in the reporting system.

Here are the implications for this draft recommendation. In terms of spending, there would be some administrative costs for the government and the Medicare

spending applications are indeterminate. In terms of beneficiary and provider, we estimate there be no direct impact on beneficiaries. Hospitals, academic medical centers and health plans should benefit from access to this information, and some physicians may receive public scrutiny.

Now we'll turn to Jeff for a discussion of the next set of recommendations.

DR. STENSLAND: As we told you last time, physician ownership of hospitals and ASCs is growing. As ownership grows, there's increasing interest in how ownership affects practice patterns, referrals, quality and cost. To evaluate the effects of ownership, researchers and payers need ownership information.

CMS currently requires that both hospitals and ASCs provide some level of disclosure as to who owns the facilities. For corporations, all owners with a 5 percent direct or indirect ownership interest in a facility must be disclosed to CMS. If the hospital or ASC is structured as a partnership, then all owners must be disclosed to CMS. For example, if 10 cardiologists each held a 1 percent interest in a group practice, and in turn that group practice held a

partnership interest in a hospital, the hospital would have to disclose the names and provider ID numbers of all 10 owners to CMS.

The main point here is that most of the information that researchers and payers need is available. It's just not publicly available.

In order to obtain complete ownership information from hospitals and ASCs, we have the following draft recommendation. The Congress should require all hospitals and ambulatory surgical centers, ASCS, to annual report each physician who directly or indirectly owns an interest in the hospital or ASC (excluding owners of publicly traded stock). The Secretary should post this information on a searchable public website.

Now the rationale here for excluding publicly traded companies is that publicly traded hospitals will not know who owns shares in their company if that ownership is less than 5 percent. The hospital cannot track every sale and purchase or stock on the stock exchange. Therefore, we excluded the publicly traded companies.

Because CMS is already collecting most of this information and entering it into their PECOS database at

CMS, there would be minimal additional costs for CMS to make the data comprehensive and public and minimal extra burden to the providers, since they are already providing this information in large part to CMS.

The Commission has also expressed some interest in disclosure of a broader set of physician-hospital relationships. This would include things such as equipment leases, medical directorships with hospitals, joint ventures. The difficulty here is to balance the desire for transparency with the desire to limit administrative burden.

CMS currently plans to gather information on various types of financial relationships such as leases through its disclosure of financial relationships report. The plan is require up to 500 hospitals to disclose their financial ties with physicians.

Our initial thought is that we should review what CMS finds through its investigations of financial relationships in their study. The information in the DFRR may shed light on the prevalence of various financial relationships and may highlight which relationships merit public reporting. However, currently it's not clear that CMS will make its findings public.

Thus, we propose recommending that the Secretary submit a report to Congress on the prevalence of financial relationships that were found during the DFRR collection period. We can review this information and possibly come back to the Commission to discuss additional disclosure requirements. Therefore, we have the following draft recommendation for your discussion: the Congress should require the Secretary to submit a report based on the disclosure of financial relationships report of the prevalence of financial relationships between hospitals and physicians.

Once again because CMS plans to collect the data, the only other cost for CMS would be a mandated report on the findings. And we don't expect any additional cost for providers since the providers are already expected to be required to fill out the DFRR.

And now we open it up for your discussion.

MR. HACKBARTH: Thank you, good job.

So round one, any clarifying questions for Jeff and Ariel?

DR. CASTELLANOS: I just have a clarify question and a question concerning the trigger of the $100. I think

we should have a trigger. I don't know what the answer should be. But I think by keeping it so low, the impact of what we're trying to do with the number of people that we may get, we're going to lose the effect.

Just for example, I know Lilly Company has a $500 limit of what they are using as a minimum. I just think $100 as a trigger is going to probably not solve what we're really trying to do, is get the person who's a bigger abuser.

DR. DEAN: There are some regulations in place now about ownership disclosure. Do you know exactly what those require? My understanding is that patients of physicians that have an ownership are supposed to disclose that, but I'm sure it's subject to this 5 percent limitation.

DR. STENSLAND: The physician, if he owns an interest in the hospital and he's referring the patient there, is required to disclose that to the patient no matter what their ownership interest is. The hospital is also required to offer to tell the patient all their physician owners. So that information flow is already set up in regulations between the patient and the physician and the hospital.

But right now there is also a second avenue where the hospital has to disclose some information to CMS. So CMS is in on ownership, at least to the 5 percent level. The patient and the physician are in on ownership. The people that are left out of it is the research community and the payers, who don't have this information to go ahead and do their research to see if ownership is affecting practice patterns.

DR. DEAN: There is legislation in Congress right now that requires some of these things. Are you familiar with those bills and where they stand?

MR. WINTER: You're referring to the drug and device -

DR. DEAN: Yes.

MR. WINTER: There have been various bills introduced in the House and Senate. There was a bill introduced in the Senate last year by Senators Kohl and Grassley and other sponsors and that's been revised but the revised version has not yet been formally introduced? There's an outline of the revised version on the website, on the Aging Committee's website, but there's no formal legislative language yet that we can look at.

The main differences are that, according to the outline, there would be a $500 threshold per recipient before payments would be reported. And then after that I believe it's a $25 threshold per payment once you get above $500. Anything below $25 you don't have to report.

The other main differences are that it completely preempts any state laws related to this issue, whereas we propose partial preemption.

The third main difference is that the revised Senate legislation would apply -- the recipients would be physicians, physician practices, and then entities that receive payments on behalf of a physician. It's sort of unclear what that really means. And we've proposed a broader set of recipients.

In terms of the exclusions, the revised Senate outline would exclude samples, discounts and rebates. They also say certain training and certain educational materials. It's unclear what that really means.

MR. HACKBARTH: Any other clarifying questions?

Seeing none, we will now entertain brief questions and comments from Commissioners on the merits. I'd ask that you keep it to a minute or two.

DR. BORMAN: In general, I like all of the recommendations.

My biggest concern relates, if you can put up number two, and I think similarly the same issue would come up for three, although we don't go into quite the explicit detail. I'm a bit worried about the public website disclosure of this much information.

It is not a very big stretch for me to imagine a rather computer savvy individual, and perhaps one at a not very mature age, who could get in and with this information sort of create a medical identity pretty quickly. I could also envision somebody who had rather just -- beyond for the fun of it -- creating a medical identity that could do significant harm.

And having had personal experience of having my DEA number abused, I really would like to be very careful about this.

So in trying to balance this, my suggestion would be that we limit the information on the public website and perhaps just to recipient name or recipient name and location. The type of payment part I don't care about. But the Medicare billing number, things that would allow you to

potentially create an identity, that that be reported but accessible only by research or request or some filtering mechanism.

I have assumed that when you talk in recommendation three about a searchable database that you were implying the same kind of stuff again publicly identifiable, and I would just have the same concern about recommendation number three.

MR. BUTLER: Let me take them one at a time. With recommendation one I think the broad language is fine, so I would support that. I think there are two elements of the details and here there is a lot of detail I would comment on. One is the $100 threshold. I'm still a little confused why we would consider $25 or $100 or $250 or the kind of numbers that are either thrown out there or are in state laws.

To me if it's $100, what is the rationale? One is it's an administrative burden. Well to me, if you've got to report anything over $100, you've got to keep track of anything. So I'm not sure it's any added administrative burden to keep track of it. So I'm not sure that's a rationale.

If the other rationale is under $100 is insignificant and it doesn't matter, well then maybe if we had the threshold at zero you just wouldn't do it if it doesn't matter.

So I actually would prefer a zero number for the threshold and we probably would eliminate some things that are being done now. So I would support zero. It's not a deal breaker, so to speak, because I can support the overall language but that's what I would do with the threshold.

Secondly, on the drugs, I would put the drug samples in, not out, in terms of reporting. I think that this is a big driver potentially of utilization and costs, and I think probably some others feel the same way. It's like getting shelf space, so to speak. Once you get shelf space it tends to be used more I think, maybe appropriately in some place but not in others. We work very hard at formularies to try to decide what to do, and this is a way to circumvent many times what gets ultimately on a formulary. So I don't think it's the right process.

We go to Costco and get the free little lunches and people walk around us as an enticement to go buy the product. I don't think the same thing should work when, in

fact, the bill is typically paid by the insurance company or patient ultimately, not the supplier.

On recommendation two, I think it's fine as it is.

On recommendation three, I think it's fine, the wording, and I fully support having Congress ask the Secretary to complete the work. I would have some additional language that would be even stronger that says let's not create an administrative burden, that the survey as designed is very broad and detailed and would require -- would go way beyond what I think is reasonable. So I think there should be extra caution on the administrative burden language.

And then secondly, I think that we should make it clear that the data coming out of that is not just disclosure but it's the kind of disclosure or the report from Congress that's going to help policymaking, not create a database that people can go seek who's doing things crookedly. I think it should be the purposes of guiding policy as the principal purpose.

DR. CASTELLANOS: Very briefly, the concern I have is the threshold and I really don't have a good answer. I think that needs to be looked at and talked about a little

bit more.

As far as the drug samples, I don't want to throw the baby out with the bathwater. I think it's important for the patient. It's important as a physician to be able to give a sample to the patient to see if that patient has any side reactions to the drug, see it's effect, and without that patient paying for the drugs and increasing costs.

Karen's concern is the same as my concern about the NPI number. I think there's a good source for fraud and abuse.

[off microphone] And I'm for all of the recommendations strongly.

MS. BEHROOZI: Thanks, this is really great. It's great that we're able to move in a consensus fashion to getting recommendations out there so quickly.

On the subject of consensus, I guess I was part of the consensus that you perceived around the issue of not putting samples on the list. Last time I could be persuaded by my colleagues in some of the conversation that we've been having around it that reporting of sample distribution is of value. But I still think that it's different. It motivates behavior in a way that's different than baseball tickets or

whatever the Medtronics thing was, Mark. It was in the Wall Street Journal.

There really are different things. That we can agree on. So if there's a different database, a different way maybe of keeping track of samples for the purpose of researching the impact on prescribing behavior alone, as opposed to the other kinds of things that really ought to be made public because the sunshine hopefully will cleanse them out of the system, I think that's worthwhile to do.

And the other point that I want to make -- I don't know, this is probably unrealistic and I'm pushing the envelope too much. On the spending implications, we're so neutral about saying the spending implications are indeterminate. Why don't we say something more affirmative about but these recommendations are intended to help rein in inappropriate spending or reduce inappropriate spending?

MS. HANSEN: I was going to originally build on Jay's on the other side of the table about the samples. And so I think that consensus moving down the table already is that I would like to see that back in. And perhaps with the factor of impact. There is the factor of impact perhaps in this case potentially in a different way than maybe in a

policy way about impact to beneficiaries. Because it's what you're given initially and oftentimes will kind of continue to color the beneficiary's perception of benefit to them versus a generic drug that might have some similar impact.

So I would support all three recommendations.

DR. KANE: I support all three. I have a couple of issues I'd like to suggest. One is on recommendation one. I noticed three out of the five states do this but we've let them off, the health plans. And then I would suggest also the pharmacy benefit managers. In my experience, they are also the targets of the kind of entertaining and education marketing that physicians and other groups are targets of. So I would add health plans and pharmacy benefit managers. Some of the states also add pharmacists but that may be just getting too broad.

My second comment is that in talking about the implications of draft recommendation one, I think several of us have said we are concerned that there are some things that could go -- some beneficial things that we have to give out. But we don't really seem to know what they are.

I'm wondering if we couldn't suggest under the impact that there may be some beneficial educational and

perhaps dispensing activities that are discouraged or are no longer provided. And we might want to monitor what those are and reinform ourselves as time goes on as to whether it was a good idea to have these disclosures or not. How do people react to these things? I don't think we know and it would be nice to have something in the recommendation or the implications where we want to monitor the outcomes, the way people's behavior does change in education and in prescribing some drugs.

On recommendation number three, maybe this is wrapped up in the piece about Congress will tell us what happens with the study, but why don't we have in there the other types of freestanding diagnostic and treatment centers such as diagnostic imaging centers and gastroenterology clinics that do the scopes? I know that quite a bit of that has gone out into joint venture and physician owned enterprise. I guess I don't see why we stop with the ambulatory surgery centers. I worry that if you don't have everybody in there that will increase the flow that way instead of to the surgery centers. They'll just start opening up other ways to make up for their income.

But in general, I support the basic message of all

the recommendations.

DR. REISCHAUER: Overall, I'm in favor of all of the recommendations. I agree with Karen and Ron with respect to the privacy issue on Medicare payment number. With respect to Peter's question of why $100 versus $25 or $500, I think the only way one can pick a threshold would be to say at what level is it likely to affect behavior? And whatever behavioral research we have on this suggests that even a friendly phone call or a pen does seem to affect behavior, although the individual doesn't quite realize it.

With respect to the administrative complexities, Peter is absolutely right. If you're going to do anything, it's going to cost the same, the administrative element. And so what I think you're trading off is a privacy issue and a gazillion entries when you think of the way we set this up. How much is it worth? And what type of payment is it? We have a pen, dinner, ticket, whatever. You're going to have a huge amount of data. So there might be a threshold just to save trees.

With respect to drug samples, I guess I'm weakly against what Jennie described as the emerging consensus, certainly not a deal breaker. My view about this is that

with the spread of formularies and the active intervention of PBMs to switch drugs that are on their formulary and this spread of generics, this is a lot less of a problem than it was five, 10 or 15 years ago. So I'm perfectly comfortable leaving it out, but if the consensus is as Jennie describes it, I'll vote yes.

MR. EBELER: Thank you. Just on a couple of the issues, I think Ron and Karen's sensitivity on particularly the Medicare billing record is very well stated and I support that.

I would lean towards including the drug samples in part just because it is the largest volume of transactions between the industry and the profession. So it just strikes me as something that's worthwhile to make sure we at least have some sunshine on. But I'm very supportive of the three recommendations.

DR. CHERNEW: I am also supportive of all the recommendations. I think in the spirit of what's been said, I agree about the privacy protections. There needs to be some sort of HIPPA-type access to certain types of information so some thought needs to be given to that.

I also think it's important that the list of

organizations and recipients that have to be reported is broad enough to capture the important ones. One entity that was missing from the explicit list but I believe is captured in spirit is physician groups. So are you give it to the physician? Are you giving it to the group, or some other organization that employs them? I think it's important to capture that in certain ways.

I'm actually supportive of the $100 threshold. If you would have had a somewhat higher number, I would have been fine with that, too, because I think there is a series of activities where it's not an explicit oh here I am, take this pen. But they're sort of a lot of small things that might go on which isn't a direct thing.

Honestly, I think in practice that's not going to be written down all the time. So I don't think there's anyone counting oh, it's at $99.50, I'm not going to report it. But they're just sort of -- it's a rough guide. And so I think some leeway to allow people to omit essentially inconsequential actions is good. I think $100 is fine. I would have been fine with $500. I understand your point about the literature.

In fact, my real advice was going to be that it

could report some of the things in categories, I don't need to have written exactly. But again, I'm ambivalent enough about that.

The recommendation I was most concerned about, although I like it in spirit, was recommendation three. I thought that it was a little less ambitious than I might have been in the following way. First was the way that Nancy said. I think there's a lot of other organizations that would be in there.

The second is it basically is a recommendation to wait and see what we find from this other activity. But I think we could do better to know not just ownership, which I consider a limited measure of physician financial relationships in some of these centers, but also income from them. So if there is a center that is paying physicians for surgery or something else, I think that the extent that those centers are reporting those types of payments anyway to someone -- they have to keep track of those payments when they're going to physicians -- I would be supportive of stronger recommendation that made them disclose those recommendations much the same way as recommendation one does.

But that's bolder than this is. So I'm supportive of the recommendation. I would have been supportive had it gone further.

DR. REISCHAUER: There is a possibility that confusion might occur because payments for services may be in a different category. And so would you suggest two separate pots here or lists?

DR. CHERNEW: I guess I'd have to think through exactly what is meant by service. I'm concerned about the classification. But maybe when we get to round three we'll have that discussion.

DR. STUART: I also support these recommendations and I support having a minimum dollar amount, even though I'm quite convinced that the social welfare would be improved if we were to get rid of all of these cheap pans.

I'm not as worried about the administrative burden on the manufacturers as I am on the administrative burden on the users, trying to go through all of this stuff that is not going to be terribly useful.

I, too, am not particularly concerned about the level as long as it's something reasonable. It's going to be arbitrary no matter what amount we pick. And when it

becomes a threshold then we also know what's going to happen, is that all of the gifts are suddenly going to be $99.99 or whatever they are. I think that just comes with the turf.

I'm a little concerned about the sample issue just because I'm not sure who gets those samples. We heard some conversation a little bit earlier about the question of practices or whether it comes to an institution as opposed to an individual. So I think there are some tracking issues here.

It's not that I'm opposed to having a recommendation relating to samples, but it might be that that should be a separate recommendation because there are some other factors associated with it that just aren't associated with this direct one-on-one giving and the influence that that may carry along with it.

Something that we haven't talked about but I would like to recommend it for discussion not necessarily in the recommendation at all, and this is recommendation one. The first bullet refers to physicians and other prescribers. Being in a school of pharmacy, I can tell you that the drug reps are all over my school and they are paying pharmacists

to do CME and a variety of other kinds of things.

And so one would suspect that the reason that they're doing that is that they expect to get at least some kind of a quid pro quo in some way, and in fact pharmacists do make recommendations to P&T committees about which drugs are on them. They also make recommendations to providers and prescribers. So it's just something to think about here, in the sense of sunshine.

MR. GEORGE MILLER: I agree with Ron and Karen about the privacy issues. And if it's something like HIPPA or to address that in some ways, I think we have two real-life physicians who are concerned about that. I think we should pay particular attention to that.

I also agree with Nancy that we should add all physicians in draft recommendation number three. I would even be so bold as to say that we need to add language that in some way, if we're concerned about increasing utilization -- I think you had that in the documentation -- that we should have some way of limiting -- I'll even use the ban word -- physicians being able to own those facilities because of increased utilization.

I think the evidence shows it has increased

utilization. And I would add hospitals in that same category, which goes to draft recommendation number four. It would eliminate number four if we had a number three dealing with not having physician ownership in facilities like ASCs or hospitals or joint venture with hospitals. I think that would eliminate the need for four.

DR. CROSSON: I support the recommendations. I would like to support the notion that has been about here with respect to samples. That's not to deny in any way that samples are different from the set of issues that are primarily being addressed in this paper, in this section.

Nor is it to deny that there aren't true values to samples. They certainly are valuable to physicians, as has been pointed out, and in trying to determine relatively inexpensively and quickly the relative tolerances of patients to various drugs. And there are values, I think, that accrue to patients who can't afford drugs because many physicians use them for that purpose.

But that's not the intent of the production of samples by the pharmaceutical industry. The intent is really, often, in most circumstances, to promote the use of expensive pharmaceuticals in the place of other effective

pharmaceuticals that are less expensive. That, in the end, has a deleterious effect, I think, on both the Medicare program and under the Part D drug benefit to the Medicare beneficiaries themselves who will reach the threshold for the donut hole much more quickly than they would otherwise. So I think it is an appropriate thing to address. It's probably an issue that we should consider as a separate recommendation for the reasons that have been discussed.

Clearly, if the industry is investing $18 billion a year in the provision of samples and most of these companies have strategic discussions and things called business plans, there must be some perceived value there.

With respect to the threshold, I have to admit an emotional attraction to Peter's argument. That's certainly our policy is zero tolerance. But I understand Bob's point that we could end up cluttering up the system or, in fact, making the system that we are proposing less politically tolerable, less likelihood of being enacted, and perhaps providing an opportunity for people to view it as unreasonable.

So I support the recommendation as it's written with the text as it's written.

DR. SCANLON: Nancy and Mike covered this to some extent. I'm really concerned about -- I'm very supportive of the recommendations in principal and concerned about the ability to evade them. You've indicated the idea of including subsidiaries of drug companies is one way of avoiding that kind of evasion. I'm concerned about on the side of the recipients that our definitions might provide opportunities for evasion.

There's no elegant way to change recommendation one and to list all of the possibilities that you want to consider so here's my suggestion, to be brief. It would be to report to the Secretary their direct and indirect financial relationships and let the Secretary -- and we can talk in the text about the issue of what happens when money goes to a practice and then that money eventually ends up in a physician's hands, et cetera.

In terms of recommendation three, I guess I also feel like we should be moving forward now. My sense is that what I would be wanting is information coming from people who are Medicare providers that have financial relationships with people that are authorizing their services. In most cases, that's a physician.

So if I'm an ambulatory surgical center, the physician is the one that determines whether a patient is going to come and have that surgery. If I'm a SNF, it's the physician that determines whether or not this person is going to be admitted. I want to know about their financial relationships. Because ownership is much, much too narrow. You can just think of all kinds of different ways, including pseudo-ownership. Particularly, if we let off publicly traded organizations. I can have a publicly traded organization that sets up a facility, engages as a group of consultants a whole panel of physicians and rewards that panel in terms of the volume that a particular facility generates in a community. And that's very close to an ownership arrangement, but it's not legally an ownership.

There are so many issues in terms of how one can be creative that I think we need to set out a goal here and then let the Secretary figure out how it is that you write regulations that are specific enough to accomplish the goal.

DR. DEAN: I, too, certainly support all three recommendations. A couple of comments.

First of all, in regard to Ron's concern about cluttering up the report with too many names on it, is

certainly a legitimate concern. But it would seem to me that maybe these could be categorized like those that received $100 to $500 and $500 to $2,500 and over whatever categories. And then you could separate out those that were relatively insignificant from those where there might be a real concern might deal with that.

Secondly, I certainly agree with Nancy's comment that we need to broaden the number of types of facilities that need to be included.

Finally, with regard to the samples, I really don't think samples should be included in this recommendation. I certainly accept all the concerns that Jay mentioned, and they're all real. But it seems to me that the interpretation of the value of samples received is very different than the interpretation you would place on these other numbers.

Just for example, if I have patients that are very needy and need samples to support them, all I have to do is call the drug rep and they'll send me a whole box of stuff. And so that would get reported as a large amount of money even though it's going, I think, to a legitimate concern.

Now, to the extent it changes prescribing

patterns, I'm sure it does, and that's a concern. But I think it probably needs to be addressed but I really believe it's enough different it needs to be a different recommendation.

To add to it, I think they're going to be tough to track because samples are not given to individual physicians. They're given to an office or at least one of the docs will sign for it but we all use them. So I think tracking it in relation to individual physicians, I think, is going to be tough to do.

Finally, I suspect there would be differences even among specialties because the drugs that some specialties use are far more expensive than what other drugs use. If you look at the current antipsychotic drugs which cost $300 or $500 a month, it's very different than the antibiotics that I prescribe.

So I think again, it's the interpretation of the data that I think would be complicated and really hard to manage. So I think it probably needs to be addressed but I really think it's different enough that it needs to be a different recommendation with somewhat different wording. I'm not sure what that would be.

Thank you.

DR. CROSSON: Just on that point, I just want to be clear what I was proposing was not that samples be included in the financial relationship between the drug company and the physician to be reported as part of that. What I was proposing was a separate recommendation dealing with the issue of samples, specifically because of the impact on the cost of pharmaceuticals and as a tool for researchers and others to try to figure out the impact of sampling on prescribing.

I don't expect, nor am I advocating, that sampling go away but simply that we understand, as we have in other areas, the impact of this on the cost of care for the program and for beneficiaries.

I think the issue of how it's tracked is going to be a problem of data interpretation for the researchers but I don't believe that it's going to obviate the value of it in the end.

DR. DEAN: [off microphone] I totally support that.

MR. HACKBARTH: Let's just frame for a second where we're going to go from here. Clearly samples is an

issue that we need to come back to and discuss some more. That falls under recommendation one.

There's also been a lot of discussion about the threshold issue under recommendation one and then also some questions raised about the scope and whether others ought to be included, pharmacists, health plans, PBMs, et cetera. I think those are the three major topics under number one.

Recommendation two, Karen and Ron raised the issue about the level of detail of information about the physician and whether in particular that needed to be on a public website where people could just grab it off a public website without having to explain the use of it.

And then on recommendation three issues were raised about why stop with ASCs? Why not include other types of procedure units? Bill raised the question why stop at ownership and not be broader about financial relationships? I think those are the major issues in play.

Let's do an easy one to start with. What I heard Karen and Ron recommend is collect the information about billing numbers and all that, just don't put it on a public website. Make it available to legitimate researchers so that they can do their analysis but don't make it easy for

identity theft and abuse of that sort. Did I understand you correctly?

Everybody agree with that?

Ariel and Jeff, any questions or any problems with that?

MR. WINTER: Beyond the NPI, are there other fields that you would want not to be available on the public website? So we have other things on here, let me go back to number two just to put up the full list. So location, specialty, name you said would be okay, I think.

DR. KANE: Isn't specialty kind of hard to pin down for some people? Just a question, I'm sure there is some value to specialty for researchers, but isn't it possible for one person to represent three or four different specialities, and it's kind of hard to know? I don't even know if the drug companies even know what specialty they're operating on behalf of when they give them.

DR. STUART: What do you do if your name Jim Brown and there are 400 of you out there in the country? How are you going to distinguish individuals with the same name? So the address is going to be on here. Okay.

MR. HACKBARTH: We've talked about Nancy's

specialty issue in other contexts and how sketchy that information is.

We've got a lot of other things here, let's just flag that and then that's something that you guys can think through some more.

Let's go now go to recommendation one where I think we've got some big hitters and let's start with the sample issue.

DR. REISCHAUER: I have just one comment before that, which maybe I'm off base. But it strikes me we're saying all manufacturers. I'm thinking what if the artificial hip is made in Europe and the issue is really the exclusive distributor in the United States, and distributors really can be not subsidiaries and yet have financial interests that would allow them to have the motivation.

MR. HACKBARTH: So let's think about how to address that.

Let's focus on the sample issue for a second. Jay, you've proposed covering samples but through a separate recommendation. Anything more you want to say about how to craft that recommendation?

DR. CROSSON: It would seem to me that -

MR. HACKBARTH: I'm try to get is a fairly specific proposal that we can then have some discussion about.

DR. CROSSON: Do you want me to take that offline?

DR. MARK MILLER: Let me take a shot. I'm going to say the physician ID number because I want to make a point. On the physician ID number what you can do is collect the information -- and Ariel was talking about this with me at the beginning of the day -- and have it available through a data use agreement between whoever is holding the data and whoever's asking for it, researcher. So just hold that thought for a second.

So over here, on the sample, what we know is that the samples are tracked by the companies and then information is available to be reported. But we have this issue that the termination point is somebody who signs it. And then beyond that the distribution is unclear.

DR. DEAN: [off microphone] The reason for that is it was set up for a totally different purpose or it was set up to slow diversion.

DR. MARK MILLER: Let's be really clear, the state-of-the-art of the data is that you could find out that

a block of samples went to some number or some ID, some physician and then that's sort of what you know.

Similarly to the ID, you could make a recommendation that says you have to collect and report that information and it's only available to researchers through a DUA process, through a data use agreement process.

But we should also be clear here, then it's going to be the researchers problem to figure out if a large block of drugs arrived at this address what actually happened to them at that point.

DR. CROSSON: So I think the number of points here are should the information be made available? Yes. To whom? Reported to a government agency so that then researchers and others can access that? Or just simply accessible by researchers. That's one question.

Is there an administrative burden? Probably not. Is the data going to be very clean? Probably not for the reasons that we brought up. In other words, if we're tracking it to a practice address, it's probably pretty clean. If there happen to be four physicians practicing there and one signs for it and then you're subsequently, down the line, trying to track prescribing of various drugs

in relationship to those samples, there is a methodologic issue that I would suspect researchers are going to have to figure out how to deal with.

What I was trying to say earlier was that I don't think that that is enough to say let's not do it at all.

DR. KANE: It's the same thing with CME. It's the same thing with education. We can't track down who it is that got that education.

DR. CROSSON: Are we looking for specific recommendation language?

DR. MARK MILLER: I'm trying to propose a separate recommendation that says this data is collected, we know what the termination point is. It would be available through more of a data use agreement process as opposed to a public dataset. That's one way we could go.

DR. CROSSON: I don't think public, meaning disclosure to the general public, in the context of samples is of particular value.

MR. HACKBARTH: Having it as a separate recommendation also allows for some subsequent text that explains the different dynamics involved in samples, as opposed to some of these other things.

MR. BERTKO: Just a quick comment that I can see people like Bruce and maybe others just needing the general geographic reference. Because if you're going to look for patterns of dispensing or even uses as counter detailing that would be good enough, as opposed to coming to the direct physician. So I think it's a good enough thing that it would still be useful.

MR. HACKBARTH: So let me ask other Commissioners. I've seen a number of heads nodding in favor of the general idea of a separate sample recommendation.

DR. CHERNEW: I just had a question about that, which is is the data collected going to be very specific, and so the recommendation that we gave this much of the following product? Or is it we gave this value of medications at this point?

To answer your question, I'm supportive of a recommendation. They think we need to think through for this particular thing exactly what's going to be reported because it is a little bit different than some of the other ones.

MR. HACKBARTH: Fair enough.

MR. WINTER: Just to shed light on Mike's comment,

they're currently required to track the name of the drug, the dosage, and the units. But they are required to assign a retail value to it. So that might help clarify what you're thinking of.

MR. HACKBARTH: So the question is are people comfortable with the general direction proposed by Jay?

MR. EBELER: I'm not familiar with these type of research agreements but you wouldn't have to be a researcher to access this? A reporter could access this, a health plan? It's accessible, you just have to go through a process to look at it?

DR. CHERNEW: Actually, maybe. It depends on what the requirement is to get the DUA. So in some cases the DUAs are very specific, that you have to have certain things. And it may be the case that reporters don't have those things. And so oftentimes you have to have a data security plan and a whole series of things. It would be harder under some DUA arrangements for reporters to get them, depending on the details of how the DUA was constructed.

DR. STENSLAND: A point of clarification. The way I hear it is I think you're saying there's a publicly

available dataset and everybody can access is on the web which has the name and the business address and the amount that was received. And then there's also a separate private dataset that links in that dataset to an NPI number. And so the press could go to the public dataset and the researchers could get that extra dataset and cross walk over to the public dataset? Is that what people are saying?

DR. STUART: I thought we had agreed that this was not going to be linked to the physician. In fact, that was one of the reasons that I thought that it made sense to have it as a separate recommendation. And frankly, I don't see any reason why this wouldn't be public information? What's so special about this?

DR. MARK MILLER: I want to capture a couple of things before we move on what that comment. The line of discussion right now is about samples, separate recommendation and kind of a separate process, for lack of a better word, which would be collected, held, and available through a process which involves signing a data use agreement. That's how we're trying to operationalize Jay's concern that samples information is available.

And this is different, and I just want to parse

this out, from this publicly available dataset that somebody could get online and see what kinds of financial relationships there are between pharmacies and device manufacturers. So I just want to pin that down. That's recommendation one.

And then we're going to have a new recommendation on samples that kind has a data use process that kind of hangs over.

DR. STUART: I'm still not sure I understand why you'd need to go through a data use agreement for this, as opposed recommendation one.

MR. HACKBARTH: I'm with Bruce on that. It seems to me that you want to use the data use structure to get access to the billing number and all of that so you can do that sort of analysis, so that's the restricted access. You'd want to have restricted access for both the pharmacy information and for the other financial stuff. But for each you'd want a public piece it is generally available without DUA limitations.

DR. REISCHAUER: I think there's a real question on whether the pharmaceutical information is of any interest to the public at all. It's not like a pen or a meal.

MR. HACKBARTH: When you say the public, are you including the press? You don't think it would be of interest to reporters?

DR. REISCHAUER: I think they should stick with the Long Island Railroad Pension System myself.

MS. BEHROOZI: I do think that there is a judgment implicit in making the information available about things like pens and meals and baseball tickets, and the other thing that I'm not allowed to talk about, that you want to cleanse the system of those things because there is no good purpose to them, the only purpose is to induce prescribing behavior that otherwise wouldn't happen.

I think what's different about samples, and even though people are saying it goes to needy people and I'm sure Tom gives it to needy people, but you guys have told us before that the samples don't always go to needy people. In fact, it more often goes to people who don't really need it. But still, there's a lot of needy people who get -- and these days everybody is needy; right?

So there's good that comes of the free sample distribution. I think Jay actually said this, we don't necessarily want to discourage the sample distribution, at

least not yet it seems to me. If we put it in this separate category and study it and if there's wildly different prescribing patterns that are induced by the sample business then maybe we should ban the distribution of samples, as George says. And that's a problem.

But to put it in the same category as those things that have benefit but are only about inducement, I'm afraid may be doing a little bit of throwing the baby out with the bathwater or tainting it.

MR. HACKBARTH: Let me just make sure I understand Mitra's comments. Where you're going with that is Mark's proposal which is no public access but access through DUAs?

MS. BEHROOZI: Right, and let it be studied, kind of like the fourth recommendation on waiting to see what the other financial relationship study provides and then go from there.

DR. KANE: Then that goes back to my original concern which I expressed at the last meeting about putting organizations with CME up there because first of all you cannot track it to the physician who's doing any prescribing because that's not in the database. They know which school they gave it to or which accreditor. We don't know how much

of that is bad or good. And the original argument back was well, it's just sunshine. But as you have just pointed out, and I agree with, it's sunshine with a little bit of a taint to it.

And since we don't know which CME - some of it I'm sure is inappropriate but some of it probably is not. Would that also be like the sample debate? Should that also be in a dataset where we learn more about it before we ban it or encourage it? Maybe we should be banning it. But I honestly know some of it isn't all bad, just like the sampling.

So for the things where it's clearly inappropriate, it should be public and on a sunshine list. But for things that maybe some of it's good and some of it's not, should we find out more about it before we put it out there for the media. That, I think, goes back to the debate last time about whether CME and even medical school -- funds that go to those organizations where you cannot link it to a physician ultimately -- should be on the same list as the physician pens.

DR. BORMAN: Just related in follow-up to what Nancy just said, I too share a bit of concern, particularly

about the CME piece because I think there is at least some good that comes out of a number of these programs. And I wonder if there's a way, for example, to have some language about that this wouldn't include unrestricted educational grants. Or that we would want to support the notion of unrestricted educational grants as an alternative.

I think what we're really trying to get at here is what are appropriate relationships. There will always be relationships across these entities and we're trying to sort out the propriety.

MR. HACKBARTH: What we have developing here is a proposal for a new recommendation that includes not just pharmaceutical samples but also other activities that have potential public good associated with them and say these aren't as clear cut. So what we want to do is set up a mechanism that would allow us to study them further before we go to a full blown disclosure. I think that's the gist of what you were proposing, Nancy.

DR. CROSSON: [off microphone] Then that would require reporting.

MR. HACKBARTH: Right. So there would be reporting but it wouldn't be reporting to the full public

first. It would be for use under data use agreements, et cetera, to study. I think that's the idea.

DR. STUART: I'm a little confused about the language here, because it seems to me the distinction is whether the benefit goes to an individual or whether the benefit goes to an organization. Now I know in the case of samples you could say maybe it goes both ways because you're going to make your patient happier if you can give samples, and so that smoothes the relationships.

But I think that if the end point is something other than the physician, then that would be a clean dividing line between the recommendations. In other words, samples don't go -- except in the case of solo practitioners -- don't go to the individual, they go to the organization. The unrestricted grant goes to the organization. The CME goes to the organization.

MR. HACKBARTH: I don't want to get bogged down on this. I think that we've got a concept that we can work with. The key thing is, Mark and Jeff and Ariel, do you have any clarifications that you want to pursue? I fear we're getting a little bit into wordsmithing right now.

MR. EBELER: I hope we haven't gone too far in the

last five minutes to untransparency and a whole bunch of things that I thought we are making transparent. I worry that we're drawing lines that this thing over here is good and this thing isn't. It strikes me that we started off with a framework of just getting the light of day on this stuff and by adding in samples but legitimately thinking of them in a different way, I'm worried that we have implicitly pulled back on some disclosure that sounded awfully important to me.

I don't want to delay the discussion but I just wanted to push back a little bit against this latest discussion.

DR. MARK MILLER: I had the same thought because remember -- and I realize the general drift that we've been on now for a year or however long we've been thinking about this. You can have a straightforward consulting relationship with a physician to help you develop a product. We're not saying that that relationship is bad. We're just saying that that relationship should be public.

So to Jack's point, I'm concerned that there's some sense that some of these things are good and some are bad and we're rendering a judgment.

If there's a clean break on this for us to work with, I think if there is a clean break it's more individual versus organization as opposed to what's good -- and I know you're not saying it that strongly -- but there's sort of this notion of what's a good relationship and what isn't. That's really hard to work with.

MR. HACKBARTH: It's maybe not is it good or not but does it accrue directly to the physician, solely to the physician, or does it accrue more broadly? That's the sort of the line that we're talking about.

DR. STUART: I just want to clarify my statement about dividing them into two parts. I certainly wasn't suggesting that there not be open disclosure on both sides of this. I don't see -- I agree with you, Jack.

I think that the whole point here was to make these relationships known to the larger world. And I think knowing more about what happens to samples, knowing more about what happens with CME, this is good. So I wouldn't put this through a DUA process or anything like that. I would just make the distinction between whether it's an individual that gets it or whether it's an organization that gets it.

MR. HACKBARTH: But if the treatment's going to be the same, why not go through that? Why not just put it in recommendation one and say you report on samples, you report on all of it? If there's not going to be any different treatment in the end it seems pointless to separate it out.

DR. CROSSON: I think that gets to Tom's concern here, which is to say that $250 box of samples that ends up in the hands of beneficiaries and needy patients, let's say, is the same as a $250 gift to that physician, which would be perhaps the implication of just including samples in recommendation one has as supposed a separate recommendation, is probably giving the wrong message.

DR. CHERNEW: In the report there's a type. So if someone is using the database you could distinguish -- this is a clarification question. You could still distinguish. You're never going to lump together samples, which have a whole bunch of other data elements and stuff, with pens or CME. There's a distinction.

DR. REISCHAUER: Especially if we don't have a dollar value for the pharmaceuticals.

MS. BEHROOZI: I respectfully beg to differ with my colleague Nancy about CME. I don't really see that in

the same category as samples because that's often used as a guise for having a party and having some education going on in the middle of it or at the beginning or end of it. I know this from friends who are physicians, none of whom are present here right now.

So just saying that it's CME, I think -- and you just can't do that with samples. There isn't a benefit that inures to the doctor. Whether' it's an individual or a group the benefit -- if there is a benefit -- inures to patients. Now maybe it's the wrong patients, maybe it's the rich patients and not the poor patients. But it's patients or insurance companies or whatever who don't have to pay for the drugs. Is not that the doc, God forbid, goes out and sells them and makes money on them or takes them him or herself.

Whereas with CME there's too much of an opportunity to hide other benefits to that doctor that are not -- yes, that do inure to those participants in the CME. So I still think they're different. I still think you keep samples in a separate category. But if you think it's throwing the baby out with the bathwater the other way then put it all on the same registry.

MR. BUTLER: Just a quick point. I just think a dollar is assigned to all of these different things. As Jay points out, you have $18 billion in this business and you say it's not really about inducement. If we're trying to impact Medicare spending, my recommendation is as it's written up it has to be in that context. It's not about physicians taking gifts. It's understanding the impact of an $18 billion stream here on overall spending.

MR. HACKBARTH: So Peter where do you go with that? Do you support a several recommendation on samples?

MR. BUTLER: For sure. It's a different category with a different level of importance and a different process associated with it, which could result in different reporting. I'm not sure what's recommended is the right one but it certainly doesn't have to be -- and I don't think should be -- thrown in with the first recommendation because it is different, very different.

MR. HACKBARTH: And would you follow Jack's lead in saying that the level of reporting ought to be the same even though we acknowledge it's a little bit different?

MR. BUTLER: His point, don't get so untransparent was right. I don't know the right answer though on how much

transparency, whether it has to be the same level or not? I'm not an expert on that.

MR. HACKBARTH: I think the two major competing alternatives we've got here are separate recommendation on samples acknowledging it's got a little different dynamic to it with potentially a lower level of reporting at least initially, but collecting enough detail and making it available to researchers so that they can probe it thoroughly. So that's one path.

The other is a separate recommendation on samples, acknowledge it's different but full-blown reporting of all types. I think that's where the preponderance of opinion seems to be.

Let us sort of try to reduce it to writing and come up with two concrete alternatives and then we can try to reach closure on it.

Also, in recommendation one we had the threshold issue. We had people on both sides, Peter saying report everything down to zero as I understand it, and some other people saying $100 or maybe even higher than $100. It seems like the difference, to my ear, is not trying to reduce administrative burden so much as not clutter up the database

was I think the way Bruce put it.

So let's spend a few minutes on this.

DR. CHERNEW: As a general rule I think researchers like cluttered databases because they can be sorted through really easily. This is not someone sitting down -- oh no, that's only -- you don't have a spreadsheet on your kitchen table. There's some other version of the way these things are gone through.

I think the bigger issue is that sort of almost an enforcement-type issue. So I view this not as necessary an administrative tracking burden. And I could be wrong, so I'd be fine. It's just it strikes me that that there's a lot of little things that happen in various places, the enforcement mechanism of making that is difficult.

Now I could be wrong if somebody feels a different way but that's --

MR. HACKBARTH: I think the enforcement threshold is way above $100. There's nobody who's going after $100 on enforcement.

DR. CHERNEW: But it gives people who are figuring out whether they're going to track if they happened to be at a trade show and they got a pen or a sandwich or something.

DR. SCANLON: The reality of the administrative burden argument has been characterized exactly right, which is that there isn't any more administrative burden if it's zero or $100 or $200.

Jay, though, I think made the critical point about the political issue here, which is if you look like you're just snooping and you want to know every little detail about everything, that you lose some of your credibility. We're looking for important transactions that may influence behavior. So that's where the threshold becomes important.

It may be true that the research says that a pen matters but that's not going to have a lot of resonance when people come up and say they're making me report that I gave somebody a pen. It just doesn't pass the laugh test. And that, I think, is the critical thing to think about in this.

DR. STUART: And we don't want it to be too elitist here, Mike, because this isn't going to be just researchers looking at this. Part of this openness is so that reporters could look at this, so that this would be available to organizations that might not be at all sophisticated about it. We don't know how that information

is going to be used specifically. But I don't think we want to make it tougher.

So I completely concur on the laugh side. This is something that you don't want to create something that you know when somebody outside of this room looks at it and says how could this group of people ever come up with the idea that every pen should be reported by name, address, and location.

DR. REISCHAUER: I think we're confusing two things. One is the value of the individual item and the other is the sum over the course of the year. That is the sum over the course of the year and there should be some de minimus, like nothing less than $25 has to be put into the calculation.

MR. HACKBARTH: You're even going a step further.

DR. REISCHAUER: That's the way the Congressional system, I think, worked when it was there. A meal below a certain level you didn't care about and you could have 100 $24 meals and it wouldn't count. But if somebody gave you a $27 meal you have to put it on the form.

MR. HACKBARTH: But do you believe with Bill's and Jay's basic point that it isn't so much about administrative

burden or even excessing the database, this is a political statement as much as anything?

DR. REISCHAUER: No, but the administrative burden comes from having to keep track of the 89 cent pen because if you put the thing at $25 you then eliminate from anyone's consideration what you're concerned about.

MR. HACKBARTH: So you're favoring a threshold.

DR. REISCHAUER: For individual items, as well as the sum.

MR. HACKBARTH: So you're favoring two thresholds.

MR. BUTLER: Maybe there's a way we can punt a little bit on this, a suggestion. We're trying to come up with an exact number. We don't really know in this room, I don't think, and we're not experts on this. Maybe we give them some guidance and say something like up to $250 should take into consideration behavior impact, should take, you know the administrative burden is not, should take into account other state's experience. Don't we have some experience with other states on this?

And maybe just have it a little bit more guiding principle criteria and say up to, rather than a specific

number. That would be one way to phrase it. Because I don't know that we really have a clue of what dollar number it should be at.

MR. HACKBARTH: In the first round, there were some people who favored, as a matter of principle zero, starting with you.

MR. BUTLER: [off microphone] I still feel that way but I'll work with you.

MR. HACKBARTH: So the basic options that we have on the table are no threshold, everything ought to be reported; or some variation on a threshold, and it could be softened in the way that Peter describes.

Who wants to go to zero and just say report everything?

MR. BUTLER: [off microphone] But I'm flexible.

DR. REISCHAUER: Or we could tell the Secretary to do it.

MR. HACKBARTH: I think that's sort of where Peter's second idea leads, is that a threshold ought to be set, taking into account, blah, blah, blah. I see a number of people nodding that that sounds like a reasonable direction to go on the threshold issue.

So you want zero? You want a specific number?

MS. BEHROOZI: Yes, because I feel like we've talked about a lot of this stuff and my own opinion is I feel like $100 accommodates the various interests.

DR. MARK MILLER: The only thing I would say about not stating a number and sort of leaving it is you'll have much less impact when you print this.

MR. HACKBARTH: Let me ask for a show of hands on this. How many would like to have a specific number, you know $100, and just stick with that, as was in the draft recommendation?

DR. CASTELLANOS: Are drug samples included in that?

MR. HACKBARTH: No, they would be outside. Okay, we're done with the threshold issue.

DR. REISCHAUER: And you're including everything in this, as opposed to having some individual...

DR. MARK MILLER: We discussed this. We came to you with $100 number because the concern was if you set an individual transaction number what you get is what you just said, 25 dinners for $24. And rather than chase that around, our point was you hit $100 and then you report, and

trying to keep a fairly straightforward principle here.

MR. HACKBARTH: Congress is going to have it's own thoughts about this issue, so I'm not all that worried about our working this one out in detail.

A more important issue that I'd like to get to, and we are running out of time, is the scope. Who's included under recommendation one. Nancy and some other people had said why do we stop with this list? Among the people who have been mentioned for inclusion are pharmacists, health plans, PBMs. I'd like to hear a little discussion about expanding the list. In particular, people have reservations about expanding the list.

MR. BERTKO: I'd only say that indicative of maybe one or two health plans, we generally would have a $25 reporting -- not even reporting, not allowed to take more than that. So this one would seem to be -- well, I won't say unnecessary but less productive for the health plan side and maybe for the PBMs. I don't know about the PBMs.

MR. HACKBARTH: Other thoughts on expanding the list of people who are required to report?

DR. BORMAN: Just on general principle, I think it would be a good thing. I think you want to set the tone

that what we're requiring here is reasonableness and propriety and professionalism across every part of this process. I would favor doing it for that reason.

MR. HACKBARTH: Do people support that?

DR. DEAN: I was going to say again, we might run into problems with the structure of the report because some of these can be tracked to individuals and some of them can't be. Maybe you'd have to have two different elements.

I think reporting the payments is appropriate, but the report becomes a little more complicated. But maybe that's okay, maybe just have a separate category for payments that go to organizations and so forth that can't be tracked to individuals.

But certainly I think the original intent was to report those direct payments to individuals. That was the first thing. But these other concerns are all legitimate.

MR. HACKBARTH: Put up draft recommendation one, please. It's not just individuals who are currently on the list. We've got a lot of organizations. And so I don't see health plans and PBMs as being conceptually different proposals and medical schools.

DR. SCANLON: I share some of Tom's concern, which

is the idea that it's the individual were interested in. And I would say it's an individual with decision making authority that we're particularly interested in. If there's money going to an organization that has not been linked to the individual who ultimately gets it, that's the problem.

One of the problems we have here is we've taken a concept, which is reporting to deal with potential conflicts of interest. And instead of doing it in the usual way, which is to say the person that makes the decision is the one that reports, we're talking about getting all of the people that give that person the money to report.

And the way we deal with it, and the way all Federal employees and members of Congress deal with it, is they report the money they get and the gifts they get and everything from all these other sources. We're now trying to not put any kind of burden on the providers, we're doing it on the giver, and that creates this issue.

That's why I guess I suggested earlier that I would like indirect and direct financial relationships with physicians because I don't want the money to go to a practice and get lost. And that may be Tom's other categories.

DR. CHERNEW: Mark had mentioned and I was going to make that point, too, that this issue of the practice is important. So I am supportive of the notion of broadening the groups because many of the decisions we care about occur at a group level. And in many cases, even if the money is given to a group, it's clear how that might flow amongst the people involved if it's not clear according to the official line. So I think a broader spectrum of organizations, to include physician practices and other types of things that aren't delivered to the physician, is useful in the spirit of this.

MR. HACKBARTH: Any other comments on this? Who would like to see the list expanded to include health plans, PBMs, and pharmacists? Who would like to see the list expanded to include those?

Okay, we will expand it.

Then recommendation three, and we had a couple thoughts on recommendation three. One was a proposal that we not limit it to ASCs. It's currently structured as hospitals and ASCs, but I think it was Nancy noted that there's all sorts of other types of outpatient operations that could be put into this category.

Who would like to see it expanded? Let me get comments on that.

DR. REISCHAUER: My point is a little different, and that is I'm an investor-owned hospital. What happens if I give stock or stock options to physicians? It would be excluded under this I think, right? And so I think you want to include.

MR. HACKBARTH: Let's come back to that for a second and focus just on whether we expand it beyond hospitals and ASCs.

DR. CASTELLANOS: I think we should and I think the independent diagnostic testing facility, I think any of the radiation centers specifically, and radiation therapy centers. As far as ASCs go, I think that would include some of the diagnostic colonoscopy and the ophthalmology, but we would certainly expand what ASC stands for.

MR. HACKBARTH: So once you start adding to the list, it raises the question of why stop? Why isn't it any entity that bills Medicare in which a physician has an ownership interest?

DR. CASTELLANOS: I think we're looking for transparency and if we don't look under each leaf, we're not

going to find it.

MR. HACKBARTH: I see a bunch of heads nodding to make it more comprehensive.

MR. BUTLER: I just have a clarification how this relates then to recommendation four, which in part is going to further define what should be collected in hospital-physician relationships; right?

DR. MARK MILLER: Here was the game plan coming into this.

MR. BUTLER: I thought that that's what we were -- let's get more -- and then we'll broaden this category appropriately when we get more data.

DR. MARK MILLER: There's a couple things in play here, so here's the implications of what you're are saying and I'll start with what the game plan was coming in. The game plan coming in was we already collect ownership information on hospital and ASCs. That's available for anybody who has 5 percent or more.

So the simple track was we're already doing this, make sure we collect everyone, not just 5 percent or more. And again, this is a hospital ASC concept. And we know there's a survey going out looking at other financial

relationships for that, and then we'll come back once we have that and make perhaps additional recommendations about relationships. So that was the strategy coming in.

Certainly conceptually there's no resistance to the idea of well, there are other relationships, why aren't we looking at IDTFs or whatever the case may be? The thing that you should bear in mind is that the ability for people to act on that will be a different time frame because that data -- and I'm looking at you guys -- is not currently available.

So in making this recommendation, if we expand the list we should also be clear that for the stuff that you have handy you should make that public immediately and then talk a little bit more about how they move to these other actors that you're referring to. I think that's what the nature of the recommendation would look like bouncing back.

But I would still say on four, on additional relationships -- well, our starting position is let's see what that survey produces before we start defining other relationships. So there's two dimensions, other entities and other relationships, that are kind of in play here.

DR. STENSLAND: Just to clarify, the IDTFs do have

to give this information. So we could work up some language about who already has to do it. And it's things like independent clinical labs, IDTFs, mammogram centers, mass immunization centers, x-ray suppliers, slide preparation facilities. All those kind of places have to fill this out. So we could work out some language.

MR. WINTER: Part A providers also have to fill this out, so I believe that would cover skilled nursing facilities.

MR. HACKBARTH: What is the this in that sentence?

DR. STENSLAND: There's a current form that they already have to fill out if they're a corporate entity, and it says who owns more than 5 percent? Or if you are a partnership you have to fill it out. So this is the current form that they're filling out and who has to fill it out.

MR. WINTER: This is what they're already collecting so it's more than just information on ASC and hospital ownership that extends to these other kinds of providers.

DR. SCANLON: I find it a little bit foreign to be against waiting for data, but I think it's the principle here that should be what's driving us. And we should do it

in a way that if there isn't a problem out there we're not creating one.

So if you set the principal, again going back to what I said earlier, the people that are billing Medicare for things that physicians authorize have to report on their financial relationships with physicians. That's the principle.

Now you don't have to do any reporting unless you have a financial relationship with the principal. So I don't feel like we're causing any harm by setting that out as our standard, that we want this transparency about these relationships.

I'm afraid that if we get data today and it doesn't show that there's something going on in one area or another we might leave it out and then who knows what's going to happen a year from now, two years from now, et cetera, when people get imaginative and they start to do something in that area.

So go down the list of Medicare types of providers and there's the potential that somebody -- and we've seen this happen in the past. People recognize an opportunity that's existed for a while but they suddenly move in and

then we're playing catch-up. I think in this instance we shouldn't play catch-up.

DR. CHERNEW: I wasn't sure about the this and whether the filling out of that form required you to have a 5 percent ownership or not.

Ariel is shaking yes, Jeff is...

DR. STENSLAND: It depends.

[Laughter.]

DR. CHERNEW: It was originally a short question.

DR. STENSLAND: They structured it so that if you're a corporate entity then you have to have a 5 percent ownership. If you have less than 5 percent ownership in your corporate entity, you don't have to fill it out. If you're a partnership, then you have to fill it out no matter how small the ownership interest is. I think this was the original way to get around this problem of publicly trading companies not knowing who's buying and selling their stock.

DR. CHERNEW: I'm not even sure I understand that, but I will nevertheless -- what I'm worried about in terms of the 5 percent ownership is that's 5 percent ownership in something that could be big. So an individual physician could have less than a 5 percent ownership which might not

be consequential to the organization on its own, but it might be very consequential to the actual physician.

You're going to ask I think for a show of hands for what people support in terms of broadening, and so I will vote to support to broaden.

MR. HACKBARTH: That is the question. So on draft recommendation three, do we want to expand this beyond hospitals and ASCs to include all providers who bill Medicare in which physicians have an ownership interest? The language of three right now is that directly or indirectly owns, and then four goes to collecting information on other types of ownership interest. Other types of financial interest, excuse me.

DR. SCANLON: I am in favor of going there in three, other financial relationships.

DR. CHERNEW: I agree with Bill.

MR. BUTLER: Now I'm confused again, and I thought I had it straight. When you say financial relationships and compensation, all those other things, that's was what was in recommendation four. The entities were in recommendation three. And I would support entities, which is a broader definition of three. But I think the compensation

relationships, we need to know more about that from that data to give better direction. I agree with this principle but I think we're not ready to guide on that until we get that data.

MR. HACKBARTH: So let me ask again. The proposal I'd like you to react to is keep the existing structure of three and four, whereby three is about directly or indirectly owns an interest. It's not about other types of financial relationships. It's about direct or indirect ownership. But extend that to other providers beyond hospitals and ASCs, to all providers who bill Medicare. That's the proposal.

And then we'd have a recommendation four about collecting more information on other types of relationships which could lead to recommendations in the future.

DR. KANE: What if it's a multispecialty group practice that's in a partnership arrangement? Is that one of the entities you want ownership of, or do you want only ownership when the physician refers to an -- do you want referral to an ancillary service or they own their own practice in a partnership or a group? Do you want that, too?

I would think you wouldn't want it if they are a direct group practice or a partnership but you would want it for things that they might send patients to that generate revenues beyond the time they actually spend seeing the patient.

MR. HACKBARTH: That makes sense to me, does it make sense to other people? So it would not include the physician partnership.

Who wants to simply broaden the list of providers under three but keep it as owns or ownership interest -- owns directly or indirectly?

Then the last question, Bob raised an issue about what does directly or indirectly owns -- does directly or indirectly owns include stock grants and options? I would think the answer to that is yes.

I think that was the full list. Did I miss anything, any big issue that we haven't talked about?

Just physicians-owned hospitals. Were not going to go there this time. We spent two years doing physician-owned hospitals.

MR. GEORGE MILLER: I wasn't here.

MR. HACKBARTH: I know. I was. That's what

matters.

DR. BORMAN: Could we consider, and this could be an easy yes/no, in an attempt to try and put some positive here, as opposed to necessarily we're out to get you, evil actors.

Is this a place where we can work in some mention in the discussion about not wanting to discourage appropriate relationships or something about the ability to foster gainsharing, actually is where I'm going? Is that sort of the flip side of this, that these are things that potentially are bad but there are some things that we want to be careful that this doesn't run over into? Just a question.

MR. HACKBARTH: I agree with the direction you're coming from, but again I would underline this is about disclosure. When we've talked about gainsharing, we've said that disclosure is an important part of that, among other things, other rules to govern the relationship.

I think we're done. Thank you, good job.

Next up is the MIPPA mandated report on Medicare Advantage and the work plan for that work.

DR. HARRISON: Good afternoon. Today Dan and I

will go over our work plan for the MA payment report mandated in MIPPA.

Section 169 of MIPPA requires a MedPAC study and report on Medicare Advantage payments. In it we are assigned three specific tasks. MIPPA directs us to study the correlation between MA plan costs to deliver Parts A and B benefits and county level per capita spending under fee-for-service Medicare.

We must also evaluate CMS's measurement of the county level spending.

And based on the findings from the first two tasks, we are to examine alternate approaches to MA payment other than the county fee-for-service approach and to make recommendations as appropriate.

The Commission last made MA payment recommendations in the June 2005 report. I'd like for you to keep in mind two of those recommendations as we go through the work plan. The exact text of the two recommendations is on this slide, and I'm not going to read them. But in short, we recommended that that the MA benchmarks be set at 100 percent of estimated fee-for-service Medicare spending. And we also recommended that the

county payment areas be enlarged from the current county level to better approximate health care markets.

Looking at the first task, MIPPA requires us to study the correlation between what it costs plans to deliver Medicare Parts A and B benefits and what it costs Medicare through the fee-for-service Medicare program to deliver the same benefits.

We are well aware that there is significant geographic variation in fee-for-service spending and the Congress would like to know if there is a relationship and, if there is, the strength of that relationship between plan costs and fee-for-service spending in an area.

Why is Congress so interested in learning more about the relationship? For one thing, the current MA payment policy presumes a strong correlation between plan and fee-for-service costs at the county level. Benchmarks are set so that they do not fall below county fee-for-service costs. This analysis could also help inform on how any future benchmark changes might affect geographic areas with different levels of fee-for-service spending.

For this analysis, we are specifically instructed to use the plan bids as the measurement of plan costs and

CMS estimates of per capita county level spending as the measurement of fee-for-service Medicare costs.

To answer this question, we will analyze plan bid data to produce correlations of plan costs with county level fee-for-service spending. We will obtain the 2009 bid data from CMS shortly. The data will contain the plans A/B bids for 2009, broken down into projections for medical costs, administrative costs, and profit. These data will allow us to compare MA plan projected costs with fee-for-service Medicare projected spending. The data should provide us with several different plan costs measures to correlate with the measures of fee-for-service Medicare.

We can correlate the average plan bid in a county with the projected fee-for-service spending in the county. Both the plan bid and the fee-for-service spending represent projected costs for 2009. We can also correlate just the medical cost component of the bid with fee-for-service spending to see if medical costs are more closely related to the fee-for-service costs, which do not vary because of profits or admin costs. This would also allow us to see if profits and/or administrative costs drive some of the variation in the bids.

These comparisons are comparisons of projections and we had hoped we could also compare actual spending, but that does not look possible for now. I know that I had put something in the paper about looking using the look back but that data is really not appropriate because it's only collected at the contract level so there's really not any geographic information in it.

However, we can learn more by using the bid data if we use more sophisticated analysis than simple correlation. We intend to use regression analysis to see to what extent the bids are a function of fee-for-service costs in the county. We would estimate the relationship between plan costs and fee-for-service spending with an equation that when simplified would look something like you see up there: plan costs would be equal to fixed costs plus a percentage of fee-for-service costs.

Such an equation would tell us how much plan costs depend on the level of fee-for-service spending in a county. We might also learn where Medicare plan payments might be advantageous or disadvantageous to plans in areas where there are different levels of fee-for-service spending. We would run separate analyses by plan type to see if there are

inherent cost structure differences such as between private fee-for-service plans and HMOs. We would examine several versions of the equations, trying to account for other factors such as market size and the number of competitors and anything else we think might pop up.

We have also been directed to study the accuracy and completeness of the county level fee-for-service Medicare spending estimates produced by CMS. The mandate specifically requires us to determine whether the fee-for-service measures fully incorporate VA spending on Medicare beneficiaries and whether they include all appropriate administrative costs. Further, we are asked to suggest how the accuracy and completeness of the estimates could be improved.

As mentioned earlier, CMS's fee-for-service spending estimates help determine the MA benchmarks and payments. CMS currently uses these estimates to update the benchmarks. CMS must update the estimates of county spending at least every three years but they may update more frequently if it chooses. Some plans had complained that the fee-for-service spending estimates did not offer a fair comparison to plan cost because the estimates do not include

the VA's cost for treating Medicare beneficiaries and they do not include all of the administrative costs it takes to run the fee-for-service program.

In response, we will examine CMS's estimation process, first by interviewing CMS actuaries who are responsible for the estimates. We will then examine the estimates themselves. We will measure the year-to-year variation in the county estimates. We are particularly interested in whether variation is more of a problem in counties with smaller populations. We will also look at how much difference there is between adjacent counties. These lines of inquiry pertain to the question of accuracy because we would hope to find stability in the estimate over short periods of time and distance.

We will also investigate the VA and administrative cost issues. However, we will not just look to see if all the costs are included, we will also think about whether and how they should be included.

I'd like to mention that in our June 2005 report we did an estimate of the county level fee-for-service numbers and the appropriateness of using them to set MA payment rates. The assessment was part of an MMA study. As

a result of that assessment, we were concerned that the county might not be the most appropriate unit to use as a payment area, and Dan will say more about that in just a couple of minutes.

The Commission has long expressed concern that excessive payments to plans are attracting inefficient plans to Medicare Advantage and are threatening Medicare's sustainability. So incorporating the findings from the first two tasks, MIPPA asks us to examine alternate approaches to MA payment. Specifically, we are asked to examine approaches other than the approach using payments based on county level fee-for-service spending.

Fee-for-service spending varies greatly across the country. Before the BBA of 1997, plan payment rates were set at 95 percent of county level fee-for-service Medicare spending. In 1997, plans were available to about two-thirds of all Medicare beneficiaries and less than one-quarter of rural beneficiaries. Currently MA plans are available to all Medicare beneficiaries. However, we believe at least some of the availability has been purchased by benchmarks that are well above the fee-for-service Medicare spending.

The Congress is concerned that variation in fee-

for-service utilization caused the geographic disparity in plan availability that occurred when payment was tied directly to county fee-for-service Medicare spending. The Congress is interested in exploring payment approaches that might support broader plan availability than that of the pre-BBA period. These approaches might involve paying rates closer to plan costs rather than focusing on local fee-for-service costs.

We will examine alternate payment approaches that have arisen from our past work and recommendations on MA payments. Recall again that we have recommended that benchmarks be set at 100 percent of fee-for-service. There are several approaches we could take that would result in a national average of 100 percent of fee-for-service without the need to set each county at the local 100 percent level.

One approach is to use a blend of local and national fee-for-service costs, which we raised our June 2007 report. We can try a variety of blends and we will include a particular formulation suggested by some analysts that the proportions of local and national spending be based on the results from our plan cost equation that I mentioned earlier.

Another approach is to use a national benchmark like that used to set payments for Part D plans. We will examine a national benchmark that is adjusted only for price difference is not for utilization differences. We can examine any other variance of interest.

We will simulate how each approach would have changed Medicare benchmarks and resulting payments in 2009. We can also estimate how many enrollees would have seen large changes in the value of benefits they receive from plans assuming that the plans did not change their bids in reaction to the benchmark changes.

Now Dan will discuss some of the other alternatives that focus on payment areas.

DR. ZABINSKI: As Scott mentioned earlier, the county currently serves as the payment area for MA local plan, but use of the county as the payment area does present some problems. Specifically, in the process that CMS uses to set county benchmarks against which plans bid, some benchmarks equal county fee-for-service spending. But some counties have low Medicare populations which can make the fee-for-service spending unstable over time because unusually high or low health care costs among a few

beneficiaries can cause substantial year-to-year changes in the fee-for-service spending in these low population counties. Consequently, it's possible that a county can have a measure of fee-for-service spending that differs substantially from its typical level, and this can be carried forward into an erroneous benchmark.

A second problem is that adjacent counties often have very different fee-for-service spending and therefore very different benchmarks. And if adjacent counties have very different benchmarks, plans may offer less comprehensive benefits in the county with the lower benchmark or they may avoid that county altogether, creating appearances of inequity between those adjacent counties.

Moreover, beneficiaries can live in close proximity but be in different counties with very different benchmarks. Because of the close proximity of the beneficiaries plans may view the beneficiaries as having similar costs but might choose to serve only the county with the higher benchmark.

In previous work on payment areas, we evaluated alternatives to the county definition that addressed the problems created by counties. From that analysis, the

Commission made a recommendation that said first, among urban counties payment areas should be defined by metropolitan statistical areas. And among rural counties you should collect counties so the payment areas reflect local health care markets.

The guidelines that the Commission used in developing the previous recommendation on payment areas included three points. First, you want to make payment areas larger than counties, and this will result in more stable fee-for-service spending over time because payment areas well, as a result, have more beneficiaries. Also, it will likely reduce the extent to which large differences in fee-for-service spending occur between adjacent counties.

At the same time, though, you don't want to make payment areas too large because, first of all, in some counties -- especially in the Western United States -- they cover a lot of area. Secondly, in large payment areas the costs of providing care can vary widely. Plans may find they are profitable in some parts of a payment area and unprofitable in other parts. If a plan is required to serve an entire area, as they currently are, the potential losses in some parts of the payment area may cause the plan to

avoid the payment area altogether.

And finally, payment areas should approximate market areas served by health care plans. In our previous work we looked at a number of possibilities for payment areas and in the end the Commission recommended that MSAs should serve as the payment area in urban areas and an entity called Health Service Areas should be used in rural areas. The idea of a health service area, they're simply groups of counties in which most of the short-term hospital care received by Medicare beneficiaries who live in an area occurs in hospitals that are located in the same area.

In this new study that Scott and I will undertake, we plan to replicate the payment area definition from the previous recommendation but we also plan to examine other alternatives that address problems presented by the county definition. We will evaluate each of these alternatives under the current approach for paying plans and the alternative payment approaches that Scott discussed earlier.

That concludes and we will turn it to the Commission for discussion.

MR. HACKBARTH: We will have a brief first round of comments -- that's right, I forgot the clarifying

comments. Any clarifying questions?

DR. KANE: My only clarification is can we just get a little history on why we don't just have national average per capita costs adjusted by the wage index and the population's characteristics? What was the philosophy behind AAPCC to begin with? So we know why we might want to move on?

We could just use the way we do DRGs, sort of a national average per capita cost and then adjust it for population characteristics and wage index, and then therefore not take into account utilization variation because we think we shouldn't. Or as long as we've taken into account population.

I guess what was the philosophy behind AAPCC to begin with?

DR. HARRISON: This was actually a little before my time.

MR. HACKBARTH: It wasn't before mine.

[Laughter.]

MR. HACKBARTH: Sad but true.

The antecedents of today's program were in 1982 where Medicare opened up risk contracts to HMOs. And that's

where the idea of 95 percent of the average adjusted per capita cost was first put into program-wide use. It had been used in some demo projects before that.

The basic philosophy was boy, we want these private plans to come in and serve Medicare beneficiaries if they can do it for less than traditional Medicare. So the concept was link it to Medicare costs in the particular market and take 5 percent off the top. And then if the plans are so efficient that they can do it for that amount, by all means come into the Medicare program.

So that was the guiding philosophy.

DR. KANE: I guess the obvious next question is if that was the philosophy, why is it still in place at a higher average? If the philosophy was to see if they can be local, as opposed to getting towards some national average standard, why are we now saying let's see if they can beat local by 120 percent?

MR. HACKBARTH: Several steps here. It started with 95 percent of the local costs. And then MedPAC actually recommended, early in my tenure on the Commission, going to 100 percent and saying let's have a level playing field and not take 5 percent of the top. If plans can do it

for less than 100 percent, they be able to offer additional benefits and we want them to come into the program.

We got to paying more than 100 percent, as Scott indicated, through a series of legislative interventions, creation of local geographic floors.

Basically what's happened over time is that the underlying goal of the program has migrated. It went from oh, let's import efficiency into Medicare, let's invite private plans who can do for less in, into a philosophy of equalizing access to private plans in additional benefits across the country. And that shift in philosophy == it's not about efficiency, it's about equalization of benefit opportunities across the country -- has fundamentally changed the program. And that's how we got to have 130 percent of local costs, 140 percent of local costs in some cases.

To me the payment stuff is driven by what is your goal for the program? If you want it to be about encouraging efficiency, then you need to go to a neutrality payment approach. And I'm all in favor of added benefits for beneficiaries, but there are more efficient ways to get added benefits if that's your goal. But obviously Congress

doesn't necessarily agree with my philosophy of that.

DR. SCANLON: One footnote on

that is that in the BBA there was an attempt to homogenize the rates because there was going to be, among the options, a blend of national and local rates. But it was an option and it never got triggered -- I think maybe it was triggered for one place, one time and then the other options always prevailed, in terms of what was going to be the rate.

DR. CHERNEW: The key variable you use to measure MA costs was the plan bid?

DR. HARRISON: Yes.

DR. CHERNEW: Could you just explain what exactly is in the plan bid more? What it's adjusted for? Does it include if they provide extra benefits? Is that in their bid?

DR. HARRISON: Yes.

DR. CHERNEW: So it's standardized for a bunch of stuff. I'm just not sure what it's standardized for.

DR. HARRISON: It's standardized for risk. It's standardized for geography. And it is only the A/B benefits. So it's the Medicare package.

Now yes, the plan does submit another bid if they're going to offer supplemental but that's a separate field in the bid data.

DR. CHERNEW: Are you confident that it's a meaningful number that's actually measuring their costs?

DR. HARRISON: It is a measure that they're going to get paid based on.

MR. HACKBARTH: That wasn't a direct answer.

DR. HARRISON: I'm confident that's the best thing we have, as confident as I would be in any hospital cost report.

MR. BERTKO: Let me expand on that. There is a process that actuaries have to certify to that says you start with this data. Now Scott alluded to but didn't state as explicitly as I will, you base it on the data that you know. Your plan data, though, is by contract generally. And in some counties, for example, you might only have 1,000 members signed up. That's not an adequate amount. So then you have to do a combining of experience in order to get the average manual rate, which then gets adjusted back by other factors.

So is it anything other than an actuarial theory

to get to the right number? No, but it's something that could be audited. And in general, I think the actuaries signing off on it are trying to do an honest job on this.

DR. REISCHAUER: You would include in that your marketing costs, your administrative costs, things which you can adjust up and down?

MR. BERTKO: No.

DR. REISCHAUER: It has nothing to do with the cost of providing medical services.

MR. BERTKO: The answer is you have two parts to it. You have the A/B costs by themselves, and you have admin and profit by themselves. So you can see them in the different fields. You see that; right?

DR. HARRISON: Yes.

MR. HACKBARTH: Other clarifying questions?

MR. GEORGE MILLER: I believe you mentioned that you decided not to use the look back methodology?

DR. HARRISON: The look back data is much more highly aggregated. And so Humana has a nationwide bid, for instance. In this data they have one number for their cost. And that wouldn't be very hopeful to try to match up with counties.

DR. MILSTEIN: In the presentation, when you talked about analytic method three, which was to look at actual plan spending, you said that you couldn't do that. I'm still not clear why can't do that.

DR. HARRISON: That is what I was just talking about. The look back data is not as detailed as the current bid data.

DR. MILSTEIN: Why is it not as detailed?

DR. HARRISON: My guess is that the plans can't disaggregate it as well as they would like to.

MR. BERTKO: Let me again just say it in different words. Particularly in private fee-for-service, where you might have 50 people in the county that Tom lives in, that's a meaningless number. And so a company could have 100,000 total private fee-for-service members, which is completely credible, which feeds into the national number. Or it might have a Californian number, which Jay's company has, which is completely credible with 400,000 Medicare beneficiaries. Actuarial wizardly.

DR. MILSTEIN: Let me reframe my question. Why couldn't we have more detailed information in circumstances where there are enough enrollees to permit a stable

actuarial conclusion?

DR. HARRISON: The data that we have is just one number per contract.

DR. MILSTEIN: Is that because CMS has not required more detailed information?

DR. HARRISON: Yes, that's correct.

DR. MILSTEIN: That is a potentially solvable problem in the geographies where there's enough plan enrollment to justify a meaningful interpretation.

DR. CHERNEW: But going forward you're going to have more detail?

DR. HARRISON: Going forward they make projections by county.

MR. GEORGE MILLER: But going forward, isn't that something we can recommend in the future so that this doesn't become a problem next year when we look at this data?

DR. HARRISON: Actually, once we have the encounter data, we would know by county.

MR. BERTKO: Let me only saying Scott's use and Dan's use of the bid data is a pretty good proxy for this because it's got to be adjusted for what actuaries expect to

be spent. And so while Bob correctly said could you move some of the numbers around? The answer is yes, a little bit. But it is going to be a pretty decent proxy. It doesn't give you a perfect number but it gives you a good estimate.

DR. MILSTEIN: Maybe this is better directed at Mark and Glenn, but here we have a situation where there appears to be a conflict between two directions from Congress. On the one hand, they have gone on record as saying they want Medicare to pay what it takes for an efficient provider to deliver a service or a package of services. On the other hand, we have a Congressional decision that violated that at one point in time, X years ago, when the MA program was getting revived.

Should we feel free to tilt toward one rather than the other signal from Congress? They both pertain to this and they're pointing in different directions.

MR. HACKBARTH: My thought on this is that an important part of the discussion in this report needs to be what is the goal? Because that really drives your payment policy. And so yes, I think we ought to be surfacing that question in an explicit way for the Congress.

Any other clarifying questions?

DR. MARK MILLER: The only thing I would quickly add is it seems to me, to the point on the look back data, we could, as part of this report, in addition to the philosophical and what's the goal and all the rest of it, make statements about what data we want in the future. Because we thought that file was going to be disaggregated enough to deal with Mike's question, which is were the bids accurate looking back, and your question. So we can make this statement. There's nothing that would prevent us from doing that.

DR. REISCHAUER: There's also a question on whether you couldn't get closer to the "truth" by averaging three years or something like that of these bid numbers.

MR. HACKBARTH: So we've gone through the clarifying questions. Other questions comments, a quick round.

MR. EBELER: Scott, in the scope of this it's not totally clear to me how we're thinking about the value of the non-A/B benefits, the extra benefits that plans are providing. It strikes me that it would be valuable for the Congress to know what is the real actuarial value of those

benefits because a big part of the debate up there is yes, you're overpaying but there's these benefits provided. There's a clear part of that that I think many of us look at and say that wasn't the intent of the program.

But even setting that aside, being able to quantify how much we're really getting for that extra money, if we're paying an extra $1,000 per person and getting X dollars in extra benefits, that tells us something. Are you going to be able to know that in this process, in high payment and low payment areas?

DR. HARRISON: Let me first give the legal answer to that, that's not part of the mandate.

MR. EBELER: Is it precluded by the mandate?

DR. HARRISON: Actually, the mandate tells us to use specifically the bids for A/B benefits.

But the bids do have data on what they're saying, what the plans are saying that they're providing in extra benefits. I don't know what we would be able to get out of the look back.

And again, as we go forward, not only are plans supposed to be reporting encounter data on Medicare benefits, they very well may also have to report data on

supplemental benefits that they're providing. So we might get some more information in the future.

MR. EBELER: I guess I would just encourage you to look into whether we can say anything about that, because it just strikes me that it's a critical part of this discussion.

DR. MARK MILLER: A couple of things on this. I would take this question as just a commissioner asking a question and we can decide whether it fits into the mandate or something else. I think the answer to this is we can't quantify the dollar amount that is attached to the additional benefits themselves, but we can routinely report the difference between what is paid and how much is provided in a dollar amount for the extra benefits.

DR. HARRISON: You mean the projected costs using the actual bids? Yes, we can do that.

DR. MARK MILLER: Do see the distinction that I'm drawing?

DR. HARRISON: Basically it's the rebate dollars. You can see what the rebate dollars are.

MR. HACKBARTH: But that's an actuarial estimate of what the added benefits will cost; right?

DR. HARRISON: Yes.

MR. HACKBARTH: And by law they have to provide all of the difference between -- 25 percent goes to the Treasury and the rest has to go back in added benefits or lower premium.

MR. BERTKO: [off microphone.] [inaudible.]

MR. HACKBARTH: That's a cost, isn't it?

MR. BERTKO: [off microphone.] [inaudible].

MR. HACKBARTH: That would elevate your cost.

MR. BERTKO: [off microphone.] [inaudible.]

MR. HACKBARTH: Before we go further, let's just talk about -- refresh people's recollections about the process here. This mandate is for a report due in 2010.

DR. HARRISON: March 2010.

MR. HACKBARTH: So remember last time we talked about potentially doing an earlier report on the narrower version of this, specifically addressing the questions in the mandate, and then potentially having a broader MA report with part two coming not this year but later on. So I just wanted to remind people of that. To the extent that we add lots of new stuff in this beyond the mandate, it's a going to compromise our ability to do something this year.

DR. CROSSON: Just on that point for a second, I remember what you said but I thought that was related to the comment that there was pressure coming to actually fast-forward the narrower report prior to March 2010. Or are we saying that we would wait until March 2010 for the narrower report and then, subsequent to that, do this?

MR. HACKBARTH: What it was saying was what we're looking at is trying to do a narrow report in 2009. I'm not sure I would use the word pressure to describe it but there's been some expression of interest in an early report if we can do it.

DR. CROSSON: In the context of that point, and then speaking to the March 2010 construct here, or as Jack said what the scope of this is, it would seem to me useful -- I don't know how easy it's going to be -- it would seem to be useful to take the time, because there is time, to think about what we would want the ideal Medicare Advantage payment process to look like, and make recommendations based on that.

And so it would seem then that that's going to require some thought about what the MA program is there to do in the first place because what the payment system ought

to do ideally, as we think about other payment areas, it ought to at least not obstruct and possibly incent structures, behaviors, outcomes, and other things that are viewed to be good, whether that has to do with higher quality, reduced cost, and the like.

For a long time we used the term coordinated care plans for now what is a portion of the Medicare Advantage program. These are just some ideas. Is that still the case? If so what does that mean? And should the payment process that we think about in some way reflect the fact that coordinated care is part of the purpose of having the MA program in the first place?

If we want these two programs, that is traditional Medicare and Medicare Advantage, to coexist on an equal playing field then it would seem to me -- and we don't want plans running for the exits as they did in the late 1990s -- that there needs to be something here that at least has to do with predictability of reimbursement over time. Because my guess is that a payment system that is more predictable for large organizations is going to be more apt then to promote the kinds of commitments that those organizations would want to have.

And then the last one, and this touches a little bit on what Jack talked about. I think we probably have to have some explicit discussions about whether or not we think the ability of the efficient plan to then turn around and provide extra benefits to reward beneficiaries for, for example, making the choice to limit provider choice is a good thing or not. Because there's some sense, at least in some conversations I've had, that people are saying that's an inappropriate use of MA resources. And I think there's an argument to be made that, in fact, when beneficiaries choose MA plans they make certain sacrifices to get certain things. And one of those things is additional benefits.

I think over the next year it will be useful, and I think ultimately create a stronger MA program, if we have dialogue -- even if we find we have different values -- if we have a dialogue about issues of that kind.

MR. BERTKO: First, let me recognize that Scott and Dan have a robust task ahead of them. So they're going to be busy.

Having said that, let me add a couple of comments here, probably a little more technical than the ones that Jay offered, which I pretty much agree with.

The first is just about the more narrow question of rating areas. I had something akin to this task in the early 1990s, as California set up a purchasing co-op. One of the things we did rather than arbitrarily draw lines is we used insurance company rating areas. So we made six companies, I think, unhappy because we didn't take any of their individual rating areas but we managed to narrow it down that they could all accept it.

That makes the presumption that under 65 type rating areas will flow and have service patterns roughly the same as Medicare. I don't think that's quite right, but it may be a useful construction in a state as large as California. For example, we ended up with six rating areas there, which everybody pretty much found acceptable.

In a state like Arizona, where I now live, Maricopa County is a gigantic county. And you could have two county level rating areas and then an all other for the rest of the state, also even more gigantic.

A second point would be we've got one natural experiment on wide rating areas, and Scott you may have thought about this already, but regional PPOs already are one or two state -- actually there's one that I think is

more states -- rating areas. And looking at the experience of those might also be useful as early feedback on what the different kinds of rating schemes might do.

A third element here, and this just expands one of the tasks you put up there about talking to the CMS actuaries, who I think do a terrific job on this. I could suggest one or two plan actuaries that might have useful feedback. And I count myself out from them now, since I'm now about two years off of a full set of bids.

The last comment is I applaud your look at the VA costs. I was one of the hecklers that said this was a missing element for at least 10 years. And so it would be useful to get into there and look at those costs.

I would also want to be sure you looked at that regionally, because I think it's going to vary dramatically by which counties military and VA retirees are setting in today. So you could have quite different numbers in different parts of the country.

DR. CHERNEW: First, I'd like to recognize that Dan and Scott have a robust task ahead of them, I'm going to offer maybe a few more technical comments. I'm actually going to try my hardest not to offer that many.

The first thing I'll say is there's a growing amount of academic work that addresses or tries to address somewhat similar topics one way or another. And in a separate point I think we should talk about it. But I strongly encourage you to utilize other people that are interested in these same things.

The one thing that I think you could do that most academics -- none that I know of -- have access to is the bids themselves are not generally available. So all the stuff that people have been working on hasn't been the bids.

My general comment is that this regression model, in the way that I read through this, sort of varies in its purpose. In one sense, it's a descriptive exercise. And in other times you read it there's a little bit more causality kind of implied where you're doing how does it relate to competition? And how does it relate to other things?

I like those activities. I'd be a little wary of the causal interpretation in some ways. There are things about that, though, that I think are important, including for example, the prevalence of supplemental coverage in the fee-for-service population which could affect the fee-for-

service costs relative.

And depending on exactly what you think your model of the cost structure is, this sort of linear model which you've interpreted as sort of fixed costs and a percentage isn't really exactly I think what you mean. It's sort of more of a descriptive exercise, and it certainly could be the case that you get something on average and what your model would tell you is in the high fee-for-service cost areas are the bids at lower? In a low fee-for-service cost are they higher? But you might imagine that effect isn't linear or there's some other things.

So at some other point I would love to talk to about exactly what you're trying to get at with the regression and work through the model that's appropriate to get at whatever the answer to that question is.

MR. HACKBARTH: Thanks for sparing us.

DR. CHERNEW: I wasn't sparing.

[Laughter.]

DR. HARRISON: I will appreciate your help.

DR. MILSTEIN: Every time we go down a road like this, one of the things we can anticipate is going to come up at the end of discussion is well, about quality and what

it costs to produce quality. I wanted to suggest as we're walking down this road and beginning to analyze what it actually costs, and considering different approaches to payment and their relationship to current fee-for-service spending, I think it would be very, very helpful if -- and I think this would not be hard to do -- if we took advantage of the information that Carlos generated for us last spring which basically classified MA plans into three buckets in terms of available information on whether the plans, on a two-year basis, were improving, worsening, or having no effect on beneficiary overall health status.

And so it would be nice as we're looking at these analyses to see the analysis for the program overall but also for the subset of plans that at least were not worsening beneficiaries health over a two-year period.

DR. REISCHAUER: Mike actually covered some of the things that I was going to talk about. But I think you want to look at this as the cost of the plans versus the benchmark versus the average fee-for-service spending in the area. And I think there is some -- I don't want to use the word gaming because John is so close to me, but there are some strategy that goes on in how one does this.

With respect to Jay's -- I think it was Jay who raised the question -- really to make this completely useful we have to ask why do we want this? I know Glenn and I don't always see eye to eye on this, but it strikes me there's three possible reasons.

One is you want Medicare Advantage because you think you can provide a vehicle for getting better care for individuals. The second is that you think you can save money. These are two separate things. The third is you want to give people choice of delivery system, whether it saves money or improves.

And there's been sort of a confusion in the policy world about how you weight the three of those, and people pull one of those objectives out whatever it's useful for the argument and forget about the other two and we go on.

MR. HACKBARTH: We agree on that. And Arnie's point about quality is in that same vein. Because you do hear well, we're getting better quality for these dollars.

MR. BUTLER: Just a comment that I think that this is one of the -- if not one of the most -- one of the more important things where we can contribute. I'd like to see as we do the updates that I don't know how frequently you'd

be coming back, but this is one that I'd like to see on the agenda more often rather than less often.

I think, with respect to Jay's comments about stability, I've been part of a plan myself that exited in 1999. Unlike hospitals or nursing homes where you may make a mistake in a rate one year and make it up the next or something, you make a mistake here and you of all kinds of newcomers or all kinds of exiters, which really destabilizes and potentially removes one of the few vehicles we have to kind of maybe reform the system.

I think everybody wants to see actually not average performance out of these but above average. Otherwise, I don't think that 95 percent thing in the beginning was a bad thought. These things ought to be able to get at geographic variation and utilization. If they don't, what's the difference? They're more constraining for individuals on balance, at least they're perceived that way by the traditional Medicare users.

Just an advocacy for keeping it on our agenda, educating us, helping us shape something that is meaningfully here. Because I don't know who else -- this is a place, I don't know who else would be coming forward with

good independent recommendations. Is there another place?

DR. MARK MILLER: None as good as us.

[Laughter.]

MR. HACKBARTH: That's what I was searching for.

MR. BUTLER: I know Barack has already suggested this is one on the top of his list for savings; right? I heard that in an interview.

MS. HANSEN: This is more of a question that using this vehicle and the fact that now this kind of funding will have occurred for a period of time. Is there a way -- this is more of a structural question -- of evaluating what some of the plans have really produced as an infrastructure to get it ready for better quality? On the one hand, I think Arnie's comment about what quality we have -- and this is just strictly an intuitive comment I'm making -- when you have the equivalent of anywhere from 17 to 40 percent more money, besides giving out the benefits, has there been some fundamental structural infrastructure changes in these plans that allow them to become more efficient and produce higher quality once the money component possibly changes?

But they basically have had R&D money from a very simplistic way to look at it for me. What do they do with

that R&D money? One is to measure quality. But did they get into play some infrastructure that allows them to then in the future become more efficient and produce the results that we're looking for? So it's more of a question, what happened to the go, besides the return for the investors? But from a systems standpoint, what was left?

MR. GEORGE MILLER: Arnie covered what I wanted to say and Jennie just teased a little more out. Let me see if I can break it down in a different area.

I would like to see the data show there's better quality versus the better benefits, and particularly in comparison between rural and urban areas. Because there's just not as much population or density in the rural areas. And I would like see how that teases out.

But to Jennie's point, I would be interested in a more substantive to know, for example, have MA plans used their funds to provide additional drug benefit or catastrophic care benefit, as an example of what Jennie was talking about? Versus fee-for-service, since they had the extra dough.

MR. HACKBARTH: Any others?

We've got to move on in just a couple of minutes.

Let me just try to focus in on a couple of things. One is the issue of the geographic unit that Dan discussed and John, you made a couple of comments about. We made recommendations on that issue in 2005 and did a fair amount of analysis, as I recall -- John, you were on the Commission then -- and came up with a series of recommendations that seemed to me sensible at the time and still do.

My inclination would be just to repeat those and not use a lot of additional time and resources going over ground that we've already plowed pretty thoroughly.

John, how do you feel about that?

MR. BERTKO: I think they were okay. I think reinspecting them and again not doing a tremendous amount of work but seeing are there any other alternatives that can be thought up quickly. And then I think what I heard Dan and Scott say is they're going to look at what that does to the payment rates.

So I think it's worth a re-look at but not with an intensive amount of work.

MR. HACKBARTH: My goal would be to be able to do a 2009 report on the narrow mandate. But that means that we're going to have to limit the bells and whistles that we

put on the train. We can say that there are other issues that we will take up in the 2009/2010 cycle, but what we did this spring would have to be pretty focused.

Now when I say that, I do think if you're going to talk about Medicare Advantage and Medicare Advantage payment policy, sort of the intro is to go through the goals that Bob, I think very concisely, outlined because that's what really drives your payment choices is you need to know what it is you want to accomplish. Is it lower cost and efficiency? Is it expanded benefits for beneficiaries? Is it improved quality?

And so I would envision some intro about that and how the implications of your choices for payment policy, and then go into the specific mandated analyses.

Do people feel comfortable with that for 2009?

Anything else on Medicare Advantage before we leave it for today? I mean on the narrow issue of the payment report. Anything else on this?

Okay, now we'll move on to the quality report and the work plan.

MR. ZARABOZO: Good afternoon. John and I are also here to discuss a report required by the recent

Medicare legislation. We will outline our proposed work plan for the report, provide some background on the need for the report, and discuss some of the issues that we included in your mailing material.

The report will deal with the methodology for the measurement of quality in Medicare, specifically how to care the quality of care enrollees receive in Medicare health plans, against the quality of care in traditional fee-for-service Medicare. The report will also examine the methodology for measuring quality across Medicare health plans.

The legislative mandate specifically asks us to look at data collection and reporting issues as well as benchmarking issues. The report is due March 2010 and the legislative language specifies that implementation should begin in 2011 when CMS plans and providers will be collecting and reporting the comparative information.

By way of background, the issue of health plans not being on an equal footing with the fee-for-service sector is not a new issue. Medicare health plans have reported data on quality for over 10 years now, but only recently has there been more intensive reporting of

information on quality in the fee-for-service sector.

The Commission has long supported having a more level playing field between the two sectors, as John will explain in more detail in a few minutes.

One thing that we should note is that there are some sources of information currently available to compare the fee-for-service sector with health plans. On one dimension of quality, which is beneficiary perceptions of quality and access to care, we have survey data from CAHPS and from MCBS. CAHPS beneficiary surveys began has health plan member surveys and as of 2000 there is also survey information for fee-for-service beneficiaries.

The Medicare Current Beneficiary Survey also enables a comparison between health plan enrollees and fee-for-service beneficiaries, including specific information about diabetics and the care they receive.

In your mailing material, we summarized some of the published research that compares quality of care in each sector. In addition, we have recently become aware of a CMS project that uses claims data to report on physician group performance on 12 process measures that Medicare health plans report on as part of HEDIS.

As we have mentioned, reporting of quality indicators in fee-for-service has increased significantly in the last two years. However, the information is often not comparable between the two sectors because health plans are reporting population-based information, that is the health outcomes for the overall enrollment, while in fee-for-service what we generally have is reporting being done mainly at the provider level. It is therefore difficult to make a sector-to-sector comparison that enables you to say that plan enrollees on the whole fare better or worse than people in fee-for-service Medicare.

We would also note that there's room for improvement in the reporting of quality in the Medicare health plan sector itself.

And now I will turn to the details of our work plan for completing the mandated report.

As required by the legislative mandate, we would be looking at methodological issues in data collection, reporting, and benchmarking. Benchmarking would include looking at how quality measures are established, the expected performance on measures, how improvement is tracked and evaluated, and now distinctions are made among plans or

providers if there's to be sorting of better performing plans or providers as in the case of pay for performance payment systems.

We would first describe and evaluate current practices in data collection, reporting and benchmarking; and then we would explore ways of improving data reporting without further collection of data. If we find that changes to current practices are necessary or that new data reporting requirements should be in place, we would evaluate the expected level of burden weighed against the value of any suggested changes. If changes are in order, we would also examine the effect on benchmarking.

We also intend to consider the role of new sources of data, such as Part D drug data and the encounter data that CMS will be collecting from Medicare Advantage plans.

I will now turn to John, who will say a little more about the expected content of the report and some issues to consider.

MR. RICHARDSON: Our analysis will be guided by the Commission's past work that has specifically looked at comparing quality between Medicare Advantage and fee-for-service and at establishing a pay for performance, or P4P,

program for MA plans.

On comparing quality between MA and fee-for-service, the Commission studied the issue in its June 2005 report and recommended that "the Secretary should calculate clinical measures for the fee-for-service program that would permit CMS to compare the fee-for-service program to MA plans."

The Commission reasoned that this would level the playing field between MA and fee-for-service when beneficiaries are comparing their options and when CMS compares the two programs' performance.

Concerning quality comparisons within MA, the Commission concluded in its March 2004 report that the quality measures used in MA are an adequate starter set for an MA P4P program.

In addition, as was alluded to in the previous discussion, the Commission also periodically examines the state of quality measurement and reporting on MA plans, most recently in the March 2008 report, and this ongoing work will inform the MIPPA mandated study.

We will also review published studies in the health services research literature that compare quality

between Medicare health plans and fee-for-service, and after identifying the analytic approaches in the data used by these researchers to make the comparisons, we would evaluate whether these approaches and data could be generalized and systematically applied in comparing MA and fee-for-service.

We also plan to consult with various stakeholders including CMS, health plans, and providers, organizations representing beneficiaries perspectives, and organizations that develop or report on quality measures, including the National Committee for Quality Assurance and the National Quality Forum.

Finally, we plan to look at quality measurement and comparison practices used in the private sector and in other public health care purchasing programs such as Medicaid and the Federal Employee Health Benefits Program.

In the final three slides of our presentation we wanted to review the main issues that we plan to wrestle with in this report. First, as Carlos noted, one of the two mandated objectives of the study is to assess how quality can be compared between fee-for-service and Medicare Advantage. There are at least three questions under this broad topic. First, what should the unit of measurement be?

Most MA quality measures used today evaluate quality at the contract level while most fee-for-service measures evaluate performance of individual providers. Is it feasible to reconcile these two different approaches, for example by creating meaningful and useful population level measures for fee-for-service Medicare?

Second, what is the appropriate geographic unit of analysis for quality comparisons? In the presentation you just heard on the payment report, Scott and Dan discussed the need to evaluate what the geographic unit should be for payment purposes. In our report, we would evaluate what the geographic unit should be for quality reporting purposes and whether any changes in the geographic unit for MA payment purposes to better reflect those health care market areas should also be the appropriate unit for quality comparisons.

Third, for reporting on quality, should benchmarks and results be reported in specific ways that would allow subpopulations of beneficiaries to make meaningful comparisons for their particular needs and circumstances? For instance, the National Quality Forum has endorsed sets of health care disparity sensitive measures that it believes can be used for reporting and improving health care

disparities and quality at both the practice and community levels. We plan to examine the potential of these measures and other reporting approaches that could make quality comparisons more meaningful for different groups of Medicare beneficiaries.

Our last point on this slide is that the three issues I just went through very quickly also apply within MA comparisons, so we'll be looking at them through that lens, as well.

We also plan to look at how quality comparisons between the sectors and among MA plans should account for exogenous sources of variation in providers' and plans' performances. We will examine whether and how different kinds of quality measures should be risk-adjusted and whether new kinds of data collection might be needed to more fully achieve appropriate risk adjustment. We also plan to consider how quality comparisons should account for the demographic differences that exist between MA plans and fee-for-service Medicare and among different MA plans' enrollments.

Looking at the measure sets themselves, we plan to look at them through the different needs of beneficiaries,

plans, providers, CMS and the Congress. Our goal is to determine if any changes in the current collection and reporting practices should be made to increase the usefulness of the measures to these varied audiences. Consistent with the Commission's previous work on quality measures, we will also take into consideration the technical reliability and validity of the measures or measure sets that we're looking at.

The last slide, in all cases we plan to examine the administrative burdens the collection, analysis and reporting of the current and any new quality measures would impose on physicians and other providers, on MA plans, and on CMS and evaluate explicitly the trade offs between those costs and the benefits that the current and enhanced quality measurement and reporting would lend.

Finally, we plan to identify any important gaps in quality measures that are in use today. This analysis could include identifying important areas of performance that are measured in one sector but not in the other or not measured in either sector. Examples of these may include measures of care coordination or care management and measures that may be used to evaluate quality across episodes of care.

That concludes the overview of our work plan and we look forward to your input and guidance. Thank you.

MR. HACKBARTH: Any clarifying questions?

DR. MILSTEIN: Carlos, can you remind us and me of two things: first of all, previously there was a -- there has been at least one comparative analysis of the impact of the immediately preceding program, Medicare+Choice, on two-year change in beneficiary health status versus fee-for-service? Can you just remind me what that showed, if you can remember?

And secondly, remind me whether or not I'm correct that CMS has already internally decided to renew that comparison, that is come up with a fee-for-service sample for evaluating two-year longitudinal change in health status versus expected for fee-for-service.

MR. ZARABOZO: That was the Health Outcomes Survey. The finding was that on a national level there were not significant differences between fee-for-service and Medicare+Choice at the time. But at a state level they said that in the area of mental health that fee-for-service performed better than Medicare+Choice at the time.

I don't think they we're aware of CMS doing this

again. They do have the data to do this. One thing that through CAHPS they had been collecting for fee-for-service beneficiaries HOS information. So when we commented on the inpatient hospital regulation, we made the comment that we were aware that they had actually discontinued that collection of information. We suggested that they should start that up again.

So we would like the data to be available for this kind of comparison to be made but we're not aware that it's going to be.

DR. MILSTEIN: So are you saying that we have discovered that through CAHPS, which the Medicare Advantage do report -- which is also applied to fee-for-service populations -- that's CMS currently has the capability of running this two-year change calculation in health status.

MR. ZARABOZO: For certain years they have HOS-type of information that could be used to compare --

DR. MILSTEIN: Can you clarify whether CMS is in the process of or could actually analyze this so we could have more current information directly on this point?

MR. ZARABOZO: As far as I know, they're not in the process of doing it. I believe that they could, with

that information, do that kind of analysis.

MR. GEORGE MILLER: Just very briefly, you mentioned -- and I applaud you for doing so -- in the reporting on page seven that you're going to look at subpopulations for health disparities. I'm just wondering if you shouldn't also add that as a bullet point for disparities among different populations under recognizing sources of variation in performance also, as a suggestion.

Thank you.

DR. CASTELLANOS: Just a clarification point. Under your issues to consider under measurement, you mentioned that health plans measure on a population basis but the care is delivered on a provider basis, while fee-for-service is measured on a provider basis. Why can't you get the plans to measure on a provider basis where it's provided?

MR. ZARABOZO: Part of that issue is we do not have access to the provider level information within the plan, is one of the issues. But presumably the plans do have that information. That is, when they report on the quality measures they are coming from the providers. They do have provider level information.

DR. CASTELLANOS: Is it possible to get that level of data?

MR. ZARABOZO: With the encounter data, it is possible.

MR. RICHARDSON: CMS recently issued, in the hospital inpatient regulation I believe, it is going to require the collection of encounter data from health plans. Whether that is of a quality and breadth that would be similar to what you might get through a fee-for-service claims system is yet to be seen. But if it were, there is no reason, I don't think, you could compare the providers under either system.

I think historically from Medicare's perspective, it was you are purchasing the services from the health plan on the one case and from the fee-for-service provider on the other. And so that's the unit of analysis you were looking at for doing it. I think going forward what you have just asked is an open question for us to look at.

DR. CASTELLANOS: [off microphone] I think it would be interesting to compare the providers.

MR. HACKBARTH: Round two, brief comments.

MS. HANSEN: Thank you. I just wanted to go back

to page six. One of the bullet points there was the examination of best practices among other public and private purchasers. So did I hear you say Medicaid systems, as well? So this would be like North Carolina's Medicaid system that has had the multiple years of experience?

Then I just wonder if it's getting to the point where we might have information ready at all from the SNP plans, as well, and bringing that back into gear. So in some ways it touches on the dual eligible component. So I wonder if North Carolina also has a subset of looking at not only their Medicaid but the Medicare population and the impact on quality and utilization there.

MR. ZARABOZO: On the special needs plans, they are currently reporting at the plan level so there will be information. I don't believe it is going to be publicly released this year. But CMS and NCQA are collecting information for the SNP plans.

MR. RICHARDSON: To add to that, we have specifically contemplated whether some of those measures could be more broadly applied to MA plans.

MR. ZARABOZO: Meaning that, in addition, they are reporting on 13 HEDIS measures and they're also reporting on

several other measures that are specifically for the SNPs. But they possibly have applicability to all types of health plans.

MS. HANSEN: There was a body of work that was done some years ago by the University of Colorado, Peter Shaughnessy, on outcomes based community quality improvement. I don't know if it was specifically dual eligible but it was a HCFA contract at that particular time. And I think it's a study of units of measurement. It went over about five years. I just never heard what came of it, but it had to do with again quality characteristics of more chronically complex populations. So that's another consideration.

And then the final tag on to what George had said, is the opportunity to really nest in the health disparities data that we already have.

Thank you.

MR. BERTKO: This one strikes me as being a very difficult task that you have. Robust means you can get done, it's just a lot of work.

A couple of thoughts here on this, and depending on when the data for the encounters comes up, an alternative

that you might be clever to try to use would be the risk adjustment encounter data, which would be a subset of all of this. I was thinking that perhaps like the readmission rates within 30 days, diabetes encounters which I think are reported for risk adjustment. And then also things like repeat emergency department visits might be useful.

A second comment and a question for you more is I think the Part D data could be a rich source of things, for example looking at compliance between people with standalone drug plans in fee-for-service Medicare versus MA-PDs. But do you think you will have access and availability of the PDE by the time you need to finish the report?

MR. ZARABOZO: I think the short answer is no.

MR. BERTKO: That's what I was afraid of. So there could be, even under our own momentum, a follow-up report that would be -- pick a number, a year or 10 years later?

MR. RICHARDSON: If I could take this opportunity to open the door to clarify that the purpose of this report is to suggest and recommend how this might be done, not to actually do it. And being aware of the fact that as data become available what we recommend CMS do could change over

time. But even backing up from that, we are not actually doing the comparisons ourselves as part of this report. We're suggesting ways to do it, ways that it should be done.

MR. BERTKO: So the last one is a comment or a question, which is I note to you and said you look at the MCBS data. I was, I think and I'm not certain, that that is valid nationally but not by state. So then makes the comparisons become a real iffy on that. Am I correct?

MR. ZARABOZO: That would be the broad global sector to sector comparisons would be based on -- I mean, that's the source of information for that kind of comparison.

DR. KANE: I'm just wondering if there's a way to separate out the effects of the plan versus the provider. For instance, in Massachusetts, I'm on the benefit committee for my employer. And we looked at all of the providers in the three plans that provided us service and there was a 99.9 percent overlap.

And so when you're looking at provider -- you're not really getting plan value, you're getting how good the providers are when you're looking at some of these HEDIS

measures.

It would be great if there could be something -- and that's not true of every market. But I think there are a lot of markets where the provider overlap is so significant that you're really not getting differences at the clinical level of plan differences. You're getting provider differences. And I'm wondering if there's a way to hold that out and just try to see if there are real significant plan value added beyond that.

I know when we were looking at plans and trying to think about which one to pick for various things, we mostly focused on how they varied administratively. I don't know if there's a good dataset for that but access -- what kind of access to referral restrictions, pharma restrictions, or whether they did case management or not.

It's hard to really just see where the plan is adding the value, as apart from the provider. And I just wanted to point that out. And it's not going to be true for every market, but I think that's really going to be a confounding factor here.

The other comment I had to make is on the population-based measures, it seems that the Dartmouth

people have figured out how to do that. And I don't know why we wouldn't take advantage of their methodology for designing a population base for fee-for-service utilization and quality.

MR. ZARABOZO: Yes, the Dartmouth people have done claims based, here's what it looks like in fee-for-service Medicare essentially for certain measures that probably cross walk relatively well for the HEDIS measures. We're aware of that.

And some of the QIOs have been doing that for state level information and going down to the county level. So there is that kind of information out there and it is, as you say, population based.

DR. CHERNEW: It's very important that this comment not be interpreted as suggesting in any way that this isn't a very valuable exercise.

But my concern -- this is actually a concern of the other one, but you have to limit your comments. So this spans both the last comment topics.

Although you do aspects of risk adjustment, I think differential patient traits and selection are extremely important. I chose to make this comment here as

opposed to before -- although it applies before just as well -- because a lot of these HEDIS quality measures are really measures of what patients are doing, as opposed to necessarily what the plans are doing.

And it's very difficult to adjust with some of the current risk adjustments methods for attributes of the patient, which very well may be correlated with which type of plan they have chosen to join.

The reason I started my comment the way I did is that's sort of a snooty academic comment that gets people never to do anything and I don't mean it that way at all. I think that the comparisons are extremely valuable. I think it's very important in the report to be careful in terms of how one frames this causally because it doesn't imply that if you're going to take everybody in one system and move them to the other system you would get the results of the other system and vice versa, and often it's interpreted that way.

I think that's particularly true of quality measures where some of these things are very much related to what people are doing. It's also related to other aspects that are unrelated to the plan like the benefit structures

that the different people have in the different settings which are typically very difficult to standardize. And a lot of the differences relate to the access to the services that are the underlying quality measure.

So if you got a mammogram or if you took your drugs or if you did some of these other things, the benefits package you have affects that. And that may vary across some of these things and we'll have to think about what that means.

So what I would encourage you to do, and I'm sure you've done this, is not for the report that you're doing because it's too much -- and maybe this is beyond the scope of what you would do and there are a lot of people interested in this broadly -- is to think of other ways to statistically identify something that might be a bit more of a causal effect as opposed to doing something that is purely descriptive and comparative.

The descriptive and comparative work -- again I will say this because I'm so insecure about being misinterpreted -- this work I think is extremely valuable. But I think it's important to recognize the limitations of what comes out for guiding policy because too often I think

it's interpreted as a causal impact if you were just to do X, Y, or Z, as opposed to a suggestive correlation that needs to be explored further.

DR. STUART: This is going to be tough and it's a good thing you're just describing the method, rather than actually doing it.

I want to pick up on a point that John raised about essentially using claims-based quality indicator measures. You know these, I don't have to go into them. But there was a piece in the chapter that referred to teaching to the test, the idea that you have these HEDIS measures, the health plans know that they have to report these. So they make sure that all of their providers work on those, perhaps to the exclusion of some others, and then maybe there's an unfair comparison. I guess I wouldn't use the term unfair, I would use the term biased.

I think that the extent to which you can use these claims-based measures that would not be affected by this particular response to quality reporting becomes really important because if you find that on the one measure that the health plans look like they're doing really a whole lot better, but on the other measures that are kind of embedded

in these individual level data they're not doing so much better, then that helps you think about an issue here.

You probably already thought about the kinds of measures that you might want to use on the Part D side. A couple things that come to mind, probably the top of the list would be work by the Pharmacy Quality Alliance, PQA, because their measures are just drug specific so you don't have to have data from the A or the B or the ersatz A and B side. Now there's also a PQRI, which is this train on the physician reimbursement time. But a lot of these measures are prescription measures.

Then, of course, you've got this whole ACOVE Project that is -- again, as I'm sure you're aware of this.

I would be very careful how I wrote about making comparisons on MCBS data. The main reason that you want to be careful about that is that on the fee-for-service side there is a comparison -- this is one of the reasons that MCBS data takes so long to be computed, to get to researchers -- is that on the fee-for-service side the gnomes that are behind this dataset are comparing Part A and Part B claims against self-reported Part A and Part B services and then they adjust those services based upon that

comparison.

Well, in the MA side there's nothing to compare it to so that just gets reported straight. And there is nothing in the documentation or the actual imputation that tells you exactly how much those self-reported measures for the fee-for-service are actually adjusted. So it's something that you just have to be very careful about.

DR. CROSSON: I just want to also make a comment, a philosophical mostly, comment about the selection of measures. I know that this work is supposed to be, to some degree, descriptive of what's going on but I think there's going to be some opportunity to make some judgments about where things ought to go also. I'm trying to figure out whether what I'm saying is the same as what Mike and Brice said or diametrically opposite. So I'll have to ask them, I'm not sure.

It seems to me that again in choosing the measures we might want to be thinking about the impact of a system that evolves over time, that's based on measuring certain things versus certain other things, and have a prejudice towards thinking like what kind of measurement would we want to do? And if we do this sort of measurement, does it have

second and third order effects which are good?

So that sort of thinking takes me in the direction of coming as close as possible to the clinical reality of the care that's being delivered.

So for example, you could measure whether or not a patient was seen during the year, a patient with hypertension as a going diagnosis who was seen during the year for a hypertension visit. It would be pretty easy to get at, I would imagine. But I'm not sure what you would do with that actually. You could also determine whether or not a patient had had a blood pressure measured any time during the year.

As Ben pointed out in his presentation, though, even in our system when we actually started with clinical information in automated form and found out what, in fact, the blood pressures were, then had comparable actionable information that impacted or hopefully progressively impacts the real life of people.

So I can imagine all of the difficulties inherent in this, but my sense is that the more we aim towards over time a system that, as much as possible, measures those sorts of things, then we have a system which feeds back into

the health care of the beneficiaries themselves as opposed to something that is sort of useful to rank plans and say this plan is A, B, C, D, or the like, which has some value but it has much less human value than the other.

DR. MILSTEIN: Any measurement system is going to be subject to confounders and to varying degrees of wrong inferences about causality, we're going to have to move forward with the best we've got because the alternative is to have nothing. As we've previously reflected on what are the options, I still continue to be impressed with the relative advantages of the functional status survey on a two-year rolling basis; A because it mitigate but doesn't eliminate selection bias because you're always measuring change versus what was predicted based on the selection of patients that enrolled in the MA plan. So if people who are very cooperative with their doctors, they're going to start out with higher health status and therefore likely a lower predicted deterioration in health status.

And also, reflecting back on the prior discussion where we're trying to -- we're sort of recognizing at the same time we don't owe a report to anybody until 2010, given how timely the issue of value of Medicare Advantage plans is

likely to be in Congress over the next year, we said can't we do something quicker and issue an interim 2009 report?

I guess I would like to encourage consideration -- nobody has to answer this question -- but consideration of whether or not, given the fact that you've told us that via the CAHPS survey we already have the database needed for fee-for-service and for Medicare Advantage plans to compute a two-year change in patient functional status relative to what would have been expected given the baseline status of the population in those two samples, is there not any researcher or anyone within CMS that has already taken the kind of off-the-shelf software that's available and run this comparison such that it might be something that we could consider at our next month's meeting. And then based on the state of that analysis, at least keep open the possibility of sharing it with Congress in 2009?

There's a lot of ifs there and maybe the probability of us getting to a useful conclusion as to whether or not Medicare Advantage plans on average are or are not contributing to the two-year change in health status that have been beneficiaries relative to fee-for-service may not be feasible. But if we had a shot at it, I think it

could be potentially very valuable in near-term evaluations in Congress of the Medicare Advantage plan.

It also would be a nice way of testing the vehicle and, in that way, highly pertinent to our 2010 report.

MR. EBELER: Just quickly, this is an area where we can get unendingly complicated and researchy. It strikes me that two things can be helpful to the Congress. One is -- I think Jay is getting at this. We should be clear about the purpose for which one is collecting these data because that can maybe help filter what we don't do as well as what we do do.

Second, John, you mentioned this briefly earlier on and I think Arnie just alluded to it. I think we should be really clear about phasing here. The key is not to wait until the millennium when we have is perfect set of quality comparisons that will hold up across everything. But if there are some places to start -- Mike's right, we have to acknowledge that that wouldn't be adjusted for certain things and you certainly wouldn't be able to do certain things with it.

But getting started down this road and then setting a glide path for the Congress, I would think would

be a big contribution here.

MR. HACKBARTH: Okay, more on this next time.

Our last topic for today is frequently re-hospitalized SNF patients.

DR. CARTER: The Commission has previously discussed repeat SNF admissions. Nancy, you've mentioned beneficiaries who appeared to cycle between the hospital, the SNF and the nursing home and raised questions about the role financial incentives play in this pattern of repeat hospitalizations and SNF admissions. You asked about the characteristics of patients who are repeatedly admitted to hospitals and SNFs and about the SNFs who treat them.

There are three concerns about beneficiaries who are frequently rehospitalized and readmitted. First is that rehospitalizations may reflect poor SNF care that patients have received. Second, beneficiaries are especially vulnerable during transfers between settings and poor transitions can result in poor care. And third, repeat SNF stays and their associated hospitalizations are costly to the program.

An OIG study examined a sample of patients who had three or more hospital and SNF stays within a day of each

other and found that 35 percent of those episodes were associated with quality of care problems and/or fragmented care that they estimated cost the program $4.5 billion in 2007.

The current payment system encourages readmissions to hospitals and SNFs. Payment silos encourage cost shifting between settings. For example, SNFs have a financial incentive to re-hospitalize patients with above-average costs and hospitals have a financial incentive to discharge patients to hospitals as a way to lower their own costs.

Second, there is no real disincentive to readmit patients to hospitals. Hospitals with available beds have a financial incentive to accept admissions even if the patient could be treated by the sending institution.

Finally, for long-stay nursing home residents, separate insurance programs create incentives to shift costs between payers, in particular between Medicaid and Medicare. Nursing homes have a financial incentive to rehospitalize their long-stay resident as a way of requalifying them for Medicare coverage and its higher payment rates.

I'm going to quickly review some analysis that

we've done looking at repeat SNF admissions and then I'm going to step back and put those results in a broader context by looking at ways to reduce potentially avoidable re-hospitalizations. Some of these strategies focus on improving SNF policies and relate to SNF recommendations you've already made. Others include ways to align payment incentives across settings and relate to the bundling recommendations you made in June.

Here's a quick graph that shows how frequent rehospitalizations and SNF stays are. 63 percent of SNF users had one hospital SNF stay but over one-third had two or more and seven percent had four or more.

There are lots of ways that we could have analyzed this and identified and defined repeat hospital and SNF use and each would be a window into the broader problem of re-hospitalizations. The OIG, as I mentioned before, used three hospital SNFs that were back to back within one day definitions.

What we did was we looked at four hospital SNF stays within a two-year period. The reason we picked that is if a facility was trying to maximize their Medicare payments within a two-year period for their long-stay

residents, that's how many would fit into a two-year period. So we took four or more as our definition of repeat users.

MR. BUTLER: I'm sorry, can you tell me a hospital SNF stay, by definition, is...

DR. CARTER: When somebody goes from the hospital to a SNF is what I'm counting.

When we compared repeat users to non-repeat users what we found was that repeat users were more likely to be dual eligible and sicker. They had higher HCC risk scores and a larger share of them -- that's in the bottom right -- had hospitalizations with the severity of illness scores of three or four.

We also looked at the mix of their RUG days for repeat and non-repeat patients and, compared to the non-repeat group. The repeat user days were more likely to be grouped into the medically complex RUGs and less likely to be grouped into the rehab rugs, which are more favorably reimbursed.

What I don't show on here is we also looked at stays that occurred later in the repeat user stay sequence, and the later stays also had higher shares of medically complex days.

We also found that the share of hospital readmissions that were potentially avoidable were high for both groups but the repeat group had higher rates of potentially avoidable readmission rates. The conditions that I included in that definition are listed on the right-hand side.

Now turning to what we learned about the SNFs that treated repeat patients, we found that there was quite a bit of variation in what the rates of repeat stays were at SNFs and they varied more than twofold across the SNFs that were included in this study.

We also found that stays of repeat users were more prevalent among freestanding SNFs than at hospital-based SNFs, and this is probably due to two things. One is the availability of physician and ancillary services in hospital-based facilities. That means that the patients can be treated without being transferred back to the hospital. But also because many, in fact most, hospital-based SNFs do not have a long-stay unit, it would be less likely to find the repeat users in them.

When we look at just freestanding SNFs and compared those with high and low repeat rates, we found that

SNFs with high repeat rates had higher Medicaid shares, larger shares of their re-hospitalizations were potentially avoidable, they had higher Medicare margins, higher ratio of their Medicare payments per day to other payer payments per day -- that's sort of a generosity measure, if you will -- and they were more likely to be for-profit.

We know that many factors go into explaining the wide variation in how frequently beneficiaries are readmitted to hospitals and SNFs, including differences in case-mix, the availability of resources at the SNF in the nursing home, and characteristics of their markets like how available hospital beds are.

Nancy, you have raised the issue that low Medicaid payment rates might encourage some facilities to re-hospitalize their long-stay Medicaid patients in order to requalify them for Medicare coverage. We did not have Medicaid data to look at this relationship between Medicaid payments and re-hospitalization rates.

What we thought we'd try to do is to think about this analysis in the broader policy context of frequent re-hospitalizations. We saw that a third of SNF users have two or more SNF stays and a large share of those

rehospitalizations are potentially avoidable. We recognize that eliminating all potentially avoidable rehospitalizations is not possible, nor is it desirable since some rehospitalizations are medically appropriate. But rehospitalizations is a problem the Commission has addressed and one that Medicare policies could influence in two ways. The program could improve its SNF policies and it could better align its payment incentives across settings.

Let's look at what we've talked about before in terms of SNF recommendations and how those relate to potentially avoidable rehospitalizations and lowering them. One thing we've talked about is revising the SNF PPS. We have done a lot of work looking at the current PPS and we know that it may encourage some SNFs to rehospitalize patients with high non-therapy ancillary costs rather than treat the patients themselves.

Second, we've recommended that CMS revise its publicly reported the quality measures and to include facility rates of potentially avoidable rehospitalizations.

The third is we've recommended a pay-for-performance quality program and use potentially avoidable rehospitalization rates as one of the performance measures.

CMS, I should note, has designed a demonstration that is working its way through OMB clearance and will include that as a measure.

To align payment incentives, two approaches could be further developed if there is Commission interest, and that is sort of what I want to hear you talk about. One idea is to lower SNF payments for facilities with relatively high hospital readmission rates for select conditions, similar to what the Commission recommended for hospitals with relatively high readmission rates for select conditions.

Adding a parallel policy for SNFs would make the policies in the two settings consistent and reinforcing. It would also align our SNF recommendations to those we've made towards hospitals.

A second idea is to further develop the bundling idea specifically as it applies to stays with high SNF and other post-acute care. Bundling could reduce unnecessary hospitalizations, eliminate therapy services of little clinical value, and encourage hospitals to find the most appropriate post-acute setting for their patients. Bundling might increase nurse and nurse practitioner presence in SNFs

and nursing homes as a way to avert potentially costly rehospitalizations.

Both of these ideas build on previous Commission recommendations and could take a similar incremental approach. For example, start with confidential reporting back to SNFs about their episode costs, followed by public posting of this information, followed then by reducing payments to SNFs with high rehospitalization rates and then a bundling pilot similar to what we discussed in the June report.

To pursue bundling approach, staff might consider specific issues raised by bundling conditions with high PAC use. For example, maybe a longer window might be appropriate for those conditions with high PAC use. Maybe we should start our examination of PAC episodes with conditions that are more prone to high rehospitalization rates or high PAC use or high variation in PAC use.

The bundling chapter discussed two important design issues that we might also further work on, that is identifying good quality measures to discourage stinting on care and adequate risk adjustment across all the sectors so that we're making fair comparisons across the different

settings.

And with that I'd like to close. We're very interested in gauging your interest in pursuing both of these approaches as ways of lowering unnecessary hospitalizations.

MR. HACKBARTH: Any clarifying questions?

DR. DEAN: The judgment about potentially avoidable, how well validated is that? And how is that judgment arrived at?

DR. CARTER: We used a methodology that was developed by Andrew Kramer at the University of Colorado. It uses five conditions, and they were on that slide. It's a little bit more specific than the ambulatory care sensitive definition, which includes many other conditions.

I think it's fairly well validated. It is one that we use in our quality measures in our regular update cycle. So it's something we're familiar with and we've looked at pretty extensively.

DR. SCANLON: I guess I was wondering if there was a way to look at what we might call rehospitalizations, as supposed to frequent hospitalizations. Because in looking over a two-year period for a group of people who are long-

term nursing home residents, this is a group that is at the end of their life. And even some of these conditions that we might think are avoidable, there's a potential for them to develop more acute episodes of them, or new ones of them.

I'm thinking that this bundling idea may apply to one subset of the overall group that we've identified but not necessarily to the entire set. So I'm looking for ways as to how to divide the group of patients up.

DR. CARTER: I wasn't sure, are you commenting on if we pursue this PAC bundle idea, sort of which conditions would we focus on? Or are you saying we should look broadly at rehospitalizations -

DR. SCANLON: I think we need to look at time periods. If we have as our marker some kind of reference hospitalization and then look within a certain amount of time -- and I think two years is too long.

DR. CARTER: I think for our bundle we're talking about 30 days or 100 days. The bundle that you all talked about prior to the June report was 30 days. And so the question -- when we're really looking at conditions where there is a lot of PAC use, do you want to look over a longer window? But certainly not two years.

DR. SCANLON: Then I guess the question I'm asking is how much would bundling, if we dealt 30-day windows, do in terms of dealing with the problem you've identified in terms of frequent hospitalizations? Because we could have, over a two year period, six months between each one of these hospitalizations and still have four. The bundling wouldn't address that at all.

So it's kind of how much of the problem will we solve from bundling, I guess is my clarifying question?

DR. CARTER: We'll just need to look at that data. One of the things we've talked about is 30 days truncates some PAC use, use even first-time use. The average SNF stay is 20 days. But if you're trying to look at SNF use plus a little downstream PAC use, you're going to end up truncating that. And obviously for long-term care hospital use you would be truncating this, as well. That's one of the things we're going to be struggling with.

MS. BEHROOZI: I'm sorry, I think it's because it's late the day. I'm sure this is completely obvious but I just want to make sure I'm not missing something.

We're talking about looking over that two-year period with the readmissions and the re-hospitalizations.

That could be somebody who is continuously in a SNF or hospital during that two-year period, or it could be somebody who goes home for some period in between, they're actually discharged to the community and then get rehospitalized again?

DR. CARTER: Yes. There were different patterns in there.

MS. BEHROOZI: So they are both in there?

DR. CARTER: Yes.

DR. CHERNEW: I still wanted to follow up on these potentially avoidable admissions which you were talking about earlier. They're validated in some way but I'm curious to some sense as when somebody says potentially avoidable, oftentimes people hear it wouldn't have happened if you just did X. But my understanding of this is, in fact, it's potentially avoidable but the amount you're changing the likelihood between say optimal care versus actual care is a much smaller change in the probabilities that you would be admitted. I was curious if you had some idea of the magnitude of that?

In other words, how much is on the table, that there was a 40 percent chance and if you gave them optimal

care there would have been a 30 percent chance in these things?

DR. CARTER: I understand your question and I don't know the answer to it. But I would agree with you that potentially avoidable doesn't mean that it was preventable. And some of those still would end up back in the hospital, and appropriately so.

DR. CHERNEW: My sense is actually a lot of these things were defined as they take a medical condition for which optimal treatment is good, like congestive heart failure. And then if you had an admission or readmission with that code, you got put into a potentially avoidable admission. Is that how it basically works?

DR. CARTER: We look at all of these diagnoses for the rehospitalizations, not for the initial hospitalizations. So say for a urinary tract infection, if that code appears anywhere on the records so they weren't necessarily admitted for that -- but anyway, so it occurs anyway.

DR. CHERNEW: I understand how they do it now. So it's basically all admissions that have say a urinary tract infection get put in there. And all admissions that have

congestive heart failure get put in there. And all the admissions that have that whole list of diagnoses, that defines the potentially avoidable --

DR. CARTER: Yes. And as I said, obviously we would agree that they are not all --

DR. CHERNEW: Right.

DR. MARK MILLER: Not on the technical point about what would the probability if the exact care had been provided, but the thing I would just get you to cast your mind back to is when we talked about this in the hospital world what we thought about from a policy perspective is looking at excessive rates of this. So it wouldn't be litigating it admission by admission. It would be saying why is this facility, on a distribution, way out at the right-hand table?

DR. CHERNEW: It's just by definition you have case-mix issues to some extent.

DR. MARK MILLER: What I'm trying to say is we understand that, and what you try and do with the policy is understand that you can't be precise in each case so you try and look at somebody who is producing a lot of these and say why are you doing that?

MR. GEORGE MILLER: But to follow up on that point, would it -- and your report indicated that some of the culprits are those that don't provide good quality of care in the beginning. So that still could be a relatively large number.

I guess my point is if that's the case, if there's a relatively large number, then putting them in the category of avoidable days could be a physician decision because the physician perceives there's poor quality care at that SNF unit and wants to move them to the hospital to get care. So would that not skew the numbers? Am I not saying that accurately?

DR. CARTER: I think what you're saying is rehospitalized - depending on the quality of the institution where the patient is, rehospitalizing might actually be providing better care for the patient. Is that what you're saying?

MR. GEORGE MILLER: Correct. But you put that in avoidable days if they had a urinary tract infection, as an example. And the physician may determine --

DR. CARTER: That's right, we're not controlling for the quality of the institution where they're coming

from.

MR. GEORGE MILLER: Right.

And I would be remiss, Mr. Chairman, if I didn't point out that the reports show that some of these are for-profit entities. It seems to me that we should penalize the for-profit entities or anyone that has a problem versus a broad brush approach to everyone.

MR. EBELER: Carol, could you say whether we've looked into whether this situation exists in other post-acute facilities? Medicare deals with several post-acute care providers. I'm just wondering whether the same analysis and potential policy tools would be relevant across those providers or not.

DR. CARTER: I'm not quite understanding your question.

MR. EBELER: We have rehabilitation facilities, long-term care hospitals -- I mean, there's a whole --

DR. CARTER: I haven't seen work done on those facilities but that doesn't mean it hasn't been done. I'm not aware of it. There has been quite a bit of work done on rehospitalization of nursing facilities and our results are very consistent with the patterns of patients and the

patterns of facilities with high rehospitalization rates. But that's different than what you're asking about.

DR. KANE: I think the question is the particularly vulnerable patient is the one whose custodial. Some of the other post-acutes are not in a -- they don't go into a custodial setting. But the SNFs are where the custodial setting can also occur. In fact, they're more custodial than they are Medicare. And so it's very easy for them to get them back on Medicare just by rehospitalization.

DR. MILSTEIN: There is a second dimension or category of potentially inappropriate rehospitalization that I know a University of Michigan health services research team has already gotten pretty far down the road in analyzing and might be willing to share with us to inform our deliberation. And that is the percentage of readmissions, including readmissions that are accompanied by surgical intervention in which the physician's explicit order in the nursing home forbids or countermands aggressive medical intervention.

And I think it would be useful the next time we discussed this to have the benefit of some of their findings because I believe those are already available though not yet

published.

DR. CASTELLANOS: Carol, good job.

One of the things I see in the real world, and I'm sure Karen and Tom do, too, is the noncompliant patient and noncompliant family. And that often adds to readmissions. I'm just curious how CMS and/or MedPAC will try to account for that?

DR. CARTER: I don't know. There has been a little bit of work done, some of the reading I've done on Evercare and PACE programs do get much more involved in trying to manage -- it's broader than compliance -- but getting much more involved with patients and their families and follow-up care outside of institutions. But that's not nearly what you raised.

DR. CASTELLANOS: It can be as simple as not taking medications or following care or follow-up. And the hospital or the physician should not be, excuse me, dinged for that. So it needs to be accounted for.

DR. STUART: But this would probably not be a concern for the long-term nursing home patient.

DR. CASTELLANOS: It sure can be.

DR. STUART: You would hope not.

DR. CASTELLANOS: I can give you examples but it can happen not only on medication but in other ways.

DR. SCANLON: With respect to these conditions, potentially avoidable conditions, I think another way to characterize them is potentially treatable in the SNF. The experience from the teaching nursing home demonstrations we started in the late 1980s was that in those demonstrations faculty from nursing schools and students were in the nursing homes and you actually did see a rise in the number of people that were being treated in nursing homes for exactly these conditions.

You also saw a rise in the number of people dying in nursing homes from these conditions, and there was, in some respects there was a comfort level that they were getting the appropriate care but that was going to be the outcome.

So there was a question of if there's a way to assure that we get appropriate care this may be the right location for the care to occur. I've talked before about my concern about how do we measure care for a deteriorating person? What's a good outcome measure for that? And I think that's one of the things that we need to continue

think about.

And then if you get over that hurdle, you can start to think about if this is a big problem for Medicare, that the custodial patient who is in a nursing home for a long period of time and is going to develop a condition, and it's going to be more expensive to send them to the hospital, is there any way for Medicare to intervene? We don't have a mechanism for that now.

In the episodes you talked about, we're looking at very short time windows, 30 days. But now we're talking about somebody who has been in this nursing home for six months, something develops, and it would be better if Medicare could somehow treat them here rather than have them hospitalized.

I don't know much of this is happening in home health but that's exactly what we would also want to be happening in home health. We've got a person with a long-term disability and they develop something like pneumonia and you don't want them off to the hospital because they can be treated in their home or in a SNF.

DR. KANE: I'm bringing this up partly because I've heard a lot about it from the provider environment.

And the particularly explosive combination is for-profit skilled nursing facilities whose measure of performance is maximizing their Medicare percent of revenue. And if you read any of these guys' SEC filings, that is their measure of success and that's what makes them profitable.

And when you've got vulnerable Medicaid patients who are custodial in those settings it's just too darn tempting to get them back on a Medicare basis for profitability, for avoiding having to provide the best quality care and helping your costs. It's just too tempting.

So the churning, especially for dual eligibles, is legend actually. People know about it. That's what Jennie started her business model on, in some ways, to try to --

[Laughter.]

DR. KANE: That's one reason that the combined capitation of Medicare and Medicaid came about. I'll let Jennie speak for itself.

I guess my only comment about reducing potentially avoidable, some of the options that we might consider still remain we still think silo-based, what can Medicare do? I think you really have to think about what can Medicare and

Medicaid try to do together? And how can we make that happen? That's how you get someone into the nursing home when they're Medicaid and custodial and they have a problem. Medicaid is saying get them back in that hospital and get them off my books. Just theoretically, but financially they're not motivated to do something about it because then they go back on Medicare.

So there needs to be some way to create an accountable organization for whom the total piece of that care is what they care about, which is the PACE kind of program or the kinds of things Jennie has done.

I just think it's a huge problem but we keep not seeing it because they're Medicaid patients, too.

DR. MARK MILLER: Another area we could look for that combination is in the dual eligible SNPs.

DR. SCANLON: Can I make one comment on that? Which is that I would also not want us to forget the one-third of long-staying nursing home residents that are private pay and not to have a benefit that was only available to dual eligibles. Because I think if it's an important benefit, we should be concerned about the entire population.

DR. KANE: Those people they make money on.

MS. HANSEN: My general comment was that I just appreciate the work, Carol. This does highlight an issue where bouncing the person back and forth to maximize revenue that Nancy said. I think, going back to what I was going to also mention, is the dual eligible SNP that you brought up right now, Mark.

But also anybody who is the private pay who might be on an MA plan. That's also an opportunity, not just a SNP itself. But if they are in a regular MA plan in some way it's really a financial incentive in some ways for the MA plan to put in some Medicare type of benefit.

So besides PACE, besides Evercare, this is the ability to have the flexibility of investing in those services. And it does go eventually into this whole bundling, which I can see is just very complicated to weave through.

So just the more we can highlight this issue, and this keeps coming back and I was saying to Jim over lunch, I'm just so delighted that the reality of what's happening with both the Medicare and Medicaid side does highlight some real issues of both the financing and the quality of a

population like this.

So I think it's very instructive that we learn from them and figure out ways to have the total Medicare population benefit. And the MA plans as a whole, let alone the SNPs, might be an opportunity.

Going back to the whole comment about Andy Kramer's five conditions, and part of it is just these are avoidable conditions that I think are then verified by, Bill, your comment about the studies back in the 1980s, that these are conditions that can keep people stable. But whether or not the financial incentive is there, which is why the bundling option -- difficult as it may be -- may be something to certainly continue to pursue because we just have to figure out where truly the right incentives are going to be.

So again, I would just underscore that I appreciate this discussion about the dual eligible because besides the fact that we don't cover technically the Medicaid side, it does give us huge lessons to be learned so that we don't bounce people back and forth.

MS. BEHROOZI: So the reason that I asked the question before is I wonder if we could modify, on page of

14, the first potential payment policy change, reducing SNF payments for facilities with relatively high rehospitalization rates for select conditions among custodial patients. It seems like that's sort of the lowest hanging fruit. I know Bruce and Ron disagreed. I think I probably agree more with Bruce that if you've got them in-house, you really should be able -- you're in a much better position to keep them from having to be re-hospitalized, even though as Mike points out it's not necessarily a given that everybody could have kept them out of the hospital.

But again, as Mark said, it's overall. I just don't see why we wouldn't right now say any institution that is not caring for its patients -- the ones that it has in-house, the custodial patients -- well enough that they are re-hospitalized too often for potentially avoidable conditions shouldn't pay some consequence in payment.

MR. BUTLER: This is a tricky area. First of all, I would like to say there is a comment in there, there's no disincentive for hospitalization. For the most part, hospitals don't want these patients. They don't tend to be profitable. They tend to be medical. They tend to be hard. And if you're just saying from a purely financial

standpoint, that's not the tendency.

The second is I think that we need to know more about the -- you put the potentially avoidable conditions. I do think that a big part crosses all of those conditions, and that is the compliance issue. They come into the hospital, you get a new battery of drugs, you get them all set to go, and you hand them off back into the home. And there is a lot that falls through the crack. And sure enough they come back because things have fallen through the crack. I think we find that, but I'm not sure.

The other secret that doesn't get widely shared, I think in a lot of markets there is not just the freestanding with the hospital but there's typically a physician that makes his living off of this. What they do is they're the medical director of the nursing home and they're also the inpatient physician. And for some administrators this is your worst nightmare because when they bring them back in the hospital, because they get paid every day the patient is in the hospital, they often end up being the very long stay -- and this is what I mean they're not always profitable -- they tend up being a long inpatient stay and they bounce back and forth. When they get in trouble in the nursing

home they come into the hospital.

There's a lot of business that's tied up in this. If you seriously looked at some of the medical directors and what they're doing -- that's not to say there are not some wonderful ones doing great jobs but I think you'd find a pattern of long lengths of stay in the hospital also for some of these that have a link with the medical director and the nursing home.

That makes me less optimistic about the ability to bundle in these settings. But I would favor, in the long run, to say the payments related to the quality side would be a good thing to look at as some low hanging fruit.

For that matter, the upside, I think we've way underpaid the hospital-based SNF units and therefore some of us have gone out of business. And I think you probably find, as the data suggests, that you may have made a mistake -- not you, but we've made a mistake because I think there's less rehospitalizations out of that patient population than the freestanding.

DR. DEAN: I would just echo what Peter just said, this is a very tricky area. I practice in a critical access hospital that has both acute patients and swing bed patients

and skilled nursing patients in the same unit, the same staff, the same nurses, the same physicians. The observation that I've made, and certainly some of my colleagues have come up with the same thing, is frequently the patients that are on the swing bed program take more time and more effort than our acute care patients because they are typically people that are seriously disabled with multiple chronic conditions and are frequently relatively unstable -- not unstable enough to really justify an acute admission, and yet still need lots of attention because of ongoing problems.

So I think we need to approach this carefully. It's not to say it is troubling that those facilities with higher readmission rates also have higher margins and are more likely to be for-profit and some of those things, which clearly are red flags and areas of concern.

But it's also true that some of these are just very difficult patients and no matter what you do there's going to be some problems.

DR. CHERNEW: Let me say that this is one of those complicated cases because you think there's something there but you're not sure exactly what or how much. So at least

based on what I've read and seen, I guess I would say that right now I'm not convinced that an institution with a high readmission rates for these types of conditions is a bad institution as opposed to having a worst case-mix, although I'm pretty sure that some of those institutions are bad institutions. It's hard to figure out how to separate those out because there could be potentially some systematic bias.

I am convinced that the payment incentives are probably really bad, and so that does probably create a lot of problems. And it creates problems, in my opinion, that probably extend well beyond readmissions for these things but extend to a whole series of things, first time admissions. The measurement issues become complicated in terms of where you define a readmission versus a first admission versus how you do the case-mix adjustments.

So I guess my opinion is going forward, at least where I would like to be, is I would like to think broadly about how to solve some of the fundamental perverse incentive problems with churning and poor quality and some of those things and do that in a way that is independent of -- for example I think the for-profits and nonprofits should have the same payment rates, for example. I don't take it

as prima facie evidence that if they're for-profit that's necessarily a red flag. I know a lot of people that would argue otherwise, but I'm not going to argue that now.

Instead of trying to worry about that, finding a way to solve the incentive problems, whatever we think they are, is where I think it is useful to go. And I'm not just convince that just taking a readmission rate as a quality measure is the right place to start.

MS. HANSEN: Mike, I would definitely concur with you that that's at the larger level. But I do think that there is in between stuff that really can get looked at relative to specific aspects of quality.

I was actually going into a more specific area for a moment and then I had a question, probably for Jim.

But the specific area was just the rehospitalization and medications. I seem to recall from previous work that we've done on rehospitalizations that for the Medicare general population that within 30 days about 17 percent or 18 percent rehospitalization. And of that 17 percent or 18 percent, anywhere from two-thirds to 60 percent were because of medication issues.

So that's kind of a whole subset to itself

relative to getting the right medications.

And I think that that's for all Medicare population, is that right? Not just the group that's in SNF? Is that right? Because I just wonder whether or not the whole medication issue is further compounded as a quality issue in a facility.

But theoretically when you're in a facility and general compliance or adherence to medications, people normally would take them actually probably better than if they were out in the community setting.

The new thing for Jim is the fact that people will die in the nursing home with these conditions, which is the normal sequela for some people, but is there a look to it relative to the hospice programs that come into it, too? Because it may be an "appropriate" death but what was the cost of care and the quality of care during that last stage. But some of these people are end-stage congestive heart disease anyway. So it's not pure in the kind of clean one dimension of rehospitalization because there is "appropriate" death in the course of people's life scale.

But I wonder whether hospice is another overlay as to whether some of these facilities appropriately use

hospice, even though we've looked at that separately from this issue.

DR. MATHEWS: There are some very interesting intersections between the Medicare hospice benefit and dual eligibles whose nursing home stays are covered by Medicaid. And we anticipate bringing you some quantitative and qualitative analysis on this point over the course of the next couple of months.

MR. HACKBARTH: Okay. We're going to have to call it for today. Thank you, Carol.

We will have a brief public comment period. The ground rules are no more than a couple of minutes. Please begin by identifying yourself.

MS. PRAGO: I'm Ellen Prago [phonetic] with the American Hospital Association.

I don't have a comment, what I have is just a simple question.

In the discussion earlier this afternoon on the reporting of financial relationships, you indicated that you would be coming back to finalize some of the recommendations, because there were still some options that needed to be worked through. Is that going to be at this

meeting or at a subsequent meeting?

MR. HACKBARTH: At a subsequent meeting.

MR. LANE: Larry Lane, Vice President of Genesis HealthCare. Genesis HealthCare is a private corporation that has approximately 250 long-term care facilities.

A couple of points on the discussion on rehospitalization. One, the bias assuming inappropriate behaviors and demonizing ownership is not particularly constructive. I've represented every part of this spectrum have been involved, including government, academic, nonprofit, for-profit, investor-owned, private. The truth of the matter is I've met scholars and scoundrels on both sides. Don't demonize our people who are trying to do their best.

Two, the reverse incentives are not just one way. I would call, particularly on the rehospitalizations, if the Kramer work points out, and our own data confirms this, 15 percent to 18 percent of our initial rehospitalizations are within three days. That's the default rate. That basically says that there were premature discharges. I think you need to look at the issue of premature discharges at the same time that you're looking at issues of rehospitalization.

Also, as I've heard the sense that this was gamesmanship for reimbursement, census drives an awful lot of nursing home behavior. And basically our own data is showing again that 20 percent to 25 percent of those who are rehospitalized actually leave our census, therefore we've lost a revenue.

So work through this not with a bias that is one way. It works multiple ways.

We are equally concerned with the issue of inappropriate transfer. And I might say that the American Health Care Association has put together a task force that I am deeply involved with that is looking at all aspects of this because our own information shows that it's an impact on quality and we have a fair amount of operational data that just has not been tabulated.

I know my own company, which has Genesis Physician Services as a component part of it, has been collecting this data. AMDA, the American Medical Directors Association, did an excellent transcript five or six years ago on this area.

Finally, I would just say the bundling issue, I've been around from the days before Al Ullman introduced H.R. 1 back in the early 1970s. Bundling has been a conclusion

looking for a justification. Let's not go too far in a stampede there because you'll find the issue has been on the table over 40 years and still has not moved.

Thank you.

MR. WATERS: Good afternoon. My name is Bob Waters. I'm here this afternoon of the Telehealth Leadership Initiative and I just have a few observations with regard to the topic of the rehospitalization of SNF patients.

Our group worked with others very aggressively to make sure that SNFs were added to the list of originating sites for physician telehealth consultations, and we were pleased that Congress did that in the MIPPA bill that they just passed.

There are a couple of key points that are relevant to today's topic about that. First, we believe that telehealth can play a significant role in reducing rehospitalizations. First of all, it will provide expanded access to physicians. Telehealth service could augment in-person visits with patient encounters via telehealth. Patients can receive care in a more timely manner, avoid physically challenging and expensive transports either to

physician offices or to hospitals, and permit SNF personnel to spend their time caring for patients rather than preparing patients to be transported to another location.

Secondly, SNFs are often and are charged with attending to patients' needs post-hospitalization. These are critical days or weeks after a procedure. And it's essential that there be continued communication with the patient's doctor. That simply doesn't happen oftentimes in the nursing home setting. And so the ability to have that communication is critical.

Third, telehealth can reduce totally unnecessary transfers to emergency departments. In many cases, when a patient may be in need of some medical attention it may not be possible to find the physician. And as a matter either of risk management or the perverse financial incentives people have suggested, the nursing home will decide to move the patient to the emergency room when if they could talk to the doctor, a doctor, smoothly and quickly using telehealth technologies they might be able to avert those hospitalizations or transfers to the ED.

The Center for Telehealth and E-Health law took a look at this issue. They estimated that if you could avoid

one-quarter of 1 percent of all transfers from a SNF to a hospital you would more than pay for the cost of the program. I think with a little conversation with people who work in skilled nursing facilities, we all know that there's many, many more transfers that occur because of those reasons.

Finally, we believe that through the care of chronic care of patients who have congestive heart failure and other conditions through either remote monitoring and other technologies you can not only keep the patient out of the nursing home in the first place but you can better manage them when they are in there.

This new benefit that is provided in the Medicare statute needs to be watched closely. The government does not have a very successful track record in the telehealth area. There have been real challenges in terms of how they've complemented prior provisions. We think it's very important that they implement this provision correctly, and we would urge MedPAC and Congress to provide oversight over the implementation of this provision, and also encourage additional incentives to the use of telehealth technologies as a way to improve the quality of care of patients in these

settings.

I have a longer statement that I will leave with the staff, that they can share with the members of the Commission.

Thank you very much.

MR. HACKBARTH: Okay, we're adjourned until 9:00 a.m.

[Whereupon, at 5:40 p.m., meeting was recessed, to reconvene at 9:00 a.m. on Friday, October 3, 2008.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, October 3, 2008
9:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair
JACK C. EBELER, M.P.A., Vice Chair
MITRA BEHROOZI, J.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.
FRANCIS J. CROSSON, M.D.
THOMAS M. DEAN, M.D.
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
NANCY M. KANE, D.B.A.
GEORGE N. MILLER, JR., M.H.S.A.
ARNOLD MILSTEIN, M.D., M.P.H.
ROBERT D. REISCHAUER, Ph.D.
WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, Ph.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: The first topic is using drug and data and risk adjustment.

MS. SUZUKI: Good morning. We're here today to discuss the importance of evaluating the risk adjustors for Part D. Dr. John Hsu, a physician scientist and internist at Kaiser Permanente, will present results of his analysis of the risk adjustment methodology under Part D. His detailed bio is included in your binder.

Before turning it over to Dr. Hsu, I'd like to give you a brief background on the risk adjustment under Part D.

The payment system under Part D is complicated, so I will only touch upon a few aspects that are relevant to this discussion. As you know, CMS pays a capitated payment to plans for each enrollee on a monthly basis. The amount paid to plans are based on bids that represent expected costs of providing basic benefits for an enrollee of average health. Each enrollee is assigned a risk score based on demographic characteristics such as age, gender, disability status, and medical diagnosis, and the risk score is used to adjust payments to plans.

Payments for beneficiaries receiving low-income subsidy or are institutionalized are further adjusted to compensate plans for higher-than-expected costs since they face low or no cost sharing and therefore are likely to have higher drug use and spending.

As you recall, CMS automatically assigns the majority of the LIS beneficiaries to plans that bid below benchmarks. So the level of LIS adjustor could affect plan behavior. That is, if plans perceive the adjustment to be inadequate, they may not bid as competitively. Such behavior by plans could be disruptive for LIS beneficiaries as it would likely increase the number of reassignments each year.

In addition to these risk adjustments, Part D has risk corridors for each plan to limit overall profits or losses. The corridors were narrow initially, but has since widened to increase plans' insurance risk, and the Secretary may further widen the corridors in 2012. Thus, the adjustment for health status is likely to become increasingly important.

As you saw in the previous slide, Medicare law requires the Secretary to adjust payments to plans that

account for variations in enrollee risk. The law requires that risk adjustment be done in a budget neutral manner so that after redistributing payments to plans based on their enrollee risk profiles, the aggregate amount CMS pays to plans is not affected. The law also requires plans to submit drug utilization data, but does not require the Secretary to use them.

CMS developed a prescription drug hierarchical condition category, or RxHCC model, prior to the start of Part D. It is similar to the risk adjustment model used for the Medicare Advantage Program. It's prospective and uses demographic information and medical diagnoses to predict expected costs in the following year. It groups thousands of ICD-9 codes into disease groups that are similar both clinically and in terms of expected costs and develops the disease hierarchy so that risk scores pick up the highest cost category.

So for example, a COPD diagnosis would override acute bronchitis, as a former has higher severity and therefore higher expected costs. But the RxHCC model is different from the risk adjustment model for Medicare Advantage since it's predicting drug spending rather than

Parts A and B medical spending.

In addition RxHCC uses more diagnoses to create disease categories. Finally, the RxHCC model does not currently use information on past drug use to predict future drug spending.

Evaluating the performance of Part D risk adjustors is important, but there are issues we should keep in mind as we proceed. The accuracy of risk adjustors affects plan decisions about how to structure their formularies and whether to bid competitively to try to qualify as premium-free to LIS enrollees. Plans may try to avoid enrollees with low risk scores relative to their actual costs. Plans could also limit access to medications typically used by enrollees with higher costs relative to their risk-adjusted payments by structuring their formularies in certain ways. As a result, some beneficiaries may have trouble accessing needed medications or face significant increases in their out-of-pocket spending.

Including drug use information in its risk adjustment methodology could raise the accuracy of the risk adjustors. However, one must keep in mind that including

past drug spending could reduce plans' incentives to control growth in spending if it essentially compensates plans for actual costs. One way to deal with this incentive problem is to base risk adjustment on whether a beneficiary used any one of the several drugs that are in a therapeutic category rather than past drug spending. But if the therapeutic categories are too narrow, so that there are only a few drugs in some categories, the outcome for those drugs would be similar to using past drug spending and may lead to less aggressive price negotiations. These things could have significant budgetary implications and we should be thinking about them as we consider potential improvements to the risk adjustors.

Now Dr. Hsu will present the results of this analysis.

DR. HSU: Great, thank you. It's a pleasure and honor to be here this morning. I'm going to be talking to you about evaluating the risk adjustors for the Medicare Part D program, as you have heard. I just want to note that this is some work that we've been doing with a research team that has been together for over six years, and I just want to note that some of my collaborators include John Newhouse

from Harvard, Richard Brand from UCSF, as well as Vicki Fung, Jie Huang, and Bruce Fireman from the Division of Research. We've also had invaluable advice from a number of other people, which I won't go into right now.

I'm going to address a very straightforward question today. Given that we are in year three of the Part D program, can we improve on the accuracy of prospective payments? And what I wanted to do is show you some data that suggests that the risk adjustor that actually exists performs about as well as expected. I'm also going to show you some data that suggests that the LIS multiplier may benefit from some additional evaluation. And finally, I'm going to show you some data that suggests that drug information can substantially improve performance.

Now, all of this is a time where I would argue is ripe for investigating these issues because of many of the things that Shinobu mentioned. And finally, the most important thing is the difference between accuracy and performance. I think one issue is, while balancing the number of different competing incentives, we're talking about payment, and I will go into that in a little bit more detail.

So specifically, we wanted to address the overall question of can we improve the accuracy of prospective payment, and we are going to address three specific questions. One is, how well does the current system, the RxHCC score, how well does it predict future drug costs, specifically plan liability and Part D drug expenditures? We are going to focus on people who are--beneficiaries that are in the stand-alone prescription drug plan. This is the majority of beneficiaries right now, as well as the beneficiaries with and without the low-income subsidy.

Another key part of prospective payment is the low-income multiplier, and what we are going to do there is we're going to observe the ratio of plan liabilities for people with the subsidy compared to people without the subsidy. A multiplier in theory is supposed to help with this residual in terms of differences in terms of expenditures.

Finally, we're going to address the question, well, how would this change if we had drug information, and we're going to look at a couple illustrative ways of looking at drug information. Shinobu mentioned that how you do it and how you structure it is very important and can create

different very different incentives. I think there are a number of ways of using drug information.

Three other points I want to bring up is, again, when developers created both the score and the multiplier, they didn't have any Part D data because it didn't exist. The program wasn't around. We're now in year three, so now we have the first two years of data and we can start to address some of these questions today. This analysis would not have been possible earlier.

We are going to focus on risk adjustment, performance, specifically on the risk adjustor itself as well as the LIS multiplier. And again, finally, the most important point is any refinements which we think might benefit from additional information would need to balance these competing incentives.

I'm going to briefly go through the methods. We're using a partial national sample of prescription drug event data. These are the files that CMS and individual plan share. We received our information directly from the plans themselves. We're going to use the data for the first two years of the Part D program, that is 2006 and 2007. We're going to focus on people who were continuously

enrolled in 2007; i.e., they have a full year of drug data. We're also going to require that they have some information from the prior year, hence we can get prior year data on their drug use. And we're going to also, for the LIS group, the people with the subsidy, we're going to require that they have continuous eligibility for the entire year of 2007. And we're going to exclude people who are institutionalized for this particular analysis.

Our main outcome interest is really plan liability, which is probably most relevant for prospective payment. We are also going to look at total Part D drug expenditures.

Our risk adjustments, there are two main approaches that we are looking at. One is the current method. Again, this is also known as the RxHCC score. It's based on prior year inpatient and outpatient diagnoses.

The second method is to combine this with two ways of looking at drug information. Now, these are purely illustrative examples. There are many ways of characterizing this data. Two of the ways or general approaches include using drug class information as well as drug cost information. Now, one can use any number of

classes, from a very small number to a very large number, and there are reasons one might want to use one versus the other. We use something was available which is we are using 48 drug classes. For example, if you had diabetes did you receive a drug for diabetes in a given year, and what were your subsequent plan liability and costs in the following your? The other way is actually looking at Part D drug expenditures in the prior year.

Our evaluation is using a simple prospective evaluation approach where we're using this information; i.e. the diagnostic and drug information from year one, to predict costs in year two. We are going to examine a couple of different types of model performance. These include how much of the variation in actual plan liability and costs are explained by these risk adjustor variables, as well as what is the average difference between the predicted and actual costs in terms of dollars?

Our study population -- I'm just going to make a few comments here. We had a fairly large sample, well over a million. About a third had the low-income subsidy. The majority of those had the full subsidy. In 2006, most people had less than a full year because of the nature of a

new program, people joining at different points in time.

In terms of our findings about the risk adjustment score, the main findings are that the current approach performs about as well and perhaps even slightly better than expected. However, that means it explains about one-fifth to one-quarter of the total variation. When you add prior year drug information, no matter how you do it, you can substantially improve performance. Let me show you what I mean by that.

Here, we are looking at a population without the subsidy. This is the majority of Medicare beneficiaries in the country. We're focusing on the people in the stand-alone prescription drug plan. The current approach for risk adjustment, the RxHCC score, explains about 21 percent of the variation in plan liability. That's your R-squared of .21. When you add drug information, you can improve this substantially. You can go up to 42 percent to 52 percent. Again, that is your R-squared of .42 or .52 when you add either drug class information or drug cost information.

When we look at the group with the low-income subsidy, we see very similar findings. The current approach

explains about 24 percent of the total variation in plan liability. When you add drug information, it improves substantially. It can go up to 41 percent to 60 percent.

Moving along to the LIS multiplier, again, the LIS multiplier is a component of the prospective payment. One can think of it as, well, you are going to risk adjust for the differences in the population and then here's a group, the duals, for example, were known to have higher expenditures than the non-duals and the multiplier, one of the functions is to help to equilibrate those payments or make it slightly more even.

In our observed PDP population, the current LIS multipliers for both the partial and the full-subsidy beneficiaries were insufficient. This is what I mean by that. Our actual observed ratios and plan liability among beneficiaries with the subsidy compared to those without the subsidy were higher than what one would expect with the current multipliers of 1.8, 1.05. In other words, one group had--the subsidy group had a higher plan liability compared to the non-subsidy group that would exceed this 8 percent or 5 percent difference. We believe because of this, the evaluation within the full Part D population is warranted.

But one more important point. One can't think about the LIS multiplier separately from the risk adjustor. These are two parts of an equation, and when one changes one, it can affect the other. Specifically, adding prior year drug information not only improves the risk adjustment score itself, performance, but it also arguably improves the performance of the current LIS multiplier, and let me show you what I mean by that.

Here we have a graph. This is the plan liability ratios by deciles of predicted plan liability. What this means is you have risk adjustment scores, and we've broken this group of folks out into deciles. So on the left-hand side of the X-axis, the people who are in the lower risk groups, and the right-hand side in the higher-risk groups. We looked at the ratio of plan liabilities for people with subsidies compared to people without subsidies, both the full subsidy as well as a partial subsidy.

As you can see from this graph, all these points, or all these deciles, are substantially above where the current multiplier line is of 1.08 and 1.05 for all of the deciles among the people with the full subsidy and all but one among the beneficiaries with a partial subsidy. So in

other words, in the empirical data, we are observing differences in these groups in excess of what the multiplier might address.

Now, as I mentioned earlier, ne cannot think of the multiplier separately from the risk adjustor. So we asked another question putting these two parts together. If drug information improves the risk adjustor, how well would the multipliers work if one had drug information included in the risk adjustor? Here you can see, compared to the prior slide, all these curves are much closer to these lines of 1.08 and 1.05. And again, we're just using something simple purely for illustrative purposes of prior year drug class. In other words, if you improve the risk adjustment approach, the multipliers have to do less work.

Some limitations to note. We are using limited data. This is not the full Medicare Part D population. We did not have access to that. I think to do it properly or to make any specific policy or operational decisions, one should look at the full sample, especially since that is now at least theoretically possible.

We focused on a limited enrollment, meaning that we only included people who were continuously enrolled.

Obviously, during the year Medicare beneficiaries might die or change plans, et cetera. And specifically among those with the subsidies, at least some of those folks with subsidies can change at any point during the year without penalty.

And then finally, we focused on risk adjustment and plan liability. We do not address, and this data does not address profitability. I think any consideration of these issues about accuracy also has to consider a number of these competing incentives, which I'll mention in a minute.

So our main conclusions are about performance with and without prior year drug information. We found that the current Part D risk adjustment approach accounts for 21 percent and 24 percent of the variation in plan liability for the group without the subsidy as well as the group with the subsidy. Again, this is about what one would expect and even slightly better than one what one would have expected based on the development work.

The plan liability ratios, however, the ones that we observed, were higher than the current 1.08 and 1.05 multipliers. Including prior year drug information can substantially improve performance. To the extent that one

makes any changes, the LIS multipliers would need to reflect such a revision. And finally, again, one needs to balance consideration of a number of different incentives, especially when choosing the type in the structure of drug information to include.

So what do I mean by competing incentives? The concern is that as one designs such things, they can create incentives out there for different things, for example, potentially adverse selection also known as cherry picking or lemon dropping, as well as potential incentives for overuse or misuse, such as if a plan were reimbursed next year for drug use in a current year if a beneficiary subsequently re-enrolls. And there is also concern about under-use or stinting in care, especially if plans did not receive adequate reimbursement for actual drug costs and were not necessarily responsible for other medical costs, including hospitalization costs or other downstream events.

Inadequate payments for the LIS beneficiaries also can affect the stability of participating plans, and importantly the number of beneficiaries who are automatically reassigned from one year to the next. Any changes to the LIS multipliers or the risk adjustment

approach, some of these changes might be needed, and there are a number of ways one could do this, including calculating empirical rates as well as calculating an entirely separate risk adjustor for the LIS subsidy beneficiaries.

And finally, we would argue that not only is this now possible, but performance becomes increasingly important as the risk corridors widen. As plans have the ability to gain or lose more moving into the future, then arguably these incentives become increasingly important.

Thank you very much.

MR. HACKBARTH: Okay. Let's do a quick round of clarifying questions. Bruce?

DR. STUART: That was very interesting. Thank you very much. I just want to make sure I understand this term LIS multiplier because I've never heard that term used before. Is that simply the percentage by which LIS is higher than non-LIS? Or is it calculated in some other way?

DR. HSU: I think the short answer is it's part of the prospective payment calculation. So a multiplier of 1.8 means that if you have a LIS beneficiary with a full subsidy, you get 8 percent higher payments.

DR. SCHMIDT: Right, and just to add onto that a little bit, the genesis was kind doing this, I think, for recognition that there is much lower cost sharing for people who receive those subsidies.

DR. CHERNEW: That was wonderful, but I have just one question about the data. Did you have the data on the actual plan the person was in, or just the data without knowing what plan they were in?

DR. HSU: We knew which plan they were in.

DR. CROSSON: I just wondered, in terms of the risk adjustment model when you add the drug usage, does it make any sense or did you look at actually combining the drug class in the prior year expenditures to see whether that improved the predictability?

DR. HSU: So including an indicator for both drug class as well as drug costs?

DR. CROSSON: Right.

DR. HSU: No, we haven't tried that. We tried a number of models with each of those separately, but not with the combination. It's something worth trying. I think there are a number of different ways of including this in more than just--I mean, the drug information is essentially

treatment information. I think it's a very powerful data source and one could do other things, including multiple uses, including information about whether a diabetic is continuing to receive medication, et cetera.

MR. HACKBARTH: Other clarifying questions? Okay, let's do a round of one- to two-minute brief comments or questions.

DR. CHERNEW: So this is a follow-up on my clarifying question. What I'm interesting in knowing the magnitude of, and I'm not sure I can explain this well, is while the percentage of variance explains matters, what really matters is sort of how much systematic their bias is in selection. So even if I explained a very small amount of the variance, if people were distributed sort of evenly across the plans I would be less worried about risk adjustment. So I'm sort of interested in sort of empirically at the plans how much the systematic biases there seem to be. And then John might know how to do this better, sort of what potential is there for that systematic bias if we got it wrong. In other words, if you did something and got in a certain number of people, how bad--so were there plans that you could say, this plan really got

killed because the risk adjustor really wasn't good and this plan really made money because the risk adjustor wasn't very good? And I think with your analysis you can do that, but I'm not sure if you looked at that.

DR. HSU: Let me take a shot at this. You're right, I mean, the R-squared is not the only way of looking at performance in there and there are other issues. And definitely to the extent that the sample size or plan population increases, you are balancing more risk. I can also--I will show you some additional slides in a second.

Importantly, we didn't address profitability. We can't. We can't say that the plans made money or lost money. We're only talking about the prospective payment component. We don't have information about rebates. We don't have information about other issues that could potentially affect profitability.

With respect to the question about distribution, another way of thinking about performance is every risk adjustment approach will tend to underpay people who have high expenditures and overpay people who have low expenditures. That is just a component of the system. But the relative amount of under- and overpayment is important.

This is a comparison looking at observed drug expenditures versus predicted drug expenditures. The diagonal line would be a system that was either a perfect risk adjustment system or even a fee-for-service, you know, payment for actual services. The deviation from that tells you the amount of overpayment or underpayment.

As you can see, we have three different lines here. The blue line, the diamonds, correspond to our current system. There tends to be more overpayment at the low end and underpayment at the high end. And again, each of these dots represent a decile. So these are an equal group of people. Now, when you add prior year drug information, one can improve that by decreasing the amount of underpayment and overpayment at the extremes.

So yes, there are a lot of different ways of looking at performance and are relevant.

MR. BERTKO: Maybe I can jump in and add an empirical answer or at least a theory to Mike's question, and that is what John has shown here earlier is that the LIS multiplier appears to be inadequate. I think I've mentioned that in previous MedPAC sessions. My other disclosures, to remind everybody, I've been one of the advisers looking over

John's team's shoulders for a while.

In the last two weeks or so, CMS has released the results of this year's bidding for 2009, and off the top of my head, about four out of five plans in the low-income side have either completely got out of low-income, because their plan cost bids went over the benchmark, or have reduced substantially the number of regions in which they're under the benchmark. I'd give you the analogy here of playing-- you get the queen of spades, it makes your bid go up, so you hand it off to somebody else. But their bid has been down because they didn't have the queen of spades this year. And that's the kind of churning that might result, in my theory, from inadequate risk adjustment here. And it's not even skewing. It's the way the regional benchmark plays against the bids that have to be actuarially counted.

And I would add one more thing here. Of course, there could be some just market business play on this in addition to the actuarial evidence that comes through. Some plans may choose to bid higher, so they lose their low-income members as they just eke over the benchmark without disrupting, say, their non-low-income members.

DR. CHERNEW: [Off microphone.] The low-income

part is systematic across plans.

MR. BERTKO: It appears to be from this evidence.

DR. SCHMIDT: We will be presenting some more information about some of the changes in qualifying plans for 2009 over the next month or two. But to your point a little bit, Mike, too, I think your question was getting to how representative is John's sample of plans. That was part of the question, if I understood it correctly.

DR. CHERNEW: [Off microphone.] How representative the people were. Even with the picture he's shown, if he distributed the people evenly it wouldn't be a problem for risk adjustment. You'll be making up on some and losing on others. But there's an adverse selection potential, as John mentioned accurately, and I'm just trying to gauge how much money is on the table.

The low-income subsidy analysis, I think was exactly right because it shows a systematic thing which I think Rachel pointed out correctly, because they don't have to pay any of the copays. There's economic theory as to why you would expect you need to adjust and you need to know something about the demographics and the elasticity to get that right. And you have suggested, and I think very

importantly suggested, that didn't quite happen.

DR. MARK MILLER: The other part of that, I think, if you look at the other end of the distribution is there's parts where you may be systematically overpaying.

DR. STUART: Now, I want to second that because I think that selection is the issue. I think that if you look at these kinds of curves, you are going to potentially get the wrong information because every risk adjustor, no matter how good it is, up to a point is going to overpay at the bottom end and underpay at the top end. As you reduce that variance at the bottom end and the top end, you, quote, increase the accuracy, but I think we've got to be a little bit careful about the language here, because if you want to be perfectly accurate, you don't play these games. All you do is you have cost reimbursement.

So when we start using the term better, outperforms, more accurate -- and you note this, John. This is not something that's unknown. But it's just very easy to kind of slide into that language and then we're addressing one issue which we think is the big issue, but in fact I don't think it's the big issue. I agree with Mike that it's a selection issue and that we need to address both from the

standpoint of individual behavior, who ends up in which plan, how they change plans, and obviously plan behavior.

I have one other question, and it came up before your presentation. You had mentioned what happens when Wal-Mart came in and started charging four dollars for generics. What do you think the role of out-of-plan use for these low-priced generics has on both your analysis here and more generally on the Part D program?

DR. HSU: I think that's a great question, so a couple of comments. Again, these are data from 2006 and 2007, and during that time period, the amount of penetration, if you will, was relatively limited, meaning that Wal-Mart was only offering a few drugs and many other chains were not doing the same.

However, that is changing to a certain degree. More and more pharmacies are offering low-cost drug options for a number of reasons, and four dollars for a month of generics is a fairly low price.

At the same time, beneficiaries have a strong financial incentive for recording their costs and getting their medications within a given system because many of these markers about where their cost sharing is and

specifically when catastrophic insurance kicks in is based on what their out-of-pocket payments are. So if you anticipate spending a fair amount of money and you're hoping to get that break at the end, then it's important that those costs accumulate.

So for beneficiaries that have high expected or high actual expenditures, I would expect that the effects would be relatively modest. But that's ultimately an empirical question. For the lower-level expenditure beneficiaries, people are relatively healthy and have infrequent use, then I think it's much more an open-ended question.

DR. STUART: Does your database have a source of-- have the company that actually filled the prescription? In other words, would you know whether it was a company that offered one of these low-cost plans?

DR. HSU: We haven't looked at that yet.

MR. BERTKO: Just one other comment here, which is to think about encouraging CMS to move to using drug data in any form, whether it is just drug class or expenditures. It's been three years. The data is at least in theory available. And I think as John's work has shown, the

performance using Part D data to predict Part D expenditures or plan liabilities is a substantially better than the current method, which of course had to be used at the start up.

DR. MARK MILLER: I think the intent of this line of research is to end at a point like that. I think--and you need to tell me if this is correct, Rachel and Shinobu--I think the idea is, in addition to just saying, you should do this, give them some sense of the direction that we want them to go and focus on. I think that's kind of the idea here.

DR. HSU: One quick comment. I completely agree with Bruce and Michael about the difference between performance and accuracy. Specifically, to do this right, one should look of the data, look at all the data from all the plans and see what's actually happening.

However, accuracy is not the end of the game. There are these different incentives and these are ultimately policy questions. How do you balance them? There are conflicting incentives. There isn't one dominant strategy. And that, I think, is a worthwhile discussion.

DR. REISCHAUER: The main points that I want to

cover were talked about by John and Mike, but just going to the LIS issue, and John suggested that there might, in a sense, be a response to this. There may, there may not be, it's probably pretty early and plans are figuring out how to do their bidding. But I was just wondering if we knew anything about economies of scale.

The LIS adjustment is sort of based on use of medications or conditions and not sort of underlying economy of providing -- I mean, it is not an empirical estimate of what it costs. So I'm a plan and I'm thinking, do I want to be LIS eligible or not? If I am, it doubles the size of my base. That allows me to negotiate harder for drugs. It shares the fixed costs of the system across there. So there's something going in both directions here and it gets rather complicated in the how one would then play this out in your bidding strategy.

The questions that I would have is researchers can pursue the perfect risk adjustor, but the question is how good does it have to be to get to an acceptable level of behavior among both beneficiaries and plans? And to what extent do we have any indication that because of a bad risk adjustor, certain people are being forced out of the market

or other ones are being unnecessarily rewarded? To what extent has it caused or might it cause access problems and all of that. We want to keep focused on those aspects of it rather than sort of the academic search for the perfect risk adjustor.

MR. HACKBARTH: Yes, and how do you evaluate that? What's the analytical approach to answering Bob's question?

DR. SCHMIDT: It's hard to know definitively what leads to turnover of LIS folks. We do know some data points. For example, Humana has announced that it is getting out of the LIS business essentially, that it has bid higher than the regional thresholds in all parts of the country for the coming year. And so there's over, I think, 300,000 duals or LIS enrollees who are no longer--or they are going to be reassigned to other plans.

Now, is that just because of the risk adjustor? Of course, we can't say that definitively, and I'm really not quite sure how one would design a research project to get that without asking Humana about its strategy in the first place.

DR. MARK MILLER: The other thing, and this doesn't answer your question definitively, but to try and

pull some of this back together, is what I would see the Commission doing. There is some technical work that people should be aware of, and as always, trying to help that end of the process.

And then to John's point, there is a set of policy questions that people have to balance off. I mean, a very--not a simple one, but one that we talked about today is expenditures versus categories. Those are kinds of statements that I think this Commission can make in terms of trying to think about the trade-offs and inside--because we know that CMS, or we believe CMS is going to take a run at improving this and we are going to push them in that direction, but give them some of the questions and at least the way we lean on balancing those various things, even if you empirically can't establish the answer to some of your questions. I think that's the objective here.

MR. EBELER: A quick clarification on the Mike-Bruce stream of questioning. Your data would allow you to assess whether people are sorting among plans on an sort of average basis or whether there is some sorting where the lower-cost people are ending up here and the higher-cost people are ending up somewhere else?

DR. HSU: So I think your question is is whether we think there is actual selection by the beneficiaries?

MR. EBELER: Right.

DR. HSU: I think the answer is yes, there definitely is.

MR. EBELER: That would be useful to sort of see how that plays out.

The second question is a little getting off that subject. This is honing in on sort of Part D-Part D. Is there anything you're learning here or that we could build on to learn about A/B spending? These are people that are in all parts of the program and is there work that you have done or does this kind of data lend itself to using some of this information to help us define what we're doing in the rest of MA?

DR. HSU: That is the billion-dollar question. So the short answer is, yes, that is possible within the Medicare Advantage realm, or at least it's much simpler. It's much more difficult on the PDP side and it has to do with data sources and things like that. We have some ongoing work on the MA side.

MR. BERTKO: Jack, if I can jump in here, the

Society of Actuaries did a comparative evaluation of risk adjustors -- this is for the under-65 population -- using a variety of things. But to answer your direct question, they took a look at hospital professional IEB data, MD data, and the risk adjustors for predicting A/B costs were improved by adding drug data to it. So the more data you have, and in classes, not in spending, generally the performance, again using that term carefully, increases.

MS. HANSEN: My comment is more general relative to the behavior of plans and what the correct risk adjustor might be to make it business-wise worthwhile for them to stay in, and thinking about it from the Commission standpoint of just what it does mean to the movement of people of the LIS population, because it's extremely disruptive and sometimes it's worthwhile to look at it from the MA side because you can capture the total cost. But especially those who are involved in PDP plans, that kind of disruption from an access standpoint is just really tremendous. So I just want to hope that that kind of tracking and visibility appears in the course of our chapter.

Thank you.

DR. SCANLON: An observation and a question. The observation is that in earlier comments about if the risk adjustor is inadequate, we can go to cost reimbursement. But that gives us certain disincentives and that we don't like. I think we shouldn't forget the role of the risk corridors and the fact that they can compensate for us with some of the inadequacies in the risk adjustor. We should be thinking about this a dual strategy over time.

The question is whether CMS currently has plans or a process in place not necessarily to change the method of risk adjustment, but to update it. Because thinking about it, if this is diagnostic driven, as drugs go off patent and new drugs come on the market, sort of the correlate that's treating that particular diagnosis is changing and there seems to be a need that this be continuously updated in terms of the actual parameters. I'm just wondering what CMS is doing.

DR. SCHMIDT: We do know that they have some research underway through a contractor to evaluate different strategies of updating the RxHCC approach. I don't know that there's a specific timetable in mind for implementing that or for reevaluating it periodically on a regular basis.

I suspect that is the case, but I don't know the exact timetable.

I should also say that CMS has a proposal to move towards ICD-10s in 2011 and that also has implications for redoing all of our risk adjustment systems.

DR. HSU: Two other comments on that. I think you're also absolutely right that drug information requires frequent updates. Doing this once every few years probably is not going to be adequate, given the number of new therapies that may or may not come aboard.

The other comment is you're right that the risk adjustor is not -- there's the risk corridor. There are other things.

With respect to the LIS assignment, there is also the issue not only of the multiplier, but the forced reassignment from one year to the next. There are many other components to this that will shift things.

MR. HACKBARTH: I confess to being in over my head in this topic in general, but what Bill says makes sense to me. You said at the outset that any risk adjustor, there's going to be underpayment at the top end of the distribution, the high-cost end, and overpayment at the low-cost end. It

seems to me that risk corridors directly address that.

Yet as I understand the legislation, there is a process underway to broaden the risk corridors and it doesn't seem to me dead obvious that that's the right thing to do.

So is it in fact the case that the legislation requires broadening the risk corridors over time? And then authorizes the Secretary--it sounds like they go even further. And is that something that we ought to be looking at as a policy option or recommendation, not doing that?

MS. SUZUKI: The current statute authorizes the Secretary to widen the corridors in 2012. It does not require the Secretary to do so.

MR. HACKBARTH: But if I understood the presentation correctly, we've already, by statutory mandate, widened the risk corridors. So that was built into the concept of the law and it's not clear to me why that's a good thing.

DR. MARK MILLER: I think this is a subject for us to talk about. For those of you more comfortable with a PPS type of notion, you have a predicted standardized payment adjusted for certain things and then when things leave the

track, you have an outlier arrangement. That's fundamentally what we're talking about here, is reinsurance at potentially the individual level and corridors more at a population level for a given plan.

I think that we're sort of talking about the policy guidance to CMS on the range of comments, actually all over the place but I think most of you, Bob, I think that's the kind of mix of recommendations or directions. We can say risk adjustment and think of these kinds of changes, but also think about how you construct the policy to capture the risk around that.

DR. SCHMIDT: And we should evaluate all of those pieces. Just to remind you, we had relatively narrow corridors at first because that was part of the way of encouraging plans to enter into this at all.

MR. HACKBARTH: And my recollection was they were sort of seen as training wheels. Let's put on the training wheels while we get started. But I'm not sure that that's the right way to think about risk corridors. Or maybe training wheels is partially, but I think that they potentially have a longer-term role as --

DR. CHERNEW: A helmet.

MR. HACKBARTH: Right, a helmet, there you go.

DR. SCANLON: I think they were thought of as training wheels for the plans, but I think we need to have training wheels for the program, which is the fact that we cannot get administered prices right, and so one way to protect yourself from not getting them right is to think about risk corridors so that you don't end up paying excessively over time and are unable to capture that. And you also are meeting the incentive to be overly aggressive, I mean, in terms of stinting. That is the other key part of this, and this has come up in other contexts. I won't bring it up.

DR. CHERNEW: I just wanted to respond to John Bertko's earlier comment about recommending that they add drug-spend. I actually heard a different message from John, and John, luckily you're here so we don't have to put words in your mouth, but I'm going to for a minute.

I didn't hear John advocating for adding drug data to the risk improvement models because what I heard him say was that even though that data could improve the R-squared and potentially, although we don't know, might reduce incentives for adverse selection, but we haven't quantified

that benefit, whatever those benefits are to the R-squared improvement or the adverse selection reduction, that has to be weighed off against the incentive effect issue that came up.

I think I heard you say that you have to weigh those things, and we haven't seen data on the two sides of the scale yet, so I'm not prepared to jump in and recommend that drug data be added. We know that it has the potential to have some benefit, but we haven't quantified the most important benefit that relates to selection and we haven't thought through the downside, which is the incentive effects yet. So I'm not sure.

What I did hear you say -- and again, my ears don't always work well because it's filtered through all of my biases -- I do see a case for potentially increasing the low-income subsidy multiplier. That doesn't involve adding drug data, because I could do that now. I could go from 5 percent to 10 percent, or whatever number you told me because I trust you. Because you did demonstrate, I think, pretty clearly that across-the-board, we're not paying enough for low-income subsidy people. And even more importantly than that, I think John presented good

conceptual and sort of anecdotal evidence, if not quite empirical, that there is this systematic ability to lemon drop by bidding above the benchmark. So it's very easy to get rid of these people, more so that other people, because if you just bid a little bit about the benchmark, you can get rid of them pretty easily and they don't have much say in it in that sense, and you have some evidence that this is happening.

So if I had to say, the first step that we need to think about is how to deal with the low-income subsidy problem, which strikes me as a different exercise than whether or not to use drug data in adjusting the risk adjustors. That's my summary of the John Hsu morning speech.

DR. REISCHAUER: Was he right?

[Laughter.]

DR. HSU: Well, let me offer a couple of thoughts. I think we're suggesting that drug information can change the game. And how you change the game, it's very powerful information and one must use it carefully, I think is our main point. There are a number of ways of doing this and you can balance these different incentives. But it's not

just a question of use drug information versus not. You to think about what you're doing, or let me put it this way. How you structure it can create very different incentives, including incentives for better quality.

In terms of the LIS multiplier, again, I think we're showing you empirical evidence that these observed ratios were higher than the current multipliers. To do this right, again, I think one should use the full data set and see what is the actual numbers across the entire country? What are the numbers in each region, in other words a reasonable choice set? And how do other factors affect this, specifically the restrictions on the formularies, the amount of utilization management, et cetera. I think those are relevant.

The concern, however, is that to the extent that there is a perception or actual inadequate payment for the LIS group, there is a concern, and I can't prove this yet, but this creates the incentive to increase your bid. In other words, you're almost running away from sort of the LIS hot potato which would obviously sort of counterbalance any desirable market incentives for cost containment.

Now, I think Bob is absolutely right that there is

this issue of size and market power versus margin and bids. This is ultimately an empirical question. To the extent that we see the LIS people being reassigned from year to year, that would give us an empirical answer about what is the market doing.

MR. BERTKO: May I respond? Mike, I'm going to drop into the bowels of risk adjustment for a minute here. I think we are all in agreement on the LIS issue. On the risk adjustment issue here, what we're doing is using A/B encounters, and I'll pick a perfect one, diabetes, and an imperfect one, say some cardiac problem. In diabetes, you always need insulin, and so the predictive power of using the A/B encounter of a diabetic is quite good. But on the cardiac one, you might have something, think it's an angioplasty, or a heart condition treated with either angioplasty or with drugs. In my mind it would be technically better to use the drug class indicator, not the spending -- I'm more of a class indicator kind of person--as opposed to saying 100 percent of the people with that particular cardiac condition are predicted to have drug usage.

So I think drug data would be better. I think

that near last slide that John showed, that the LIS adjustment would be less using a risk adjustor with drug data in it is also an important indicator that this might be useful stuff.

DR. MARK MILLER: I've got to add one other thing. On the utility of the data, you're right, I think that needs to be thought through. I also think one thing that we might want to think through is its utility for risk adjustment more broadly in sort of the A/B world. So there may be a couple of reasons to be thinking about this.

But the other thing I want to say, because I want to be careful about this comment is taken out of the meeting. So you made a statement that the LIS multiplier may be insufficient and that your first action would be to increase it.

Now, since we're not seeing any problem with plans entering and people coming to the table to provide the benefit, I would presume that that would be in the context of a budget neutral adjustment.

DR. STUART: I would like to pick up on a point that John just made, and that is that we got into this business -- we started with the HCC predicting A and B cost

and then we said, okay, well, let's use a variant on that to pay drug costs. But we're looking at an MA plan that presumably has some incentives under the system, depending upon the nature of the payment, to substitute services where they can be substituted and hopefully provide even higher quality care.

Now, what that argues to me is that you really, for these kinds of plans, you don't want separate risk adjustors for the A/B side and the Part D side. What you would really like to have is a form of the HCC that covered both drugs and A and B.

So as far as the MedPAC research is concerned here, what we might be thinking about is for these MA-PD plans to see whether a unified risk adjustor would do a better job than these two working maybe at odds with one another.

DR. HSU: One quick clarification. These are from PDPs, so this data is not from MP-PDs, but your point is taken.

DR. STUART: Oh, and there are PDPs out there, aren't there?

DR. CHERNEW: I don't want to just keep going back

and forth with John, but I guess my comment would be I understand that the drug data could do a better job of predicting. I am just not sure that's my metric of success because I worry about the incentive effects of that.

So I'm not opposed to using drugs and I can think of reasons -- in fact, right now, I'm sorry, I have to go.

[Laughter.]

DR. CHERNEW: I'm not opposed to including drugs in a risk adjustment thing, and I agree exactly with what John Hsu said, how you do it is important and the metric of how well you get the prediction is important. What metric you use to know if it's working is right and how well you predict across the spectrum isn't the only metric. It's not even the most important metric that I would look at.

MR. HACKBARTH: Questions? Comments? Thank you much. Nice job John, appreciate it.

Okay, next, Dana is going to talk to us about psychiatric hospital PPS.

MS. KELLEY: Good morning. In January 2005, CMS changed the method for inpatient psychiatric facilities from a cost-based system to a PPS. The change to a PPS creates new financial incentives for providers and may therefore

affect patterns of care, including the types of cases admitted it to IPFs, services furnished, and lengths of stay. Monitoring the adequacy of payments to IPFs will be crucial to maintaining access to and quality of care for severely mentally ill beneficiaries, who are one of the most vulnerable populations in Medicare.

It's been many years since the Commission has looked at inpatient psych facilities, so today to bring you up to speed, I'll provide details about Medicare's coverage and payment policies and then I'll present information about the use of inpatient psychiatric care, including some changes since the PPS was implemented. And finally, I'll discuss future work. There are no policy decisions that need to be made today, but please let me know if you have any questions or if there's any additional work you'd like to see.

First, let's review some information about the Medicare beneficiaries who use IPF care. Overall, an estimated 9 percent of beneficiaries are thought to have a severe mental disorder such as schizophrenia or major depression. This compares with about 6 percent of the general adult population. Severe mental illness is very

common among beneficiaries under age 65, affecting approximately 37 percent. This is because mental disorders other than mental retardation are the most common reason disabled workers receive benefits under Social Security Disability Insurance.

The severely mentally ill are a very vulnerable and costly group. Mental illness and substance abuse problems accompany a number of other illnesses, such as diabetes, heart disease, neurological diseases, and cancer. The IOM reports that mental illness and substance abuse significantly compromise treatment outcomes for general health conditions and increase the use and cost of general health care. Mental illness is also a major risk factor for the development of adverse behaviors, such as smoking, eating, and a sedentary lifestyle.

Medicare beneficiaries with mental illnesses or alcohol and drug-related problems who are considered a risk to themselves or others are eligible for Medicare's inpatient psychiatric facility benefit. Beneficiaries treated in IPFs are responsible for the Part A deductible and for a copayment of $256 a day for the 61st through 90th days of care. Beneficiaries treated for psych conditions in

IPFs are covered for 90 days of care per spell of illness, with a 60-day lifetime reserve, which is the same as for general inpatient care.

Over their lifetimes, though, beneficiaries are limited to 190 days of treatment in freestanding psychiatric hospitals. This limitation does not apply to psych services furnished in a distinct part psychiatric unit of an acute care hospital or critical access hospital, so it's not clear how much the 190-day limit restricts access to inpatient psychiatric care.

Inpatient psych care may also be furnished in so-called "scatter beds," that is in acute care hospital beds not within distinct part psychiatric units. In those cases, Medicare pays under the acute care hospital PPS rather than the IPF PPS. Again, the 190-day limit does not apply.

To be certified under Medicare, IPF's must be primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill patients. The goal of care is mood stabilization and restoration of the ability to live independently. In addition, IPFs provide supervision and behavioral management to minimize risk of

harm to self or others. Most IPF patients receive drug therapy in the form of antipsychotics, mood stabilizers, antidepressants, and/or anticonvulsants. Patients also received individual and group therapy, family therapy, psychosocial rehabilitation, illness management training, electroconvulsive therapy, and other treatments. At the same time, some patients may receive care for medical comorbidities such as diabetes, infectious disease, wound care, and cardiac care.

Overall, Medicare payments make up about 30 percent of nongovernment IPFs' revenues. In 2006, Medicare spending for IPF care was about $4 billion, and this amount does not include spending for care in scatter beds.

Historically, the great majority of psych beds in the United States were housed in State or county mental hospitals. The downsizing and closure of many of these hospitals since 1970 resulted in a large decrease in the total number of inpatient psych beds and shifted capacity to the private sector.

As you can see here in the third column, the number of IPFs was continuing to decline prior to implementation of the PPS in 2005. Between 2000 and 2004,

the number of IPFs decreased on average almost 2 percent per year. But since the PPS was implemented, the decline has slowed or reversed for all types of providers. The number of government facilities in particular has grown by almost 3 percent since 2005, and this is something we plan to look into further, just to get a sense for what's driving those numbers.

It's not clearly demonstrated on this slide, but beginning in 2004, the number of psych units in critical access hospitals has grown dramatically. That growth followed a provision in the MMA that allowed critical access hospitals to establish distinct part units of up to 10 beds. In 2007, 70 critical access hospitals, or about 5 percent of all CAHs, had psychiatric units. These may allow some rural beneficiaries to receive inpatient psych care closer to home and also may help in the retention of mental health professionals in rural areas. But there's little research that indicates how well the services furnished in these units match rural communities' needs.

When the PPS for acute care hospitals was implemented in 1984, inpatient psych facilities remained under cost-based payment largely because the per case DRG

system was thought to be a poor predictor of resource use in psychiatric patients. Congress mandated the development of a per diem PPS for IPF care in 1999, and as I said, it was implemented in January 2005. Under the IPF PPS, Medicare pays for the per diem costs associated with furnishing covered inpatient psych services. The base payment rate for each patient day in a IPF is based on the national average daily routine operating, ancillary, and capital costs in IPFs in 2002. For rate year 2009, which began on July 1, the base payment rate is $638 per day. That rate is adjusted to account for patient and facility differences this are associated with significant differences in costs.

IPFs also receive an additional payment for each electroconvulsive therapy treatment furnished to a the patient. In rate year 2009, the ECT payment is $275. One might be concerned that this add-on for ECT might increase utilization, but that doesn't seem to be the case. About 2 percent of IPF patients in 2006 received at least one ECT treatment during their stay, the same percentage that received ECT treatment under cost-based payment.

This slide lists the patient adjustments to the base payment rates under the IPF PPS. The first is

diagnosis. Patients are assigned to one of 15 psychiatric diagnoses, DRGs, such a psychosis, depressive neurosis, or personality disorders. Medicare assigns a weight to each of the DRGs reflecting the average costliness of cases in the group compared with that for DRG 430, which is psychosis. That's the most frequently reported DRG. Infrequently, a patient is designed to a non-psychiatric DRG. In those cases, the facility does not receive a diagnosis adjustment.

Payments are also adjusted for patient age. In general, payment increases with increasing age over 45. The adjustment factors range from one for patients under 45 to 1.17 for patients 80 and over.

Payments are also adjusted for 17 specific comorbidities, such as renal failure, diabetes, and cardiac conditions, that are secondary to the patient's principal diagnosis and that require treatment during the stay.

And finally, per diem payments decrease as patient length of stay increases.

The base payment is also adjusted for certain facility characteristics. These include adjustments for differences in area wages, cost of living, and teaching status. The teaching adjustment parallels the IME

adjustment paid under the acute care hospital PPS. The payment is an add-on adjustment to the amount per case based in part on the number of full-time equivalent residents training in the facility. Payments are also adjusted by location, with IPFs in rural areas being paid 17 percent more than urban IPFs. And finally, payments are adjusted for IPFs that have emergency departments. IPFs with EDs are paid 12 percent more for their patients' first day of stay.

The IPF PPS has an outlier policy for cases with extraordinarily high costs, drawn from an outlier pool of 2 percent of total payments. Medicare makes outlier payments when an IPF's estimated total cost for a case exceed a threshold plus the total payment amount for the case. In 2009, the threshold is $6,100. Medicare covers 80 percent of the costs above the threshold plus the cost of the case for -- I'm sorry, the payment for the case for days one through nine, and then 60 percent of the costs above this amount for the remaining days. The different risk sharing rates are intended to counteract the financial incentives to keep patients longer.

To examine trends in IPF care and assess changes in utilization since the PPS was implemented, we looked at

IPF claims from 2002 and 2006. In 2006, IPFs had about 473,000 discharges, in increase of 0.5 percent per year since 2002. But on a fee-for-service basis, the number of discharges is declining, falling from 13.9 cases to 13.6 cases in 2006 per 1,000 fee-for-service beneficiaries.

We found that use of IPFs varies significantly by State. IPF discharges range from a high of 28.4 per 1,000 fee-for-service beneficiaries in Louisiana to a low of 1.6 in Hawaii. It's not clear whether this variation reflects differences in patient populations, treatment patterns, or supply of inpatient beds. Some States with relatively few IPF discharges may experience comparatively high scatter bed to use. Some States may also have more and better community-based care that will help patients manage their conditions and avoid acute episodes requiring hospitalization. Future analyses will examine the combined number of inpatient psych discharges and scatter bed discharges by State to try and tease this out a little bit.

This slide shows the most common types of cases in IPFs in 2006. By far, the most frequently occurring IPF diagnosis, accounting for almost three-quarters of discharges, was DRG 430, psychosis. The next most common

discharge, accounting for 8 percent of IPF cases, is DRG 12, which is degenerative nervous system disorder, such as Alzheimer's.

Admission to an IPF is usually an acute event as most beneficiaries enter a facility directly without a related hospital stay. In 2006, almost half of all IPF cases were initiated by referral from a physician or a clinic, while 35 percent were admitted directly from the emergency department, and those numbers are relatively even across the different types of diagnoses.

The types of cases treated in IPFs have changed somewhat since the IPF PPS was implemented. As you can see here, the number of cases with degenerative nervous system disorders and alcohol and drug use with comorbid conditions climbed 46 percent and 44 percent, respectively. By contrast, the number of cases assigned to DRG 429, organic disturbances and mental retardation, which is the third most common IPF condition, fell 25 percent over the four-year period.

IPF patients tend to be much younger than Medicare beneficiaries treated in other types of facilities. In 2006, 64 percent of IPF discharges were for beneficiaries

under age 65, and these are the non-ESRD disabled. Almost a third were for beneficiaries under the age of 45. Between 2002 and 2006, the number of IPF beneficiaries between ages 45 and 64 swelled almost 20 percent, compared with declines of around 5 percent for other age groups. This growth directly reflects the aging of the baby boomers.

Younger beneficiaries tend to present with different diagnoses compared with older beneficiaries. Less than 1 percent of IPF beneficiaries under age 65 are diagnosed with degenerative nervous system disorders. By comparison, 21 percent of IPF beneficiaries over age 65 receive that diagnosis. A diagnosis of psychosis is also strongly age-related. 85 percent of IPF beneficiaries under 65 are diagnosed with psychosis, compared with 52 percent of beneficiaries 65 and older.

African-American beneficiaries are disproportionately represented among Medicare IPF patients. Although comprising only 9.8 percent of Medicare enrollees in 2006, blacks represented 18 percent of IPF patients. 77 percent of Medicare IPF patients are white and 2.4 percent are Hispanic.

Diagnosis patterns also differ by race.

Minorities are more likely to be admitted for psychosis than are whites and less likely to be admitted for degenerative nervous system disorders. In part, these differences are related to age. Minority patients in IPFs tend to be younger than white patients. But these differences could also be due to differences across racial groups in access to care and diagnosis and treatment patterns, not just within inpatient psychiatric facilities but also in community-based services.

After declining for many years, Medicare covered length of stay in IPFs has held fairly steadily since the PPS was implemented, declining from 12 days in 2002 to 11.8 days in 2006. Length of stay differs across different types of IPFs, with government-run facilities and freestanding psych hospitals having the longest Medicare covered lengths of stay. Length of stay also differs by diagnosis.

In addition, length of stay depends on the source of admission. Patients admitted through the judicial system, usually prison inmates, had the longest lengths of stay, averaging 18.4 days in 2006. Longer lengths of stay were also seen in patients admitted from acute care hospitals, not the emergency department, and from skilled

nursing facilities.

In the coming months, staff will consider the question of payment adequacy under the IPF PPS. First, we will look at patient access to IPF care. Although supply has stabilized somewhat since the implementation of the PPS, inpatient psych capacity had declined sharply in the past several decades, due in large part, as I said, to the closure of many government-run facilities, but also to increased managed-care penetration and increased utilization management of mental health services.

However, it is not clear whether the overall reduction in capacity has adversely affected patient access to care and that's a hotly debated topic among policy analysts. Many public health professionals believe that bolstering community-based services maintains access to care and improves quality of care by preventing acute care episodes so that fewer beneficiaries need inpatient care.

We'll also look directly at measures of quality in IPFs. Quality of care can be difficult to measure in these settings because there are few meaningful, frequent, and easy collected outcome data, such as mortality. However, some in the industry, such as the National Association of

Psychiatric Health Systems, are working to develop process measures, such as proper intake and assessment procedures, discharge and aftercare planning, use of restraints and seclusion, and appropriate drug regimens. These may be helpful to us in the future.

As always, our payment adequacy analysis will also analyze cost report data to determine IPFs' costs and margins, and we will look at providers' access to capital.

Another issue we will consider is accuracy of payment. Research has found that degree of social support, need for assistance with activities of daily living, and presence of dangerous behavior such as suicidal tendencies all are strong predictors of costs in IPFs. But the PPS does not incorporate these elements because there's no information about them in the claims data that were used to develop the payment system.

In looking at payment adequacy, it will be important to consider what any differences in profitability across providers are due to differences in the profitability of cases. If that's the case, we will need to consider whether and how to refine the payment system so as to improve the distribution of payments.

Another issue we want to consider his use of scatter beds to provide inpatient psych care. The use of scatter beds is growing. Preliminary MedPAC analysis found that between 2002 and 2006, scatter bed discharges increased by 5 percent compared with a 2 percent in IPF discharges.

When inpatient psych care is furnished in scatter beds, Medicare pays under the acute care hospital PPS. Hospitals with psych units can therefore decide whether to place a patient in a distinct part unit where they will be paid on a per diem basis under the IPF PPS, or in a scatter bed where they'll be paid under the acute care PPS on a per discharge basis. Decisions about patient placement within the hospital may thus be made on a financial rather than a clinical basis.

Quality may be an issue, as well. Some argue that IPFs are singularly focused on providing psychiatric treatment and also can furnish higher levels of security, thereby furnishing better care than that offered in scatter beds. More research is needed to compare the types of patients, payments and cost, quality of care, and outcomes across different inpatient settings. This will allow us to consider the adequacy of care in scatter beds and whether

payments in each setting are appropriate.

So now I will turn it over to you for discussion of these issues or anything else you would like us to look into.

MR. HACKBARTH: Clarifying questions?

DR. CASTELLANOS: Mark, this is a clarifying question to you specifically, and perhaps it shouldn't be made up in a public meeting, but if you can turn to page 11, the top five States and the bottom five States, as I recall, these States were also the top five, or a lot of them were, for the long-term hospitals and also for the freestanding hospices. A lot of those made that list--those three lists, and the bottom five made those three lists. Maybe it's a coincidence. I'm just wondering if you could have any input on that.

DR. MARK MILLER: I guess I'll be taking that one. So there are certain States that whenever you look at utilization rates tend to pop-up. Louisiana and Mississippi are decidedly ones when you look across, and it seems to be regardless of what you're looking at. I don't want to make blanket statements, but frequently, no matter what you're looking at, they show up as high utilizers.

On the hospice data, and I'm looking at Jim as I'm saying this, I think they were there, but there were also some other States that were somewhat surprising in that top list. For some reason, I want to almost say Utah was in that, which is typically thought of as a low utilization State but then on hospice popped up as a high.

But you're not wrong. There's a couple of States that show up on the top of that list that regularly show up as high utilization States on all kinds of different metrics.

DR. CASTELLANOS: Is there any reason for that that you can say?

DR. MARK MILLER: Remember, what goes on in these kinds of analysis when they look across the geographic stuff, the Dartmouth stuff, all that stuff. There is a real attempt -- and in own work when we have tried to look at geographic variation, there's a real attempt to control for differences in prices, so it's not different payment levels.

MS. KELLEY: But not here.

DR. MARK MILLER: But not here.

MS. KELLEY: But not here. No. This is just the straight numbers.

DR. MARK MILLER: And is there any adjustment for risk here in this?

MS. KELLEY: No. These are just the raw numbers.

DR. MARK MILLER: All right. But to your general question of why do certain States frequently show up, so let's just say Louisiana and Mississippi, not necessarily on this chart, but more broadly, why do they keep showing up? There's always adjustments for prices and risk in there and so it doesn't appear to be those things. Sometimes CON comes up in that context. Often, you kind of terminate at there seems to be significant differences in practice patterns and you know this is the subject of kind of back-and-forth here of necessary, unnecessary, and volume of service and that type of thing.

I don't know. That's my best shot.

MR. HACKBARTH: We're looking at a particular dimension of it, States that make heavy use of new provider types, long-term care hospitals, freestanding psych hospitals, for-profit hospices, the examples that you gave. But it's quite possible for States to be very high-cost without doing those things. So it's not like this is the only way to generate high cost.

MS. KELLEY: The other thing I was going to add is that there is also perhaps a historical perspective here in that some of the States that have the high use of IPF services still have old mental hospitals. You'll notice that it's all Western States there on the bottom. They didn't have the reliance on State-provided care that older States do.

DR. REISCHAUER: This is a clarifying question which may be beyond your scope, and that is I noticed you had, in addition to wage indexing, we have a cost of living adjustment for Alaska and Hawaii. I was wondering, do we do that for hospitals and other provider groups too? So it's the same adjustment there for those two?

MS. KELLEY: Yes.

MR. GEORGE MILLER: Yes. I have a question on the discharge by beneficiary race. Did you also slice the data to determine where the referrals came for that, particularly in the Afro-African community?

MS. KELLEY: No, but I can do that and I will.

MR. GEORGE MILLER: I would be interested in that. Thank you.

MS. KELLEY: Okay.

DR. CROSSON: On the facility adjustment slide also, the additional 17 percent that's paid to rural locations, is that irrespective of size? Is that a proxy for smaller facilities?

MS. KELLEY: It is probably a proxy for smaller facilities. It is irrespective of size. But yes, it's just on the rural location regardless of size. The smaller psych facilities definitely have higher costs.

DR. MARK MILLER: The only thing I would add to that is that in the Commission, it hasn't -- I don't have that we've had these conversations recently, but in the past when these kind of issues have come up, the discussions have kind of involved low-volume and trying to think about adjustors that way versus just the geographic territory that the provider is sitting on.

DR. CROSSON: That's what I was asking. This seems to be without that consideration.

DR. MILSTEIN: This is an area of medicine where there tends to be a lot of variation not only between States but within States having to do with a variety of things, including how relative subjectivity and interpreting level of care guidelines, et cetera. So this is an area where I

think it would be extremely helpful if it would be possible to include--let me get to the question. Forget the preface.

Are we going to be able to, as part of our new access to encounter data for the Medicare Advantage Program, have a chance to see how these facilities get used in the very same States when patients have the benefit of more of an organized approach to keeping them out of trouble and more thought given to when patients might actually benefit from these inpatient experiences?

MS. KELLEY: What we won't have is detailed information about the services that patients are receiving on the fee-for-service side. So we have the claim, but we don'--all we have is the claim information. We don't have any assessment information or detailed information about the specific services that they're receiving, whether they're getting -- go ahead.

DR. MILSTEIN: You answered -- in your answer, you said fee-for-service coverage. I just meant the Medicare Advantage population.

MS. KELLEY: Right, but I was assuming you wanted to sort of compare.

DR. MILSTEIN: Yes.

MS. KELLEY: Yes, and we won't be able to say what kind of -- we will know -- whether someone was hospitalized and what particular condition and how long they stayed, but we won't know whether they received family therapy versus intensive individual therapy. We won't have the information like that.

DR. MILSTEIN: [Off microphone.] [Inaudible.]

MS. KELLEY: Absolutely. I think so. I mean, we can do that on the fee-for-service side and I think we can do that with the encounter data.

DR. MARK MILLER: Right, with the only lowering of expectations is we have heard this statement that the data are to be collected and we have no idea at this point, and I am kind of looking at Carlos over your shoulder, of what level of detail and when any of that is going to happen. So yes, in theory.

MR. ZARABOZO: [Off microphone.] [Inaudible.]

MS. KELLEY: Carlos was saying that historically, the MA plans have much higher, dramatically higher cost sharing, up to, I think he said $500 a day for every day, and also that there's many fewer disabled beneficiaries in MA plans so there wouldn't be an apples-to-apples comparison

of patients.

DR. DEAN: I was just curious about the eligibility for inpatient care. You listed risk to themselves or others. That's usually the criteria that are used for involuntary admission, but the criteria for at least, in general, inpatient psychiatric admission to the general population are not nearly that restrictive.

MS. KELLEY: I don't know in practice how restrictive the requirement is, and that's something I can look into.

DR. DEAN: In my experience, it's simply someone who is not doing well and is not managing in an outpatient setting and needs a more controlled environment, not because they're a danger to themselves or they're going to hurt somebody, although certainly the people that meet this criteria should be hospitalized, everybody agrees with that. But that is a fairly small proportion, at least in my experience, of the people that actually qualify for inpatient admissions.

MS. KELLEY: That is the way the coverage policy is written --

DR. DEAN: Really?

MS. KELLEY: -- but in practice. I think you are right and I can look into that a little more.

DR. DEAN: I was just curious, because it is much more restrictive than at least I'm familiar with in practice.

DR. CHERNEW: This is fascinating and an area I don't know much about. I was confused because the PPS was implemented in 2005 and the statistics were typically from 2002 and 2006. So I was curious as to whether or not when I look at those statistics, particularly the ones on changes in, say, DRG types, there was one data and slide where there is this dramatic shift. Should I interpret that as an upcoding, that if I looked at the graph, it would kind of be flat and I would see a spike after PPS in that kind of way? Or is that sort of some general trend? So I guess--

MS. KELLEY: It's more trends. I picked 2006 because that was the first year that all the facilities would have been fully under the PPS, since they were phased in in 2005 based on the beginning of their fiscal year. The 2002 was also an artifact of the data that I won't go into, but yes, in general, it is an even trend line and not so much of a jump after the PPS, although the one difference

being in the growth in facilities has definitely ticked up since the PPS.

MR. HACKBARTH: Peter has the last of round one clarifying questions and then we will go ask for hands on others.

MR. BUTLER: Two clarifying. One is you say that 35 percent of the admissions come through the ER overall. Now, the freestanding units and don't typically have ERs, so what does that translate into percentage coming in through the ERs for the ones that aren't freestanding, 50 percent or something like that?

MS. KELLEY: Offhand, I don't know, but I'll look into that.

MR. BUTLER: So it's a --

MS. KELLEY: Yes, it's much higher for hospitals.

MR. BUTLER: There's probably a better way to look at it.

MS. KELLEY: Yes, that's a good point.

MR. BUTLER: Secondly, you report capacity by number of units or number of hospitals as opposed to beds--

MS. KELLEY: Yes.

MR. BUTLER: -- which would probably give us a

better idea of the capacity by the various units, because they're different bed sizes, I'm sure.

MS. KELLEY: Yes, absolutely and that's something that I wanted to do using cost report data and I haven't gotten into the cost report data yet. But I wanted to use that rather than the other data source we have, which tends to be a little less reliable.

MR. HACKBARTH: Round two, let me see hands.

DR. CASTELLANOS: First of all, I think great report and I appreciate it. There are two questions I have. One, and maybe Arnie as a psychiatrist could help us. I see that the African-American is just a really high percentage and the Hispanic, based on a population of 12 percent, is really under. Is that an access problem? Is that a cultural problem? Based on this --

MS. KELLEY: I think it's probably -- as I said before, some of it is related to age, that African-American beneficiaries who use the service are younger and they are much more likely to have psychoses then older beneficiaries are. But in terms of the actual use of the benefit, I'm sure that there's a whole variety of things going on. I think it's probably access to care, differences in diagnosis

and treatment. I think it probably has a lot to do with access to community-based services that differ across the socioeconomic groups. And probably there's some cultural differences, as well.

DR. CASTELLANOS: Thank you. The second question is based on some material that you distributed to us ahead of time. On page ten, you said there were codes available that describe some of the social issues that impact on care delivery and management, to include sight, hearing, and lack of housing. Are those codes that are paid or are they just codes? And do they exist for general medical conditions, too?

MS. KELLEY: They are V codes that can be used in general medical conditions, as well. They are not paid codes red, or they are not used as a basis for payment. But CMS has encouraged facilities to code these in IPFs because there is so much research that suggests these kinds of social issues are important predictors of costs.

I looked to see if there is more coding of these conditions in the two different time periods and there has been quite an increase in the use of the codes, but it's still a very small percentage of cases have the codes in

there.

MR. HACKBARTH: Bob had -

DR. REISCHAUER: Another explanation for the very low Hispanic number is not just that in the population over-65 is a much smaller fraction Hispanic, but the under-65, a significant portion are undocumented and so would have a hard time qualifying as disabled under Medicare.

MS. HANSEN: Glenn, could I just make a comment on that relative to the cultural component, is that I notice with the Hispanic and the Asian-American, as well, there is also a factor, not just culture but specifically language, because I notice that the diagnoses are disproportionately on psychoses rather than perhaps issues of dementia. If there's a language barrier, sometimes even getting an accuracy of diagnosis is there. So there are some levels here that are much more contextual.

MR. BERTKO: A couple of quick questions. The first is, I was struck by the number and the percentage of psychoses at about three-quarters. Have you given any thought to bundling on all of this? In the under-65 and even Medicaid, a lot of this, I think, is managed by managed behavioral health organizations. Not to suggest this, but

just to say is there a possibility of some bundling thoughts?

MS. KELLEY: There is a possibility of some bundling thoughts, yes.

MR. BERTKO: Okay.

[Laughter.]

MR. BERTKO: Good answer. The second was --

DR. MARK MILLER: We even mentioned them among ourselves before this session.

MR. BERTKO: Okay. Does the mental health parity bill going through Congress now have any effect on benefits and potentially on payments?

MS. KELLEY: Interesting you should ask this question. We've been trying to figure this out for the last couple of days. I don't think that it does affect Medicare. It will affect Medicaid managed care plans, but it doesn't appear to apply to Medicare. The previous mental health parity act in 1996, which sort of started us down this road, also did not apply to Medicare.

Right now, there is relative parity in Medicare between general medical health and mental health, the only difference being that the lifetime limit on services

provided in the freestanding hospitals only. So I don't know in practice how much of a difference it would make.

DR. KANE: I'm just curious to know if there's a way to, probably when you're looking at the access issue, to account for the presence or absence of a VA provider and how easily available that might be in a particular health service area as you look at -- that might be one of the explainers of differential rates of utilization if there is an effective VA provider there.

MS. KELLEY: I hadn't thought of that and that is a really good point. I don't know if we can -- I'm sure we can sort of work around that.

MR. BUTLER: A couple of comments. The first is all the calls that I get when people need access to care, it seems like it's either a particular surgeon they want to get because they're well known, a primary care physician, or a mental health for a child or for a parent. And I mentioned that one third, even though it might be the number one request. And I don't think that is really understood. And it only happens when suddenly a parent or a kid or something needs -- and I'll tell you, it's very difficult to try to explain how we coordinate care and what the value of the

inpatient stay is and all of these other things. So that's just a comment that I think we ought to be aware of.

Secondly, I think in the data, specifically on the data side, I assume that as we go through the payment cycle policies that we'll have pretty good data on profitability by type. And I hope it's as current as we can be, because I suspect if my data is right the hospital-based ones are going downhill fast and profitability in the freestanding are going in the other direction. And it's very difficult to kind of adjust your cost downward. This isn't where there's supply costs and implants and things that you can work on. It's all a labor and there's only so much we can do.

And I suspect the data, when I got to the bed issue, a lot of us are either shrinking, capping the number of beds or are considering getting out of the business. Maybe that's right or maybe it's wrong, but it's happening and I think we need to be aware of that trend.

The other thing, a couple of small comments. The scatter bed issue, I didn't like the language that says that hospitals can financially make decisions. The hospitals don't financially -- that's not how it works. I think,

first of all, it's directed by the physicians, not the hospital. And I can't think of any examples where I've said or others have said that, hey, put this one over here, keep this one in the unit. It just doesn't work that way.

I think more likely than not, you get somebody in a scatter bed because they have some medical needs that can't be treated on the unit, even though their principal diagnosis is psych. So I think we need to know a little bit more about that.

And finally, if you have any data--you say how patients are getting into the units. You don't say a lot about where they're going when they're discharged. Again, this is almost a candidate for medical home, too, when you think about it and it does get to the continuity of care. And if we're really going to be responsible about this, I kind of get not offended, but a little uncomfortable that we're just looking at the unit of analysis being an inpatient stay, because this is such a bigger picture, a bigger story. So I think we at least need to be sensitive to that and kind of think that through as we try to tweak the rates for the units.

MS. KELLEY: I do have the data on patient

discharge, where they go afterwards, and I can present that next time, probably after the January cycle. I totally agree with you about the sort of morass of issues surrounding this, but this is really our first step into this and I hope we can do some more work looking more broadly at community-based services, as well.

DR. MARK MILLER: This is a both a work process comment and maybe to reduce your anxiety level. You should not anticipate -- this is correct, be sure -- we should not anticipate that in our update cycle, which will start in earnest in December, that we are going to deal with this as an update. This is on a longer path. We just opened this box up. We're not coming in and saying, okay, here's all the financials and making an update recommendation. This one plays out over the year. Think of this as next fall, we would be talking about more of the financials and thinking of an update. So you'll have an entire cycle to kind of talk through these issues before we get to kind of policy questions about what to do about it.

MR. BUTLER: I just want to make the point that a lot is happening in our institutions, even in the next year, related to issues like this. We may not be addressing it,

but hospitals are addressing this and adjusting capacities related to this. So don't be surprised. We shouldn't be surprised if the bed issue in the hospital-based ones declines faster than maybe the numbers are suggesting.

MS. KELLEY: We'll also have -- the next time I come back, we will have more recent data, as well. When I started this analysis, the 2007 claims data were not available yet, so we will be able to run more recent data and the cost reports will reflect that, as well.

DR. CROSSON: I think Mark has sort of addressed what I was going to ask, because I thought maybe we were heading towards looking at this in this cycle. What I was going to ask specifically was whether or not, given the skew of utilization, which is pretty dramatic, and we've seen that for a number of these types of facilities, and like Ron, I had this map burned into my eyes with this large concentration of black dots down at the bottom.

I hope and I assume that we are going to take a closer look in all of these adjustments, for example, the one I brought up before, the empirical 17 percent increase for rural areas irrespective of size or volume, and look at how all of this nets out, all of these adjustments net out

versus the kind of utilization distribution. We've got plenty of time to do that, then.

DR. MARK MILLER: Yes, and I shouldn't have left the impression, and it may have just been the choice of words, it's not that you're not going to see this again this cycle. The objective -- the working plan at the moment is to end up in June with a chapter that's kind of a primer on this that says what is this and what does this animal look like and what are the issues that one might want to be thinking about? And that would all be done with your guidance and kind of bringing data and analysis in front of you. And then I would see us maybe next cycle getting serious about policy changes. But we would look at all these questions, the disparities issues, the adjustors, what's happening with hospitals' base, and try and tease that out over the next year for a discussion chapter in June, then serious talk next cycle about what policies.

The urgency that Peter points to is important, but I think our typical pattern is to try and sort through some of these things and then get to asking ourselves if there are things to do. So I think we're saying the same thing.

MR. GEORGE MILLER: John covered my point about

the parity bill, so I won't cover that issue, and also Peter very elegantly covered the issue of about no CEOs or case management department determines when a psych patient comes in the ED to determine if they should go to a medical bed or a psych bed. That just does not happen. It depends on his condition.

But I wanted to ask the question as an access issue, if you've looked at the impact of the fact that at least in the hospitals I'm familiar with covering the ER, we can get a psych consult and what that impact may be on your work and how that may develop into a policy issue. That also, I think, may relate to my question about referral patterns and how that may impact.

MS. KELLEY: I haven't looked into that yet, but I do know from the reading that I've done that that is an issue and that is behind some of the closure of hospital-based units as well, is not be able to get that coverage.

MR. GEORGE MILLER: Yes. Thank you.

MR. EBELER: I, like John, was struck by the fact that about three-fourths of these folks are in the one DRG, psychosis. We've got to assume that, seeing that, it's a

relatively homogeneous group. Is that correct in this case? Or is this a fairly heterogeneous group?

MS. KELLEY: I think it's a fairly heterogeneous group.

MR. EBELER: It might be worth exploring that, because you start with that assumption in a PPS system and I just think it's probably wrong here.

MS. KELLEY: Well, that was really the primary reason why the original PPS wasn't applied to psych hospitals, was because the DRG system was just not a very good predictor of costs in the psych hospital. So much is dependent on some of those patient-specific things like their support system at home, dangerous behavior, whether or not they need ADL assistance. And so I think this payment system was developed to try and sort of bridge some of those difficulties while still using claims data.

There are quite a few people in the policy community who think that an assessment tool is really needed here to pull out more information. The industry fought that suggestion and the development of that would have taken much more time than CMS had to sort of get this up and running.

MR. EBELER: The second question relates to the

fact that we're really talking a lot more here about the disability insurance side of Medicare than the aged side of Medicare, which is a valuable educational opportunity for the Congress. As we think about that, the age splits may need to get more sophisticated. In particular, I know you started off with under-45. As I understand it, the adolescent -- the N starts getting small, but the adolescent psychiatric issues, I think in some communities are particularly troubling. I think we may want to contemplate some more refined age splits in that area.

MS. KELLEY: I can refine the ages done--I can do it very finely. The Ns are going to get very small, but certainly I could do, you know, 20 to 45 and sort of look at things like that, too.

MS. BEHROOZI: Actually, in a similar vein in terms of refining the demographics, did you look in the data at the prevalence of dual eligibles as compared to their presence in the overall, either disability Medicare or general Medicare?

MS. KELLEY: I did not and that's something I can look into.

MS. BEHROOZI: I think it would be interesting,

both in terms of overlaying with race and geography and age to see how all of these things intersect and see what kinds of further research or conclusions might be warranted.

MS. KELLEY: Okay.

DR. DEAN: I was curious, is there data about the use of the scatter beds broken by geographic areas, because I was just shocked by this variation in utilization.

MS. KELLEY: I have all that data. I have not had a chance to -- I have all the data and I haven't had a chance to go through it yet, but yes, I have it by geographic area.

DR. DEAN: The admission by States. And I wonder, if you look at the bottom five, those are all relatively sparsely populated, maybe with the exception of Hawaii, relatively rural States.

MS. KELLEY: Yes.

DR. DEAN: And I wonder if some of that variation is made up by an increased use of the scatter beds, the low utilization in the bottom five.

MS. KELLEY: I think almost certainly the scatter bed -- adding the scatter beds will change our distribution of States. When you look at -- and I realize these are

facilities and not beds, as Peter was pointing out, when you look at the map of the United States and lighting up where the facilities are, the Western part of the country is really very blank when it comes to actual distinct part units or freestanding hospitals, and surely these patients are getting care in scatter beds.

DR. DEAN: We're 125 miles from the nearest inpatient facility, and I'm sure in Montana it's probably much, much bigger distances than that, so --

MS. KELLEY: The next time I present that information, I'll have the scatter beds in there.

DR. DEAN: Thank you.

DR. MILSTEIN: This is an area of medicine in which even relative to other areas, what we're paying for here is largely, I think, a consequence of failure in ambulatory care. I think it actually happens to be true of non-psychiatric hospitalizations to a much greater degree than is widely accepted, in my opinion anyway. But here, we're in a, I think even more in a zone in which failure of upstream ambulatory care is generating the vast majority of this utilization. So I'm glad that the scope of our evaluation can include examination of ways in which, rather

than focus a lot of effort on getting the payment system right, we think about innovations in Medicare that could reduce the frequency of these admissions by a very large percentage, very much along the lines, I think, of what Peter was suggesting.

DR. KANE: I have a quick thought about the reasons there might be such geographic diversity in IPF admissions. Does Medicaid, the Medicaid DSH distribution policy, vary by -- I think it does vary by State and I wonder if somehow, some States favor inpatient psych hospitals for a particular reason. That just rings a bell from something I've read, probably five or ten years ago.

MS. KELLEY: Possibly, but there is no--possibly. I'm just going to leave it at that. That's something I can look into.

DR. SCANLON: There was a point in time where there was concern that States were using the DSH money and giving it to State mental hospitals and there was actually a prohibition on a bill back probably seven, eight years ago to limit the amount of DSH money that could go to State and county mental hospitals.

MR. HACKBARTH: Any others? Okay. Thank you,

Dana. Well done.

The concluding session is on health care growth.

MR. GLASS: Good morning. For the past few years in the context chapter, we've documented growth in the health care sector as a share of the U.S. gross domestic product or GDP. In this briefing, we'll describe trends and some of the key measures that contribute to GDP, such as constructing spending, employment and wages. We do this to illustrate the increase in capacity that's building up in the health care sector and how it may be related to the sustainability of the Medicare program.

First, let's take a look at spending in the economy. Health care sector spending increased by over 50 percent in the last decade in real dollars while other sectors combined to increase by about 20 percent. In annual growth rate terms, health care has been growing at about 5 percent per year compared to around 2 percent per year for other sectors, in other words more than twice as fast. Health care is now 16.6 percent of U.S. GDP.

We're going to present some information on health care sector construction, employment, and wages relative to other sectors which may provide a more concrete feel for the

sector's growth.

Let's look at construction spending. At past MedPAC meetings, we have talked about trends in hospital construction and how it reached record levels in recent years. That pattern is true for health care construction spending as a whole. This slide shows that growth in overall health care sector construction has been much greater than in the rest of the economy. Spending on health care sector construction increased 50 percent, again in real dollars, while construction spending across all other sectors increased by approximately 15 percent.

In annual terms, health care construction spending has increased by about 5.5 percent per year, a little less than three times the rate of other construction. And again, these data are expressed in real or constant year 2007 dollars, meaning that spending in each year been adjusted to 2007 dollars, in then years or nominal dollars, the increase is even more rapid.

Now, Zach will take you through what's been happening in health care employment and health care wages.

MR. GAUMER: Thank you, David. We'll now turn to the topic of employment, where over the last several years,

the health care delivery sector has grown rapidly. On the slide above, you can see that from 1999 to 2008, total employment for the health care delivery sector increased 20 percentage points faster than the rest of the economy, and I want to keep in mind here that available employment and wage data throughout this presentation are limited to the delivery portion of the health sector and do not include industries such as pharmaceuticals and health insurance.

Represented by the blue line above, health sector employment increased 25 percent, while employment across all non-health care sectors, the orange line, increased 5 percent. On an annualized basis, health care employment increased at an average rate of approximately 2.5 percent while all other sectors increased about 0.5 percent.

Throughout the last year, the Department of Labor has reported that the U.S. unemployment rate has been increasing. Despite that, the health sector has continued to add jobs. Further, the U.S. labor force has grown at approximately 1 percent per year over the last decade, suggesting that the health sector has been attracting labor and capital away from other sectors of the economy.

While collectively the health sector had faster

employment growth than the rest of the economy, employment growth rates of individual industries within the health sector have differed.

For example, employment within general hospitals, represented by the green line, increased 17 percent. This is less than the entire health care sector, but still 12 percentage points more than the employment growth rates across all non-health care sectors.

The most dramatic employment increases were for diagnostic imaging centers and home health services. Imaging centers, the red line, increased 58 percent at approximately 5.2 percent per year. Not far behind that, home health care services, the purple line, increased 53 percentage points, or 4.8 percent per year.

It's important to note here that the home health care category includes the home health industry, the hospice industry, and other employers providing services in the home setting.

In the past, the Commission has questioned rapid Medicare spending growth in imaging, home health, and hospice. These are the same industries that displayed approximately twice the employment growth as the health care

sector overall.

Now let's turn to health sector employment as a share of the U.S. labor market. Health sector employment accounts for about 9.7 percent of all non-farm employment in July 2008. This amounts to approximately 13 million of the 138 million jobs in the U.S. labor market. Today, the health care sector's share of the U.S. labor market is similar to that of the manufacturing sector and the leisure sector, as you can see. However, the health sector's relatively large share of employment is somewhat new to the U.S. economy. Since 1999, the health sector's share of the U.S. labor market has increased 1.4 percentage points. This was the largest increase of all the major sectors of the economy over the last decade. And just in contrast, the largest decrease was that of the manufacturing sector, which decreased 3.6 percentage points.

Looking at the health sector in more detail, we found that as of July 2008, general hospitals accounted for the largest share of the sector, approximately 33 percent. This is highlighted in green above. Outpatient care centers, in light blue, and physician offices in darker blue accounted for approximately 17 percent each. Nursing care

facilities, in yellow, accounted for approximately 12 percent. Home health care, purple, counted for 7.2 percent. And diagnostic imaging centers, in red, accounted for 0.5 percent of the health sector employment.

Now, looking beyond 2008, the Department of Labor projects that the number of people working within specific health care occupations will continue to grow at a rate faster than the national average. Labor projects that from 2006 to 2016, the total number of employed Americans will increase across all occupation types by 10 percent. In contrast, Labor projects that the number of health practitioners will increase approximately 20 percent, and growth in this area will likely be driven by registered nurses as well as pharmacist-related staff, which are both projected to grow at about 25 percent each. Health care support occupations are also projected to increase almost 27 percent during this time, and growth in this are will be likely driven by home health aides, which are projected to increase 50 percent.

Finally, we examined wage growth within the health sector and compared these wages to average wage growth across the entire U.S. labor market. Since 2003, the

average hourly wage of employees working within general hospitals increased faster than the average hourly wage of employees working within nursing homes, which in turn grew faster than the national average hourly wage. While wage data were not available for the health care sector collectively, we used wages for general hospitals and nursing care facilities, the two major facility-based institutional providers that account for approximately 45 percent of the sector, as a proxy for a sector-wide average.

Looking at the green line above, average hourly wages of employees of general hospitals increased approximately 20 percent. The average hourly wage of nursing homes increased 15 percent. And across the entire labor market--that includes all occupations in all sectors including health care, that's the gray line, increased 12 percent.

We will talk more about this point in our conclusion, but I want to be clear that we are not saying that any one sector's wages are too high. However, we believe that in the long run, there needs to be comparable growth rates in the health and non-health sectors of the economy.

To further understand the dynamics of wage growth, we examined specific occupations within these sectors and industries. Comparing the wages of three key non-clinical occupation types -- management staff, office and administrative staff, and finally computer and mathematical staff--illustrates that wages for these widely employed occupations increased factor within general hospitals and nursing care facilities than in the U.S. labor market overall. In the first grouping of bars on the left, we reiterate the findings of the last slide, which basically said wage growth across all occupations was faster at general hospitals than the national average. Again, the national average is in gray, general hospital are in green, and nursing care facilities are in yellow on the slide.

In the next three groupings of bars, we see that the wages of management staff increased faster than general hospitals and nursing care facilities -- excuse me, management staff increased faster in general hospitals and nursing care facilities than the national average. The same is true of the following two groups of bars, representing office and administrative staff and computer and mathematical staff. In each of these three groupings, we

see approximate a 4 percent difference in the wage growth of general hospitals or nursing care facilities and the national average.

Because wage growth for non-clinical occupations, which are widely employed across various sectors, appear to have been more rapid within certain health care industries than the U.S. economy overall, this may support the theory that industries like general hospitals and nursing care facilities are under less financial pressure to constrain wage growth than other sectors of the economy.

DR. GLASS: So in summary, the health care spending grew over twice as fast as rest of the economy in recent years. Health care sector construction spending increased over 50 percent, nearly triple the pace of all other construction spending. And health sector employment increased almost five times faster than employment in the rest of the economy. Hence, the health care sector is now a greater share of the U.S. labor force than it was in 1999.

Employment growth has been faster than the national average for all the key health care industries, but the rate of increase has been fastest for diagnostic imaging and home health care services. Finally, average hourly

wages have also grown faster within the health care sector than across the economy overall. In particular, faster wage growth within general hospitals and nursing care facilities for non-clinical occupations suggest the health care sector may be under less financial pressure to constrain costs than other sectors.

So to finish up, as we have shown, the health care sector is growing more rapidly the rest of the economy, twice, three, or even five times faster, depending on which measure you look at. It is absorbing capital and labor and building capacity, both bricks and mortar and people, capacity Medicare is going to be expected to pay for in two ways.

First, there could be an increase in supply sensitive services and the volume of supply sensitive services, which Medicare will have to pay for. Or there could be pressure to make payments adequate for increased costs if other volume does not increase with capacity.

For the taxpayers that pay for Medicare and the workers that pay for health care, or the lower line on those graphs we have, and health care is the upper line, and they are diverging and that is an issue. We're not saying growth

has to stop. With respect to wages, for example, we're not saying health care wages have to decrease. But it would appear that there needs to be comparable overall growth rates in the health care and non-health care sectors for growth to be sustainable over the long run.

So given your past concerns about the rapid growth in Medicare spending on imaging and other services and the evidence and geographic variation, one question might be, at the margin, are we getting good value for this investment or are we buying capacity we may not want?

Also, is the growth relative to the rest of the economy sustainable for the Medicare program and the taxpayers that fund it, and really for the nation more broadly?

We look forward to your discussion and whether you think this material would be a helpful addition to the March report. We'll be happy to try to answer any questions.

MR. HACKBARTH: Clarifying questions first.

DR. CHERNEW: My question has to do with the levels relative to the growth, so this is true generally without but particularly in the wage section. My understanding was that wages in the health care sector were

lower in terms of level to start with. So though you show more rapid growth, they still may be lower for comparable jobs. I was curious if you have data on the level.

MR. GAUMER: Yes, you are correct about that. Levels of wages, if I were to put that chart up, you would see that the gray line in terms of level was higher than health care in that regard. But we were looking at growth rates, yes.

MR. HACKBARTH: And do so will you add level in future presentations?

MR. GAUMER: Absolutely. Yes.

DR. CROSSON: The slide on the growth of construction spending, I wonder if you have State data and whether California is overrepresented, particularly in those last two years, because we have, as you probably know, legislation in the State that requires seismic retrofitting of all hospitals, I think by 2013, and in some cases reconstruction of the hospitals. So do you know what amount of that change California accounts for?

MR. GLASS: No, I don't, but we can look into that. We recently got an update to our detailed construction permit starts and we can look and see how those

are distributed by State.

DR. KANE: Mike asked my question.

MR. EBELER: In the job growth categories, can we -- is it possible to look at job growth in sort of administrative functions versus clinical functions? I noticed in the wage areas, you broke that down.

MR. GAUMER: We did it take a look at the clinical areas and what we did see was that it was kind of mixed. You know, we had hospital and we had--or general hospital and we also had nursing care facility and what we saw was general mixed levels for some occupations. The nursing care facility might have had higher wages or faster growth, and vice-versa for general hospitals.

MR. EBELER: But just in terms of numbers of individuals, there is a sense that we're needing a lot more administrative people to deal with the complexities of this issue. I don't know if the data support those anecdotal points or whether we could look at that.

MR. GLASS: I think we might be able to. We will see if we can look at it. So you want data by occupation within nursing and general hospital and whether that's changed over time?

MR. EBELER: Yes.

MR. GAUMER: Actually I will say I've looked a little bit at that, and I think I looked from 2002 to 2007. There hasn't been a tremendous amount of change in the hospital setting between the number of office and admin staff. Not much, but we can look into that more and get back to you.

DR. MILSTEIN: Could you elaborate on the last slide, why we are posing these as questions, because these seem to me to be -- these are both questions that we've considered before and we've answered before. So in posing them as questions, what might we do this time that would be different than what we've previously done and drawn conclusions about?

DR. GLASS: I guess we were trying to elicit discussion from the Commission.

DR. MARK MILLER: Well, actually, I would say this. We use this point all of the time to say, look how fast the health expenditures are growing relative to the economy, and we talk about sustainability. The one thing that really struck me about this is -- it didn't dawn on me so precisely until you start to see construction and

employment -- that you're building capacity behind those numbers. It's real obvious once somebody points it out, but it was sort of -- it's part of the sustainability issue is building this and then generating the services that come behind it.

So one of the take-aways I got from this was kind of a little bit more rich picture. But I think some of the reason that the questions come is that -- and this is obvious -- I mean, this growth is also someone's job. And so this question -- and I think it's going to continue to be something that we grapple with each step of the way.

MR. HACKBARTH: Looking at it from this perspective, jobs and wage growth, it is interesting and different in that ordinarily, when you see job growth or wage growth, we're all applauding. That's a good thing. And in the economy all the time, some sectors are going more than others. Not everybody is growing the average. So that's sort of an interesting take on why is this a bad thing that we've got job growth and wage growth in this sector.

Obviously, the answer ultimately comes down to the fact that if we were confident that this was driven by value

assessments and people were paying with their own money, that we would all applaud. But the crux of the problem is it isn't driven by consumer assessment based on use of their own dollars. It's driven by third-party payment with silos and bad incentives and all of that.

Any other clarifying questions? Okay, then we'll go to round two.

MS. BEHROOZI: I'm not even sure I had raised my hand yet, Glenn, but you knew I had something to say about wages in the health care industry. And actually, while I certainly appreciate that you've said that we wouldn't want to endorse a position that wages should be lower, I still, I think, need to take issue with the conclusion, the link that you make where you say the faster rate of wage growth for non-clinical occupations suggests less financial pressure.

I think that there are other reasons that wages could it be growing and, at the risk of wading into the territory of the economists and screwing up--I have a little experience at collective bargaining besides providing health care for workers in the health care industry, so I'll try to address it from that point. I really think the wages are separate from, as Mark identified, from the capacity

building factors of construction with an offset for what Jay has identified about the need to modernize just to not fall down in an earthquake. And even employment growth builds capacity, obviously. But if you're looking at post-acute care maybe shifting to home health aides away from institutional settings ultimately in the long-term, when we see enough evidence and do enough research, maybe that's not bad capacity building.

But putting those two aside for a second and just looking at wages, thank you, Mike, for asking about the level, the absolute level first. If the health care industry has to compete with other industries to recruit people, particularly in support occupations like information technology, which we are finally in the health care industry recognizing is as important as it already has been recognized in the hospitality industry, say, now we have to start paying salaries to draw people away from those other industries where they been making more.

It may be also a result of shortages with respect to particular occupations. In the paper, you have a chart that reflects, among other things, the rate of increase for registered nurse wages. It really isn't much more in

general hospitals than in non-health care settings. In fact, it's a little lower in nursing homes, and I think that's because -- it's already pretty high in the overall economy, which might include working as a marketing agent for a pharmacy benefit manager or something like that. I think because there's a shortage of RNs generally, and maybe in a hospital you have to pay an RN a little more because it's a lot harder work than working as a marketing agent for a PBM.

So those are both reasons--and again, I'm wading into the territory of economists, but those seem to me to be reasons separate from whether the employer is facing financial pressures.

And now talking about everybody else, I think it's important to distinguish out the levels of employees or wages that you're talking about, because in collective bargaining, I have never seen a wealthy employer being profligate with their spending on low-level employee wages. In fact, they are looking to make a profit and they don't do that if they just hand it over to their workers -- and whether that's good or bad, I'll leave that to George -- that's just not a function of having extra money. They just

don't do that. They don't give it to their workers.

They do reward themselves, if it's a privately-held entity or boards reward their top management. And so if you sort out the CEOs, whether in hospitals, forgive me my colleagues, or in nursing homes, and the top management from the hourly workers, you might see different patterns emerging. I would submit that it's at the higher level that maybe you see some influence of financial pressure or lack of financial pressure, but not at the lower end. In fact, I had mentioned to the chief management negotiator who might deal with it, there was this conclusion that overall wages had been growing faster the rest of the economy. He was highly insulted because he feels like he's been keeping a pretty tight rein on union-represented workers' salaries.

And so I think that would be an important way to assess whether it's really about financial pressure or not, because it would be a really bad thing, despite articulating and we don't want wages to go down, if somebody would sort of look at a presentation within a paper in MedPAC that reached this conclusion about financial pressure and said, well, we've really got to squeeze payments to hospitals and nursing homes until they start bringing their wage growth

levels down to the rest of the economy.

Thank you.

MS. HANSEN: Thank you. First, a request on slide eight. This is more the employment side of where people are in sectors. I wonder if we could figure out the information on how much Medicare generally spends in these areas. It could be a kind of overlay so we get a sense of proportionality. I know we have it in different places, but just to use it relative to this type of slide, even know it's not a perfect cut.

And the second part, since some of the growth that we're considering also crosses our dual-eligible population, if there's just a way to just get the relative spend with the over-65 population of the Medicaid, if there's a way to capture that at all. Just again, for -- I know it's definitely more Medicare-focused, of course, but as we've been talking a little bit more about dual-eligibles, just to get a sense of where that expenditure aspect is going.

Then going back to more of a comment of why we're doing this, which is what Arnie asked, what's different about this time, one of the things I was thinking about is that since our Medicare system traditionally had been built

much more on acute care with that payment approach, it seems like the direction of what we're moving toward was some prevention, especially with some of the changes even in the Medicare benefit side of paying for that first year of prevention.

And then the whole aspect of chronic disease surrounding it is just to me -- maybe this is an opportunity in this chapter to kind of continue to say we really need to kind of extend the boundaries, that it's, again to Peter's point, it's not just that silo aspect of being in acute care.

Which brings me to something that I hear Arnie bringing up a lot relative to just the importance of not just doing the same marginal improvement on this for these facilities and locations, but probably some intrinsic system design change, like more industrial engineering of how to use available bricks and mortar and resources.

I'll give you an example. The public hospital in Oakland, California had a classic issue of ERs. The CEO was facing that. There would be always the stack-up of ER patients waiting and diversions. And so they really looked at redesign of the process, and this is not unique to this

hospital. But what they were able to do was with the same bricks and mortar of existing hospital ER rooms, modify some of their more acute screening urgent care aspect, be able to do some funneling much better, and having their people check people post-hospital care, so that some of the people were coming in through the ER for both primary and some acute care were diverted so that the net outcome was they didn't have to expand their ER beds at all. They had more than enough capacity. But it was the same bricks and mortar. And so the whole aspect of redesign processes is probably really an important component.

I have two more points. The other one is about bricks and mortar in that the more you build, the more you have to fill and keep doing. So not only do you have to upgrade to make sure they are earthquake safe, there are things about just renewing and the competitive environment between hospitals, so the whole question of how much can we think about now doing outside of the four walls of structured institutions with the cost of construction.

And the final point is relative to some talk we had yesterday about telemedicine and the whole aspect of using it. How does Medicare anticipate using ways of

supporting people in chronic disease management or even in what's being done at UCLA with using robotic ICU physicians to be able to do this so that you, again, minimize and more efficiently use personnel, which is all another aspect.

So one is industrial design processes. One is deployment more efficiently of the talent and skill of personnel so that maybe with the nursing shortage, nurses may be doing some different kinds of things.

So this is just an opportunity to raise these questions besides doing the kind of arms race of building more facilities in bricks and mortar.

MR. GLASS: There may be a little mismatch between the way Medicare sorts things, like nursing care facilities on this thing includes the custodial and not just the SNFs.

MS. HANSEN: And that's why I say it isn't going to be a perfect fit, but is just this sense of proportionality of where the dollars have to go, or do go, generally.

DR. KANE: First, I want to reinforce Jenny's idea that there is lots of -- perhaps in highlighting the growth in capital spending, we might also look for ways that some of that could be reduced through better operational

efficiencies. I have been very involved with that lately and think there are lots of huge opportunities there that are -- for some reason, I think many hospitals haven't felt incentivized to take advantage of. It's much easier to build than to become more efficient with your bricks and mortar.

On the presentation itself and the possibility that might be a chapter somewhere, I think you need to put something in there about the demand side. Everything is going up, but maybe just to be a little balanced, what are the projections of demand for hospital care, nursing home care, and how does the growth in that relate to the growth in the supply side? Granted, it's a projection and it has assumptions, but I think it would be really helpful to have that up there as a way to balance this.

And then as someone who often works at the State level in health policy, the number one obstacle to making State policy that encourages cost containment is the hospital lobby that rightfully claims to be the engine of economic growth in the community and the sole employer in small towns. It is really hard to offset that political position in a local setting like a State.

So I think it would be really helpful for those of us who do labor in that kind of hidden environment, at least in terms of the national level, is to get some sense of what we give up when health care is the engine of economic opportunity. For instance, get a sense of--well, the most obvious one would certainly be the proportion of wages now going into health benefits. But I think there's other things that we give up that we don't quantify. It would be useful if you're going to start down this path to add the things like the highways, the education, research on alternative energy, transportation. What sort of public goods are being -- and even private goods are being underinvested? Or what's the rate of growth in some of these other things that our country things are highly valuable that is being crowded out by the growth in health care spending.

Otherwise, yes, it's growing, but it's hard to say -- I mean, most people say that's a good thing and I think we really need to be clear in our thinking about why it's not necessarily a good thing and why health care is something that people have to buy to survive here, whereas a lot of these other things get pushed out when there's no

constraint on the cost.

MR. HACKBARTH: I agree with that comment and it makes me think of one thing that we may want to add. There's been a lot of newspaper stories during the presidential campaign about how average real wage growth has been basically nonexistent in the most recent growth cycle, and I'm sure at least part of that is due to money being put into health benefits. And if there's something that we can contribute in terms of analysis and data on that, that might be worth adding.

DR. REISCHAUER: I want to congratulate Zach and David for pulling together some very interesting facts and figures on the role of the health sector in the American economy and its recent growth and sort of the components and how they have contributed to this, but then offer a strong word of caution about going forward with something like this and including it.

First of all, this is very limited--not very. It's somewhat limited relative to what Americans think the health sector involves. It doesn't include, as you noted, pharma, device manufactures, you know, all the people who produce stuff, wheelchairs, whatever. It doesn't include

non-hospital-based research and university-based research, which is a big chunk. It doesn't include the insurance industry. And it doesn't include government administrators, CMS, when we're talking about employment, things like that. So we're looking and saying, oh, wow, look how big the health sector is. Really, it's a lot bigger than this.

Having said that, and it's interesting stuff and we should all be familiar with it, it really, as Glenn said, tells us absolutely nothing about whether this is good or bad, whether it's too much or too little, whether it's growing too fast or about the right amount, or whether it's sustainable or unsustainable. I could have taken the agriculture sector and flipped everything, all the diagrams over, because employment, capital costs, everything has been going down and you wouldn't say, oh God, we must be starving at this point.

[Laughter.]

DR. REISCHAUER: An awful lot of this has to do with everything else, you know, the judgment on whether it's sustainable, good, bad, whatever, has to do with what else we've been doing all these years, and you don't want to imply--I mean, you didn't say, but you didn't want to imply,

as most people will looking at this stuff, that you can look at this and that's why it's too much or it's unsustainable or something like that.

I mean, economies change all the time. Some sectors grow, others shrink. It has to do with the demand of individuals and the policies of government. We want to focus on those and why we believe those are distorted and this is really the result of that and you have to make that very clear.

MR. BUTLER: Well, you kind of got my blood going on this one in the sense of some of the conclusions, or the direction anyway. I think fundamentally, it kind of is against the overall theme that we have that reductions and variation in care, geographic variations, the utilization side may be the biggest opportunity that we need to influence in terms of cost.

But let me make a couple of very specific comments. I'm more comfortable with looking at the construction than the employment side of this. I was the initial chairman of an AHA Workforce Commission in 2000 which included a wide range of people, including Andy Stern from SEIU and others. We were desperately trying to address

shortage issues and what to do with it. And we looked at things like pharmacists and hospitals and said, boy, the number of prescriptions in the country went up from two billion to three billion in ten years and the output from the pharmacy schools was flat. In fact, it was shrinking. And so we were trying to line up the shortages and so forth. We were all desperately collectively trying to look at this.

And so when we look every year at how we set salaries, it is a totally market-driven deal and we are dealing with shortage. We don't sit there and say, well, we had a great year. Let's give a bigger increase. That's not how we manage our institutions and we're not that lax about how we handle these things.

So I'm very, very leery about saying, you know, because hospitals and others are doing well, they're giving higher salary increases. I just don't believe the market works that way. And I think if that's a conclusion, I think that's a wrong one.

Now on the construction side, I would just say construction, there are a lot of opinions about whether you still should regulate through certificate of need on construction. I'm still kind of in the middle on that. I'm

not a totally free-market guy by any means on this, but construction spending does not equal capacity.

If the perception is we're building a lot more beds that aren't going to get used, that's not what's happening. I know the exact numbers on beds, but I think most of this relates to significant construction, but it's really almost reconfiguring institutions to do something totally different from what they used to be doing.

I can remember when DRGs came in and we had a whole floor of cataract patients that kind of went away the next year. And at that point in time, we might have had 5 percent outpatient business. Typically hospitals now have 50 percent outpatient business, and the technology and the processes have totally changed.

Just to give you one example, we have a joint replacement surgeon who does 1,000 joints a year that are same-day. They walk out of the hospital the same day the procedure is done. That presents a totally different platform and a totally different anticipated facility than what we've had in the past, and that's where a lot of this spending is going.

Now, maybe it's too much. Maybe it ought to be

looked at in a different way. But just don't equate capacity with hospital inpatient capacity because that's not necessarily what it is.

Lastly, I would say that there are a number of hospitals, at least in our market, that are on the bubble and I think we will have hospitals failing no matter what we do on the payment side. I think some of the newer capacity, if it's there, is going to accommodate some of that.

In general, I'm not quite sure what we're trying to do with this in the chapter, but I'm obviously a little bit uncomfortable as having this as a key piece of what we're trying to report.

DR. MILSTEIN: I agree with Peter on almost all things, but not on this one. I think this is very important for us to take on. I mean, there was a -- for those of you who have not read the Comptroller General's report that was pulled together last year on the impact of the U.S. health care system on many facets of the health of the nation, including physical health, it's worth reading. It includes observations by some that health care cost growth is on the brink of becoming our single biggest threat to national security. I'm not enough of an expert to comment on the

wisdom of that observation, but anyway, there at least are plenty of danger signals. So I think as tough as this area is going to be to navigate, I think it's worth navigating.

A couple of suggestions. One of the arguments in favor of more investment in the health care industry is that it happens to be one of the industries that potentially could affect productivity in other sectors of the economy, right? Healthier workforce, more production. The health economics group at Rand has published a very nice working paper actually examining the empirical relationship between growth in the health care industry and impact on other segments of the U.S. economy that could be potentially useful to bring in.

And then secondly, Jack Wennberg and Elliott Fisher have sort of begun to move down this path. But on this issue of what's the value shortfall, I think we now have much better information that could populate a chapter now on questions like -- that would allow us to essentially model how much more health, or better performance on quality indicators might we have in the United States if all United States health care system performed like the hospital medical staff diads that nationally perform in the top

decile, not the State, but the hospital medical staff diads. Now we have that information at that lower level of analysis.

And then along the length of what Jennie and Nancy were saying, there's a chance to kind of further embellish that analysis and get the numbers out in front of the public on the -- because so far, what we're talking about so far is if you were to pursue that modeling just mentioned it would primarily pertain to geographies that are getting very high quality with very low volumes of services using the Medicare standard pricing.

But I think this analysis could be further embellished by integrating the points that Jennie and Nancy were referring to and to essentially add the supplementary analysis and say okay, and then what would be the incremental gain over and above that if at these institutions that are already getting at the top of the charts, high-quality, low total spending, if they were to adopt the most efficient methods of production.

And there are other sources for that information. UHC, for example in Chicago, has some nice information on the actual lower production costs, you know, what's the

lowest production cost, presumably among institutions using these reengineering methods.

So I think it would be -- whether we then, having looked at that analysis, say, well, let's spend a whole lot less and get current levels of quality, or let's spend even more but get a whole lot more quality for it, that's a separate discussion item. But I think if we could use this opportunity to take newly available information and begin to give the public and the Congress a sense of the magnitude of opportunity, either on lower cost or higher quality or some combination thereof, it would be, I think, a real -- it would tremendously, I think, sort of benefit increasing national attention and dialogue around this issue of is more health care spending good or bad and is the capacity that we're building to enable that higher spending good or bad.

DR. CROSSON: I have a similar ambivalence about the topic, and part of it is that I have been, I realize, somewhat confused by what I've read over the last few years about whether increased health care spending is good or bad. I've certainly seen folks say things like, well, 25 percent of the gross domestic product is okay if that's what people want to invest in, for example. I've had a hard time

understanding how in the way we think about the sustainability of the Medicare program that would work in terms of affordability. But assuming that we had some sort of redistributive effort and we actually did want to invest in health care as a country, maybe that is okay.

It seems to me it has something -- and here's where I'm not sure we want to go, but I could use some help from the economists because I don't really understand this. Nancy and Bob got at it a little bit. Segments of the economy grow and others wither over time, but in terms of the overall wealth of the nation going forward, does that mix matter? So, for example, because I have this sort of fundamental belief that if we make stuff and send it to some other country like China that has a lot of money and they send a lot of money to us, that we have more money.

[Laughter.]

DR. REISCHAUER: [Off microphone.] But you have less stuff.

DR. CROSSON: Right. So, I mean, I guess what I'm asking is, and maybe this is out of scope for the Commission, but if you're going to take this on, I'd like to sort of understand the notion of whether or not increased

investment in health care in the context of a global economy long-term fundamentally increases the wealth of the nation, and therefore after we figure out how to redistribute the cost, perhaps we could actually afford it, or whether, in fact, this decreases our wealth over time because it's a self-enclosed embrace and we should be working very hard, as Arnie says, not just because of the values that we bring to the table from meeting to meeting, but because in the long term if we don't do that we end up a relatively poorer nation than we have been in the past.

MR. HACKBARTH: I think this begs for an economist response. Do we have volunteers?

DR. STUART: I'll take the first crack on this and there will be others that can follow up. This is going to seem like piling on, I know. I really agree with what Bob Reischauer has said here, is that on the one hand, it looks like you're taking certain indicators that are really almost in a sense arbitrary. There's a lot more that you could do. And so then the question is, well, let's pour more resources and do more of this. Then we see kind of where Mark is going and it says, well, geez, these things are going up, we're building capacity, well, let's build this forecasting

model that says, well, here's where we're going to be in 2016, and then all of a sudden, what you're doing is you're replicating what the Office of the Actuary and CMS does in the National Health Accounts.

And so one of the perhaps ways it can get around this -- I think everybody around the table is suggesting, well, in a way, we want more information, but what we really want is to be able to interpret it. So the question is, are you working with the National Health Accounts group on this, because they do a lot of this and they've got all the sectors down there and they've given you the -- they've got the numbers. But they don't give any interpretation. They don't put flesh around this stuff. In fact, you're not even sure how good it is.

And so perhaps what you've got around the table is that you've got a resource to help interpret these data trends that are already available to MedPAC from the Office of the Actuary. And it sounds like you're kind of duplicating a little piece of what they already do.

DR. REISCHAUER: Let me try and answer Jay's question and my colleagues can correct me.

Arnie put his finger on it. To the extent that

health care improves the productivity of the labor force, it can affect economic growth over the long run. Unfortunately, we're at the wrong end of the age distribution, being the Medicare Payment Advisory Commission and not the SCHIP and Medicaid Payment Advisory Commission. Certain investments younger in life would probably have more to do with this, although this can lead to greater labor force participation rate of people 65 and older and disabled coming into the market.

Certain sectors of the economy have more potential for technological development, which is high-value-added and which keep the country sort of at the forefront of high-value-added, high-wage in the world economy. But other than that, it's not really a question.

There's another issue, which is is this a horrendously inefficient sector, and I think the answer is yes and that we could produce the health output that we produce now at a third less cost, which would improve satisfaction because then we can take the one-third and buy dog food and iPods and other things that make us happy along with a little more health. And so there's sort of lots of room for us to do this, and probably the greatest

contribution we can make is helping to devise systems which change the structure of our current delivery system in ways that it produces the same or better output for a third less inputs.

MR. HACKBARTH: I do want to go back to the queue, but it seems to me that's the statement that we want in the chapter. In a way, too much data may obscure the message as opposed to bring it out.

MR. GEORGE MILLER: I am glad I follow Bob because I think that statement will put it in context. I was, like Peter, a little concerned about this chapter. I'm a typical hospital CEO. That's what I do and I went in this business to help people. That's the flavor of what we do.

I've worked in rural hospitals across Texas, where we were the number one employer in our community and we supported that community with jobs, pharmacists, physicians, DME companies all grew around because we were there and we helped make a difference. The growth in jobs, some of it, and I'd like to ask the question, has some of it, or have you dissected it to look at how much of the growth in jobs in health care are because of regulations, quality measures, volume of patients, and I think Nancy or Jennie said because

of demand, a shift from the outpatient environment--excuse me, a shift from the inpatient environment 30 years ago to now an outpatient environment, and Peter mentioned that may also lead to the construction side that we can put in a separate category.

The Hall-Burton Fund created a chassis that was inpatient driven, and now as Peter described, we're going to more of an outpatient, hip surgeries done in one day, gallbladders done in one day, that type of thing. We also have an explosion in the ER growth that we're taken care of the 47 million uninsured in America through our ERs, and because of that, that also is a growth and we need to, I think, take a look at that. And also just pure competition for some of our workers. I heard mentioned Wal-Mart. Walgreen, CVS, all those others didn't have pharmacies ten, 15, 20 years ago. They now have them and we're competing with them for the pharmacists.

Imaging techs - the technology has grown so fast in the last 20 years, we didn't have those folks and that's part of that growth that has proliferated. So I'd like to have those dissected a little more.

One other thing about hospitals. We are there 24

hours a day, seven days a week. We respond to every disaster, every hurricane, and we're there. We are the center of the community. While I appreciate Bob's concern, if we can do it more effectively, more efficiently with one-third less, that would be great. But we are probably what we are because of some of the other issues that have directed us in this way. I understand the sustainability issue, but I would caution us to be very, very careful in how we approach it. I'll leave it at that.

DR. CHERNEW: First, let me start by saying that I think the general economics of this is it's about well-being, not wealth. They are obviously related in some ways, but in the end you want people to have the services that they want.

I very much agree with Bob's first comment, and his second, but particularly his first, but let me say that when I think about the chapter, I'm really torn. What I like about it, to be in the spirit of the rules here, is it emphasizes the opportunity costs of cost growth, and economists believe that if people aren't working in hospitals or working wherever they're working, they will get other jobs and build other things and do other stuff. The

problem with that general notion is that while that is probably true -- I believe that to be true on average in the long run, that's not true in all places. It's not true for all people and there are certain transition costs which are real.

So there's important public policy questions about how you move as industries -- it's easy to say some industries rise and some industries wither, but there's people behind the rising and people behind the withering and we have to care about the people, as well, and that's a separate public policy question. But I don't think it should be used to justify a lot of inefficiency. If we get a lot of people digging holes in a dry lake that no one wanted, they would be employed but we wouldn't be very happy with that as an economy.

So the problem that I think I'm hearing about this chapter is it's an important issue, maybe the most important issue. I certainly think it's the most important issue, how we deal with cost growth. And I think that a discussion of that is important, the opportunity costs of that is important. But we're puzzled with what to do with this chapter and everybody has a different view about what --

like Arnie's comments, which I agree with, though, we're taking this chapter in a completely different way and I think it's because people are puzzled by what the normative implications of all of this are.

It's not clear whether this is good or bad. It's not clear whether we are sure what the opportunity cost is. And more importantly, it's unique in that we typically think of cost growth as a demand-side thing. We're getting these services to people who want to buy them as opposed to we are getting a service -- and then the building is just a shadow of all that. The employment is just a shadow, an imaging. So you see imaging grow. We want -- and so that's, I think, typically what's going on.

And so I can't figure out whether I think is a really unique way and useful way to look at or whether it just confuses things. I guess my general view is that a chapter that focuses on inefficiencies in particular, that I think the evidence is just on average all this spending is good, at the margin there's a ton of waste. Our job is to keep the good, the stuff that we like, that's valuable, and try and cut out the waste, and the more that the society does that, I think the better off we will be and we wouldn't

have to worry about the broad macroeconomic sense of things. We don't have a lot of distributional issues to worry about and a whole set of other things.

And I think if the chapter can be put in that context, it's useful. But I guess where I come down now is the way it was structured now, it's extraordinarily interesting but hard to see how the message gets us where we might want to go. One guy's view.

DR. MARK MILLER: There's a couple of things here. This isn't a chapter, okay? This is not where this was intended to go. It was intended to be essentially almost like a part or a discussion, almost a text box in the context chapter because we throw around the gross number, health care expenditures growing faster, try to color some of that behind it.

But the few things I would say is I absolutely agree, and I think some of the comments came out over here, is the point is what policies are driving this kind of behavior or these kinds of trends, and that should be our focus.

The difficulty and the fact that there's a discomfort here, I think in some ways is actually a good

thing because, I mean, the question is the value, and if you think about how the value is going here, we've talked about the transition costs that you've just touched on, very important point. But let's remember the entitlement is for the patient, not for the providers here. And I think that's a question that we have to keep asking ourselves.

I think another point on the construction, I mean, I think you guys have made this point very well and we've tried to be balanced when we've talked about construction. But $30 billion was spent on construction last year. How much of that went to mental health? How much of that went to managing diabetes? How much of that went to IT? Where is that money going? It's being driven by our payment policies into certain areas where all of us, I think, have raised questions about the value dollar-for-dollar.

So I don't want to strongly defend this particular set of charts and graphs. You've made your points very clear. The questions that I think we're trying to tease out were those kinds of questions, which in the end are value questions about how much this gross number goes to.

MR. HACKBARTH: Well said, and a good note on which to end. Thank you, David and Zach. We will now have

our public comment period.

Seeing none, we are adjourned.

[Whereupon, at 11:52 a.m., the meeting was adjourned.]