MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, September 17, 2009
11:20 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, J.D., Chair
FRANCIS J. CROSSON, M.D., Vice Chair
MITRA BEHROOZI, J.D.
ROBERT A. BERENSON, M.D.
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JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
NANCY M. KANE, D.B.A.
HERB B. KUHN
GEORGE N. MILLER, JR., M.H.S.A.
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BRUCE STUART, Ph.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: It is time to get started. This is, of course, the first MedPAC meeting of a new cycle, and I would like to welcome all of the people in the audience. I see a lot of familiar faces as well as some new ones.

As always, we have got a bunch of interesting issues to deal with, both in this meeting and in coming months. For this meeting, we have got important topics like geographic variation and Medicare expenditures, graduate medical education reform, comparing quality in Medicare Advantage and traditional Medicare.

In addition, in future meetings in this cycle, we will be wrestling with our usual array of payment issues and improvements, including in physician payment maybe in particular, and also some issues around benefit redesign.

Those of you who have attended meetings in the past know that it is our practice to have a public comment period at the end of the morning session and then also at the end of the afternoon session. As I regularly do, I would remind you that that public comment period is but one opportunity to talk to the Commission. Frankly, it is not your best opportunity. The most important opportunity to

communicate with us and have an impact on our work is to reach out and talk to the MedPAC staff, who go to extraordinary lengths to listen to all input, information, ideas on our work.

We will also be exploring some other ways that people might provide input for our work and probably talk a little bit more about that at our October meeting.

So, with that preface, let's turn to the agenda, and the first item on today's agenda is a discussion on the context for Medicare payment policy. As you know, each year in our March report, we include such a context chapter.

Evan?

MR. CHRISTMAN: Sure. Thank you. Good morning. Yes, as Glenn mentioned, I am going to be covering the sustainability and financing challenges facing Medicare.

A key financing challenge is that growth for all payers in health care costs has exceeded growth in the gross domestic product. An analysis by CBO compared the growth in health care spending per capita to the growth in GDP, adjusting for changes in demographics, and you can see the results here. It found that over a 30-year period health care spending has exceeded per capita GDP growth by more

than two percentage points between 1975 and 2005. For these reasons, health care spending has grown as a share of our Nation's GDP, and it is expected to continue to do so.

Here you can see the impact of the excess growth, with health care spending rising from 9 percent in 1980 to about 16 percent in 2007. By 2018, costs are expected to be over 20 percent. The lower three areas are public spending, such as Medicare and Medicaid and other public programs, and the top bar is private sector spending.

Public spending by federal, state, and local governments has risen to about half of all health care spending, and it is expected to grow faster than private spending over the next 9 years. About three-quarters of the public spending is Medicare and Medicaid, and I would note that for Medicare these projections assume the SGR mechanism requiring negative updates is not overridden.

The rising share of public spending does not suggest that the public sector is less efficient in controlling growth than others. For Medicare, the comparison is sensitive to the periods compared. However, as you saw on the previous slide, over the longer periods of time, the rates of growth for Medicare and private health

insurance have been quite similar.

The next graph shows how the future growth in expenditures compares to Medicare's revenues. Starting from the bottom, this graph shows the share of GDP for each of Medicare's revenue streams. Note that this display combines revenues for Medicare's separate financing mechanisms for Parts A, B, D, and Medicare Advantage. The two largest areas are payroll taxes collected for Part A, the yellow area at the bottom, and the general revenue transfer for Part B and D, the green area second from the top. Note that this green general revenue wedge grows significantly in the future, more than other sources of revenue. This is because Medicare is allowed an unlimited tap on the Treasury to fund some of the costs of Part B and D. As those costs are expected to rise significantly in the future, the draw from the general fund rises automatically, and consequently, Medicare will be more reliant on the general fund for financing.

Another way of measuring this is as a share of corporate and personal income taxes, the primary revenue source for the Federal Government. Between 2009 and 2030, the share of these taxes required to fund the general

revenue transfer is expected to roughly double from 11 percent to 24 percent. And, again, these projections do not include the impact of any proposed changes such as fixes to the SGR or filling in the Part D cost-sharing.

Now, in contrast, funding for Part A is limited to the dedicated funds that are collected primarily through the payroll tax. In 2017, the resources for Part A will no longer be adequate to cover annual benefit expenditures. The red area at the top, labeled "H.I. deficit," shows how over time the gap between Part A's liabilities and revenues will grow significantly. For example, in 2017, the trust fund will only have adequate resources to pay about 80 percent of benefits due. By 2030, it will only have sufficient revenue to cover about 40 percent of benefits due.

This picture shows how the current spending trend for Medicare has placed the program on an unsustainable path. In less than 8 years, Medicare will no longer have the resources to pay some benefits. Without major changes, over time the share of federal revenues required to sustain benefits will grow significantly. From a fiscal and economic perspective, there is a significant need for

constraining growth.

This next table examines the Hospital Insurance Trust Fund's finances in more detail. Remember that the H.I. Trust Fund funds all Part A benefits, and it relies mostly on payroll taxes to fund its operation.

Since 2008, the trust fund has been in a deficit on a cash basis; that is, its annual revenues from payroll taxes and other sources have not been adequate to cover annual expenses. In the near term, the trust fund has sufficient financial reserves to cover these annual deficits. But in 2017, these reserves will be exhausted, and Medicare will be unable to pay all benefits expected to be due.

Next we will look at the graph in the middle here. Every year the Medicare trustees assess H.I. solvency, and this graph shows how the insolvency date for the trust fund has changed in each report. Since 2000, the years of solvency have declined, in part due to changes such as the MMA, but also due to other changes, such as increases in benefit expenditures or changes in revenue.

To the left of the yellow bar is 2009. It shows that we have 8 years of solvency, according to the trustees'

report for this year, and the black bars count down to 2017, the year the trust fund is currently estimated to be bankrupt.

In addition to rising costs, changing demographics will also put pressure on H.I.'s financing. The forthcoming retirement of the baby-boom generation will begin a demographic shift that will over time shrink the size of the workforce relative to the number of retirees. For H.I., this means relatively few workers paying the annual payroll tax used to pay benefits and more beneficiaries requiring those benefits.

While the demographic shift is important, it is worth noting that most analysts consider rising per capita costs as the primary problem. H.I.'s revenues are likely to be strained as long as per capita benefits continue to grow faster than GDP.

The factors underlying the past and future growth should be familiar to you. First, most analysts believe that 50 percent or more of the long-run increase in spending is attributable to technology. New technologies and medical techniques can yield improvements in health, but they can also yield new costs and inefficiencies. As the Commission

has noted, technology poses a unique challenge because the evidence base to guide the appropriate use of new technology often lags actual adoption. As a result, the costs of new technology may sometimes outweigh the benefits.

Second, the nation's income has been rising. Many analysts believe individuals demand more health care as incomes improve, as the marginal value of increased life span or function may be worth more than other goods.

The availability of insurance has provided beneficiaries with financial protection from the costs of ill health, but it has also insulated beneficiaries from the full cost of care. Consequently, some beneficiaries may consume more care than they would have otherwise. Estimates of the insurance effect on the increase in per capita growth vary, but range from 10 to 20 percent. A special issue in Medicare is the availability of Medigap insurance that covers the beneficiary cost-sharing for Part A and B. Recent work by the Commission suggests that the availability of this insurance may raise Medicare spending by 17 to 33 percent.

Because the U.S. system relies on the private sector to deliver most health care services, prices are

particularly important in the U.S., and some of the growth in spending is attributable to changes in prices. Prices provide incentives, can affect what services and regions are served, what technologies are developed, and the specialties physicians in training select. In addition, many analysts believe that prices for health care services in the U.S. are higher than other countries.

Changes in longevity and demographics will also have an impact on health care spending. With the retirement of the baby-boom generation, the elderly are projected to grow as a share of the population. In addition, life spans are expected to increase. These factors will cause Medicare spending to grow, and CBO has estimated that they will account for approximately 30 percent of the growth in future years.

Trends in disease morbidity also affect health care spending. An analysis of patients with chronic conditions found that all of the growth in per capita Medicare spending since 1987 has been due to the increase in treatment for patients with multiple chronic conditions. The number of beneficiaries with five or more chronic conditions increased from 31 to 50 percent between 1987 and

2002. This alone would suggest that the burden of disease has increased. However, the share of those with five or more chronic conditions reporting excellent or good health status increased from 33 percent in 1987 to 60 percent in 2002. This seeming inconsistency between disease morbidity and health status suggests a higher rate of diagnosis and treatment for chronic conditions, that treatments are improving health outcomes, or that both are occurring.

Now, in practice, many of these factors can occur simultaneously in the delivery system. For example, new imaging services can improve care, but numerous incentives can also encourage inappropriate use. Recent work by the Commission noted that physicians who operate their own imaging devices were more likely to order those services than physicians that did not. In this instance, the other factors listed here may reinforce this increasing utilization. Insurance makes consumers less sensitive to the value of the service, and inaccurate prices may encourage more supply and utilization than warranted. That illustrates what many have concluded about our health care system: that reforms need to address the combination of the factors driving excess growth, and there is no single

solution.

Finally, another factor cited is defensive medicine stemming from malpractice concerns, but it is not considered a major driver.

Next we will compare spending in the U.S. to other industrialized countries. This comparison from the OECD shows how much the U.S. spent in 2007 -- about $7,300, significantly more than other industrialized countries. To the right of the green bar are other major OECD countries, all with significantly lower spending than the U.S. The final is the average of all 30 OECD countries -- about $3,000, less than half of what the U.S. spends.

This graph does not control for other factors that affect spending, such as differences in the burden of disease and personal income. However, many analysts believe that U.S. spending is higher even after adjusting for some of these differences.

Also, though the U.S. does have higher spending, annual growth is generally not different than that of other OECD nations. This suggests that all health care systems struggle with high rates of growth.

Some analysts question the value of much of the

U.S.' health care spending. An influential study by RAND found that a national sample of patients received only about half of the care that was considered appropriate for their conditions. Further, reviews of the geographic variation in Medicare spending indicate that higher spending is not always associated with better quality or outcomes.

The U.S.' performance compared to other countries' is mixed. It does better than some countries on some measures, but not consistently better. This mixed result on quality is a contrast to spending comparisons like you saw before, where the U.S. is generally ranked the highest. Also, the level and quality of care also varies among patients in the U.S., and many low-income and minority groups receive care that is inferior relative to the care received by others.

In addition to taxpayers and the Treasury, rising Medicare spending will also impact beneficiaries directly as an increase in premiums and cost-sharing. This chart shows how the growth in the Medicare premium has outpaced the growth in the COLA provided for Social Security benefits. The premium has increased by about 80 percent since 2000, while the COLA has only increased by about 20 percent. And

in the future, these trends are expected to continue. The average out-of-pocket costs for Part B equaled about 26 percent of the average Social Security benefit in 2008, and this share is expected to rise to 40 percent in 2030.

However, it is worth noting that many beneficiaries will not be subject to the increase in the Part B premium slated for 2010. This is due to a provision that limits how much can be taken from a beneficiary's Social Security check for the Part B premium. Under current law, a beneficiary's Social Security payment cannot decrease due to an increase in the Part B premium. In 2010, there will be no COLA increase for Social Security. As a result, 75 percent of Medicare beneficiaries will not pay the expected increase.

The Part B premium increase for 2010 includes the cost of the revenue lost from the hold-harmless. Consequently, premiums will be higher for the 25 percent of beneficiaries that are not protected by the hold-harmless.

Some forecasts contain no COLA increase for 2011 as well, and so it is possible that this scenario will be repeated. However, once the COLA increase returns, it is expected that fewer beneficiaries will be affected by the

hold-harmless.

The Commission recognizes that Medicare is not sustainable in its current form and has considered a number of changes to improve the program. These changes address a number of areas, and first there is accuracy and equity in payment. We use the update process to assess payment adequacy and, when appropriate, to constrain costs. We also look at price accuracy, such as in our recommendation to update Medicare's assumptions regarding the use of imaging services used to set payments.

Second, we have looked at ways to improve quality and coordination. We have recommended that Medicare move towards pay-for-performance and explore bundling, as well as examined other means for improved care coordination.

Finally, we have also examined ways to get providers and patients better information for decisionmaking, such as comparative effectiveness research and public reporting of quality measures.

This completes my presentation. Please let us know if there are any other aspects of the Medicare sustainability challenge we should include.

MR. HACKBARTH: Thanks, Evan.

Let me just say a word about the context for the context chapter. We have got two broad goals in this.

First is to speak to an audience that looks to this chapter for updated information on costs, cost trends, you know, status of the Medicare trust funds and the like, and there is a segment of our audience that uses this as a resource each year, and so we would like to meet that need.

A second thing that we have often done in the past -- and it is included in this draft -- is provide some summary of, you know, MedPAC's perspective on policy issues.

And as we get into the discussion, I would welcome people's thoughts about whether we ought to continue to try to do both of those things in the chapter. For sure we need to do the first, and I would entertain ideas about whether there are other ways to try to do the second piece, which is summarize what our perspective has been and where we think things ought to go in the future with Medicare payment policy.

Last year, in the transmittal letter for the March report, we had a summary of sort of my take on where the Commission has been in terms of policy recommendations and how we think Medicare policy ought to evolve in the future.

Potentially that is a candidate again this year, so we could strip it out of the context chapter and put it in the transmittal letter. There may be some other approach that people have in mind. But I want to try to break this into the different functions that we are trying to pull off and see if we have got some ideas about how to handle those.

Okay. We will use our standard format for discussion, so round one, just to remind people, will be clarifying questions. And I would urge people to keep those very brief, you know, clarifying questions: What do you mean by the statement X? And let's see if we can quickly go around and get all of the needed clarifications.

Then round two will be an opportunity for people to make broader comments or suggestions. And then if we have time for a round three, Jay and Mark and I will try to identify a few issues to invite more detailed discussion on, and, you know, I would like to try to get to round three. So let's keep rounds one and two quite focused.

Let me see hands for clarifying questions, round one, and we will just go down the row here.

MR. GEORGE MILLER: Just a quick one on the financial impact to the Treasury of the hold-harmless

provision, the 75 percent of beneficiaries. Do you have a dollar amount of what the magnitude of that impact to the Treasury is?

MR. CHRISTMAN: I don't. And if I'm thinking about it right, it doesn't affect the amount that Medicare gets from the general fund. It just affects how much beneficiaries who are not subject to the hold-harmless pay. So, in effect, when we hold that increase back from a certain portion of the population, it gets passed to the other.

MR. GEORGE MILLER: It's cost-shifted.

MR. CHRISTMAN: In that sense, yes. I think the advocates of this measure argue that, you know, some population is being protected. It should not change the cost of Medicare to the Treasury.

MR. GEORGE MILLER: Okay. Thank you.

DR. CASTELLANOS: Good presentation. I know it is clarifying. It is on page 17 of the text that you gave us, and you mentioned something about survival gains were stagnated since 1996, especially with myocardial infarctions. But you extended that into cancer, and you said since research also suggests that survival gains for

cancer have been stagnated also since 1996.

That is not true, at least on some of the literature that I looked at. I was unable to bring up that Cutler article, but perhaps maybe you can get me some information on that at a later date. But I don't think that is a fair or straightforward --

MR. CHRISTMAN: We can take a look at that and get you the article.

DR. CASTELLANOS: Thank you

DR. CROSSON: Yes, Evan, if you could turn to Slide No. 4, which is the long-term projection of Medicare expenditures. You know, often when you see long-term projections like this, you get past a few years in the future and you have some data, and then everything else is a straight line some direction from there. This one isn't. Do you know or could you speculate on why the period of time from about 2020 to 2040 seems to have a much steeper slope either than what we have experienced in the past or what will come after that? Because it seems to me that if you went then to Slide 6, is this the effect of demographics? Is it technology expectation? What is it?

MR. CHRISTMAN: I think there are two things going

on. One is that the trustees' long-term assumptions on costs causes excess growth to gradually fall over time. So the per capita growth -- they are still high in that period that you are talking, but the excess growth is coming down every year. And that is one effect that you would expect the line to gradually taper off. But you do point out sort of -- I have noticed that, too -- the bump between 2020 and 2040. And this is a period where the number -- if I recall correctly, the number of beneficiaries entering Medicare is much higher than normal, and you can kind of see the end of the baby-boom tide, I guess, somewhere around there, around 2030 -- in the late 2030s. I would not know that it exactly comes out to the end of what people call the baby-boom generation, but if you look at the annual entry into Medicare, it starts to tail off in that period.

[Comments off microphone.]

DR. SCANLON: I think why it occurs in that time period is because they use actual data or trends for the first 25 years of the projections, and then they impose the assumptions so that it is only one percentage point more than GDP. So it would be within that time frame that you would see that impact.

DR. MILSTEIN: Evan, is there a structural or a conceptual reason why either in framing the problem or discussing potential solutions the chapter does not discuss or consider lack of and opportunities to harmonize with the private payers and their strategies for, in essence, addressing the same value problems?

MR. CHRISTMAN: That's something we certainly have discussed in the past, and we can put that back in. I think that that is just something that sort of slipped through this here.

DR. MARK MILLER: What we try and do with this chapter is a standard set of information that gets repeated and updated every year, and then sometimes we try and bring in a different focus in a different year to try and mix things up a little bit, that type of thing, bring information in. We did do that at one point. What it kind of got dropped for this year was this notion of should we talk about MedPAC's vision in this chapter, but, of course, Glenn has said maybe there is a different vehicle for that. So maybe it is also part of that conversation, and we can bring that back into the mix.

MR. HACKBARTH: Okay. Any other clarifying

questions?

DR. DEAN: Would you just expand on your answer to George's question. I didn't understand. If what is coming into Medicare through Part B premiums actually goes down or stays flat, I would assume that the government's portion of those payments would have to go up.

MR. CHRISTMAN: I guess what I would say is that they set the premiums so that the total amount of premiums paid equals 25 percent of Part B's expected expenditures. And so, as a result of the hold-harmless, they spread that 25 percent over a smaller base, and so those people pay a higher premium, but the same amount of total premiums is paid.

DR. DEAN: So the premiums will actually go up.

MR. CHRISTMAN: They will go up in part because Part B expenditures go up every year, but a second --

DR. DEAN: Yes, okay. I thought it meant that the actual premium would be going --

MR. CHRISTMAN: I'm sorry. There is sort of an extra layer, yes.

DR. DEAN: I see.

MR. CHRISTMAN: Part B premiums go up every year,

so that is one piece that is driving up the premium. The second piece is that fewer people are paying the Part B premium this year, so obviously it is higher.

Right now, there is not a lot of good information from OACT that allows you to quantify that effect. When that comes out -- I think they will do it in the fall -- we will add some detail on that.

DR. DEAN: Thanks.

MR. HACKBARTH: I saw hands over here. Were you just trying to jump the queue on round two, or did you have round --

DR. CHERNEW: [Off microphone.] I thought you were about to say "round two." [inaudible]

[Laughter.]

MR. HACKBARTH: Right. Any other round one?

DR. STUART: This is a real quickie. Obviously, the Great Recession of 2008 and 2009, I assume, is not reflected in this. But is there any qualitative assessment from the Office of the Actuary in terms of how that is going to affect the future? Because it is not just something that is going to be a dip. It is going to change the slopes here at some point, it strikes me.

MR. CHRISTMAN: I mean, as I recall, OACT puts together the trustees' report in the January-February time frame, so that March report that came out this year in June, or whenever, sort of reflected what people thought about the economy at the beginning of the year.

I would note that the Hospital Insurance Trust Fund insolvency data I believe moved forward 2 years this year, but whether it factors in what people think about the full impact of it, I couldn't say.

DR. KANE: Yes, going back to the Part B premium for the 25 percent -- and I know that is supposed to be the higher-income people -- do we have any sense of how many of them are under an employer-based post-retirement coverage and what that might do to employer-based coverage if it keeps going up? In other words, when the Part B premium is loaded onto the 25 percent, it's getting higher much faster? Do we know who that's affecting and how that might affect even like in post-retirement coverage?

MR. CHRISTMAN: I guess I'm not sure I entirely follow your question, but there are sort of three populations that are going to be paying the premium: new enrollees who don't have a Social Security check payment

from the previous year that would decline; individuals subject to the income-related premium; and individuals who have their premiums paid by State Medicaid programs.

So I'm not sure I really know how to tie it to the employer issue that you are talking about.

DR. KANE: That's related, so now we know who the three groups are. And then what is the impact of this rapid hit on those different parties.

MR. BERTKO: Evan, if I can expand on Nancy's question, I think she's got that second group there for which some retiree benefit plans pay the Part B premium. And so I think you are requesting -- I mean, would more employers cut back CAP or something to that group because we've now got a leveraged impact from the push on the 25 percent that are paying?

MR. CHRISTMAN: Yeah, I'm afraid that I'm kind of thin on the income-related premium and this angle of it. The only thing I really know about it is that the last time someone did an estimate of it, I believe that about 5 percent of the Part B --

MR. BERTKO: It's not that group. It's the second group that are not income-related but still are in a place

where they might be paying premium.

MR. CHRISTMAN: Okay, so that would be new enrollees then would be the group. I don't know the size of that group.

DR. MARK MILLER: [Off microphone.] It's not income-related. Is there a secondary impact from their employer? Okay. We'll look at it. I hear what -- I think I...

MR. HACKBARTH: Any other round one? Okay. Round two. Who doesn't have a round two? We'll just go down the row.

DR. BORMAN: There's a couple of things about the presentation, and starting out, sort of the good part that I like is that, as Mark has pointed out, we see some of the same data presented in a similar way, and it kind of re-grounds us in where the conversation is about. And so I find that very helpful.

Looking at that from the flip side, however, it does beg the question a little bit of are there some other ways or other perspectives from which to look at this contextual problem that we have that we are spending money that we don't have and present it in a more -- or in an

equally intense, attention-grabbing way.

I understand these graphs better every year, but as I talk to colleagues, as I talk to people at various levels of training, when I say to them the H.I. Fund goes into bankruptcy at X time, I get what some have termed the MEGO response, my eyes glaze over. And I think that we are and should be at a point where we want to engage people generally in their thoughts about their health care because in the end there are a lot of choices that have to be made here that are not black-and-white medical science and that will relate societal values.

So, to cut to the chase, is there something that we can present as a figure, as a number, as a calculation, that is even sort of more generalizably understandable? And I recognize the report is to the Congress, and I do not mean to impugn their ability to understand complex graphs. That is not the point. I am thinking about the audiences that I talk to, and one that has occurred to me is the notion of the Medicare dollar. You know, we present this in a very traditional way in the sense of Part A, Part B, and to some degree in later things, Part C and Part D.

But the reality is if we really want to cut across

silos and think about the whole thing that we deliver, it just might kind of be helpful to know, after you appropriately, relatively weight in all the various programs, just how much is out of general revenues and how much on a percentage basis, because the Medicare dollar kind of carries that implication that it's coming out of some dedicated Medicare funding. And I think what a lot of my colleagues and just my neighbors don't understand is how much of this is really sucking from the general revenue. And I just think that might be a helpful thing to be able to get out there, would be some sort of calculation or number that relates to that, and it seems to me that this was the part of where we do that kind of thinking that might be helpful.

The other thing that I would comment is that, as always, it's helpful to have a basis for comparison, but I almost think we are starting to lose value from the continued comparison to other countries. There are so many things that make each country different from each other in terms of cultural values, in terms of how data are collected, in terms of expectation of outcomes, how systems are structured, that I think we have enough data of our own

to say that, number one, we are spending a boatload of money, we can't continue to spend at this pace; number two, we spend very differently within our own country. Who knows why? Lots of potential different reasons. But we have enough evidence within our own country that we don't really need that external comparison, because I think we have come to the comparison or the result, the conclusion that we can't just wholesale become France or Italy or Japan or whomever in our health care system. We can't do an immediate transposition.

So I wonder, I just would sort of increasingly maybe think less about that, and maybe this is an opportunity to use that, our own internal variation tells us the same thing, that we have got to think about this in a different way, if that makes sense.

Those are my two comments.

MR. GEORGE MILLER: I want to go in the chapter to page 18 and what struck me about the disparities issue and see if we have a remedy or a solution. While I really appreciate the data and the analysis, the concern on my part is how do we change what is, at least apparent to me, an inequitable situation that both racial and socioeconomic

Medicare beneficiaries are not receiving the same level of care. How do we address that? What recommendation came we come up with to address this issue? Not only they are not getting the same level of care, but when we do get served, we have higher mortalities. That is a major problem for me. Do we tie in performance, pay-for-performance issue for -- and I realize we are looking globally. You know, how do you address it at the level that it is being reported. That is just problematic to me. And, again, it is more than just demographic. It is socioeconomic also. So that's also a problem. I just consider it just grossly unfair and certainly not equitable, but I'm not sure the best ways -- do we have best practices to address it? Can we make recommendations? Do we penalize folks? What are the tools to help correct this inequity?

MR. HACKBARTH: Let's take a look at how to better address the topic.

DR. CASTELLANOS: Evan, can you turn to Slide 6, please? I really appreciate your comment, especially the one about defensive medicine. I think you commented that it really wasn't considered to be a major driver.

I think there's been some national attention just

recently on the issue of malpractice and defensive medicine, and I think if you look at the provider community, especially the physician community, I think you may get the importance that this is probably more of an issue than you give it credit for.

But, more importantly, if possible, is there a policy viewpoint that we can deal with this, especially with the issues of delivery system reform that we are looking at where we can look into controlling some of these excess costs with the defensive medicine?

MS. HANSEN: A short comment here relative to just an appreciation of this chapter elevating some of the beneficiary economic status and impact of their rising costs. I know we've talked about it. I think this is the most robust piece I've had the chance to see, so I really just want to say thank you for that.

The second thing is I also would love to underscore I think what John and Nancy brought up about what that is going to mean in terms of that 25 percent who will pay more, just with that start cutting into that middle-income population that has started to feel the squeeze from different ways. So I just want to bring that one up,

especially with the retirement plans that affect government budgets as well with their pension plans.

And just my last comment is that I do think having the context of the recommendations in this chapter seems helpful to just say, you know, this is the status where directionally MedPAC may go, whether we, you know, order this in some other way, but I think it just makes a more complete package.

DR. CHERNEW: As always, this was a well-done and sobering chapter. In response to Karen's comments, actually there is a number that they report, like an actuarial value which tells you how much taxes would have to go up to keep everything in balance, and there's some version of that that is sort of understandable.

But my quick comments are: I think the chapter does a great job of talking about a lot of the issues, but some nuances that I think are important get lost. One of them is the distinction between the level of cost and the rate of growth of cost, which comes out in other work that we are going to talk about today. But in the second on rate of cost growth, there are several things there that I think are more factors for why costs are high as opposed to why

they are growing rapidly. And so I think I'd like to talk more about which ones fit in which bins, if you will. But I think clearly, from the other work we will see today and work I have done, the cause is different. Things that cause high levels don't necessarily cause high growth, and vice versa.

The second point I'd like to make relates to the section on the value of new medical technology. I think in general the literature is pretty clear that overall, on ag, the new medical technology which is driving up spending is worth it. In fact, the returns from new medical technology on average are tremendous.

I think it's very important to note that that doesn't mean there is not a lot of waste in the system at the margin, that we overuse new technology, so we could do a much better job with the same technologies if we could use them more effectively, because with all the good stuff comes a lot of waste in the system, and we struggle with how to get that out. So the distinction between is it good is a more nuanced answer than yes or no. It is how it's applied.

And the last comment I'd make that relates a little bit to what George said is although the Part B

premium rising is something we have talked about because of the hold-harmless, I think that's a little bit of an anomaly. The real issue is people are increasingly not going to have access to supplemental coverage, in my opinion, and that is going to create a huge burden that is going to well dwarf the Part B premium issue. And we need to think through -- all the graphs that we present are typically for the average person. We average, you know, what on average are people spending. But in certain subsets of the population, the burden is going to actually be crushing. And it's not the lowest group, but it's that other. And I think those burdens are going to be crushing, and how we think about that will have ramifications for how the policy things around benefit design and stuff get put later. So I think it really does help our context.

DR. BERENSON: First, two comments on the purpose of the chapter. As I was reading it, I thought -- this is my first year so I was officially reading it as opposed to in the past when I was unofficially reading it. But as I was reading it this time, I said, "Hey, I've read this before," and it was helpful to have you and Mark clarify the purpose for repeating a lot of stuff. And I see that, and

yet to me the most compelling part of the chapter was the new information where you can actually get into some detail, so the box on cost-shifting, I think there will be an opportunity to spend a little more time on is the high spending worth it, with the conversation we're going to have later, Michael's point about exploring in more detail, the increasing data that's available about the difference between baseline spending and rates of growth.

So I would like to see the chapter -- I see the purpose now of having some continuity in the same sort of macro topics with updated data, but I really think the emphasis should be on sort of what's the cutting edge and what relates to other work that the Commission is doing that contributes to that data.

The second point on this I would make is that I just see a big disconnect between most of the chapter, which is about macro-level trends and findings, and then we're going to bundle payments in Medicare. It just seems like the two don't hang together very well, and I would explore other ways of trying to identify -- unless we have -- vision should go in this chapter, but the stuff of here's the seven or eight specific things we're working on seems to me maybe

should be in some different place.

And the substantive comment I was going to make is I agree with Ron that defensive medicine -- it's hard -- there are estimates all over the world, I mean all over the place, on 1 to 2 percent to 25 percent of health care costs. I don't think there's any way to know at this point. It's incredibly hard research. But I would not dismiss that area as one that deserves to be on the list as a cost driver.

MR. HACKBARTH: Bob's comment triggers a thought that I want to throw out so people can comment on it as we go through, if you wish.

One piece of this is data that is likely to be pretty much repeated year after year, just in updated form.

A second piece of this could be that we, you know, shine a spotlight on one, two, three -- I don't know what the number is -- particular issues, and those might change from year to year. It is sort of here is a focus.

And then the third piece is some summary statement about MedPAC's policy views, vision, and I think it might be useful to make a distinction between the recurring data and some new issues that we want to rotate on an annual basis.

DR. KANE: Yeah, I think related to whether there

are additional topics that may be included, I think this whole issue of how Medicare interplays with other payers, not just the private sector, which Arnie started mentioned, but also Medicaid, and I think we talk a little bit about dual eligibles. But I think as a general theme, we view Medicare and its interactions as fairly passively interacting. And I know I was giving a talk to the Pacific Business Group, thanks to Arnie, a few days ago, and they said, "Well, what could the private sector do to help?" I wish I said, "Work with Medicare." But I couldn't think of any device by which they could do that. And I think we need to -- you know, it would be interesting to start actively thinking of how can Medicare and the private sector even create zones of collaboration or all-payer experiments or some way for Medicare, and Medicaid and the private sector, to try to create an all-payer vision of how resources should be allocated instead of this fragmentation, which we have all noticed but still continue to operate under.

The other topic that I thought would be a good way to highlight some of the issues that are sort of brought up, but sort of in a more fragmented way, is the whole issue of program governance and administration. Fraud falls under

that. The costs of administration falls under that. The ability to innovate falls under that. But I think that whole topic, when you fragment it, you don't get quite this -- it would be nice to pull it all together and say what should be the organizational structure, the types of resources, and then take the functions of each one and say maybe, you know, fraud, the protections there, should we look at that or, you know, we have been looking at the ability to innovate. But I think that is a big topic, and we just have not highlighted it. It gets buried in other things.

So those two would be -- how do we deal with the implications that we're really only one player of many and it has a lot of implications for Medicare as well in terms of the inability to contain cost, but it also has, you know, opportunity and then program governance and administration.

DR. MILSTEIN: Just a few technical suggestions.

First, I think it's important in the discussion to separate factors that explain our higher level of spending from factors that explain growth in spending. And I think, you know, there's more we can do to help in terms of the reader grasping that. If you look at Slide 6, if you sort

of think about it, those things can be expressed either in the amount of those things we use, like technology, which you can use to explain higher spend; but they also can be reconfigured to explain growth in spend, because technology does not explain growth in spend. Growth in technology explains growth in spend. And so helping to clarify that, what do we know that accounts for our higher-level spend and what do we know that drives spending would be helpful.

The other thing, I think, at least this year -- maybe we have done it in the past. Mark, you can comment on this. But I think it would be really useful in this year's chapter to really pay more attention to the central role of improvement in health industry productivity growth, you know, more health per dollar consumed -- more miles per gallon, in essence, in the health industry -- and our ability to sustain Medicare without increasing beneficiary cost-sharing or increasing taxes, because that's really -- it's a central factor, and should we -- at least in this draft, we don't nail it, and maybe it's because we have nailed it in the past. But I think it's very important because the notion that our health industry can't do in rate of productivity growth is -- there's no basis for asserting

that at this point.

Then last, but not least, I think it would be -- we may want to consider, without making this, you know, overly complicated, as we reflect on the different strategies that we lay out broadly, would be in some ways comment or maybe we can have a little rating system as to, you know, the degree to which we think those things have gotten a reasonable try in Medicare versus the degree to which we think there is a big unexploited opportunity, because some of these -- you know, some parts of the mind have been worked over pretty well and have either succeeded or faced degrees of political resistance that caused them to be of less yield than we hoped.

MR. BUTLER: So if I can recast your original question, I'd put it this way: At one end of the spectrum is give them the charts they always want year after year and the other is "not only give them the themes but plop in some important things, somewhat randomly, but ones where we think we got mileage, I'm more on "give them the charts" end of the spectrum, because I think when I look at the staff's time and effort, when I look at the timeliness of the -- and the information you'll get from the chapters, it's probably

better to firm up that message later on in the year than to spend a lot of time trying to capture it all in this chapter, especially when you're kind of trying to put this to bed, in effect, while we get on with the rest of the work. So that would just be kind of a general response that I would have to that.

I think one major exception that we haven't really come back to is it seems when we get into the updates, we suddenly say service after service, we're doing it silo, we're doing it silo, we're doing it silo. So the theme of crossing the silos I'm not sure is quite as apparent in how this is written up as it -- you know, you could hit on that one in particular and how we're really trying to reshape Medicare across the various services, not just provide updates.

Now, the one issue that I do have issues with is this cost-shifting one, which is one of those where you would say we have done previous research, now we're shining a light on it, because we think it's interesting, worthwhile, we can make a unique contribution.

I agree with all that. I'm not sure that it belongs in the chapter at this time, although I could

support it. But I think what we basically have done is we have brought forward not word for word but a somewhat shorter version with less data than exactly what we put in last March's chapter. So it's not new information. It's cast in a little bit different light. But the fact that we use words like "hypothesis" and -- you know, it's almost like a work in progress; whereas, I kind of sense the context chapter should be not kind of that so much. I think it belongs more in the hospital update chapter with additional analysis, is what I would favor. But that's not to say we shouldn't rigorously go after the topic, because I think we should.

Now, some of it relates to the words, if I were to just contrast two kinds of comments. And I'm drawing right from the draft. So when we say things like, "Some argue that providers raise prices for private sector payers when their costs exceed their Medicare payments." There are words like that that suggest that they just pick up the phone or run through their charge master new prices, when it's really a rigorous negotiation. Now, they may have incredible clout, and they may do things that are aggressive and so forth. But it's not cast some of these words in

quite the way I would perhaps do it.

Then there are some other technical things that I think we need to just kind of work more on, and exactly the data that we bring forward I think is extremely important, and we have very limited summary data here where we had more data in the chapter. And so I think if we do bring this forward, I think this particular section needs a little bit more massaging before it's ready to go.

MS. BEHROOZI: Actually, before, I had written some comments before Bruce talked about the Great Recession of 2008-2009 and before Mike talked about how Medigap policies or employer-based retiree coverage -- I don't think you said that, but maybe that's implicit -- is likely to go the way of the dodo or whatever it is, but, you know, there's likely to be a lot less of it, particularly as it becomes more expensive, and also your comment about the crushing debt on beneficiaries.

I would just suggest, Evan, you've got a lot of this stuff in the paper, but maybe pulling together the sort of picture of the 21st century beneficiary that we had started talking about a couple of years ago, I think. You talk about people under 65 losing insurance, right? I mean,

the latest report, you know, another few million people have lost insurance. That puts pressure on Medicare as they retire. You talk about it in the context of the health system overall, but in particular, that has implications for Medicare when those people who have not had access to care retire and suddenly do have access, and maybe portends a change in the health status of Medicare beneficiaries.

Long-term high unemployment that, you know, we're already seeing and is predicted to be persisting for a long time means that there -- and we've already seen a real wage decline for those who are working. So, you know, bringing those two things together, people are going to have a lot less money when they retire, whether it's because they will have spent less time in the workforce and their Social Security benefits won't go up the way they should -- not to mention that they have to wait longer to get Social Security benefits -- their retirement savings, if they had any, were decimated at the end of last year. Maybe they're climbing back up close to zero, but not, you know, the kind of money that they thought they were going to have to retire on, and people are simply making less in terms of income to be able to put away.

So that what you identify in the paper in terms of the growing costs to be borne by beneficiaries, I think it would benefit from putting it in the context of people having less money to bear that cost. And they are not all going to be dual eligibles; they're not all going to be LIS-eligible. I think it would just be helpful context-wise since that's the chapter.

DR. DEAN: Just a couple things. First of all, with regard to the growth of technology as a cost driver, it's also really tied in with the prices for new technology, because each new procedure that's introduced, at least it seems, is introduced at a higher price than some of the predecessors, especially when it's new, and some -- maybe the legitimate costs are, but then it stays at that price. And so more and more there is the attractiveness to use things just simply because of the way they're priced. I don't know what the answer to that is, but it might be worth a comment.

The other thing I would comment about has to do with the defensive medicine issue. You know, as Ron and Bob have talked about, certainly quantifying the dollar cost is terribly difficult. I think there is another cost that is

even harder to quantify, and that is the whole behavioral aspect of this, and the cynicism and the fear and the rigidity that it sort of introduces into physician behavior that I think may even be a bigger factor in terms of interfering with the efficiency and the smoothness with which the whole system works, that if there was a way to back this influence out of the whole process and take away, like I say, the fear -- which, you know, at least in my practice, I try my best to forget about the whole thing and not to pay attention to it. But it's hard to do, and I know that many of my colleagues, that really is a dominant issue in terms of their whole behavioral approach to how they deal with patients. And it's for the most part a negative one.

And so I think working to try to reduce the influence of that is terribly important, even aside from whatever dollar cost it might save.

MR. BERTKO: Okay. A couple technical issues, Evan. I am going to follow up Bruce's comment here on payroll taxes, and I am not going to ask you to try to reforecast what OACT does. But having a conversation with them that says, you know, might ask and answer the question of, Are the payroll taxes forecast now less than you did

last year? And then directionally saying, If this happens, it accelerates that date forward from 2017 to something else. And we now have a data point because the same thing happened last year.

The second part of it is in the longer-term factors you recognize health status, but I am going to suggest you think about whether you specifically would put in something about the upcoming obesity epidemic, both in terms of incidence, and then I at least I think I've read some stuff where it says akin to not having health insurance, being obese for a long period before you're ready for Medicare leads to more co-morbidities, you know, obviously, diabetes, joint problems, and things like this which will, in fact, accelerate the cost.

My recollection, although I'll look to Mike and Bill on this, is that when we asked this question in 2004, we got kind of a shrug of the shoulder, "Can't tell," from our colleagues over on the other side of the table. And I'd be interested to know whether they've done anything more since then.

Thank you.

MR. KUHN: Thank you and, Evan, thank you, that

was a good report. I appreciate that. Let me focus on three things, if I could.

One, on page 9, where you talk about erroneous payment rates for the Medicare program, there is an interesting final sentence here where we talk about that perhaps might require higher administrative expenditures in order to grapple with this issue. Right now, as I recall, within the Medicare program they spend one-fifth of 1 percent dealing with erroneous payments. And so I think putting some context here in terms of what the current spend is, let's everybody know how little they spend compared to what private plans do, where they really make determinations in terms of panels of physicians and others. And so I think making sure we once again kind of differentiate between the two but also show that there is an opportunity for Medicare to improve in this area might be a useful thing to have.

Then on page 21, where we talk about the beneficiaries -- and I think that's a very good discussion and talks particularly about the interaction with the freeze on the Social Security update this year and how that impacts the Part B premium, that's going to go on. But we're silent -- and correct me if I'm wrong here, but we're silent on

what may happen to the Part C and Part D premiums, that is, for MA and PDP. Those I don't think are constrained by the same activity as Part B, and so Medicare beneficiaries, while they are protected on Part B, they will not be protected on Part C and Part D premiums, and they could see their actual Social Security checks go down next year as a result of that. And I think we need to be very clear about that and recognize that aspect.

And then, finally, on page 29, where we're talking about research, I'm a huge fan of research in this area. I'm a big fan of -- I'll wear it on my sleeve -- unabashed fan of CMS' Office of Research. And it would be helpful, I think, to talk in here -- and we talk about how that research budget is declining. But I think OACT has some pretty good information in terms of the ROI that's been achieved for research that CMS has done in the past. And if we could talk to OACT and see some of the returns that they have as a result of research, it would be useful to have that as well.

Thank you.

DR. SCANLON: Two points and they're kind of about tone, I guess, or maybe contributing to tone. The first one

is about the drivers, the factors driving growth, and it relates to the technology. And I think that when we talk about sort of technology being a major driver, it conjures up in many people's minds the idea that in order to control costs, we're going to have to stifle innovation. And I think we definitely want to avoid that because it's not true.

Part of it is that the studies I've seen which talk about technology and lead to a conclusion that says it's 50 percent of the growth, they could have used the word "residual" instead of "technology." They controlled for a number of things, and then when they didn't have anything else to control for, they had 50 percent of the growth that was unexplained, and they said, "Well, that's technology." Okay. And I think that there's two different aspects of saying that the residual needs to be broken down.

One is it's not all new technology that maybe is driving it. It's how technologies maybe are used as a factor here. If I'm a provider and I give a lab test, you know, the question is: Do I do it for someone with a chronic condition? Do we do this every 60 days? Every 90 days? You know, every year? I mean, there are issues like

that that are part of this factor that is driving things.

And that relates to the second factor, which is I think that provider behavior is a portion of this. You've got to capture it in the organization of a delivery system to a degree, but it's more important, I think, than just that.

And so I think we have to be careful about sort of what we ascribe to technology, that putting a number on it is dangerous. At a minimum, what we need to do is describe how complicated this is, that provider behavior is also a factor sort of in this.

The second point relates to international comparisons, and I agree with Karen that we're not going to adopt sort of the French or the German or the Swedish system, or anything like that. But I think that -- I mean, I don't mind the comparisons in terms of look how far out we are, I mean, at a simple level, how far out we are in terms of our share of GDP and, you know, ask ourselves, What are we getting for it? I mean, I think that's a very sort of legitimate question to be asking.

I think there's research that can be done that's much more intense that says is there anything about what

they do that we could apply sort of in the context of our system, and that may sort of have some value.

The comparison with the rates of growth and the fact that the OECD average is the same, sort of roughly the same as ours, I think that one is a dangerous comparison, because the OECD average is an average of -- just as it is in the U.S., very different experiences. I saw sort of the details of the OECD average recently. We had Germany, which is one of the lower-level per capita spending, having also low rates of growth, something around 4 percent. We also in the time period that this study was looking at, you had Great Britain, who had a very high rate of growth, but they made a conscious decision saying, "We've invested too little in health care. We're going to expand it."

So there is this issue of, Is growth control really impossible or are there lessons, are there examples where you can find ways that you can control sort of the growth? So I think we have to be careful about how we use those kind of data.

MR. HACKBARTH: We're just about out of time here. Let me offer an idea. We can maybe have a few comments now, but we're probably going to have to defer longer discussion

until the next meeting.

Evan, I think you've done a great job here, as usual. There's a lot of good material here. I sense, though, an opportunity to maybe sharpen the chapter a little bit by breaking down exactly what we are trying to accomplish into different elements.

I think, as I said before, it is important to serve the audience that looks to this chapter for updated statistics on basic parameters for the Medicare program and health care spending in general. And I would have that section clearly labeled. You know, people can look at the chapter; if that is what they're shopping for, they know exactly where to get our annual statistical update.

I would label equally clearly a second section. I can't think of the exact name for it, but I think of it as sort of spotlight issues where in any given year we might take two or three issues that we want to focus on, and a number of them have come up in the course of this conversation: the idea of harmonizing between public and private payers, both Arnie and Nancy mentioned that; malpractice, you know, what's the state of literature on malpractice might be another; levels versus growth could be

another.

But, you know, my vague vision of this is we have a section that says we're going to shine a spotlight on three important issues this year. No pretense of comprehensiveness. In fact, I think we're sort of getting into trouble by trying to be too comprehensive, so we are touching in a very superficial way on too broad a front. And I think we can gain by narrowing and focusing a little bit more.

And then the third piece would be, you know, the summary of the MedPAC perspective. You know, here is what we think the challenges for Medicare are going forward. Here are key recommendations that we have made to that end. Here are broader directions that we think need to be pursued.

In my mind, I'm not sure if that third thing is best put in this chapter or someplace else, like the transmittal letter, but we can come back to that.

Does that sort of breaking this big chapter down into component parts make sense to people? Anybody have a quick reaction to that?

DR. STUART: Just very quick and, that is, I think

there actually are some countervailing trends here, and it might be useful to think about what some of those are.

For example, anybody who is nearing retirement and is depending upon their 401(k) is rethinking that issue about whether this is the time to retire. And we've seen not just over the last couple of years, but we've seen over the last 7 or 8 years increasing labor participation among the elderly and, in fact, higher rates of increase in labor participation among the older old.

What these do is two things. First of all, for people who postpone retirement, it postpones the time when they are actually getting Medicare benefits. Secondly, it means that they are contributing to Medicare premiums over that period of time.

Third, to the extent that working has some health benefit, assuming that you are not a worker in an asbestos mine, then it might actually postpone future expenditures.

Now, that's just an example, but my guess is that there may be some other countervailing factors if we really thought about it from that standpoint, because all of this is saying everything is pushing it up.

MR. HACKBARTH: So to me that might be an example

of a spotlight issue that, you know, here's all this stuff that you hear over and over and over again. Here's something that's maybe a little discordant with that.

DR. STUART: Right, and we don't know. I mean, it's early in the game, but --

MR. HACKBARTH: Right, right. Any other reactions?

MR. KUHN: Glenn, I think that's a nice framework, and I think that would pull it all together. The only other thing I would add to that, if there's a way to put it in there -- and to a degree, it's kind of in there now, but, you know, a lot of this is a lot of people saying, "Gosh, look how far we have to go. The road is so long and so hard, and the hill is so big to climb."

But, you know, each and every year, whether it's new legislation from Congress, whether it's new regulations out of CMS that implement perhaps recommendations of MedPAC, or other innovations out there, it would also be nice if we could capture it in that chapter and say, "Oh, by the way, and look what has been accomplished this last year." And so we can show the progress that everybody won't say, "Oh, woe is me. This is so far to go." But when you turn around and

look behind, they can say, "Look how far we've come," as well and that might be useful to add there, too.

MR. HACKBARTH: Okay. Well, let's close the conversation now. We'll be coming back to this, obviously.

We'll now have brief public comment opportunity before we break for lunch. Anybody wanting to make a comment?

Seeing nobody rushing to the microphone, we will break for lunch and reconvene at 1:30.

[Whereupon, at 12:34 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION [1:33 p.m.]

MR. HACKBARTH: Okay. It is time for us to get organized. Our first topic this afternoon is comparing the experience of LIS and non-LIS beneficiaries in Part D. Shinobu?

MS. SUZUKI: Good afternoon. Last fall, we discussed our Part D work plan and presented a list of projects that we plan to do, including many that involve analysis of claims information. This will be the first opportunity for us to present the results of our claims analysis, which will be complemented by real-time information we collected from our recent focus groups of Medicare beneficiaries.

In this presentation, Joan and I will focus on two groups of beneficiaries, those who receive extra help with their premiums and cost sharing and those who don't, and report our findings from their experience with the drug benefit.

I would also like to acknowledge our colleague, Rachel Schmidt, who has been central to our work on Part D.

Just to give you an overview of our presentation, in the first half, I will be showing you a series of charts

and tables that show some findings from our analysis of the 2007 claims information. It is a very rich source of information. The data that will be presented today is only a small portion of what we can learn from the data.

Charts and tables in the next couple of slides will show you distributions of spending, characteristics of beneficiaries with high spending, and at a very aggregated level, how the spending and utilization patterns differ for those receiving the low-income subsidy and those who don't.

In the second half of the presentation, Joan will talk about what we learned from our recent focus groups. We conducted 12 focus groups with low-income subsidy beneficiaries and non-low-income subsidy beneficiaries with high spending and asked about their understanding of the drug benefit, how they are using or not using the drug benefit, and their experience with plan marketing activities. Our findings suggest that LIS and non-LIS enrollees have different experience using the drug benefit and we are going to tell you what we have learned from analyzing the data and from talking to beneficiaries.

This chart shows the distribution of spending by the level of total annual spending. Spending here includes

all payments to pharmacies for ingredient costs, dispensing fees, and sales tax, regardless of who paid for them.

In 2007, 38 percent of enrollees had an annual spending of $2,000 or more and accounted for 82 percent of total spending. Twenty percent had spending less than $250 and accounted for about one percent of total spending. Spending on drugs is somewhat less concentrated than Parts A and B spending because more beneficiaries are likely to take some medications during the year, while medical service use may be concentrated in a smaller set of the population.

Here, we are looking at the characteristics of Part D enrollees by levels of annual drug spending. As we expected, we found that beneficiaries with high drug spending are more likely to be disabled and receive Part D's low-income subsidy. On the far-right column, you will see the 46 percent of the Medicare population that are under age 65. So this is showing that nearly half of the people with spending over $6,000 are disabled.

If you go down to the next set of numbers, you see that 76 percent of those with high spending receive the low-income subsidy. What may not be obvious from these numbers is that in many cases, being disabled and receiving the low-

income subsidy are very much related because the disabled population tends to have lower income and so is more likely to be eligible for the low-income subsidy.

So what the numbers in this slide show is that LIS enrollees account for 38 percent of the enrollment, but more than half of total spending, and it is because they use more drugs and more expensive drugs, on average, compared to non-LIS enrollees.

In 2007, LIS accounted for $33 billion of the $62 billion spent on drugs covered under Part D. Non-LIS enrollees, who accounted for over 60 percent of enrollment, on the other hand, accounted for only $29 billion of the total.

At the bottom of the table, you will see that LIS enrollees had 4.6 prescriptions per enrollee per month compared to 3.4 for non-LIS enrollees. And the average cost per prescription taken by LIS enrollees was $71, compared to $43 for non-LIS enrollees.

The next two slides look at difference in drug use by LIS and non-LIS enrollees by type of drugs. The first point I would like to make is that generic dispensing rate for LIS and non-LIS enrollees are different. At the bottom

of the table, you can see that generic dispensing rate across all drug classes are lower for LIS enrollees, so 58 percent compared to 67 percent for non-LIS enrollees.

Here, the generic dispensing rate, or the GDR, is defined as the share of generic prescriptions dispensed regardless of whether certain drugs in the class have generic substitutes. So it accounts for both generic substitutions for drugs with generic substitutes and therapeutic substitutions for drugs with no generics. You can see the GDRs for low-income subsidy enrollees are lower across all five classes shown here.

Comparing the GDRs for different groups of beneficiaries can be complicated because it doesn't necessarily reflect beneficiaries' choice of generics over brands or vice-versa. For example, for antipsychotics, generic prescriptions accounted for 17 percent of all prescriptions dispensed to LIS enrollees, compared to 28 percent for non-LIS enrollees. But the GDR can be influenced by availability of generic substitutes and the medication needs of the individuals in each group.

So the difference in the GDRs could reflect the choices made by the beneficiaries, or the availability of

generic substitutes, or the specific medication needs of the beneficiaries in each group, or some combination of all of these factors.

So we have seen that the average spending per enrollee was much higher for low-income subsidy enrollees compared to non-low-income subsidy enrollees and the generic dispensing rates for LIS enrollees are generally lower than non-LIS enrollees, even when we compare the rates for drugs within the same class.

So here is another way to look at the spending for two groups of beneficiaries. I have chosen two classes, antihypertensive therapy agents, where total annual spending for LIS and non-LIS enrollees were similar, and antivirals, where we saw a very large difference in total annual spending between the two groups.

For antihypertensive drugs, the main difference was that for LIS enrollees, the subsidy picked up what are paid for out of pocket by non-LIS enrollees. In fact, the average annual out-of-pocket spending for LIS enrollees were similar across different classes of drugs, which is what the subsidy is intended to do, while it varied widely for non-LIS enrollees, ranging from a little less than $100 to over

$500 in some classes.

For antivirals, the most striking difference is in how much plans paid for antiviral medications taken by the two groups. Plans, on average, paid $520 per user for non-LIS enrollees, while they paid over $3,000 per user for LIS enrollees. We saw this in a few other drug classes, and additional research in what plans are doing to manage their costs may shed some light on why we see this kind of a difference in some classes and not in others.

Health status and different medication needs are also likely to affect plan costs and may be beyond their control. In the case of antivirals, some of the difference in cost may be due to the fact that medication taken by LIS enrollees are more likely to be for treatment of HIV and AIDS, which tend to be more expensive compared to other antiviral medications.

To summarize, there may be many factors that affect the generic dispensing rates. Availability of generics is one. Some drug classes may have very few or no generic substitutes, and even within the same drug class, some drugs may have many generic substitutes while others have none. So differences in medication needs could result

in very different GDRs for LIS and non-LIS enrollees.

Another factor may be that financial incentives faced by the two groups of beneficiaries are different. In 2007, LIS enrollees paid $1 for generics and preferred brand name drugs and $2.15 for non-preferred brand name drugs. Non-LIS enrollees, on the other hand, paid, on average, $5 for generics, $28 for preferred brand name drugs, and $60 for non-preferred brand name drugs, and they may have paid more for drugs on specialty tiers. So compared to non-LIS enrollees, LIS enrollees face a much weaker financial incentive to switch to generics or ask for therapeutic substitutes when such options are available.

Finally, plans' use of various utilization management tools may also be a factor. The majority of the LIS enrollees are in stand-alone PDPs and most are in plans with premiums below the regional benchmarks. There may be systematic differences in plans' use of utilization management tools between, for example, stand-alone PDPs and MA-PDs or those with premiums above and below the regional benchmarks.

Joan is about to talk to you about beneficiary experiences and I would like to lay out some basic numbers

to provide you with a context. Most enrollees are in plans with coverage gaps. Under the standard benefit design, the coverage gap starts once a beneficiary reaches the initial coverage limit, which was $2,400 in 2007 and ends when he or she has reached the catastrophic limit. In 2007, that occurred when a beneficiary incurred $3,850 in out-of-pocket spending. After reaching that point, beneficiaries' cost sharing is greatly reduced.

In 2007, 8.3 million enrollees had spending high enough to put them in coverage gap, but more than half received the low-income subsidy. LIS beneficiaries aren't affected by the coverage gap because the cost-sharing subsidy effectively eliminates the gap for this population. A much smaller number of people had spending above the catastrophic limit, and the overwhelming majority were LIS enrollees.

One of the goals of the focus groups is to learn about the experiences of individuals who hit the coverage gap and to understand how the benefit structure is affecting those with high spending.

And with that, I am going to turn it over to Joan, who will talk about the findings from the focus group.

DR. SOKOLOVSKY: Well, as many of you probably know at this point, every year, we conduct focus groups in different parts of the country with beneficiaries and physicians and sometimes other providers to hear from them directly about their recent experiences with the program. This summer, we conducted 12 beneficiary groups in Baltimore, Chicago, and Seattle, working with researchers from NORC at the University of Chicago and Georgetown University.

Although focus groups cannot have the precision or comprehensiveness of the quantitative findings that Shinobu presented to you, they enable us to gain more real-time knowledge of how the benefit is working. They also supplement our knowledge by providing information on how beneficiaries are using, or in some cases not using, the benefit. We wanted to hear from beneficiaries about how Part D was working for them. The goal was, again, to supplement the knowledge we have gained through PDE analysis with beneficiaries' discussions of how they used the drug benefit.

This year, we had six groups of participants who are receiving the LIS subsidy. One focus was to see how

these beneficiaries who had to switch plans, some of them, when their original plan's premium no longer qualified for a no-premium LIS participant. We wanted to see if switching plans affected their ability to get their drugs.

We also had six groups of non-LIS beneficiaries who had high drug use, and I want to really emphasize here, we were not looking for beneficiaries with average drug use. We specifically screened to see what beneficiaries who hit the coverage gap were doing to continue to get their drugs.

The participants in our groups had diverse backgrounds, and particularly among the LIS groups, many were disabled.

Overall, we learned that the experiences of the two groups were very different. I will be going over some of the differences in the next few minutes, but the most important difference is the one that Shinobu has already mentioned to you. Those receiving LIS had no gap in their drug coverage.

Let me start with the group of beneficiaries who were receiving LIS. In general, many had limited familiarity with the drug benefit. Although we asked many different questions, both to screen people to participate in

the focus groups and once they arrived at the focus groups, trying to identify beneficiaries who had to change plans because their plan's premium was now above the low-income threshold, we eventually discovered that for many of them, this was just not a meaningful issue.

They had a hard time explaining their enrollment status. For example, they might know that they were in a plan sponsored by Company X, but they wouldn't know if they were in that sponsor's stand-alone drug plan or Medicare Advantage plan.

Many had medical and drug coverage that was really stitched together from many programs, including Medicare, Medicaid, a drug plan, sometimes a State pharmacy assistance program, and frequently cards that entitled them for care at a free clinic. To give you an example, one woman told us that whenever she saw a provider, any provider, she gave the receptionist her Medicare card, her Medicaid card, her plan card, and her clinic card and left it to the receptionist to choose which was the appropriate card for this particular encounter.

In addition, some people told us they had medical conditions, things that caused chronic pain or memory loss,

and that also made it hard for them to cope with plan communications and respond to them in a timely manner.

A few beneficiaries did mention receiving a letter telling them that they had to switch plans if they wanted to continue to pay no Part D premium. Most seemed to accept the switch without looking at alternatives, although we did have one beneficiary who said she called the number that was on the letter she received and got a lot of help finding a new plan.

A few beneficiaries reported that they were paying Part D premiums, although based on their copays, they seemed to be receiving LIS.

Remember, if someone chooses a plan once, CMS will not automatically switch them, even if their plan's premium goes above the LIS benchmark, and we simply couldn't tell if these beneficiaries knew they and a choice and could get a plan without a premium.

Since your mailing materials went out, CMS has announced that they are going to start mailing these people letters, telling them that they do have a choice and telling them, I believe, the plans in their region that are available to them with no premium.

Now, more people reported switching plans because of contacts with plans. Some of you may remember back to 2007 when we reported to you about marketing abuses that targeted the LIS population. We saw more of that this year, particularly for those people who lived in senior housing. An agent, we were told, would knock at the door and say that Medicare sent them. They would try to convince the beneficiary to change plans, sometimes successfully. Only later would the beneficiary discover that her physicians did not accept this particular plan.

Most beneficiaries reported no problems getting their medication after switching plans. A few of them talked about delays, sometimes not as a result of switching plans, but because the plan they were in had changed their formulary or because the particular drug they needed required prior authorization. In many cases -- in most cases, the problem was resolved to the beneficiary's satisfaction. One person did tell us that she considered going to a hospital emergency response and getting admitted to the hospital so that she could get her medication, but, in fact, her problem was resolved before she resorted to this strategy.

Now, I want to switch gears and talk to you about the beneficiaries that weren't receiving LIS who had high drug utilization. Non-LIS beneficiaries with high drug use reported a very different experience. Most had come to know how the benefit worked very clearly. They knew when they could expect to hit the coverage gap and they were very conscious of costs and felt cost pressure when they knew they were going to go into the gap.

In contrast, I should mention that only one LIS beneficiary mentioned drug costs as a problem.

Of focus group participants who hit the coverage gap, almost none of them continued to take drugs in the coverage gap in the same way that they had been taking it before they hit it. Every group discussed different strategies in terms of how they coped, and in every group, there were some people who were actually taking notes on ideas that other focus group participants had.

A few of the most common strategies that we heard were asking their physician for samples, switching to generic drugs, and sometimes, if there was no generic for the drug they needed, asking their physician if there was a similar drug available that did have a generic that they

could switch to.

Some of the other strategies that we heard of upon occasion were getting a prescription for a drug that was twice the recommended dosage and splitting the pill, or just splitting the pills that they had so they would go twice as long, taking pills every other day for the same reason, or stopping some drugs. Some people talked about buying drugs from Canada. Other people, and we heard this more than once, the idea was that you would buy your generic drugs from Wal-Mart or some other discount store and not use your insurance card, and here the idea was that if the plan didn't know the cost of the drug, it would hold them off the gap for a little while.

Some strategies were done in collaboration with their physicians, but in other cases, they never told their physician, for example, that they had stopped taking some of the drugs.

One thing I did notice compared to previous years when we have asked similar questions was that -- and this is just my impression -- it seemed to me that more beneficiaries were telling their physicians, I just can't afford the cost of the drugs. Is there anything we can do

to lower the costs?

Only one of our participants ever reached the catastrophic phase of the benefit, and she was the only one who expected to reach it this year.

Well, we have covered a huge amount of territory in this presentation, so I would just like to summarize a little bit. Beneficiaries with higher annual drug spending are more likely to be disabled and receive LIS. The generic dispensing rate for LIS enrollees is lower than for non-LIS enrollees, and non-LIS enrollees are less likely to have spending that is high enough to reach the coverage gap or the catastrophic phase of the benefit.

Most non-LIS participants with high spending reported using multiple strategies for dealing with the coverage gap. LIS focus group participants reported more unsolicited contacts with insurance agents than non-LIS participants.

We will continue to talk to beneficiaries about their experiences with the program, and one of the things we would welcome is your suggestion for additional topics to talk about.

We are also continuing our data analysis,

comparing the LIS and non-LIS experience. One thing that we might look into further is to understand the difference in generic dispensing rates, the role that health status, different cost sharing, and different plan management techniques play.

Another focus is to focus on the experience of beneficiaries who switch plans. For example, how does switching plans affect their adherence to drugs?

We would like your guidance on future directions to take this research, and with that, I will turn it over to you.

MR. HACKBARTH: Thank you, Shinobu and Joan.

Let's see the hands for people who have round one clarifying questions. We will start over here.

MR. BERTKO: For Shinobu, the comparison on the generics you have perhaps isn't too useful because it reflects a different mix of drugs. Is it possible for you to go through the data and pull out the drug classes that only have generic equivalents and then have that comparison, which would be perhaps a little bit more useful in determining strategies and such?

MS. SUZUKI: I think that's the direction that we

could go if the Commission is interested.

MR. BERTKO: I would say this certainly was something that we looked at at a regular basis as a Part D plan, because otherwise you don't know exactly what -- and it shouldn't be overly difficult with the information and the PDE.

DR. DEAN: This is very interesting and somewhat troubling. I was concerned, too, about the generic prescribing rate and it seemed like in some of those categories -- I understand the antipsychotics and the antivirals. There, it is a very confusing situation. But certainly the anti-hyperlipidemic drugs and the peptic ulcer drugs and the anti-hypertensive drugs, there is a wide range of generics available there. And I wonder, do these programs have any criteria that say you need to try a generic first? I mean, some insurance companies certainly do that.

MS. SUZUKI: So, yes, that is another area I think we could investigate further, to see if it is the plan benefit -- the formulary design that is affecting the generic dispensing rate.

MR. BUTLER: On Slide 5, at the risk of

oversimplifying here, but wee if I understand this right. Total spending per enrollee per month, $300 versus $156. If you were to say the health status of these enrollees, LIS and non-LIS, are the same --

MR. BERTKO: [Off microphone.] They are not.

MR. BUTLER: I am just saying, if you were to say they were the same, which you say they are not, and you were to move up to the $32.9 billion spent on the LIS, if it had been at the same rate, it is like half the spending that would currently -- it is, like, a $16 billion difference, is that right?

So if you were to say that the 156 were the spending rate that LIS was incurring, not just the non-LIS, you would have, like, $16 billion less spending than you currently do. Granted, there is a huge qualifier in this, the health status of the -- it just kind of points out understanding that dimension, I think.

And if I understand it right, the price per prescription is a bigger explanatory variable than the number of prescriptions, but each contribute to that difference.

MS. SUZUKI: Mm-hmm.

MR. BUTLER: Okay.

DR. MILSTEIN: Does MedPAC have available tools in evaluating per capita drug spending to so-called illness adjust so we have a sense, given how sick the population is, given the distribution, do we have a tool that would allow us to essentially -- I have two questions. That is question one. Do we have a tool that would allow us to evaluate per capita spending on a risk-adjusted, i.e., adjusted for illness mix and severity?

MS. SUZUKI: We do have Part D risk scores and also medical, sort of chronic condition warehouse-type indicators for conditions. It is possible to look at claims information, although that would be a more complicated thing to do.

DR. MILSTEIN: My second -- in terms of following on on John's line of thinking --

MR. BERTKO: But can I add to that, just reminding everybody that the risk adjustment that Shinobu refers to is the one that comes from A/B scores and doesn't reflect D. So in some ways, as we heard last December, it is a bit inadequate and outdated.

DR. MILSTEIN: I guess what I am asking is, do we

have a tool that is specifically designed to adjust per capita RX spending for risk factors that would be likely to affect RX spending as opposed to A/B spending? That is my first question. We do or we don't?

MS. SUZUKI: I guess there is -- my understanding is that RxHCC is really used for payment adjustment and it is not intended to capture all the variations in spending that may occur. So in that sense, if you are talking about predicting the drug spending and use perfectly, that is -- RxHCC may not give you what you want. But at the same time, it is something that is used for payment adjustment and it is a proxy in some ways for medical -- or the diagnosis that leads to higher drug spending.

DR. MILSTEIN: Am I correct that you did apply that in these comparisons?

MS. SUZUKI: These numbers are not adjusted, but the tables you have for review will have average risk scores by different groups.

DR. MILSTEIN: Okay. That is my first question.

My second question is, again, is it pure -- is that patients who are being treated at centers that treat disproportional shares of low-income beneficiaries are

eligible for what is called 340(b), you know, advantaged pricing. Do we have any way of -- does that apply if someone has Medicare RX insurance, and if so, do we have a way of reflecting it in our comparisons?

DR. SOKOLOVSKY: We certainly heard in our focus groups that beneficiaries were, upon occasion, getting their drugs from clearly what were 340(b) institutions. I do not believe -- and this was, again, why it was so difficult for them to say how much -- what was paying for their drugs. I do not believe that if they were using their drug card, I don't know that that would reflect the 340(b) price.

DR. MARK MILLER: Can I just follow up on that? In the data that you have using the -- that you are reporting out, if somebody went and got their drugs that way, it wouldn't be reflected in that data. And if you need to think on this, we can regroup offline and answer that. But just to understand what is going on in the data, I had that thought in my head, too.

MS. SUZUKI: I don't think that the 340(b) prices would be reflected. It would be -- the data we have are payments to pharmacies, and 340(b) prices are for entities, very specific entities that qualify for that program, I

think, something like FQHCs or --

DR. MILSTEIN: I guess my question is, do any of the entities that participate in the 340(b) program also participate in the Part D drug program as dispensing pharmacies, and if so -- you don't have to answer this on the spot, it is for a future report -- and how might we bring this into these comparisons and other analyses so that we can hold that source of variation to the side.

DR. STUART: [Off microphone.] There is an answer to this, and that is that to the extent that that information is communicated to the health plan, then it can be counted toward troop, but that wouldn't affect the LIS side. It would be the non-LIS side. So that is how it would have to come in. It would not be part of the PDE data.

DR. CHERNEW: The question I -- I'm sorry. You weren't answering --

MR. HACKBARTH: [Off microphone.] No. I just was -- go ahead.

DR. CHERNEW: No. I was just going to ask -

MR. HACKBARTH: [Off microphone.]

DR. KANE: So on page seven of the paper, you talk

about -- well, actually, you mention it, too, that it is a $1 copay for both generic and preferred multiple sources for the LIS people. What was the theory behind having that copayment be the same, whereas it jumps up to $2.15 for nonpreferred? But why is the copay the same for generic and preferred brand?

DR. SOKOLOVSKY: I don't know that we can necessarily give the thought, except that many of the preferred brands may not have a generic substitute and the goal was to make the drugs affordable for the LIS population.

DR. KANE: So what -- okay. The reason I am asking that question is someone from a drug plan came up to me and said that having them the same means a lot of people are going for the brand rather than generic, and you could just make it $1.50 and you would make a huge difference. I don't know -- that is just a totally unsubstantiated -

MR. BERTKO: I believe Joan's answer is exactly right. It was a policy choice back when the law was written.

DR. MARK MILLER: Just to draw this together, I think what Shinobu and Joan were saying at the end of the

presentation is the patterns of these data suggest at least three policy areas to look at. What are we doing with cost sharing, even for the LIS population, and I am not saying we are going to go in that direction, but that is the kind of question. What are the plans doing and what tools are available to them, because they also should have a stake in focusing on it. And then the third thing is -- now I have forgotten, but -

DR. SOKOLOVSKY: Health status.

DR. MARK MILLER: What was it?

DR. SOKOLOVSKY: Health status.

DR. MARK MILLER: Health status, that was it, this line. [Off microphone.] I think those things -

MR. HACKBARTH: Bruce?

DR. STUART: I have an answer and then a question. The answer is that these are due to differences in health status. There is no question about that. And once you control for that, you are going to find a lot greater uniformity, at least in the utilization rates. Whether you have the same uniformity in spending rates is another issue.

The question, however, is LIS is really a collection of programs. It is not a single program. It

includes duals that have been around forever. It includes people who -- most of the LIS population are people who came in under the basic plan, but then there are levels above that. And I am certainly not asking you to completely disaggregate that, because I think that probably obfuscates rather than helps.

But there is one thing that is really important here, and that is that even in 2007 -- now, this was the second year of the program -- the people that came in through the dual auto-enrollment route, for the most part, were long-time users. They know the system. Part D is a little bit different, but not a whole lot different. There wasn't as much change as people thought that there might be. And so the patterns of utilization and patterns of spending are going to be driven largely by that.

The newer LIS, the ones that came in for the first time that were not Medicaid entitled and just were starting up, whether it was in January of 2006 or whether they came in in 2007, they were learning the system. And I can tell you from earlier experience, looking at a brand new public program in Pennsylvania, that the people who start on a new program who didn't have coverage beforehand, it takes time

for them to get used to it. We found that it took almost two years for people to get up to some kind of plateau in terms of their utilization rates.

And so you might want to think about that in terms of the comparisons. But at the very least, you want to separate out the duals from the non-dual LIS.

DR. CHERNEW: I followed the questions along this line, but I haven't yet gotten exactly the answer. What actual data elements do you have? In particular, do you know what Part D plan the person is in and do you know what medical conditions they have from other claims data, or do you only know what is in the Part D data? So could you identify people with diabetes or people with heart disease, or is that only possible through the medications they are taking?

MS. SUZUKI: For this analysis, the data we looked at are mainly Part D claims information. We do have other files that are currently not linked to the Part D PDE data that would have, say, if someone had diabetes in the past year through medical claims.

DR. CHERNEW: And those are linked? You have them, but they are not linked, but they are linkable?

MS. SUZUKI: Right.

DR. CHERNEW: And the Part D data you have does have the plan that the person is in? You know that they are in -

MS. SUZUKI: Yes.

DR. CHERNEW: Not just the company, like Humana, but the -

MS. SUZUKI: The actual plan enrollment information.

MS. HANSEN: Thank you. First of all, I just appreciate that this is the first report of this level of detail that we have had a chance to have.

My question is probably more on the focus groups, and I know that the sample was such that these were high users. Was there any representative sample on older beneficiaries, because I see that the younger Medicare beneficiaries, or the non-Medicare-aged beneficiaries -- the young disabled who are represented. Was there some representation of the older population?

And then a second quick question that just triggered the question that Arnie asked about one set of programs. But the out-of-pocket going to Wal-Mart

phenomenon is a newer phenomenon. I don't know that we could capture any of that. Do you have any thought on it?

DR. SOKOLOVSKY: First, to your first question, in terms of the older old, I would say that even for the over-65 population, it was geared younger rather than older. I don't think we could say -- it varies from year to year, but my impression -- at some time, we will have it actually collated, but my impression is that they geared younger this time.

In terms of your second question -

MS. HANSEN: Could I just ask on the data set, then, again, with that data set, is that able to be sorted out by age, as well, across with comorbidity?

MS. SUZUKI: Yes. Again, so it is linkable to a file that has chronic condition information.

DR. SOKOLOVSKY: Now I am blanking out on your second question -- oh, the Wal-Mart issue. That won't be captured in claims data. That is the very reason why they are using it, so -- and that is one of the things that we hope the focus group adds, because it is not in the claims, but how much it is, we can't say.

DR. CASTELLANOS: Good job, Joan. One of the

things I really like about it is the focus groups, because it gives you real world experiences. That is where I live.

You mentioned that you went to them and talked about their experience with the drug program, but you also mentioned you asked them about access to care. Now, I know that is a little different than your main emphasis here, but we have two really distinct groups of patients, and I was wondering, if you don't have that, if you could get me that information on their access to care. You mentioned you had asked them that.

DR. SOKOLOVSKY: I didn't want to kind of scoop, but we will have a full presentation on that issue later.

DR. CASTELLANOS: Thank you.

MR. GEORGE MILLER: Yes. On your Slide 3, dealing with the 38 percent of Part D enrollees account for 82 percent of the total drug spend, were you able to break down the characteristics of those 38 percent and why they spent so much? Is it because they may have had a higher concentration of high-end drugs, chemotherapy or HIV and that type of thing, or do you know what the characteristics are and why they had such a high spend?

MS. SUZUKI: So we haven't looked at the

characteristics of the drugs used by beneficiaries in each band -

MR. GEORGE MILLER: Have not?

MS. SUZUKI: Right.

MR. GEORGE MILLER: Okay. Have not. Is that something you may do in the future? Let me rephrase the question. Would that give us information that we can use in the future to determine why that large disparity in spend by such a small population?

DR. SOKOLOVSKY: One of the things that we did last year when we were looking at biologics -

MR. GEORGE MILLER: Right.

DR. SOKOLOVSKY: -- was to, in fact, look at LIS, non-LIS -

MR. GEORGE MILLER: Right.

DR. SOKOLOVSKY: -- and those were, for example, for MS, very highly skewed towards LIS.

MR. GEORGE MILLER: Okay. Okay. And just a quick follow-up. Do you know what percentage of people reach the catastrophic benefit? That is Slide 15, but it is just a question. You said non-LIS would not reach the catastrophic. Just overall, do you know what percentage

have reached the -

MS. SUZUKI: We had 2.3 million, and of those, the majority, I think 1.9, were LIS. That leaves around -

MR. GEORGE MILLER: Just curious. Thank you.

MR. HACKBARTH: Karen, did you have -- okay. Round two comments. Let me see. Let us start with Herb.

MR. KUHN: Thank you both for the presentation. I guess my initial take-away here is we have got a real issue of price sensitivity, particularly with the LIS community, as we think about this.

On a go-forward basis, as we want to begin to think potentially down the road about possible policy and perhaps even targeting resources in that area, I think your one notion that you already mentioned in terms of really looking at plan design is important, particularly looking at tiering and step therapy that might be part of those particular plans will be very helpful to know about.

But the other part that would be helpful to hear, as you kind of ticked off the various other research areas, it would be nice to get more granular in the data to kind of see where these individuals are. Are they institutionalized, that is, are they in long-term care

facilities? So I think if they are in long-term care facilities, that will give us a much better idea if we need to target policies in those areas that could get results that might be helpful in the program as we go forward.

And then, finally, what would be interesting to see in the future in terms of additional data runs here, if it is possible, is to kind of see if we have cost and utilization variation across the country. I think there is a hypothesis out there that we have kind of nationalized costs in terms of drugs, and that would be interesting if we could validate that as part of this process, too.

MR. BERTKO: Kind of a combination of observation and further question. I think, kind of following on George's question here, you may need to separate out the disabled populations from the elderly population, because I think there are really two different questions there, elderly LIS versus non-LIS elderly, and then the disabled. I think you have carefully told us several times that the disableds are disabled because they are really sick for a variety of reasons.

The second question or observation is for Joan on the switch to generics end of it. The question would be, in

2007, were people doing coping behavior early on, that is, did they switch to generics at the beginning of the year, or did they switch to generics when they hit the coverage gap? I think, in my mind, 2007, I am guessing, was still a learning year about the coverage gap and that a look at 2008 data might be useful if you can put your hands on that, if it is not too early for that.

DR. SOKOLOVSKY: To give you a very impressionistic response, and that seems to be what I specialize in anyway -

[Laughter.]

DR. SOKOLOVSKY: When we first did this, when the drug benefit first started, we heard a lot of talk about suspicion of generics from everybody we talked about, talked to. The non-LIS population, and again, not average beneficiaries. These are people with high drug utilization. These people hit the coverage gap not just this year, but mostly -- some of them were new, but most of them already had this pattern and they had switched to generics, were switching to generics, and in some cases, one woman was talking about the generic giving her a rash but she was going to stick to it at least until January because she just

couldn't afford it any other way. So even if they didn't like the generics, they had switched, and mostly they switched and said it was fine and I did not get the impression they planned -- if it was working for them -- to switch back.

I had a brilliant idea in our first -- in Baltimore, I was still hearing a lot of suspicion about generics among the LIS and I thought that was going to be a neat theme that would go through, but it didn't hold up, so I had to drop it.

DR. DEAN: Thank you. This is very interesting stuff. First of all, I would comment on the fact that so many of the people had difficulty identifying what plan they were in and so forth. That is completely consistent with my experience. I spent a large portion of my time trying to figure out what drugs people are actually taking, even though I was the one that prescribed them. It is a challenge. These are confusing names. People are on four, five, six, sometimes more. It is hard to keep track of it, and I think it just testifies to the fact that these are complicated regimens and we need to be -- and then when you throw in three or four different sources that they might get

them from and different payers and so forth, it gets to be a very complex undertaking.

Second of all is a question. Is there any data out there about what happens clinically to people when they hit the coverage gap? I know there was a study a while back when some of the Medicaid programs cut back -- I think it was on some of the antipsychotic drugs -- and they showed there was clearly an increase in hospitalizations at that point. Has that been looked at at all, do you know?

DR. SOKOLOVSKY: I imagine that there are people out there right now trying to look at that, but I have not seen the results.

DR. DEAN: I guess I would also mention, you already answered this question for me, but I think it would be important, and I understand you are already beginning to do that, to look at the geographic breakdown of where these people are, because I suspect, I don't know, but I suspect there is a higher proportion of the LIS people in rural communities, and secondly, that it leads to an ongoing concern that I have had about access to pharmacy services in rural communities because we are seeing a steady decline -- you have heard this complaint before, but we really are

seeing a steady decline of pharmacies in small communities, especially small independent pharmacies, many of which are the sole providers in their communities, and we are losing them steadily and there is nobody going to take their place.

And so if that continues to happen, we are going to have to find some other mechanism to provide access to these services, because, for instance, if the pharmacy in my community, which I think is stable for the moment, but they keep telling me that it is a struggle, if they go out of business or decide not to continue, the next closest provider is about 50 miles away.

And Wal-Mart makes this even more complicated, Wal-Mart, Walgreen's, whoever, with their $4 policy, because more and more we see people that for chronic drugs are willing to do that to get their $4 prescriptions, and yet when they need something on an urgent basis, they need their antibiotics, they expect the local pharmacy to be there. Unfortunately, in all too many communities, that is not the case right now, and I think the prospects are even more worrisome for the future. I am not sure what the answer is, but I think it is something we need to watch.

DR. MARK MILLER: We are obviously shocked to hear

you say this, Tom.

[Laughter.]

DR. MARK MILLER: Two things I would draw your attention to. In the charts that we asked you guys to review that give you some more detailed cuts on the data, there is some breakout on pharmacy availability by geographic area of the country and specifically trying to look at this, so look at those, tell us what additional cuts you want us to get into.

And, Joan, it is always awkward to have these conversations in public, we are contemplating some work here, correct?

DR. SOKOLOVSKY: We actually have a project ongoing which I had told Tom about before the meeting -

DR. DEAN: [Off microphone.]

[Laughter.]

DR. SOKOLOVSKY: But as you see, it didn't work -- to look at, in fact, what is happening to access in rural areas.

DR. DEAN: [Off microphone.] -- I think it is an important topic.

DR. MARK MILLER: [Off microphone.] Well, I also

want to say that out loud -- out loud on the mike that we are aware of this and there is going to be some stuff that we are going to be able to bring forward on it.

MS. BEHROOZI: Just anecdotally, we had done focus groups among our beneficiaries in our plan because we noticed that among our home care workers, which is our lowest-wage cohort, who can access generics for free and preferred brands where there is no generic for free, and otherwise they have to pay the full difference, which can be quite a lot of money, not $2, not $15, it can be a lot more than that, we noticed that too many of them seemed to be paying that difference and we encountered a lot of distrust of generics and it really broke down rather specifically ethnically, I mean, like from certain islands in the Caribbean, we found more suspicion. Anyway, so I don't know if any of that is useful to you, but I am happy to share it with you and see if you see any of it recurring in your future work.

But one thing that I just wanted to draw attention to, I think I sort of mentioned it earlier, where you observed in the paper -- I am not sure it came out quite as strongly in the presentation -- that people's confusion

about the premiums they were paying, not just what plan they are on, but what they are paying and what they are paying for and what is all included in the package kind of thing, you observed that this would make it difficult for an individual to shop for the most cost-effective plan choice, and I just want to emphasize that and help us all remember that as we are talking about people making choices and plan designs being different and cost sharing being different.

In many cases, people are not really making choices, and the fact that they might stay with a plan, I think that is something that Rachel's research showed, that a lot more people stayed with plans than you might have anticipated. We shouldn't assume that there is too much choice going on there, but rather they don't have to make a choice. That is a better thing. So I think that is a really important observation, and to the extent that future work can kind of dig under that a little more, that would be great if it could.

DR. MILSTEIN: Quickly, I guess this is a little bit more round one than round two, but so much of what we talk about is the beneficiary's involvement with choice, whether it is picking supplemental health or benefit

redesign options or Part D coverage or the things we are talking about here, and I have never quite gotten a good handle on the percentage of beneficiaries that are cognitively impaired and are in no position to exercise choice and what their profile looks like. It is a little bit like Herb's institutional status question to some extent because those folks tend to be in those kinds of settings more.

So do we have any sense -- and they are not in their focus groups, either, because you can't pull them in, yet they may be a pretty high explanatory variable of some of the expenditures that are going on in Medicare. So do we have any idea what the "N" might be for that population? I know over-85 age is roughly 50 percent Alzheimer's, and we hear statistics, but in terms of the beneficiary population overall -

DR. SOKOLOVSKY: Honestly, we do have those numbers and neither of us can recall them immediately. But one of the very kind of anomalous things out in the research now is when you look at people who are choosers, the highest percentage of people who are choosing voluntarily are in nursing homes, and we know they are not choosing, but those

count as the people who are choosers.

DR. MARK MILLER: [Off microphone.]

DR. CROSSON: For the record, he did make a choice to turn his microphone on.

You know, it seems to me from the presentation that we have at least a suspicion of two suboptimal situations in these two populations, one in the LIS population, perhaps less use of generics than would be possible or appropriate, and in the non-LIS population, suboptimal use of medications, at least on the part of some individuals. And when you look at the benefit structures that you listed out, the out-of-pocket costs, differentials, it is pretty easy to see why that might be.

So it would seem to me that if we do further work, and it sounds like there is a general consensus that we need more data to be sure we know what we are talking about, for example, if we are talking about the use of antiviral agents between the two populations, do we have an equal distribution of AIDS versus influenza or are we dealing with AIDS in one group and influenza in the other group? So it seems that we would need to know that.

And then, also, the question of when are we

talking about situations when generics are actually available and when are we talking about situations when they are not available? Something, we could sort that out, and we still see this difference or these two suboptimal situations persisting, then it seems to me that -- and I would support us doing some work on looking at the differential benefit designs and seeing whether there is perhaps some relatively modest changes that could be made, for example, to the LIS benefit that could result in some substantial improvements in the use of generics.

DR. KANE: To follow up on that, I think there is an aspect about copayments, for instance, that actually influences the relationship between the manufacturer and the plan in terms of the negotiation around the prices and rebates, so even -- and this is just something, again, following up on the rumor I heard that even a $1.50 or $1.75 copay on the multiple preferreds would encourage the manufacturers, the drug manufacturers, to offer a better price to the plans and the plans would care more about asking that than when the copay is the same and therefore there is no incentive to pick the generic.

So it would sound like a fairly complicated set of

decisions that got involved with this copay structure, and perhaps one recommendation might be to get a focus group of manufacturers and drug plan people together to sort of talk about that, because I am just going from a one-person conversation, but it did sound like it could be a meaningful amount of money if that is, in fact, the way people are actually behaving around the lack of a copay differential.

One minor thing. On the chart on page three, this one, it would be much more useful to me if the income breakdowns were based on where the coverage gaps started than the catastrophic gaps started. I just -- so it is like not quite corresponding, so you have got 61 percent under 2,000, but there are 67 percent who aren't under the coverage. It would just help to have the income breakdowns of where the coverage gaps occur so that you can sort of see more clearly what proportion of the population is hitting which part of the coverage.

And then the piece that I felt was -- we should talk about whether we could do this, and I don't know if you can or not, but it seems to me there is absolutely no quality metrics yet here and that we should be thinking about what might be doable with what we got. I have been

sort of the broken record about let's look at the drug benefit, but one might be, you know, the number of enrollees taking drugs that shouldn't be taken together. Is it possible to start looking at that yet? I don't know.

Number of enrollees taking less than 12 months of a prescription that they should be taking for 12 months if that's the condition they've got, maybe hypertension and hyperlipidemia, the kinds of things where they should be taking 12 months and they are only taking six or eight. Maybe even by condition for some important conditions to see what kind of the distribution of prescriptions are and how that might compare to, say, a VA person with the same condition, where we know they are in a much more controlled, integrated environment with quality standards and evidence-based protocol.

Are there any kind of quality metrics that we can start looking at and developing from what we have got now? Even knowing how unlinked it is to some of the other data files, that would be useful.

DR. SOKOLOVSKY: We have started looking into quality issues. I should say that yesterday, I was at an ARC research meeting specifically on pharmacy quality

metrics, and this is an ongoing, intensive effort, but they are really not there yet. I mean, even measures of adherence, the different quality groups measure them different ways. So there is a limit to how quickly we can go into that, but we are very interested in it and we have been approaching it in different ways.

MS. SUZUKI: Can I respond to Nancy? One thing, I just wanted to clarify, so this is gross drug spending, and the breakdown is pretty arbitrary. One thing is that even if you pick the standard benefit designs, dollar amounts for different parts of the benefit, we wouldn't actually be capturing the right number of people who hit the gap or who went above the catastrophic because it's a true concept to get the number of people who hit the gap or who hit the catastrophic limits, so someone with supplemental coverage that doesn't count toward the troop -

DR. KANE: That's okay, but I think just even whether or not they even have to pay out through the gap, how many people are hitting that dollar amount, whether or not they are going to be responsible for paying would be helpful. You have it in here as a number, 67 percent, but it is just -- that is 61 percent. It is just like there is

a little bit of inconsistency from the data.

DR. STUART: Let me pick up on a number of strands here. We have done a fair amount of work, actually, on LIS. It is for 2006, not 2007, and there are caveats associated with that. We looked at a group of people who have diabetes and used adherence rates with medications typically recommended for diabetes. Once we controlled for everything that we thought we could control for, it turns out that the LIS and non-LIS had virtually the same rates. We're not exactly sure why, because there clearly are differences in cost sharing, but just to share with you that that can be done.

To get back to a point that Jay said about cost sharing within LIS, actually, there is a natural experiment by the way that the LIS system is set up so that if you are in a nursing home, which is what Herb was talking about, you face a copayment of zero. Everything is free. Whatever is prescribed is free. And then it goes up gradually, up to $5 for brand name drugs. Now, it is a narrow range, but you can look at the eligibility criterion for which the person has LIS and then you will know what their copayment is. And if you control for other things, you should be able to gain

something from that comparison.

Picking up on a point that John raised about disabled, one suggestion I have here, and it sounds like it is a really technical one, but I wouldn't use the term "disabled." I would really use the term "SSDI," "Social Security Disability Insurance," and the reason that I say that is that because you have such a high proportion of SSDI enrollees who are in LIS -- in our diabetes study, 37 percent of all of our sample were under 65 -- but by the same token, a large percentage of the remainder were former SSDI. So it is not like they weren't disabled in a clinical sense. They were clearly disabled. They just lost that moniker because of the way administrative records for Medicare are kept. And if you look at that group of people who are older than 65 and were former SSDI, they look a lot more like SSI than they do other aged, and so that gives you some flavor of this.

And the final point, and this is a real frustration for anybody that is going to do work in this area, and that is that there is no mention here of whether people are in PDPs or in MA-PDs. If you're just looking at the drug side, you can compare MA-PD and you can compare

PDP. The problem is, on the PDP side, by definition, you have the A and B claims, and by definition, on the MA-PD side, you don't have the Part A and the Part D claims. So at least contemporaneously, it is impossible to risk adjust to make a comparison between MA-PD and PDP because you only have the information necessary to do the RxHCC or whatever risk adjustor you want to use because you simply don't have information on which there are diagnoses, let alone information to determine what their true risk is.

Now, there are ways of getting that information, because there are historical files, as you know. The Chronic Condition Warehouse actually has a file called the Chronic Condition Summary File which maintains a list of selected diagnoses -- and by the way, dementia and Alzheimer's is one of them -- a list of diagnoses for the first time that they show up in Medicare records. So if the individual was old enough, was in Medicare, started out in fee-for-service and then enrolled in an MA plan and stayed in an MA plan, at least you would have that historical indicator that they had Alzheimer's. The last time I looked, if you have it, you always have it. And so for some of these diseases, you will be able to identify cohorts of

former fee-for-service enrollees who are currently in MA plans. But you have got to be really pretty careful about those kinds of comparisons. But at least it is something that you could do with these data.

DR. CHERNEW: Thanks. I just want to add my voice to two points. The first one is I think it's absolutely imperative to control for clinical condition. I think the level of control even in the vast drug classes and disabled or not is way too crude and I think it's very likely, in the spirit of what Bruce said, that a lot of the things may go away if you don't control, and that's crucial if one begins to try and disentangle. It makes a big difference which of the three things in your slides is really going on for what one thinks one should do. So I think controlling for that is absolutely imperative.

The second thing is, I understand that macro measures of quality of care, if you are looking at plans, are still under development in a whole number of ways, but there is a vast literature which I think is pretty replicable where you could find conditions where we think people really should be adhering to these medications much the way Nancy said, that this is a condition, someone has

hypertension or someone has hypercholesterolemia, because you don't know -- when you see more or less use, you don't know if that is good or bad, and the reason you don't know, in part, is because it is both.

For some areas, when you see the low-income subsidy people using more, you think, oh, that is horrible. They aren't being charged anything. We need to charge them more to get them to use care more efficiently because they are doing this, that, or the other thing. In other cases, if you see the low-income subsidy people are using more, you think that is great because the cost sharing for the other people is pushing them away from taking drugs that are really high quality that we want to encourage.

And so I think it is really important to find examples, of which I think is feasible, to be able to draw some normative conclusion, because otherwise when we see the discrepancy, we are apt to not know whether or not the low-income subsidy people should be charged something to make them more efficient or we need to close the donut hole for the non-low-income subsidy people, both of which, I think -- and I hate to say this because it is such a pitch for my work -- both of which things like value-based insurance

would try and balance as opposed to making us choose something that is going to be bad in both one case or the other.

MS. HANSEN: Thanks. Let's see. First of all, we were talking earlier about, probably in our earlier sessions, about making sure that we weave race and diversity through different things, so I wonder if we could also identify some of our data according to that.

Secondly, the question of our ability -- we have talked about MTM in the past, too, and I don't know whether it is a way or whether it would be too gross of a manner to correspond the likelihood of using MTM relative to the data that we have with this population, because when you have so many people taking multiple meds, oftentimes, I know the trigger is a gray trigger, because different plans have different floors in which you use MTM. But any way to judge the possibility of using MTM in this process?

DR. SOKOLOVSKY: What we learned last year was not only do different plans define who can get MTM in very different ways, but then what they provide is equally different. And CMS is working on -- first, actually, for the first time, saying in the data who is getting it, which

we don't have now, but beginning to have plans report that, and they are beginning to look at what are the effects of different interventions on people. When that happens, I think it will be a really good tool, both in terms of improvement and also in terms of research ability. But we don't have that yet.

MS. HANSEN: Two final things. One is, of course, that the last part of your findings is troubling relative to marketing, you know, and how a lot of the -- some of the people you have talked to in the focus group are approached by salespeople to possibly switch and so forth. And this, of course, goes back, as I think you mentioned, back to 2007, where there are some real concerns about marketing. Is there any more work that can be done on that aspect to basically create more light on this issue?

DR. SOKOLOVSKY: I believe that CMS and the IG are working to kind of come up with standards that could be -- more enforcement, I should say. I mean, the standards are already in place. What they are doing is illegal to begin with. But I think they are working on ways to improve enforcement.

MS. HANSEN: Okay. And then final, just a

shameless pitch, as Mike was saying. You know, we found -- in the course of the past few months, we have offered free on our website at AARP.org a donut hole calculator that people have been using, and individuals have given direct testimony, with approval to say this, that within, like, a couple of hours, that you could really figure out what drugs you are, back it up into all the different plans, come up with the generics, and then have automatic letters generated to your physician. People have been saving several hundred dollars just in the course of doing that one activity and finding -- knowing much better how much time they save themselves from falling into the donut hole. So this is available. Especially that might be useful for the non-LIS population that would fall into the donut hole.

DR. CASTELLANOS: Just two observations. Can you do Slide 14, please? This is just an observation. This is not just limited to the LIS and non-LIS population. This occurs throughout every population, every age group throughout the United States, these strategies that people use for medications. And this is a real world problem.

I mean, you talked about Wal-Mart. We have Publix in our community that give out free antibiotics, generic

antibiotics in the State of Florida. And I saw a colleague out in the audience who is an ophthalmologist, and reminds me I saw a patient the other day coming in and wearing his wife's glasses. And I said, what the hell are you doing? He says, well, mine are broken and I can't afford any others. So, I mean, this is a real world problem of financing for drugs.

But more seriously, and it is really a point that Jennie just made about the unsolicited contacts, both in the health plans, the insurance agent, and I think Peter and Herb mentioned it in the nursing home. This is a real problem. People are forced, or unsolicited or solicited, perhaps they are not capable of understanding everything, to go into other plans, and that has repercussions as far as medications, reactions, loss of physicians, and losses of ability to care.

I think, as you said, they are looking into it. I hope it is a problem of enforcement, but maybe we just need stronger rules, and I think we should look into that and see how we can better protect this most vulnerable population.

MR. GEORGE MILLER: [Off microphone.] First, Jennie and Ron covered my -

MR. HACKBARTH: I have got one summary thought, and then I think Jay has some, as well.

During this conversation, as well as almost every previous conversation we have had about Part D, we keep coming back to the point that this portion of Medicare is uniquely designed to depend on the choices of Medicare beneficiaries to discipline the system, and yet every time we look at it, you have got to come away wondering how valid that premise is.

Joan, could you talk a little bit -- is there a plan to address that issue systematically going forward? This sort of statistical analysis is very helpful, but that is sort of the big policy elephant that is always in the Part D room. Can we, in fact, count on beneficiaries to make the choices that will drive this system the way, in theory, it is supposed to work?

DR. SOKOLOVSKY: I think, so far, what we have seen is that you can't -- so far. We have also wondered as that -- although premiums have been going up in dollar terms, they haven't been going up that much. It could be that people will be more sensitive when the differences are greater. We don't know that going forward.

In terms of our agenda, I would be anxious to know what you would like us to do on that issue. I don't think it is on our agenda right now.

DR. MARK MILLER: No, I think that is about right. In some ways, you almost get cross signals. You get -- you know, when we look at Rachel's stuff, you see that the premiums jump in significant terms and percentage, but not in dollar, as Joan said, and not a lot of movement. But then you go and you talk to the focus groups and the group that falls into the donut hole suddenly becomes very price sensitive and starts moving to generics. So you are really getting cross signals, at least based on what I can discern, and it is hard to tell at this point how it is going to play out. So I completely agree with you.

And I think in terms of the research strategy, I think there is sort of this -- and it is always a slow build and people are never satisfied as we go, but first understanding the D data and getting the right adjustment so that we can focus in on patterns which lead us down the road, linking in the A/B data and starting to sort of begin to see how things work across the two programs. But the notion of sort of testing -- and obviously many of the

things that Jennie has said about how you get the information out for the beneficiary to choose and that type of thing.

But as a specific agenda item on testing the beneficiary's ability to kind of choose across plans, I don't have a clear picture on how to approach that at the moment, which is not a no, but at least I don't have it at this point.

DR. SOKOLOVSKY: One thing I just want to add is although the beneficiaries that were in the donut hole were very price sensitive as far as drugs were concerned, we didn't hear a whole lot talking about, maybe I should find a different plan.

DR. CROSSON: Well, I just wanted to thank you, Shinobu and Joan, for bringing this forward, because I think, as you can see, there is a lot of interest here. My sense is that we didn't elaborate at this point a particular central issue that we wanted to debate further into round three, but that there was a lot of interest in having you come back and try to bring some more specifics to the analysis, particularly in the area of the issue of generic -- - where we are talking about generic availability, the

disease status between the two groups, institutional status, perhaps the question of MA-PD versus PDP plans, so that with you can we bore a little further into this and try to figure out whether we think there are substantial differences here that would then suggest that we try to work on some recommendations with respect to changing the -- or making recommendations for changing the benefits design. So I think if that seems to be the general consensus, that would be my thought.

MR. HACKBARTH: Any concluding thoughts from Commissioners before we move on to the next? Tom?

DR. DEAN: Just one comment on the generic prescribing rate. My concern was not so much the difference between the LIS and the non-LIS, it is how low those numbers are across the board, because in some of these categories, like especially the lipid-lowering drugs and the antihypertensive drugs, in my view, those numbers ought to be 90 percent in both categories. There really isn't a difference between -- even though they have other morbidities and other clinical conditions, especially in those conditions, those shouldn't vary between the two.

MR. HACKBARTH: Okay. Thank you very much. Good

job.

Next, we turn to measuring regional variation -

MR. ZABINSKI: Okay. Today Jeff, David, and I are going to discuss a topic that is of considerable variation to policymakers, that being regional variation in service use among Medicare beneficiaries.

Some key findings from our analysis include the following: first, that regional variation in service use is not equivalent to the variation in spending -- that is, the variation in service use is less extreme. Also, not only does service use vary by region, the rate of growth in service use does as well. But there is very little correlation between the regional level of service use and the rate of growth. For example, we find high growth in both the high-use and low-use regions. Therefore, policies that aim to make Medicare more sustainable should constrain both growth and variation in the service use levels.

Now, the first step in analyzing regional variation in Medicare service use, we first examined how Medicare per capita spending varies by region. In this diagram, we collected urban beneficiaries in the Metropolitan Statistical Areas, or MSAs, and the remaining

non-urban beneficiaries in the rest of state non-metro areas. The spending in each MSA and non-metro area is then weighted by the number of beneficiaries in each region.

To provide you with some orientation of this diagram, consider the very middle bar marked by "95 to 104." This bar indicates that about 23 percent of beneficiaries are in MSAs that have spending that is within 5 percent of the national average. The take-away point of this diagram is that there is very wide dispersion in spending across the MSAs. For example, per capita spending in the highest-cost MSA is 107 percent higher than the lowest-cost MSA.

The next step in our analysis was to address the spending in each MSA for regional differences in several factors, including input prices, such as the hospital wage index; beneficiary's health status as measured by risk score or CMS HCC risk adjustment model, which uses diagnoses to determine a beneficiary's expected cost. We also adjusted for special payments to providers, including IME, DSH, and GME payments that go to some hospitals; special payments that go to some rural hospitals; and HPSA and PSA bonuses that go to some physicians. Then, finally, we also adjusted for differences in the rate of Part A and Part B enrollment

between regions.

The result of these adjustments is a measure of service use that reflects regional differences in providers' practice patterns and care decisions. We are interested in this measure of service use because it lets you separate areas where the practice of medicine is more resource-intensive from those where it is less so. This allows policymakers to focus on factors that can help control program spending.

On this diagram, we show the distribution across MSAs and non-metro areas of the spending that we showed two slides ago and the service use that we discussed on the previous slide. As you can see, there is less variation in the service use measure than in the spending measure. For example, if you look at the middle bar, 95 to 104, this indicates that 41 percent of beneficiaries are in MSAs that have service use that is within 5 percent of the national average, but only 23 percent of beneficiaries are in MSAs that have spending that is within 5 percent of the national average.

A different way to think about this variation is that under the service use measured, the MSA at the 90th

percentile is about 30 percent higher than at the 10th percentile. But under the spending measure, the MSA at the 90th percentile is 55 percent higher than the MSA at the 10th percentile.

Two points we want to emphasize on this diagram are that both urban and rural areas fall in both the high-use part of the distribution and the low-use part. Also, there is substantial variation that remains in the service use measure; therefore, there is ample room to bring down service use in high-use areas. However, the regional differences are less dramatic than would be suggested by simply looking at raw spending.

On this slide, we show the average level of service use relative to the national average over 2004 to 2007 for seven MSAs in the first column of numbers. The second column shows the MSAs' average annual growth in service use relative to the national average from 2000 to 2006. The key take-away point from these first two rows or columns is that MSAs with low relative service use can have high relative growth rates, such as MSA-C; and MSAs with high relative service use can have low relative growth rates, such as MSA-F. Indeed, looking at all MSAs, we find

a negative correlation between beginning level of service use and the rate of growth.

The final column of numbers in this diagram shows the relative expected per capita increase, which is simply the product of the level of the service use in the first column and the annual growth rate in the second column. This last column of numbers reflects the expected annual increase in service use for each MSA. As you can see, some high-use MSAs have lower expected increases than some low-use MSAs. For example, once again MSA-C has low service use, but high expected increase in spending, while MSA-F has a high service use but a low expected increase. This result suggests that to control future spending growth, we need to address both the level of service use and the growth rate.

I'll turn things to Jeff, who will discuss some unusual factors that affect service use in outlier regions and also discuss the method and data issues that we ran across.

DR. STENSLAND: All right. Dan just showed you a graphic of the relative service use, and he emphasized looking at the difference in service use from the 10th percentile to the 90th percentile, and this was roughly a

30-percent difference in utilization, which is substantial. He did not emphasize the extreme outliers.

In the lowest category of service use, there are only Hawaii providers. In the highest category, there was only Miami. Service use in Hawaii is under 75 percent of the average, and Miami reported service use as over 135 percent of the average, and there is no other large MSA that is close. I will just talk for a couple of minutes as to why we focus on the 10th and the 90th percentile and not the outliers.

The low rates of service use in Hawaii, which include low use of hospitals, SNFs, home health, and hospice, may reflect some characteristics unique to Hawaii that result in low use of institutional care. In contrast, reported service use in Miami was more than 10 percent higher than any other large MSA, and the OIG, the Office of the Inspector General, has raised concerns that some of this high level of reported service use may be some abuse in the system.

In the green bar, we show 2006 DME and home health spending in Dade County, where Miami is located. Reported spending was over 500 percent of the national average for

both services. Now, note that spending in Dade County is also dramatically higher than in the three neighboring South Florida counties, and this suggests there are differences within South Florida, and there are probably great differences among providers within Dade County.

The Office of the Inspector General is aware of this high level of billing for DME and home health, so this is nothing new. In December 2006, the OIG has a contractor visit 1,472 South Florida DME providers. After the visits, 634, or 43 percent of those visited, had their billing numbers revoked.

The point of showing this data on outliers is to explain why we are focusing on the roughly 30 percent difference between the 10th and the 90 percentile. That is because the types of policy innovations we talk about -- improving care coordination or a movement toward evidence-based medicine -- may help move that 90th percentile down toward the 10th percentile. But the data we see in the two outliers in the distribution of service use may be driven by factors other than how care is delivered or organized.

Now, there are several methodological choices that must made when evaluating regional variation. For example,

we are looking at risk-adjusted spending for the aged and disabled and allocating claims to regions based on where the beneficiary lives. Other researchers may choose some different methodologies.

The data we use is Medicare claims that have been aggregated to the county level by the CMS Office of the Actuary. Because our data is at the county level, we need a county-level risk adjuster; therefore, we use the average HCC score in the county, which is what CMS uses to predict the costliness of individual beneficiaries. There are certainly other methods of risk-adjusting, and certainly the different methods of risk-adjusting are open for debate. I also want to stress that the results we have here are preliminary, and there is always room for further refinements.

One question that has been raised is whether the regional variation for Medicare beneficiaries is consistent with regional variation for the privately insured. In a 2008 article by Baker, Fisher, and Wennberg, they did find a positive correlation between Medicare regional variation and privately insured regional variation, and we have looked at some of the data comparing GAO data on the privately insured

folks that are Federal employees and our own regional variation data for Medicare, and we also see a moderate positive correlation. And the general message is that there does seem to be some factors, either common amongst the beneficiaries or common amongst the provider systems, that affect both the privately insured and the Medicare beneficiaries. So, to some degree, you have these things moving together, but they're not moving in perfect tandem. The correlation is not particularly high.

So, in summary, there are just a few key points to remember. First, service use varies less than variation in raw spending, but substantial variation in service use exists. And there are some high-use areas that have low growth rates and some low-use areas that have high growth rates. And while the methodological issues we discussed do affect the magnitude of the regional variation, I think it is important to note that there is a general agreement that regional variation exists, and it is not fully explained by prices or patient health. There is also a general agreement across the studies that the rate of growth in Medicare spending across the country is too high. So while there is some difference on methodology, I don't want us to forget

the points where there is some general agreement.

Now it is open for discussion.

MR. HACKBARTH: Okay. Can I see hands for first round clarifying questions? Ron and then Jennie.

DR. CASTELLANOS: If you could just tell me again, I don't remember what the HCC CMS risk factors are. Could you just enlighten me?

DR. ZABINSKI: Well, it's a risk-adjusted model. It generally uses diagnoses from the previous years to predict current year expenditures. It also includes some demographic variables such as age, sex, Medicaid status, and a few other things.

DR. CASTELLANOS: Does it include socioeconomic, body weight, body mass?

DR. ZABINSKI: No.

MS. HANSEN: On Slide 4 and in the text, I was just -- adjust for spending differences, the last little bullet says Part A and Part B enrollment. Apparently, according to the text that we have here, sometimes in different parts of the regions the Part A or Part B coverage differs significantly from the national average. Could you just explain what may lead to that, these major differences?

DR. ZABINSKI: Well, let's see. I think part of it might be due to immigration rates, people who, say, just immigrated and weren't paying Part A, you know, the payroll taxes, throughout their working lives. They immigrate here and, you know, then they become Part A only. Part B.

DR. BERENSON: Have you had a chance to look in your research at how your methodologically altered prices, essentially service use variation, compares to the Dartmouth Atlas geographic areas? You said that there are some high service use rural areas, et cetera. I assume there are some variations. Have you looked at it?

DR. STENSLAND: We haven't done a formal analysis, but essentially what you're going to see that happens is once you adjust for prices, the coasts don't look as high as they do before you adjust for prices. So there are going to be places out in California along the coast that have very high wages, and maybe if you just look at the raw spending numbers, it's going to look very high. But once you adjust for prices, they're not getting a lot of units of service. And so that will be some difference that would show up.

DR. BERENSON: But does Dartmouth do as good a risk adjuster as the HCC?

DR. STENSLAND: I don't think we can opine on what's the best risk adjust --

DR. BERENSON: Well, all right. But I mean --

DR. STENSLAND: There's lots of different Dartmouth analyses out there now. It's hard to -- you mean just on the raw one where they just do age, race, sex, that's one the website? That's one.

DR. BERENSON: That's the one that most people are looking at, I believe.

DR. ZABINSKI: You know, at times they use the -- you know, to control for health status, they use people in the last 6 months of life, that sort of thing.

DR. BERENSON: Okay.

DR. MARK MILLER: Jeff made a point when he was saying this, that certainly the risk adjustment methodologies were open to discussion, or something along those lines, and this links back to something that Bruce said earlier, which is when you look across the country, the HCC will in part be driven by -- is driven by diagnosis, and that may be driven in part by how frequently coding occurs for a diagnosis. We're trying to look at that right now.

DR. STUART: Well, there was one other thing, too,

and this may be just completely off the wall. Will local intermediary differences, coverage differences, have an effect here?

MR. GLASS: To the extent that this comes from claims data, I suppose that is possible. But I'm not sure how we would ever detect that.

MR. BERTKO: But, David, don't the MACs all process claims in virtually the same way? I know there are separate things in some relatively minor areas, but they process a cardiac claim the same way every place, I think.

MR. GLASS: I would think so. I mean, there are local coverage decisions, but I mean, other than that.

DR. CROSSON: I just want to continue the pattern recognition MedPAC Rorschach test that Bob started. You know, in addition to the pattern change that you saw when you adjusted where you created service use patterns versus actual costs, when you look at the different patterns between absolute service use and growth rate, is there any obvious pattern that jumps out, or does it appear to be just a random scattershot?

DR. ZABINSKI: Let's see. One pattern I notice is for some reason the Bay area, central California -

DR. CROSSON: Just for coincidence.

DR. ZABINSKI: No, seriously. This is the first -- I didn't even think of you being from the Bay area.

[Laughter.]

DR. ZABINSKI: But, you know, central California, not just the Bay area but even central California, like Stockton and so forth, they started out with their spending, they were sort of lower than average, and they moved down to fairly low levels on service use. That was one that sort of struck me, but I don't know. It largely --

DR. CROSSON: well, not to step into it, but what about when you look at growth rate. What I'm saying, is there anything that sort of jumps out at you when you say here is the pattern we see with absolute spending, now here is the map of the United States when we look at growth rate. You said that they're not superimposable, but is there anything obvious from the two different patterns? Or does it just appear to be --

DR. STENSLAND: There's nothing dramatic, but there is a negative correlation. So for the ones that are lower, you generally see a little higher growth rate. And it's not always the case, but there is a little bit of a

negative correlation there?

DR. CHERNEW: Can I say something [off microphone]? Because we actually have a paper on exactly this point that is under review. If you look at the map, you'll see regions that are -- it's not really completely random. You'll see regions that move one way or another. But there are very few variables that predict one -- income, for example, is a variable that predicts higher spending and higher growth, but there are very few variables like that, including if you look at a whole bunch of health status variables like obesity rates from the BRFSS or other things. It's remarkably hard to find variables that look like they predict both and find a really meaningful pattern.

DR. CROSSON: Excuse me, but what I was hearing, I thought what I was hearing in Dan saying was that maybe what we're dealing with is a negative correlation which suggests something like reversion to the mean. Is that --

DR. CHERNEW: Yes, but it is much -- there is some of that, but it's not a huge -- if you look and say, oh, you're high, you're going to be low, you'll find some that are high and grow faster and others that are --

DR. MARK MILLER: To put that a little bit

differently, I don't want to overstate that negative correlation. That's a relatively small value.

DR. CHERNEW: Right

DR. MARK MILLER: I think it's important because people's intuition might be, oh, high and growing fast. That intuition is not necessarily correct, but I don't want to make this strong statement or people to walk away with a strong statement that these are opposite trends.

DR. CHERNEW: And most of the cities that you see that look good if you listen to the news in terms of levels are cities that don't look good if you look in terms of growth rate. If you were listen to the news, people say, "Oh, this is a great place," at least in the data we have, we looked at the ones we saw in the press, and we didn't see them looking good.

DR. STUART: You mean Lake Wobegon is not --

DR. CHERNEW: That's what we found.

DR. MILSTEIN: Just to help move things along, I have prepared three short-answer questions.

First, is it feasible to adjust these for incidence of Med Sup since we know that's such a powerful driver of service use? Is there even a way of doing that?

That's the first question.

MR. GLASS: I think Med Sup, basically the knowledge of it comes from the Medicare beneficiary survey. Is that correct, Dan?

DR. ZABINSKI: Yeah.

MR. GLASS: Yeah, and that doesn't do so well for small areas.

DR. MILSTEIN: Okay. Thank you.

The second question is: One of the statistics, I think, you know, if you look at our transcripts, that really sticks in our mind is this question of, you know, order of magnitude, by how much would Medicare spending go down if the average Medicare spending kind of emulated the spending of the lowest spending decile? That was, you know, based on something that was planted in a lot of our brains early on because it was in a paper. And so have we had a chance to model that yet so we can know -- because I know the prior number was like 29 percent, and then more recently it has been updated by the Dartmouth team to about 20 percent. Now that you have applied these additional refinements, you know, unit price neutralized, et cetera, what is the -- you mentioned 90th versus 10th percentile. What if the median

moved to the lowest spending decile? What's the nature of the -- by how much would Medicare spending go down? Do we know that yet?

DR. MARK MILLER: We can do the arithmetic on this.

DR. MILSTEIN: Okay.

DR. MARK MILLER: And, you know, come back to you and talk to you about it. You know, one of the take-aways from this is if you take raw data and adjust it at least for these factors, you get half the variation, you know, from 55 to about 30, between the 90th and the 10th.

In answering that question, though, some of it gets into one of the things that Jeff was trying to deal with at the end of the conversation. We talk about the extremes here. And is that a fair way to think about it?

And then, two, the reason that that particular number -- and the arithmetic is doable. It just takes a calculator. We can do it. But that statistic has gotten a lot of cachet. What it actually means is what I find difficult in sort of expressing the number. You know, because what policy will get you to that point is the much harder question.

So we can go through this exercise. We can respond to this request. But I also want us to talk about how that number gets used, because in some ways that number has driven a lot of conversations. But how you capture that I think is --

DR. MILSTEIN: I think the reason I bring it up is it does at least give the Commissioners a sense of the potential size of the opportunity. Then we can go on to the second question. Is there a feasible policy to go after it?

The third question is, you know, I think one of the things that was important to all of us in the prior iterations of this that weren't this well adjusted was that there appeared to be either no correlation or a positive correlation between low spending and available quality scores. And my question is simply: Do we intend, you know, in the next version of this analysis to have examined that? Or are we not planning to do that?

DR. ZABINSKI: Well, you know, we looked at that relationship the last time we did this, and we looked at the June 2003 report. But as far as -- you know, at that point in time, there was a readily usable quality measure at the geographic units we were using, and right now we're not

aware of one that really exists that has been updated. So I don't think it was really part of our plan.

DR. MARK MILLER: [Off microphone] she's not speaking to me anymore, but, you know, I think we need to have a hard conversation -- I mean, what Dan is saying is we need to have a hard conversation about what the measure is, and we were not comfortable at this point sort of throwing one up and putting it out -- at this point, anyway.

MR. BUTLER: I'm trying to get to the sound bite that is a little crisper or easier to say that the 10th to the 90th has gone from 55 down to 30. What exactly is the percentage of variation that can be explained by service use versus non-service use? Do you simply take the difference between the -- going from 55 down to 30? What would be the -- can you answer that?

DR. ZABINSKI: Well, as any number -- I mean --

MR. BUTLER: Because I think that's what ultimately gets reported. You won't get all these, well, the difference between the 10th and the 90th is this and now it's this. Somebody will interpret this quickly and say how much variation is explained by service use versus other factors.

DR. ZABINSKI: I would say there's a lot of ways you can measure variation. If you want to go with straight mathematics, standard deviation. Standard deviation goes down by about 40 percent when we go from the raw spending number down to the service use number.

MR. HACKBARTH: I'm confused by your question. So this is a measure of the variation in service use.

MR. BUTLER: Right

MR. HACKBARTH: You're using the term explained by service use.

MR. BUTLER: We're trying to adjust for the raw spending, right? Do the variation in raw spending.

MR. HACKBARTH: Yeah.

MR. BUTLER: And say what is the explanation for the variation in raw spending, and so when we adjust for prices, when we adjust for some health status, when you adjust for GME or DSH and IME, et cetera, you've eliminated some of the variation in the raw spending.

MR. HACKBARTH: Right

MR. BUTLER: How much? What percentage of that variation is, therefore, reduced by adjusting for these factors?

MR. HACKBARTH: I see. So -

MR. BUTLER: Is there a single number? So that you can say, you know, Dartmouth is saying this but it's really only this?

MR. HACKBARTH: So what we've tried to do is develop a measure of variation in service use.

MR. BUTLER: Right.

MR. HACKBARTH: As opposed to a measure of variation in spending.

MR. BUTLER: I understand.

DR. MARK MILLER: The way I would try to have this conversation, because there is this real desire throughout to say, "Oh, then what does this mean relative to Dartmouth." And I think part of the reason that they have -- you know, they and I are going to have a hard time explaining or speaking to that is they are -- whether, you know, we're aware of it or not, there's multiple Dartmouth analyses out there which adjust for different things. First point.

The second point is if you want to make a statement about the change in variation, probably the closest we can get to it is Dan, which is saying using our

data before and after you adjust it, this is what we've found. And we can have some degree -- well, we have confidence in that statement, but I would not want people to say, "Oh, so that's different than Dartmouth because that may be running off of a different metric," if you see what I'm saying. And so I want to be careful about the use --

MR. BUTLER: Right. That's what I'm trying to get at, too, the messaging --

DR. MARK MILLER: I kind of thought you were.

MR. BUTLER: And, obviously, I'm not.

DR. MARK MILLER: And among our own data we can say, you know, you reduce the variation, standard deviation by 40 percent when you adjust for these three things. But if someone were to go off and say, "Oh, and, therefore, that means relative to Dartmouth," we would not have the sentences to fill that in.

MR. BUTLER: Right.

DR. MARK MILLER: Because you may be looking at a data set that's partially adjusted for some things but not others.

MR. BUTLER: I'm happy to leave Dartmouth aside and said we explain 40 percent by accounting for these

things.

DR. MARK MILLER: You guys all right with that?

MR. BUTLER: And if it is the 40 percent number --

DR. ZABINSKI: Yeah.

DR. MARK MILLER: That's what I thought.

MR. BUTLER: -- or whatever the number is, that would help.

The other question is around the 10th and the 90th. I want to be a little clearer, because somebody said, "Oh, that's just Dade County," or "That's just Miami," and they're the only ones in the last 10th. Is that right?

DR. ZABINSKI: No.

MR. BUTLER: Because, by definition, you've got a 10th.

MR. BERTKO: [Off microphone] they're the [inaudible]

MR. BUTLER: Exactly. So a little bit -- and this is more of a comment than a concern -- is we throw this out and say, "You see, this is why we exclude them." And the rest of the world is going to say, "Wait a minute. I want to know to the extent that that's occurring in the 10th to 90th percentile to some degree, as an explanation of what's

happening on service use." So by excluding them and saying don't pay attention to them, you're almost inviting just the opposite to occur.

DR. MARK MILLER: Would you say that again [inaudible]?

MR. BUTLER: Okay. If this is the kind of stuff that we're going to show and we're going to say leave out Dade County because -- don't focus on them too much because they've got this fraud and abuse issue, and $5,000 of their per capita spending is explained by these two things, so it's not like everything else that is occurring in the rest of the world. I think just the opposite may occur.

DR. MARK MILLER: Okay. The first thing I want to -- I'm sorry this is taking so much time. The first thing I want to make sure we're getting the message across -- and it doesn't sound like we did, so I really want to use this as a pivot point.

In a sense, what we're doing with the 10th and the 90th is trying to say let's be cautious in how we interpret the degree of variation. But, you know, in Miami, we fully think that part of what you see in Miami is the basic variation in practice patterns that could be addressed by

some of the policies this Commission hopefully is trying to push out onto the world. It was definitely not, "Oh, just ignore Miami." What we're trying to say is there may be additional factors beyond practice patterns that drive an area even beyond what -- you know, out to the extreme, and that fraud, bluntly, may be part of that story. And if that message isn't coming across to you --

MR. BUTLER: I think we would like to think that there is a lot of evidence-based medicine that is not being practiced appropriately that could reduce variation in service use as a Commission. This invites me -- because of all those things I read, that thing just jumped at me. It almost says -- and I'm going to go look at all the other components of the service, like Gawande articulates, and see if there's patterns of abuse or misuse based on economics as opposed to just not applying good evidence-based medicine.

I don't know if I'm saying it well.

DR. STUART: But there is a mathematical anomaly here that you guys probably have adjusted, and that is that there are zeroes here. And, by definition, all of the zeroes are going to be in the 10th percentile. And I can tell you from some experience that zeroes tend to be

persistent. In other words, you've got people that are here that are not using, and it may just be a statistical artifact that some of the people that are in your analysis are Medicare secondary payers, and, you know, they're working elderly and they're in there on the eligibility side, but they're not using any services.

So the 10th percentile I think actually may not be what you want to use. Or, to put it another way, you might want to exclude the zeroes and then recast it toward people that are actually using the system, because it's pretty hard to talk about whether the system is doing a good job or not for people who are persistent non-users.

MR. HACKBARTH: I think we're confusing things here. This is a distribution not of individual expenditures. This is a distribution of MSAs.

DR. STENSLAND: It's MSAs weighted by the number of people in MSAs.

MR. HACKBARTH: Right.

DR. STENSLAND: So there are no zeroes in that chart.

MR. HACKBARTH: Right. [Off microphone] Any clarifying questions?

DR. DEAN: You may have already answered this and I missed it, but on Slide 6, could you repeat again how we got to an expected rate of increase?

DR. ZABINSKI: It's just simply the product of the numbers in the first two columns. So for MSA-A, it's the 0.73 times 1.09.

DR. MARK MILLER: Conceptually, what's going on, Tom, is the way to think about that last column is this: If I'm a high-level and a high-growth area, I'm contributing more to growth in utilization than an area that is the exact opposite -- low-level/low-growth. And then what we're trying to illustrate with this chart is you can get the combinations in between -- low-level/high-growth, high-level/low-growth -- and how much they contribute will be a product of those two things. And that's what that last column is trying to capture.

DR. DEAN: Thank you.

MR. HACKBARTH: Other clarifying questions?

[No response.]

MR. HACKBARTH: Okay. Round two comments.

DR. BERENSON: Let me pick up on two things that have said.

One, I very much -- well, it's what Peter was talking about with his outliers. On the one hand, I take his point that we don't want to just sort of eliminate the outliers and say that's the IG's problem. In fact, I want us to think that we are worrying about waste, fraud, and abuse just as much as practice patterns or physician behavior.

In fact, in an article I wrote in 2003, I had McAllen, Texas, identified as -- in fact, they were spending as much on home health in 1998 as Miami is spending in your data here. And Atul's article, it was a terrific article, but I've always thought this kind of data could be used as much or maybe even initially for surveillance purposes of what's going on other there.

Another example I'll use is I retrospectively -- remember the Reading, California, case of the surgeon who was operating on healthy hearts? The 1998 Dartmouth Atlas had Reading, California, three standard deviations away from -- they were way out, and somebody could have been looking at that, and I hope the IG is. But I think it's something that CMS, if they had enough resources, should be actively doing themselves. So that's point number one, but I do

agree that we need -- I'm not sure that 90 to 10 works as well as some other metrics, 80 to 20 or reduction in the median or something like that.

The second point I wanted to get to was the discussion between Arnie and Mark, and your term was "size of opportunity." I think even if we don't know what precise policies will flow, I think it's important to sort of establish that there still is significant spending variation because it plays into the greater politics around whether anything is going to take care away from Medicare beneficiaries. I think if we have an ability to contribute to the discussion or to the facts around how much spending variation there is that doesn't affect outcomes -- and, you know, this analysis doesn't do that. There's other work that is -- you know, the Dartmouth work attempts to do that, and some other work is attempting to do that. I think there's a value to producing the data even if we're not quite sure.

I frankly -- and I have been publicly with Jack Hadley sort of saying that I don't think geography is a good way to base policy. You have individual policies that should result in a reduction in spending variation, but that

going after high-cost areas, unless it's fraud and abuse or something like that, might not be the most productive way to proceed. But I think there's a value to the whole sort of enterprise to get this data out, and even if that's all we show, that this supports what Dartmouth has been doing in their careful research, but the magnitudes are not as great, but they're still pretty significant, I think that would be of service.

DR. KANE: I think if you go back to Slide 4, some of this is just sort of -- maybe if we just change the way we use the language to describe what we're doing rather than saying adjust spending as though the adjustments excuse it, just say which -- of the raw spending, how much of it is explained by regional pricing health status.

For instance, I would not want to excuse the fact that IME is, you know, used variably across the states. Even in Massachusetts, for instance, we have a tendency to way overuse teaching hospitals, and it has helped drive our costs up, and I think that is a reason for our high spending. And you wouldn't want to say, well, we're just adjusting that out.

So I think rather than saying adjust spending, say

here's the categories that help explain, and then just enumerate them and leave the value judgment out that there might be some reason to excuse it as a way to present this.

Another thing, I think -- and I agree with Bob, that calling this sort of a geographic variation maybe be politically important -- or not -- but wouldn't it be more useful to look at variation not geographically constrained but just what's the variation out there by quartile and, you know, cost practice? And then, you know -- I mean, yes, they break down also geographically, but there's huge variation in spending, and for different reasons, across the country. And we can explain some of it, but then there's still this huge variation, rather than kind of burying some of the variability that's within the state.

Then finally, I think a lot of this would also be more better packages with an analysis of the degree of cost burden on the beneficiaries. As you see this variability, if you're going to do this geographically, perhaps try to come up with how much cost-sharing variability there is as well, because spending, the way it's presented now, looks like it's a good thing, because, you know, people are getting federal dollars. But, actually, spending isn't a

good thing for the population necessarily, unless they're dying because there's not enough spending. Spending is expensive and people are cost-sharing right along with it.

So would it be helpful just packaging this with some indication of the affordability of what's going on in the high and the low -- if you want to stick with geography, just say here's the cost-sharing implications of this level of spending.

So I think we just need to kind of package this in a way that a little more addresses the purpose to which we're trying to get at, which is it's bad to have high spending unless all the variation is due to quality differences.

MR. HACKBARTH: I'm going to pick up on Nancy's first point, and I agree, the way this is packaged, it's very important. You can look at prices and health status and special payments and characterize those as justifications, as it were, for, you know, higher levels of spending. I'd prefer to think about them not as justifications but, rather, steps that you take if you're trying to get to assessing differences in service use.

I think there are legitimate policy grounds on

which one might disagree with the existing IME indicia adjustments, and I don't want this to be interpreted as, oh, MedPAC thinks that that's all perfect, and that justifies, you know, higher spending in Boston or New York or anyplace else. I don't want that to be the message.

These are adjustments we make because our goal is to identify how much use of service varies, and there's plenty of room for legitimate policy debate about whether these are appropriately done within the Medicare program. It is a subtle difference, but I think it's a very important difference in terms of our public message.

DR. MILSTEIN: First of all, I think this is extremely high-value information that you're producing in terms of congressional need and policy need. I'm very glad that this is being pursued.

Secondly, this is a slight variation on what I think Nancy just suggested, but to make this, I will call it, "policy feasible," you can imagine a policy that might work around this, you know, we know from SGR that group punishment does not -- you know, it turns out to be not policy feasible. And so, you know --

MR. HACKBARTH: [Off microphone.]

DR. MILSTEIN: Not effective. Yeah. And so my feeling is, you know, within the limits of MedPAC's staff resources, doing this analysis at the level of the hospital and their associated medical staff, what it enables is for there to be winners as well as loses, you know, within metropolitan areas and, therefore, within congressional districts. And I just think it's -- you know, we have to think about policy feasibility, and, therefore, I think it would be very useful to take these wonderful refinements that you've demonstrated and apply it to a different unit of analysis, which is the hospital and their affiliated medical staffs.

MR. HACKBARTH: Along those lines, can you say anything about the variation within MSAs, you know, even just examples? Is that something that you've looked at?

DR. ZABINSKI: Yeah, we can do it. I haven't done it in this case, but we can do it.

MR. GLASS: Remember, this is county-level data, so that's the smallest unit of analysis that you can --

MR. HACKBARTH: Oh, right. So you're not building it up from hospital -

MR. GLASS: We'd have to use a different data

source --

MR. HACKBARTH: Yeah, right.

MR. GLASS: -- to go out in that direction.

DR. MARK MILLER: Let me just thread a couple of thoughts together, because that is exactly -- the first thing I was going to say is this data set's smallest unit is county, and so the variation might not be quite what you're getting at. And there were a couple of statements about, well, why not practice and -- and you and Arnie are really -- tell me for sure, but you're speaking to HRR, that type of thing. So we have interest in that, too. This data set does not easily do that. We haven't given up, but this data set does not easily do that. So I don't want to overpromise. We do understand the objective, and we understand why. And so that is not a "Hell, no," but this data set is going to give us a little bit of fits to try and do that.

Remember these thoughts and these statements for a couple of other reasons. Number one, we went through exercises a year, a year and a half ago, on trying to use the episode data to look at practice patterns, and remember many of the questions and statements that you made at that

time; two, that there were real questions and concerns about some of that. And that's going to come up again tomorrow in looking at those patterns, and that may inform some of these things. But I do hear you on can we get below the MSA level. We'll keep trying to dig on that.

MR. HACKBARTH: Having been reminded that these are county-level data, my recollection is that I've seen work that you've done that says take a state, a low-cost state like Iowa, and look at the variation at the county level within Iowa. And my recollection is that the variation among Iowa counties is almost as large as the national variation on this measure of service use. Is that right?

DR. ZABINSKI: Yes, that's right.

MR. HACKBARTH: You know, I think that's a point -- you know, it doesn't get all the way to the hospital referral area, but it does remind people that there's variation within the variation.

MR. BERTKO: So I'm going to repeat a couple of things with some more push. First of all, this adds additional support to many of our conclusions that variation is still big and still a problem. And going from what Arnie

and Glenn and Mark were saying, to get to some attribution, I think it would be useful down to the HRR or some other kind of hospital level. And my suggestion just for explanatory power is if you picked low, medium, and high and the appropriate counties, in some places, like Ohio, where I grew up, you have 88 counties, which almost focus on some hospitals once you get outside of Cuyahoga County with Cleveland and some others. But the attribution methods, whether done, very bluntly, just by zip code or by a Dartmouth-style algorithm, could be done with a lot more work. So this is not to say do it now for this particular report, but maybe put it in the hopper for future work.

I think the explanatory value of showing what happens at those very high ones, whether they have huge variation, and the low ones, do they have less variation, or do they still have a lot of variation, would be very useful to us. This is a fruitful area.

And, Bob, your comment about surveillance just triggered my thought. This is what private plans, when they're on the top of their game, do all the time. We got a dashboard that showed about 2,000 or the 3,000 counties, and my favorite story is watching human growth hormone pop up in

that same county that these guys found there because it was three or four times the incidence, which was, you know, fanatical. You know, we ought to be helping think about how to use that, if for nothing else, we could save money.

DR. STENSLAND: Maybe I just want to put a little bit of a damper on some of the optimism.

[Laughter.]

DR. STENSLAND: When we're looking at the counties -- we did something similar when we did our ACO work last year, and we were looking at these individual hospitals. And when you get into small -- there are two sources of random variation -- or variation. One is just random up and down of these individuals. The other is maybe some systematic differences in the way medicine is practiced. And if we get down to too small of an area, like individual counties, especially small rural counties where you only have a few hundred people, a lot of the variation you're going to see might be random variation, where they look low one year, then the next year they look high.

And so we can try to move it down, but if we get down -- you know, we have not done a formal power calculation, but if we get down below, say, 5,000 people, if

we get down below that, we get a little nervous that we're picking up ore random variation and not so much systematic differences.

MR. BERTKO: Yeah, let me just suggest the Midwest is filled with small counties and lots of eligibility, and that might be a place to just look around. You know, it wouldn't be systematic, but it would be perhaps illustrative.

DR. CHERNEW: I think it's important as we go through this chapter to keep in mind what we think the purpose of it is, and sometimes I vary in my view.

My opinion in general is, given the current controversy and policy importance of geographic variation literature and the extent to which that literature has come under attack, I think it's useful for an organization like MedPAC to say something authoritative about that utilization. And I think in that sense you've done a good job.

I think you could expand it a little bit, because there's a lot of work which doesn't use spending and try and get utilization, but there's whole bodies of literature that say for people with heart attack, do they get

revascularized? There's no price adjustment. There's no -- you know, there's just a lot of literature that could be at least cited that demonstrates that if you go to different places, practice patterns are different for different people in the care that they get given the condition they have. And it will make the point.

I think that it's useful to quantify it, to some extent, but in all honesty, if it's 50-percent variation or 30-percent variation, we have to figure out what to do, and we have to be very careful not to blur some possible explanation as meaning that's how we have to act.

So if we found, for example, that a lot of it was prices, that doesn't mean just cut rates in those areas, because as I said before, making prices lower in a high-cost area does not make the area look like a low-price area. There's all kinds of system things that go in there.

I think that the chapter is strongest if it's limited to making sort of the broader point, the broader descriptive point that there's a lot of variation and we have to go somewhere. And the further we try and use this to motivate policy, the further we speculate beyond what the data really justifies, I think the less credible and useful

the chapter begins. I just think, given where we are now, it's useful to defend the point, which I think has come under attack because of magnitudes, but not for the same -- so I think emphasizing your agreement slide is really key.

DR. BORMAN: Just a relatively quick comment and it really actually builds to some degree on what Mike was saying, I think. I don't want to put words in his mouth.

DR. CHERNEW: [Off microphone] I agree with you.

DR. BORMAN: But it would appear to me that what I'm hearing is there's variation in variation. We can slice and dice this in a variety of ways. It will be sensitive to the variables that we pick, either on the input side or the output side. There's a hugely important concept that there is variation.

As Mike said, where we go beyond that I think is really what we're hinging on, and I would agree with Mike that it's very important that we establish -- and this very elegant thing I think does establish -- that you can make variation say a lot of things, but maybe we do need to be content with there's variation. And instead of taking these parts out as the things to act on, go back to -- you have some of -- what I think Nick Walters said to us a whole

bunch of times, let's pick the high-volume, high-risk, high-growth, whatever it is, features and use this about there's variation for those things here and here and what practices can we extract out that help us do better for everyone, find the rising tide that raises all ships of care in this, as opposed to get -- this has almost become our silver bullet -- not necessarily MedPAC's silver bullet, but in a lot of the conversation, this is the silver bullet that if we can only unravel this, we have the answer.

You know, it is our national culture to want to find the answer here, and even though we know there is not the answer, we keep searching for the answer. And I think to defuse this concept would be a good thing, and this enables us to do that to some degree.

DR. CROSSON: Just one comment to underscore I think what Nancy and Bob said earlier about packaging. This is very good work, and it's very useful and it's very timely. And the report I think is going to be well received and probably fairly widely read.

But I think it would be a shame if one of the conclusions that people drew from it was that somehow this meant that there was a limit to what could be achieved down

the line in making care more appropriate and the like, because I don't -- I mean, now I'm going to sound like Arnie. Sorry.

[Laughter.]

DR. MILSTEIN: This is a good thing.

DR. CROSSON: Yeah. But, I mean, the assumption in sort of taking the variation from the 10th to the 90th percentile of whatever it was, 55 percent, and saying, well, maybe we get half of that, maybe we could move the high utilizers down to the median, that's just a thumbnail notion. I mean, that's not determinative. It doesn't say anything about whether over time, through some of the changes to delivery system and incentives that we have talked about we can move the whole curve down, right?

So I think we just need to make sure that we do not -- that in writing it up, we actually counteract that potential. Does that sound like you?

DR. MILSTEIN: [Off microphone] Absolutely.

MR. HACKBARTH: I want to pick up with what Karen and Jay were saying, or at least what I think they were saying. One way to look at this is this is an analytic tool. It's useful to invest in trying to refine it in order

to provoke certain policy discussions. That's how I think of this.

I've been a little bit uneasy as I've seen in the health reform debate some people start to look at this as, oh, this is the framework for a system of policy adjustments that we're just going to wrench these things and line them all up. It's maybe a subtle difference but I think a very important one. I think the work we've done has been very helpful on advancing this as an analytic tool for thinking about policy. I think the step of trying to isolate differences in service use as opposed to just total expenditures raises an important set of questions. So great work on that.

Our plan in raising this, our short-term plan in raising this, was to get your reactions to it with an eye towards, if you feel comfortable, producing a policy brief in short order explaining the variation in service use as opposed to this being something that we go back to time and time again to develop a chapter for the March report or the June report. So that was our intent in raising this.

Mark, do you want to pick up from there?

DR. MARK MILLER: Yeah, I guess so. That was the

intent. We did this because this is a subject of conversation. We think that there has been some serious misunderstandings in how to think about this. We can certainly take this set of comments away and be more clear and careful in how we lay these out, for example, particularly the discussion surrounding this slide, as well as other things that were said, and come out with something, say, within a month. You know, we've laundered it, you've reviewed it, that type of thing, and put it out for the debate or for people to see. So that's a plan.

The alternative is is if you think, well, no, there's adjustments and different ways to look at this and qualifications, then we can go back to the boards. But I think what Glenn was saying was that where we're headed was trying to put something out in the short term to try and bring some clarity.

MR. HACKBARTH: Reactions to that? Let me frame it this way: Anybody have deep reservations about our working towards a policy brief explaining variation in service use within the next month or so? Comments, Bob?

DR. BERENSON: I'm all for that. I guess my question would be whether we either comprehensively or at

least by example use some geographic areas and identify what happens when you make these adjustments and how it changes, because I do think there is a two -- I mean, there is a food fight going on in Congress, and it's obviously that some places on the east coast and the west coast, in particular, have been fingered as high-cost areas. And to the extent that this analysis would show that some of them are not what one thought, I think it's useful to illustrate that.

I guess I'm saying I think our work is very much in support of the basic Dartmouth research, but it differs from some of the Dartmouth Atlas. And to the extent that that is what's driving what's going on on the Hill, to the extent we could be a little specific on that, I think it would be helpful. And we're going to be asked, I assume, so I think we should try to take charge, control over it.

MR. KUHN: I, too, agree that this is the right way to go, and the sooner, actually, we can get this out the better, to kind of deal with some of the hyperbole and all the activity that's going on on this issue out there.

In terms of Bob's point, to the extent that we can be as illustrative as possible is great, but let's not hold up the process if that's going to take a lot of analytical

work. But the sooner the better.

MR. BUTLER: You caught my attention when you said "variation in service use." I'm wondering whether you shouldn't have a fundamentally different title to kind of capture what we're saying rather than -- and maybe you're suggesting this. Rather than say "regional variation in service," it, in fact, becomes "variation in Medicare utilization rates" or "Medicare utilization," or something like that, then go right into the public discussion of regional. But it might help kind of capture the themes that you've been hearing.

DR. DEAN: I think this has probably already been said, but I think in setting it up, I think it's important to make the point that this is not a justification for the high-cost areas. This looks at one aspect of utilization patterns. It is important. But it doesn't say this shouldn't let the high-cost areas off the hook and say, "Okay, you're fine. You're doing great."

MR. HACKBARTH: Other comments?

[No response.]

MR. HACKBARTH: Okay. Thank you. Good work.

Let's see. Next, and our last session for today,

is a discussion of the MIPPA mandated report asking us for advice on how to compare quality in Medicare Advantage and among Medicare Advantage plans, on the one hand, versus traditional Medicare on the other. For the audience, this is a report that's due in March 2010. Carlos?

MR. ZARABOZO: Good afternoon. Today, I'll provide an update on our work on the Congressionally mandated report on quality comparisons in the Medicare Advantage program and quality in Medicare Advantage as it compares to the traditional Medicare fee-for-service program.

This presentation summarizes work that John Richardson and I are doing on this topic. Unfortunately, John is at home sick. He is our principal quality expert at MedPAC, so I can take this opportunity to say that any errors or omissions are entirely John's.

[Laughter.]

MR. ZARABOZO: Section 168 of the Medicare Improvements for Patients and Providers Act of 2008 requires the Commission to submit a report to the Congress on how performance and patient experience measures can be collected and reported by the year 2011 so as to allow comparisons of

the quality of care between Medicare Advantage and fee-for-service Medicare and among Medicare Advantage plans.

The statute specifically directs the Commission to address technical issues, such as the implications of new data requirements and benchmarking performance measures. The report is to include any recommendations for legislative or administrative changes that the Commission finds appropriate.

Here is a list of the topics that we intend to address in the report. They include a general discussion of the priorities for quality measurement as they pertain to the mandate; a discussion and analysis of the current systems for measuring quality; and a discussion of key issues arising from the mandate and issues of concern to the Commission, most of which we have discussed in past meetings dealing with the MIPPA mandate. As noted, the MIPPA mandate specifically asks that we address data needs and the issue of comparability for comparison purposes.

We also discussed the question of disparities in health care as they relate to the evaluation of quality. In addition, we plan to address the question of the resources that CMS would need to undertake any changes in the matter

of ongoing stewardship of quality measurements. The report would, of course, contain any legislative or administrative recommendations the Commission would choose to make.

I want to pause here for a moment to mention that on the question of disparities, there was a separate MIPPA mandate to have the Secretary report on how to identify disparities, how to report data on disparities, and specifically mentioned HEDIS, for example, of wanting HEDIS to be reported by race, ethnicity, and gender. So that is being somewhat separately addressed.

In your mailing materials, we present one option for defining the priorities of quality measurement in the context of the mandate. Our goal in presenting this option is to frame the key issues for your discussion purposes.

We suggest that current measures should be improved and expanded and that there should be more outcomes measures. As defined by the Institute of Medicine, outcome measures reflect the end result of care, either from a clinical perspective or a patient-centered perspective. In contrast to process measures that often focus on a single dimension of care for a specific condition, outcome measures provide an integrated assessment of quality because they

reflect the results of multiple care processes provided by all the health care workers involved in the patient's care.

As the National Quality Forum has stated, outcome measures also focus attention on systems-level improvements, because achieving the best patient outcomes often requires carefully designed care processes, teamwork, and coordinated action on the part of many providers.

Regarding the data issues, the National Committee on Vital and Health Statistics report in 2004 suggested that administrative claims and encounter transactions represent an attractive short-term option for capturing additional data elements that represent important health care processes and/or health outcomes while we continue to pursue the benefits of electronic health records and a robust National Health Information Infrastructure.

Another issue that we discuss in today's presentation has to do with the question of comparability for comparison purposes, MA to MA and MA to fee-for-service. Specifically, we discussed the issue of the correct geographic unit for reporting purposes.

Several types of outcome measures are currently being used as quality indicators, including mortality rates,

hospital admission or readmission rates, intermediate clinical outcomes, such as control of blood glucose or blood pressure levels, and patient-centered measures, such as the Consumer Assessment of Health Care Providers and Systems, or CAHPS, which is a set of surveys of plans and providers -- of people enrolled in plans and beneficiary views of their providers.

In order to have comparisons on these measures between Medicare Advantage and fee-for-service, we need comparable data from each sector, both for determining what care was provided and the outcomes from that care, as well as data that allows for risk adjustment of the results to ensure a fair comparison between the sectors.

In the case of CAHPS, we have such comparative data because both MA enrollees and fee-for-service beneficiaries are surveyed through CAHPS.

As for other data, some of the information needed for evaluating outcomes is available from claims data and fee-for-service, as those data are currently submitted. However, the Commission previously recommended in 2005 that fee-for-service Medicare should collect laboratory test results to enhance the information in fee-for-service.

On the Medicare Advantage side, CMS does not collect similar data from plans, but will do so through the encounter data collection process that will begin in 2011. To the extent that the encounter data are comparable to fee-for-service claims data that includes lab values, the two data sets from the two sectors can be used for risk-adjusted quality comparisons.

We would also look to Health Information Technology, or HIT, in the future, where we envision that an aspect of the meaningful use requirements of the American Recovery and Reinvestment Act for Electronic Health Records would include their use in quality measurement.

In this table, we show that many of the measures can be used to compare data from Medicare Advantage plans and fee-for-service using fee-for-service claims data. These measures include the rate of preventable hospital admissions for ambulatory care sensitive conditions, that is those conditions for which appropriate ambulatory care would have obviated the need for admission, for hospital readmissions, for preventable emergency room visits, and for mortality for certain conditions.

As we noted, for intermediate outcomes, we would

need additional data beyond what is current in fee-for-service claims and there would have to be similar data coming from MA plans.

Turning now to focus on the situation in Medicare Advantage, the current primary source of clinical quality information in Medicare Advantage plans is the Health Care Effectiveness Data and Information Set, or HEDIS. Medicare plans have been required to report HEDIS since 1997. The HEDIS measures are primarily process measures, but include some intermediate outcome measures for diabetics, people with cardiovascular disease, and blood pressure control for individuals with hypertension.

With regard to the use of HEDIS measures as a basis for comparing Medicare Advantage to traditional fee-for-service Medicare, HEDIS measures can be computed from fee-for-service using claims data. In your mailing material, we have a discussion of the comprehensiveness of the HEDIS measures and we examine the issues involved in using HEDIS measures as a basis of performance measurement in fee-for-service.

Regarding HEDIs, there is an issue about the comprehensiveness of the measures for certain age groups and

for certain conditions. For example, there is a limited number of measures that apply to the oldest Medicare beneficiaries. None of the intermediate outcome measures apply to Medicare beneficiaries over 85, and only one, the measure for control of high blood pressure, is applicable to beneficiaries between the ages of 75 and 85.

The measures for diabetics apply to beneficiaries between the ages of 18 and 75. The reason for this, as we understand it, is that even though there is a significant proportion of Medicare beneficiaries over 75 with diabetes, it is difficult to develop uniform measures that are appropriate for an older age group with medical needs that essentially vary from person to person.

With regard to using HEDIS as a basis for comparing one plan to another, we have previously discussed the different standards that apply to different plan types, such as the inability of some plans to use medical record review to report a rate on a particular measure. This is also an issue when comparing MA plans to fee-for-service.

One way to address this is to use the HEDIS results that are based on administrative data only, that is, without the medical record review component. This still

does not give you an apples-to-apples comparison because the administrative data within MA encompasses a broader range of data sources than the claims data of fee-for-service. For example, MA plans can use lab values for reporting their HEDIS results. If fee-for-service claims data included lab values, as we recommended in the past, that would increase the comparability of the two data sources. However, even this enhancement of fee-for-service claims would not make the data completely comparable because, for example, the administrative data that plans have that are the basis of HEDIS reporting can include information from the plan's Electronic Health Record System, and some plans have very advanced electronic health records.

The issue of making sure that any comparisons are apples-to-apples comparisons is an issue that has very broad relevance for any measurement system. If we want to judge the relative health outcomes for one group of beneficiaries compared to another group, we would need risk adjustment and other adjustment mechanisms to ensure a fair comparison.

Another issue is the matter of the small numbers. For example, in rural areas, providers may have too few patients and plans may have too few enrollees for

statistically valid results. In your mailing material, we discuss possible ways to address the small numbers problem, for example, by using three-year rolling averages.

Another issue is the question of the appropriate geographic unit for reporting of results. One aspect of this issue is the general question of how to define an appropriate geographic area for comparing MA plans with fee-for-service. We have assumed that MA plan performance should be compared against the performance of fee-for-service in the same appropriately determined geographic area, such as a market area or the "geo units," as they were called, that had been developed for CAHPS reporting. This would also be true for MA plan-to-plan comparisons. The comparisons should be done at the appropriate geographic level. As of now, however, MA plans can be reporting results for very large geographic units.

Here is a map of the four Medicare contract areas that one Medicare Advantage HMO used to have in California. Butte County in the north was under one contract. The Oakland-San Francisco Bay Area was under another contract. Most of Southern California was under one contract. And the rest of the counties the HMO covered in the State were under

another contract.

In the case of Southern California, the structure of this HMO included five regional components, that is, five areas that the organization identified as separate market areas for commercial rating purposes. All told, therefore, this HMO was operating in at least eight separate market areas in California.

Today, this organization is reporting CAHPS, Health Outcome Survey, and HEDIS results on a Statewide basis. It seems unlikely that the experiences of care for beneficiaries enrolled in this plan and the performance of its providers is entirely uniform across the State. However, under current reporting standards, the beneficiary, or Medicare, for that matter, has no way of knowing how this plan performs in a specific market area.

And for those of you from the Bay Area, I would point out that the Bay Area has finally achieved its goal of detaching itself from the rest of California.

[Laughter.]

DR. CROSSON: I am going to get on the phone right after the meeting and let everybody know.

MR. ZARABOZO: You now have oceanfront property,

by the way.

[Laughter.]

MR. ZARABOZO: In addition to raising any issues to include in the mandated report that you feel we have omitted from our mailing materials or presentations, there are several items that we would like the Commission to discuss. Given the timing and the language of the Congressional mandate, which states that changes should be in place in 2011, our report would be likely to include any recommendations for immediate changes to the current measurement tools.

The situation that we just described regarding the geographic area is something that is amenable to an immediate fix; that is, plans and CMS could begin reporting HEDIS, CAHPS, and Health Outcome Survey information at smaller geographic levels.

We also may wish to comment on what is feasible to have reported by 2011, using current measurement tools and current or soon-to-be available data sources. For example, the Commission may wish to comment on what form the MA encounter data collection should take in order to include data necessary for quality comparisons.

Similarly, the Commission may want to weigh in on the issue of ensuring that Electronic Health Records will become a rich source of data for advances in quality measurement.

As a reminder of what the mandate says, there are two parts to the mandate. One is the comparison of one MA plan to another, and the other part of the mandate is the question of how to compare MA to fee-for-service Medicare.

The next slide shows that the two parts of the band-aid often parallel each other, but can also be different, especially on the question of the data that should be used for the comparison.

For both the MA to MA plan comparison and for the fee-for-service to MA comparison, there needs to be uniform reporting of measures and reporting of the appropriate geographic unit. An MA, for example, PPOs, HMOs, and private fee-for-service plans should all be reporting on the same basis for the same set of measures. Similarly, in the fee-for-service to MA comparison, reporting should be on the same basis in each sector.

With respect to the MA plan to plan comparison, we have suggested the need to expand the measures to encompass

a wider range of the Medicare population and a wider range of medical needs of the population. We have also suggested that there be more emphasis on outcomes measures. Such an expansion would involve additional burdens on the plans and on CMS. For example, moving to more outcomes-based measures could potentially involve more extensive use of medical chart review, which is labor intensive.

For the fee-for-service to MA comparison, the currently available fee-for-service data are the fee-for-service claims. Enhancing fee-for-service claims data with additional information would be an added burden on providers in the fee-for-service sector.

The closest analog to fee-for-service claims in MA would be the soon-to-be collected encounter data, if the encounter data specifications are similar to fee-for-service claims specifications. The claims and encounter data can be the basis of measuring outcomes in each sector, and if both data sources include lab values, intermediate outcomes can also be measured.

Of course, the type of data collection for quality reporting in MA is burdensome, though it is not clear how much additional burden there would be above and beyond the

anticipated burden of the 2011 collection of encounter data that CMS is proceeding with.

In the future, where more and more plans and providers move to Electronic Health Records, and if those Electronic Health Records contain the necessary information for improved quality measurement, we would expect to improve data collection with a lower level of burden and improved ability to monitor and evaluate quality and improved ability to provide meaningful reporting of results both within the MA sector and across the two sectors, MA and fee-for-service.

However, there is a delicate balance to consider, which is how far should we go with potentially major changes to the current system if a newer, better system is coming? And with regard to the newer system, when will it be available and will it be the rich source of information that we hope it will be?

Thank you, and I look forward to your discussion. We have the room -- the room is reserved until midnight, in case you are interested.

[Laughter.]

MR. HACKBARTH: Well, let's hope. Okay. Let me

see hands for clarifying questions.

DR. STUART: This is a clarifying question regarding MA encounter data, and depending upon the MA plan, those encounter data actually could be claims. And in the case of private fee-for-service, they are claims. In the case of network HMOs, they are probably claims. In the case of staff-level HMOs, some of them may be claims, too. So I am just wondering, do we have any sense about how much of the data that is flowing into CMS now from MA plans really is claims as opposed to encounters?

MR. ZARABOZO: It's not flowing in yet. They are going to announce -- I think 2011 will be the collection --

DR. STUART: Oh, 2011.

MR. ZARABOZO: -- starting the collection of the information, so -

DR. STUART: Okay. But the thing still holds. Do we have any sense about what the proportion would be?

MR. ZARABOZO: I think we'll know more later in the year, and again, one of the comments that we made here was, potentially, we would like to say something to CMS about what we would like to see in the way of information in the encounter data.

DR. BERENSON: Yes. I am not still completely sure I understand the mandate. Is it to report on the use of measures for beneficiary choice, to be able to have informed information to make decisions about where to get care, or is it for policy makers to know how fee-for-service and Medicare Advantage sort of globally are performing to sort of help the policy making process, or both? I mean --

MR. ZARABOZO: Both. We have interpreted it as both, because it says collection and reporting of the information by 2011 and we assume that reporting meant for beneficiaries and also for CMS --

DR. BERENSON: So you are interpreting it as both?

MR. ZARABOZO: Right.

DR. BERENSON: Okay. My second question is a more technical question. It is on Slide 6, administrative data available for outcome measures. The first two, preventable admissions for ambulatory care, sensitive conditions from the AHRQ PQI and readmissions, in the material you gave us to read, you had done sort of some preliminary analysis based on 13 States that have provided from the HCUP database. Could you -- is this available from all States and you just chose to -- what is the status of that?

MR. ZARABOZO: No. The situation is that there are 13 States in which you could identify MA enrollees versus non-MA enrollees. And then there are an additional two States, and you and I had a discussion about this -- it is actually Iowa and Rhode Island are the additional two States where that might also be the case.

And your next question would be, what about Nevada?

DR. BERENSON: I should probably tell people why we are having this. Carlos and I had a little talk earlier, because two days ago, AHIP released, and with a fair amount of prominence, a report apparently using data from two States, California and Nevada, to demonstrate that Medicare Advantage plans were more successful, and I am just wondering whether they are using the same database as what you are referring to, and I guess the follow-up question that should be probably round two but is in round one, is did they cherry-pick the data to just pick States that were where they actually had good data?

MR. ZARABOZO: And I think they don't specify why they chose -- I mean, possibly they chose the two States because they are neighboring States, but as you know, they

are very different in their managed care make-up.

DR. BERENSON: Correct.

MR. ZARABOZO: It says it is HCUP data. Now, when we got the list of the 13 plus two States, Nevada is not in that list, so I'm not sure what the issue is with HCUP data coming from Nevada, so I'd have to look into that.

DR. BERENSON: But we are talking about basically the data that you're referring to --

MR. ZARABOZO: Yes.

DR. BERENSON: -- what we could be using is also the data that -

MR. ZARABOZO: Correct, and this is the data -

DR. BERENSON: I'm not expecting you to have analyzed their study now. I want to just sort of see whether we're talking about the same databases.

MR. ZARABOZO: Right, and the mailing material included the AHRQ study of the 13 States where they said they found no significant differences between MA and fee-for-service, different from the findings of the -- and also, it's -- a lot of it is utilization, and the discussion of quality would be things like preventable admissions. They talk about admissions, readmissions, so quality may be a

slightly different issue from utilization, and it's only hospital utilization as opposed to all utilization.

DR. MARK MILLER: I'd like to just comment on that a couple of ways. The fundamental answer to the question about the availability of the data is it's not for all States.

MR. ZARABOZO: Correct.

DR. MARK MILLER: Okay, and so as a source that you could comprehensively -- I want to be sure that that came out of that exchange.

DR. BERENSON: And no prospect that it will be -

DR. MARK MILLER: I want to address that point. I will let Carlos take the prospect question, and you can think about it quickly while I'm running my mouth on this one --

MR. ZARABOZO: That's a John question and he's not here.

DR. MARK MILLER: Oh, okay. Well answered. We'll find out for you.

The thing I do want to get across is, however, if you want claims-based information, which this is largely that type of measure, then it gets you back into the

conversation that I think Carlos was framing between the, well, do you want to use the fee-for-service claims data and the encounter data as a way to build that and build it more comprehensively. And so I just want to make sure that if that is a road -- and Jay, I know your views on this -- if that is a road people want to think about, you don't have to depend necessarily on HCUP to do that. You would build it, I think, from those sources. Is that about right, Carlos?

MR. ZARABOZO: Right, and if you have the encounter data and fee-for-service claims data, it allows you to do the same thing that the HCUP did, right.

DR. MARK MILLER: [Off microphone.] That's what I'm trying to say.

MR. ZARABOZO: Yes.

DR. MILSTEIN: Thinking about the mandate that's been given to us raises for me a couple questions as to how far afield we are going to go in responding, because at the end of the day, as you were alluding to, this -- it addresses the broader question of how do you measure quality in the Medicare program.

But with respect to that, you did reference the idea of EHRs may provide a new source, and obviously there

are other changes unfolding in the Medicare program that are sort of in equal areas of new opportunity. I'm thinking about the, assuming the PQRI program continues to move forward, that's another source of -- you know, question one is were you planning to sort of address that as a potential data source and were you also planning to, within the scope of this mandate, talk about the value or utility of being able to link A/B with D data.

MR. ZARABOZO: On the D data issue, we have taken it as a given that the D data are available and would be used for this purpose.

DR. MILSTEIN: [Off microphone.] In both MA --

MR. ZARABOZO: Right, in that sense, that --

DR. MILSTEIN: [Off microphone.] -- linkability of -- I'm sorry. What about PQRI?

MR. ZARABOZO: On the PQRI, I guess you could say that that may be an issue with the encounter data, as to what do you want to see in the encounter data that would be comparable to PQRI information coming from fee-for-service. So potentially, yes.

DR. MILSTEIN: [Off microphone.] You mean -

MR. ZARABOZO: Right. The equivalent of PQRI data

coming from MA. That is -- yes, via the -- I mean, right now, we're thinking via the encounter data.

MR. BERTKO: Carlos, nice job in John's absence here, you pinch-hitting. Your slides, particularly, I think it is Slide 8, give me at least the inference in that first column that there is not much there yet under current measures and that putting a square peg into a round hole might be quite a bit of effort. Am I interpreting that correctly?

MR. ZARABOZO: You could say that.

[Laughter.]

MR. ZARABOZO: I think you just did.

MR. BERTKO: You are a difficult guy. Okay.

MR. ZARABOZO: Last time, I was described as a hostile witness. I think that was a year ago.

[Laughter.]

MR. BERTKO: So the second part, and this is a little bit to follow up with Bruce's question, since I am two years removed from doing real work, it strikes me that it is possible you could have a one-by-one expert panel interview of very large MA plans and see where they are on the data stuff in terms of the kinds of data you would want

there, because if they are going to be pushing it through anyway, it would seem in 2011, even with flawed data, we would be at a good starting point with very little extra work, and I would suggest to everybody else the penalty for non-submission by other plans is big enough, because they look bad. And so the incentives, I think, are aligned in the right direction here. So it seems a waste, if I can infer from your comment there, to go down path one when we can more clearly go down path two.

Note he doesn't say anything again.

MR. KUHN: Carlos, thanks. Good presentation. I'm curious to go back to the chart that Bob was talking about earlier, and it looks at the PQI discharge data. And as I looked at that, and I think as the description indicated, it was almost a mirror image of one another, from MA to fee-for-service. And, I guess, is there any information that you all have that indicates that there is no differentiation between the providers that are in the MA plans, or providing services to the MA plans versus those in the fee-for-service? Could that be one rationale why we are seeing this kind of data reflection here? I am just kind of curious. Are they different types of providers that just

come up even, or are they commingled here?

MR. ZARABOZO: Well, of course, in California, you have Kaiser, which is not a fee-for-service -- I mean, some of the California data included fee-for-service people in the Nevada-California study coming from AHIP and that -- it said emergency, but I think it is the cost enrollees, actually, that are in the what appear to be fee-for-service data in California, because those go through the intermediary.

DR. CROSSON: Cost and a small number of people who never converted to risk program.

MR. KUHN: Okay. I was just trying to get a sense of who were the providers here, to the extent that --

MR. ZARABOZO: The California case, for example, is a special case because of Kaiser, so yes.

MR. HACKBARTH: Other round one -- oh, I am sorry, Jennie.

MS. HANSEN: I think John asked the question already, because it was back to Slide 8 and it had to do with those measures on the left, for example, the limited number of measures for oldest beneficiaries. I know right now, we have the AHRQ prevention quality indicators that you

had on Slide 6, but that, for example, if NCQA that actually has a geriatric physician panel --

MR. ZARABOZO: Yes.

MS. HANSEN: -- that has been working on this, so this could be possibly an add-on sooner, is that what you were saying?

MR. ZARABOZO: As you recall in the mailing material, we included additional measures that were added in 2007 from the geriatric panel. So they are adding more measures, and those measures are coming from the Health Outcome Survey. That was the urinary incontinence discussions and osteoporosis testing, things like that for the older population. So they are aware of this issue and are adding measures for the older population.

MS. HANSEN: So again, clarifying, it's in the process of being added at this point?

MR. ZARABOZO: Well, based on their record of having added measures to date, then I assume they will continue to add, given that they had this geriatric assessment panel. But I don't know what their future plans are.

MR. HACKBARTH: Okay. Let me see hands for round

two questions or comments. Ron, Mike, Nancy, Arnie, Peter.

DR. CASTELLANOS: Carlos, I apologize. I was out of the room and it may have been discussed. I think we're going to have a tremendous bias in the material that you get from the MA plans and the fee-for-service plans. As John said, the MA plans are much more motivated to get this data and they can put the pressure on the physician to get that data. The fee-for-service, unless we have HIT and some meaningful use, that data -- you're going to have claims form data.

I can tell you, the attitude in the physician community is, if I don't get paid for it, I'm not going to do it. And I'm sorry, but that's the attitude. I know we want the data, but it's going to be extremely burdensome for the physician community and I think we're going to have to balance the legitimate use of this data to the availability, whether we're going to get it from MA or fee-for-service.

MR. ZARABOZO: I think one point that was -- we're talking about using the currently submitted claims data from fee-for-service providers and getting something equivalent from Medicare Advantage plans. So to the extent that you can -- there, you may have a bias in the other direction,

which is the data coming from Medicare Advantage is for the purpose of meeting the encounter data submission requirement. It is not for the purpose of getting paid. Whereas in fee-for-service, you don't get paid unless you submit a claim.

So to the extent that information about quality can be derived from claims, the bias might go in that other direction if it's encounter data from MA being compared to fee-for-service claims data.

DR. CASTELLANOS: You can have a lot of encounter data from the MA plans, but, you know, Slide 8, on the right, you're not going to have that data from the fee-for-service --

MR. ZARABOZO: Right. Things like lab values, additional information that you may want to get from the fee-for-service would be an additional burden that doesn't make a difference in payment, or potentially doesn't make a difference in payment. So, yes, it would be a --

DR. CASTELLANOS: But it does make a difference in measuring outcomes and quality --

MR. ZARABOZO: Right. Right.

DR. CASTELLANOS: -- and that's what we're really

looking for.

MR. ZARABOZO: Yes.

DR. CASTELLANOS: So I think there's going to be a bias.

MR. HACKBARTH: George, did you have your hand up?

MR. GEORGE MILLER: That's okay. Thank you. I'll make the comment I made a little earlier and it concerned page three of the chapter that was sent out. The statement is made that there should be overall financial neutrality between fee-for-service and the MA plans and that there should be -- MA plans should get higher payments if their quality is better. In my reading, I didn't see discernible difference in quality between MA plans and fee-for-service.

So my question is, if that continues to be the case and the data and the research bears that out, should there be a different payment methodology for MA plans going forward? Should there be a penalty, or could we as a Commission even recommend, if that bears out, that maybe MA plans have met their usefulness if they are not showing demonstrated improvement in quality?

MR. HACKBARTH: What the Commission as a whole has said in years past is that, in terms of the general payment

methodology, we think that Medicare Advantage plans ought to be paid the same amount as would have been incurred in traditional Medicare. And then a bit more recently, we have said that the only justification that we can think of for potentially paying more than traditional Medicare incurs is if there were measurable improvements in quality. And this exercise is about laying the infrastructure to be able to make head-to-head comparisons between particular MA plans and fee-for-service in more or less the same area.

So, you know, to me, right now, the payment issues are important, but they're not directly related to this task. Now, if it would make you more comfortable, we can include in the report a summary statement of what MedPAC's views have been on payment policy, a neutrality, what I just said, but that's not the principal issue in this report. Does that help at all, George?

MR. GEORGE MILLER: Yes, it does, but again, the overall arching concern about the long-term viability -

MR. HACKBARTH: Yes.

MR. GEORGE MILLER: -- in the earlier discussion, I'm wondering, how do you put that in this framework? I certainly understand that we need to get the mechanisms

aligned so we can make the appropriate quality determination, but it seems to me that we have some here and there doesn't seem to be, at least from what I read -

MR. HACKBARTH: Yes -

MR. GEORGE MILLER: -- a measurable difference in quality so far.

MR. HACKBARTH: Well, Carlos can maybe help me out here, but we have some preliminary sort of data, but my recollection of all the tables and accompanying text is look at these with caution because the numbers are not always comparable.

Carlos, do you want to pick up there?

MR. ZARABOZO: In fact, that was sort of the intent of all that data, which was showing, well, yes, you could maybe do these comparisons, but when you look at the actual numbers, there are so many questions about, well, this result is unusual, this result is unusual, that you can't really draw a conclusion or you need to work with it more to figure out what exactly is happening here, like one question being is it a matter of reporting? Some people are better reporting than other people, things like that.

The CAHPS, we had some CAHPS information about the

relative -- I mean, CAHPS is the best source, but again, that's a beneficiary perception survey, so that -

MR. HACKBARTH: In fairness, there was the one table based on the Masspro analysis where the MA plans tended to look better than fee-for-service, although there again there was an important caveat that often the private plan data was calculated using medical record information, chart information that wasn't available for the traditional Medicare side. So they are really not directly comparable statistics.

So my answer to the question, do we know how MA plans compare on quality to traditional Medicare? My answer is, we don't know, and that's what this is about trying to figure out.

MR. ZARABOZO: Right, and the mandate is to discuss the methodology for doing such comparisons. It is not strictly to do the comparisons. And the reason that we did these comparisons was, again, to show the point these are really hard to do, a lot of issues involved here. It is not clear that we are quite ready to be able to do this comparison.

DR. CROSSON: What I heard George saying, or at

least one of the things I heard George saying was let's make sure that the payments to MA plans in some way reflect quality. And if you look at some of the legislation or potential legislation right now, both on the House side and the recently released Senate Finance Committee bill, each of them in their own way contains some element that speaks to that, in the sense that in the process of reducing MA payments down to the level of fee-for-service or approximating that, there's also a suggestion that plans compared with each other that produce higher quality would receive higher payments. That may not come to pass, but that's what's currently there.

DR. BERENSON: I just wanted to clarify MedPAC's previous position. I've read that legislation, and actually, there were -- in one version in the House, there was going to be a pay-for-performance and a pay-for-improvement component, and then I saw that Ways and Means took away the pay-for-improvement, I believe. Do we have a position on whether we -- I mean, the way you articulated it, it was if plans compared to local fee-for-service performance could demonstrate improved quality or higher quality, that might be a basis for payment. That's

different from any kind of pay-for-improvement strategy, and have we been very specific on what we're recommending?

MR. HACKBARTH: We have not. We have not. Help me out here, Mark. But my recollection is that we did not talk about additional payment above fee-for-service levels for pay-for-improvement. We said for, you know, high quality. My recollection, now that I really focus on it, is that we left ambiguous whether that was high quality relative to other MA plans or only high quality relative to fee-for-service.

MR. ZARABOZO: The MA P4P recommendation from the past was to use the rebate dollars to -- and it was -

MR. HACKBARTH: Well, that even goes sort of further -

DR. MARK MILLER: You are talking about the most recent -

MR. HACKBARTH: Yes. That goes further back, so bear with me for a second while I sort of build up the steps. Step one is financial neutrality between Medicare Advantage and traditional Medicare, and we've had that recommendation for eight or nine years now.

Then a little bit after that, about five years

ago, we made a recommendation that P4P be introduced in the Medicare Advantage, and there, it was going to be a budget-neutral system where we would redistribute dollars within the MA program based on quality.

And then a little bit after that, we sort of added a kicker and said part of the rebate dollars ought to be added to that P4P fund to give extra punch to P4P and Medicare Advantage.

And then, finally, most recently, we said that, in thinking about a transition strategy to get from where we are now, paying on average 114 percent of traditional Medicare costs, to a lower number, one thing that Congress might think about is allowing plans that have demonstrably higher quality to keep some of the additional payment.

DR. MARK MILLER: Relative to other plans.

MR. HACKBARTH: Relative to other plans.

DR. MARK MILLER: Right. But then -- [Off microphone.] So what we said, though, in that report is that as you're going through the transition, so you are right on all the way up to that point. So during the transition, you might say, those plans who do better relative to other plans might not be brought down to 100

percent -- one way to think of it is not be brought down to 100 percent as fast, but we said a reasonable termination point is that you could pay a managed care plan more than fee-for-service if it had better performance than fee-for-service, and now we're interpreting that as in an area.

What the Congress said to us is, great. How? And that's what brought us to this study, where we're trying to now work through the measurement issue to capture that between -- among the plans in one vector and between fee-for-service.

MR. HACKBARTH: George, thank you for raising this. You know, I think it would be helpful for this report to sort of have this history to establish context.

Let's see. Mike?

DR. CHERNEW: Thanks. I think it's clear from some of this discussion that eh report is going to have to have a pretty good limitation section. I wish people would start by reading the limitation section instead of getting bored before they get to it. But I want to add three things or mention three things that I think should be in the limitations section that I think are going to be important.

The first one is the analysis is going to try and

control for case mix, so one has to think about how one controls for case mix, and part of that is by selecting the measures. So you want to select measures that you think are going to be somewhat, you know, AMI, you think is going to be standard. That is in and of itself sort of case mix adjusted.

But to the extent that socio-demographic and other variables are across these or the extent to which different types of people have selected into MA plans versus not into MA plans, it's going to be hard to get a full adjustment for the differences in individuals, even with the type of claims adjustment type things that you do, or even given the quality measures one has. And I think that's going to require a call for studying the effects of the case mix differences.

The second one is a conceptual question, which is a lot of the measures, particularly the ones that are sensitive to prescription drugs, like admission rates for congestive heart failure and such like that, but really a lot of them are going to be sensitive to the supplemental coverage that the individual has. So the Medicare Advantage plans typically have better coverage.

Are we conceptually trying to compare a Medicare Advantage plan to a person in fee-for-service without supplemental coverage, or a person in fee-for-service with generous supplemental coverage, and the nature of that supplemental coverage is likely changing over time, so I'm not even sure what it means to say a Medicare plan is better than fee-for-service or not because the Medicare plans have an advantage. They provide better coverage. But the AMA plans typically provide better coverage. That gives them sort of a bump. But maybe that's one of the things we want to give them credit for. So there's some conceptualization about what actually the measure is.

And the third one, which I think is important for the limitations section, is often in this discussion, the entire framing assumes that these are independent entities in one way or another, and in fact, I believe strongly that when the managed care plans are in an area, their value isn't only in changing care for the managed care in all these, but also for fee-for-service. In fact, HEDIS, one of the main things, was really developed through all the managed care plans and a lot of the gains in HEDIS that you've seen across the whole system, I think could be traced

back to efforts largely by originally managed care plans to measure quality of care in a bunch of ways, and I think that there should be some recognition that the value -- that these are not really separate entities on their own islands that we're comparing, but in fact, policy-wise, one needs to think about how these interrelate since they're sharing the same provider system.

And the last point I'll make, which I'm not sure it's a limitation or not, but it relates to these two purposes, about whether we want to compare individual plans or whether we want to compare the MA plan or types of MA plans in general to fee-for-service in general, is statistically, it's going to be very difficult, because of a lot of chance and randomness, to do as good a job comparing health plan A to health plan B all the time in some of these measures, and you can do certain statistical analysis to sort of smooth some of those things to answer the average question.

And so I think there's a question going in not only in when you do the data, but what type of statistical analyses you want to do in order to answer specific questions. Reporting a whole litany of plans and seeing a

distribution is going to have a lot of chance in those plans, my guess is, from year to year, and I think that that's worthy of thinking about depending on how the data's going to be reported and used, because sometimes it's hard to get stable measures in a plan but easier to draw broad conclusions across plan types.

DR. KANE: Yes. Actually, just to reinforce what Mike just said, this whole thing has been bothering me a lot because I know, for instance, in our area in Boston, the three health plans have exactly overlapping provider networks, and so I'm not sure what you're really measuring here. I guess -- I think it might be useful to try to think more about what value-added does a plan have as opposed to the fee-for-service. And I agree. If someone has supplemental coverage or not, it would make a huge difference on the fee-for-service side.

So maybe the question shouldn't be plan versus plan or plan versus fee-for-service, but one would be, does a provider act differently depending on which type of plan the beneficiary is in, a fee-for-service? You know, we can have a little bit of data that does that. On page ten, I think the hospital stuff suggests no for the 13 States that

have the data, and we don't know whether they are perfectly classifying. My experience with that payer data is it's still a little fuzzy, whether the hospital is really properly classifying a patient as Medicare Advantage or not. But it looks like, no, the providers don't seem to treat -- the hospital didn't treat them differently.

So where should we be looking for the differences where we might get bang for the buck if we put any resources into it at all? And the only place I could really think of would be around maybe primary care and care coordination measures as opposed to these really amorphous things that aren't, to me, picking up much.

So I guess I'd like to have us focus more on what kind of measures would really pick up any value-added of managed care, and that might be things like easier access to the appropriate specialists, or some of the things you might actually measure a medical home on as opposed to this kind of claims data that doesn't tell you whether this provider is uniquely fee-for-service or MA.

I'm just having a hard time seeing -- you know, until you kind of can tell me that provider is going to act differently for the different types and think about where

they're going to act differently, I think we're just fishing here for random variation.

MR. HACKBARTH: You know, I think the point that Mike and Nancy have made is an important one. Many, many MA plans -- in fact, probably most MA plans -- are large, open network plans that include a high percentage of the providers in any given community. And given that those plans include virtually all providers in the community, you would think that, A, their results are going to be pretty similar to one another, and B, they're going to be pretty similar to fee-for-service, which uses the same.

However, a couple points. One is that not all MA plans are big, open network plans. There are some that are distinctly different, and there you might see pretty large differences.

The second point I would raise about this is that in the case where you have these large overlapping networks, and I think this is where you were going, Nancy, the choice of measures may be influenced. I would think that if we have only outcome measures, the likelihood that you're going to detect differences in big network plans is pretty small, whereas even among the big network plans, there are some

programmatic differences in outreach and the like that could improve quality at a much more granular level that would never show up on outcomes.

Now, I'm not sure, you know, what to do about all of that, but I don't think it means, well, you don't want to measure quality at all -

DR. KANE: No, but I think -

MR. HACKBARTH: Go ahead.

DR. KANE: I think that Carlos's heroic effort to try to find meaningful measures out of what exists, and all of what exists is pretty much at the provider level -- I mean, a lot of the hospital stuff is at the provider level. The HEDIS stuff doesn't exist in the fee-for-service. I think we should just maybe rethink, what's meaningful to go after rather than what exists, because what exists really doesn't address the problem that we have, which is how do providers that are in both behave differently when they have a managed care plan helping them gain access or coordinate the care or, you know -- certainly, Kaiser, you're going to have -- Kaiser is going to look different because they're all one managed care plan and they're exclusive.

But when you start thinking about -- you know, a

lot of markets where there are big open plans and everything. What's the value added of managed care? I think that's worth thinking about, and is it measurable? But I think the existing measures that you're trying to create comparability across don't ask that question first, and I think that's what's kind of frustrating and I think we maybe need to go back and think more about what those measures are.

MR. HACKBARTH: I've been a bad moderator here in sort of -- this is an important issue, but I do want to get to the rest of the queue. People are waiting patiently. We can come back to this in the next round, Mike. So I have Jay and then Arnie.

DR. CROSSON: So I will pick up a little bit on what Nancy was saying and what you were saying, Glenn, because I think -- a couple things. First of all, we have a mandate we have to produce a report and it happens to be on these two topics. So I think we're going to have to figure out how to get to the best report that we possibly can.

But I think a couple things. I'd like to talk a little bit about the type of measures and the outcome versus process thing, because I -- and this is an odd thing for me,

because for years in my own organization, I was arguing to move to outcome measurement because I think that a lot of what had gone on 15 years ago or so was very processy and a lot of the review that went on internally and externally was not producing what it could have been.

But now I'm going to argue the opposite, because I think –

DR. MARK MILLER: [Off microphone.] No, man, stay with that thought.

[Laughter.]

DR. CROSSON: While I think outcomes do actually measure the final end point of care, they have that going for them, and they do, as Carlos mentioned, get to things that are complicated and interacting, like care coordination that either results in a good result or it doesn't or not, nevertheless, from a programmatic perspective of trying to apply quality measurement broadly, they're limited. First of all, there aren't that many outcomes that you can measure, that are measurable.

I think with respect to process measures, there are many more processes, of course, than there are outcomes. The things that are done, decisions along the way, do this,

do that, do it correctly, incorrectly, and the like, which broadens the set. Now, let me be clear. I'm not arguing to move away from outcomes towards process measures. I'm arguing that we probably need to consider moving towards a measurement set that contains both.

I think there are time issues with respect to outcomes and process measures. For example, if you wait to measure the care of diabetes for the outcomes, it may take ten years or 20 years, where, in fact, if you measure processes, you can do it more quickly.

There's less need for risk adjustment when you're doing process measures than outcome measures. Sometimes that's a problem, and Michael brought up a set of issues like that.

And process measures are often more actionable than outcome measurements. I mean, if you show the mortality difference that exists between two hospitals, you still have to understand what it is that's being done differently in one hospital versus another that results in the differences in outcome before you can actually take the steps to change something.

So I think my own sense is that although we should

emphasize the need to move to outcomes, I think we should also argue in the report for the validity of process measures. And the reason is, not that I think we want to have an army of chart reviewers or the like, but I do think that what the use of clinical information technology will give us in systems that turn processes into data points -- this was done or it wasn't done in the care of the patient -- will very soon dramatically expand the number of process measures that can, in fact, be accessed.

And this is now my own personal belief, that we're going to get there faster than we think. Part of that is the stimulus money. I think that's going to help. The process of determining what is -- what's the term?

MR. HACKBARTH: Meaningful measures.

DR. CROSSON: -- meaningful measures, I think, will get the thinking going along. And I also think that, in the end, the capital costs of information technology for practicing physicians will fall once it becomes clear that we're moving in that direction because there will be organizations, companies that arise who can push this technology through the Internet for a monthly charge, which is much more accessible by many more physicians than the

situation is now.

So I would just argue that we should think about this in two phases. One is a short-term or intermediate-term, where we do what we can, make some changes, make additions that are reasonable, produce the best thing that we can do in the short-term, but make sure that in so doing we don't hamstring the more important long-term effort, which is to make sure that the development of clinical information technology and its spread is done in such a way -- I'm not a technical person, but that the information that is in the system is designed in such a way that it's capturable, so that we could envision a day when the benchmark that we all talk about when we're comparing quality, we all refer back to Beth McGlynn's study, which was actually 454, as I remember it, process measures, and then the subset of that, ACO measures for the Medicare population.

I think we can envision a day when some significant number of those can be accessed automatically from a clinical information database and used for comparison purposes, and once that happens, we have an extremely robust quality measurement set and a lot of the problems that we're

talking about go away.

DR. MILSTEIN: Because I have several points to make, I'll try to make them very succinctly and just run right through them.

First, I think it's important to bifurcate the chapter, organize around the two purposes on which Congress has asked us to comment, because I think you land in very different places depending on whether you're talking about information for policy versus information to enable beneficiary choice.

Another comment is that this issue of, you know, the scores for MA being higher because some of the plans send armies of medical records folks into doctors' offices to improve the scores relative to what you'd know just from claims data, the good news there is that this is an issue that's been alive for so long, it's actually possible to know for a given measure, on average, how much the score increases when you send the medical records folks out. And so you don't have to standardize. You can just simply adjust for what's known about what is referred to in California as score creep due to hybrid measurement methods.

Third is that, with regard to this EHR and the

degree to which we say to Congress, it's around the corner, my view is that we should model this in our report. We know what the -- thanks to ARC, we know what the current adoption level and the adoption rate is. Yes, it's true due to, you know, the new stimulus money we don't know how much that rate might increase.

But what I'm hearing from the trenches is that for non-large, well-organized practices, this is less like learning to ride a tricycle and more like learning to ride a unicycle. So I think we ought to model the dates so that a lot doesn't get bet on EHR adoption by smaller practices is around the corner.

Fourth, just in terms of how we portray this, I would just say we should move as quickly as we can toward not lumping in one line the HOS with CAHPS, two very different concepts in terms of what you're measuring, especially because the HOS happens to be our best available, well-tested, feasible, currently used measure of outcomes. I mean, it's as close to what most beneficiaries who I talk to want to know as anything we've got. It's risk adjusted, change -- it's change in mental and physical functioning over a two-year period relative to what would have been

expected based on the baseline status of a large sample of beneficiaries. So I just think if outcomes -- per Jay's comment, we want to balance process and outcomes, it's our best available measure -

MR. HACKBARTH: Arnie, I'd be interested in hearing what you have to say about the discussion of HOS in the chapter, which I would -- my take on it was, well, this is not a very discriminating tool. What -

DR. MILSTEIN: Yes. I have a very specific -- that was my next comment.

MR. HACKBARTH: Oh, okay.

DR. MILSTEIN: Thanks for asking. That is, one of the reasons that HOS doesn't show any differences among plans or anything in almost comparison is because, arbitrarily, those who have applied it to MA plans within CMS -- I wouldn't say arbitrarily, a decision made within CMS to only show to beneficiaries difference, whether it is different than expected, with 95 percent level of certainty.

I think available information on not what statisticians accept, but what beneficiaries would accept as a meaningful difference is all over the map and there's absolutely no reason why you could not enable beneficiaries

to not -- there's no reason to blind beneficiaries with respect to differences about which you're 90 percent certain rather than 95 percent certain, because when you do surveys of beneficiaries, it turns out that their tolerance for level of certainty is not the same as professional statisticians. They want to know about differences at lower levels of certainty. And if we were to do that, a lot more -- substantially more MA plans would be shown to be different than expected, both for mental and physical functioning change over a two-year period.

So that's -- the other comment I would make is that -- oh, yes. In the section where we addressed this use of this information for -- to support enrollee choice, both MA versus non-MA and then within MA plan, to go further than we've ever gone before -- I'll just give you a broad charge -- on discussing how we might lower the information gathering and cognitive burden on people over 65.

And last but not least, this issue of, well, gee, you know, in a situation where in a given area almost all the plans are pretty much using the same providers, why bother, it was just something that was dealt with in California, performance measurement, where a lot of the

organized medical groups in California serving the network plans believed that they were adding all the value. The plans were adding no value. And vice-versa, the plan medical directors thought they were adding a lot of value and the medical groups were just, you know, billing pools.

And so, fortunately, a nice piece of health services research has been done to basically show us, at least at a point in time, answer the question, to what degree are quality differences attributable to delivery system versus plan, and I can just -- my best memory of the answer is it was pretty even, which shocked both sides. But it's a clue that measuring performance between MA plans, even when the networks are overlapped, may have value, because there is, at least as of five years ago, there was such a thing as value added from network plans with respect to quality.

MR. BUTLER: It's very complicated, but I'll just make two brief comments. To me, I think part of this gets tied back to our discussion of the previous session, and that is at the heart of the question is the service use almost. What does a managed care plan -- it's called managed care for a reason. So I think there is a

fundamental question, and the outcomes aside, what does the service utilization profile look like in a managed care plan versus a fee-for-service plan? If that is kind of where we are heading in trying to reduce -- and it's consistent with the theme that we have here at the Commission -- so what does that specifically do when we look at the plan versus -- or among plans. That's the first half of the chapter, to me, almost the central focus in my own mind, because I think we're never going to get quite as far and as fast as we want on the outcomes or the process measures.

The second half of the chapter, I think the eyes of the consumer is does a managed care plan facilitate or are they a barrier in, in fact, coordinating the care for me? It's almost as simple as that. Price aside, which is is this a good deal or not, are they my trusted agent that makes it easier for me to navigate the system or harder? It's almost as fundamental as that, because the rest is based on, is this a good deal in my economics, and I'm going to match up my benefit plan.

So there are some ways we could frame this that makes it a little simpler and also be responsive by acknowledging all the problems and shortcomings of the

current data.

MR. KUHN: Thank you. You know, as I've listened to the construct here, I like the notion of the accountability that we're trying to establish here, that is an accountability on a couple levels. That is between fee-for-service and MA, and then within the MA world looking at the various ones in there, whether it's a PPO, private fee-for-service, or whatever the case may be, and can look at those different issues.

And I think part of the charge here that we're going to have to deal with is, okay, where do we sync up on the measures between the both? Readmissions, I think, is one where they all sync up across the way. But, for example, ambulatory care sensitive measures, not really good in terms of measuring on the hospital side. But we could look at and just say kind of, where is the state of the measurement in terms of the bake-off between the two, for lack of a better term, and what additional measure development do we think could help us move in this direction. And I think, yes, we need to be very aggressive in kind of giving CMS some direction on the encounter data as we go forward.

But beyond that, and it's kind of a little bit what Nancy was talking about, and I was thinking about this earlier and then more so when she was talking about it, is is there also a chance for us to press the envelope a little bit here and look a little bit harder at the true clinical benefit or the real evidence of managing care that's out there, and let me give you a scenario that I think is what goes on, and maybe Jay and others can tell me if this is really true in the managed care world.

But my understanding is that in the managed care plan, when they see a diagnosis code, perhaps comes in for diabetes, that triggers certain actions by the plan to begin managing immediately that person as soon as they see that code the first time as it comes through. Compare that to the fee-for-service side of the world. The MAC gets a claim in with a diagnosis code for diabetes. They pay the claim. Nothing happens. It's basically up to the physician independently on their own devices to go and manage that patient, and they may or may not depending whether they go see a subspecialist, an endocrinologist or whatever the case may be that's out there.

So the chance for us to maybe reach a little bit

into the future and think about the true role of managing care as perhaps these new delivery systems, whether it's the medical home, ACOs, other things start to go forward. So this report, hopefully, doesn't just look at the here and now, but helps us begin to think five years down the road where we hope some of this stuff will be and really kind of testing that value might be a good value proposition for us to think about as we go forward here.

So encounter data, yes. In terms of really kind of managing the true value of managed care, yes. And then in terms of the EHRs, I mean, the fact that we have encounter data now but maybe five years from now -- got our fingers crossed -- we could have a wealth of new information starting to flow through the Health Information Exchanges that are out there, the possibilities kind of boggle the mind here. I don't even know where to begin on that, but I think we have to come back and look at that a little bit more and think pretty hard about it. I don't have any specific direction for you all right now, but this is something that we could not, should not, overlook as a possibility.

MR. HACKBARTH: You know, Herb's comment makes me

think about another example where you might find a material difference among even plans with big networks, in the readmissions area, based on what sort of investment and the effectiveness of the investment made by a plan to bridge the transition from hospital to outpatient.

MR. KUHN: And that's really captured, and again, they have those sensitive measures they're doing now. And again, it's a chance for us to really measure the true value of -

MR. HACKBARTH: Right.

MR. KUHN: -- managing care and show that differentiation. It could be pretty exciting, pretty powerful.

DR. BERENSON: Could I just jump in on that one? I mean, I do think readmission is a good one, but it could be that there are -- I mean, a lot of those readmission issues are marginal -- congestive heart failure -- and it may well be you have patients who in a fee-for-service environment are just readmitted, whereas in a managed care environment are equally sick, but they don't readmit and do something else. And so that's -- I mean, I think readmissions is a good quality measurement. I think you

mentioned that it's not a perfect quality measure because you get different behavior. I mean, you just have to take that into account. That was my point.

DR. SCANLON: Yes. My comment relates in part to some of the things that Jay was saying, because I think that I would say that, apart from what the major purpose of the report is, that we should take advantage of the opportunity to really push on the whole idea of meaningful use, because I think this goes way beyond sort of this report and there is a real issue that we not squander this investment if we want sort of a better future.

I see the possibility with Electronic Health Records that ultimately you get databases that you not use just for quality comparisons, but you can use them for post-marketing surveillance of devices and drugs. You can use them for improving payment methods, improving risk adjustments. You can use them for fraud, waste, and abuse, sort of to identify target areas. You can use them for comparative effectiveness.

But getting to that point is not an easy step. I mean, right now, in some respects, there's a possibility that you end up with Electronic Health Records that are

sitting in individual physicians' offices and sitting in individual hospitals and it's very hard to get the information out of them.

The idea of Health Information Exchanges is seen as one way of getting some of that information. There are very, very few of them around the country, and even if we get more, there's a question of how are we going to -- and ultimately aggregate the data so that we can really use it for the purposes that we want.

One thing to consider, and I think there's at least a short-term aspect to this, which is maybe sort of an incremental step, is to think about we should change the nature of claims, or what we have on claims and encounter data. We've got a recommendation from a number of years ago about adding lab values, and our AHRQ has shown that lab values make a big difference in terms of risk adjustment. It wouldn't be much effort to put that into sort of a new kind of a claim for the future.

One of the failures that people complain about with respect to HIPAA is we really didn't get claim standardization. We got standardization of kind of the front piece and then there's all kinds of payers are adding

on addendums to that and so that providers have to fill out all kinds of different forms. If we got serious about administrative standardization and said, here is the record that we want you to provide because we know you can provide it through your Electronic Health Record, then we would potentially be saving providers a lot of hassle sort of in the process.

Jay's point about the future in terms of clinical measures, I think, is also a critical thing to think about. The Policy Committee, the HIT Policy Committee that was set up under the Stimulus Act has portrayed sort of this meaningful use as an evolutionary process, that you can't specify meaningful use today and think that it's going to be satisfactory five years from now or ten years from now.

You need to think about it sort of as something where you add requirements as you go along, and that's a somewhat novel concept for government. There's this notion that government says something and then, well, you can't renege. You can't ask for anything different or anything more. And they're saying up front, no, we are. We're going to ask for new things as time goes on.

And I think it's good to establish that principle

and to stick to it, because the kinds of clinical measures that Jay was talking about, they don't necessarily exist today, okay, but they're going to exist at some point in the future, and when they do exist, we want to say, we want to capture them because we need them in this database, and we don't want to hear that, oh, it's too much to retrofit. No, you should have built in the capacity to retrofit from day one. I mean, that's sort of a key sort of part about this.

I think one of the last reasons sort of that I would say why it would be valuable for us to weigh in and say we think meaningful use should be really meaningful is related to the comment that Arnie made, which is a comment that I've heard about, I mean, in terms of people are saying, this is a tough job to implement sort of the IT. And the answer is, yes, maybe it is, but you're capable of it. I mean, when all you folks applied to medical school, you said you were the best and the brightest. Riding a unicycle shouldn't be that difficult, okay. So let's go forward and do this.

And I have -- sort of my economist perspective is that it's in your advantage to say it's too difficult to do because then you don't have to do it. But the demand side

of this market should be saying at this point in time, we need this information. We need it for a variety of reasons, for quality reasons, for worrying about control over costs, and it's absolutely essential that we get it.

MR. HACKBARTH: Okay. We are at 5:15 now, which is the appointed time to end this, so rather than try for a round three, we're going to call it quits for today and Jay, Mark, and I, we'll put our heads together after a careful reading of the transcript and talk to Carlos about how we can significantly advance the ball for the next discussion, which I think we really need to do. We need to start focusing in.

DR. MARK MILLER: [Off microphone.] I have some ways to structure the choices.

MR. HACKBARTH: Okay. So this -- although it wasn't maybe as entirely focused as we could have dreamed, I think there was a lot of important stuff here that gives us the raw material for taking that next step.

Thank you, Carlos, for filling in for John in a pinch.

[Off microphone.]

MR. HACKBARTH: Yes. So we're now to the public

comment period and the usual ground rules. I know Dr. Rich knows his ground rules. Number one is introduce yourself and your organization. Number two is please keep your comments to no more than two minutes. I know that's brief, but as I always remind you folks, the most important way to contribute to our work is by working with the staff, as I know many of you do. After the two minutes are up, this light will come back on, and at that point, please bring your comments to a conclusion.

DR. RICH: Thank you, Mr. Chairman.

My name is Bill Rich. I'm the Medical Director of Health Policy, American Academy of Ophthalmology, and I wear a new hat. I'm Chairman of the Health Professions Council at the NQF.

To address Dr. Kane's point about the need for comparative information to measure physicians and patients' choice of comparative efficacy of drugs, we are looking at appropriateness measures. But that is really going to be dependent upon what is in comparative effectiveness. If you look at the IOM priorities that came out last month, there were very few head-to-head drug recommendations. So I am not as optimistic as I was before the IOM came out.

Secondly, the whole issue of how the NQF is looking at measure outcome, we are actually seeing very substantive outcomes measures for the first time. The difficulty is incorporating them in to -- collecting them. That is going to have to be done through something other than administrative claims data. We are not going to have HIT or EMR, especially in specialties, until well after 2011. So you're going to see the development of registries, which CMS is pushing and stimulating. Many specialties are in the process of adapting registries.

However, there doesn't seem to be -- to help you in your last issue of discussion here, Mr. Chairman -- people are not collecting the same data. CMS has really taken the lead and we're not really seeing either MA or the commercial plans adopt any meaningful process or outcomes measures. Hopefully this report will actually stimulate the collection of that comparative data that doesn't exist now.

The last comment I'd like to make is on a personal level. Dr. Crosson really put his finger on it. You need meaningful process measures and outcomes measures, and the two are not necessarily linked. A recent article in Health Affairs showed that the outcomes of hip replacement surgery

was not related at all to the process measures. However, there are certain process measures that have marked impact on health outcomes: hemoglobin A1C, retinal exams. And so there really has to be a combination of the two.

But I would hope that this report will emphasize the need to coordinate common collection of data. We have to figure out a mechanism because HIT, unfortunately, is going to be down the road.

Thank you, sir.

MS. HELLER: Hello, I'm Karen Heller, Executive Vice President from the Greater New York Hospital Association and my comments are about the topic of geographic variation. I want to praise and thank the Commission for the study it's doing. It is vitally important to get out there standardized Medicare spending data.

I understand that there's a controversy about IME and all the other add-ons, but the Commission and various Commissioners are on the record about that. It's important to distill the true differences in utilization. And so I thank you.

I also want to point out, I've been working with

CMS on this and was a little concerned about something they told me on Monday, which is that the risk scores in that Medicare Advantage section reflect the average of the managed care and the fee-for-service.

So even though we're standardizing by the risk score, the risk score is probably -- since the fee-for-service population is generally sicker -- we're probably understandardizing even with this -- even with that. But I agree, it's the only thing that's available.

Then lastly, and I'm sure everybody has looked at this already, but a question came up about quality measures. The fact of the matter is that there is an inverse correlation between the spending data and the new risk-adjusted mortality statistics for hospitals. This has been available now since early July.

And so I don't think the inverse correlation is strong enough to get into a peer-reviewed article, but it's still something that's there and something to be looked at and added to the discussion.

Thank you.

DR. ROSINSKY: My name is Ned Rosinsky. I'm a psychiatrist associated with the Johns Hopkins Medical and

Surgical Association and an amateur public health researcher.

I just wanted to address the point made by Dr. Chernew regarding patient mix, first. The Wennberg Atlas, to my reason, has no socioeconomic data whatsoever. Socioeconomic issues are related to footnotes which, when you trace them back, come to aggregate data based on ZIP codes. And the footnotes to those studies by Elliott Fisher do not support his stated assertion in the articles, that they are reasonable proxies. They are not reasonable proxies.

In fact, there is research at the Harvard School of Public Health by Nancy Krieger that shows that between one-third and one-half of poverty is covered up when you compare ZIP code aggregate data with 30,000 people apiece to block track data of 1,000 people apiece.

So the lack of finding of these regional variations by Wennberg that is explained by -- it could be explained by socioeconomic differences in the populations, is thrown into question. For Wennberg, it's past history. He doesn't even bother to put it in the atlas. But to my mind, it is very much on the surface, and I appreciate the

comment made by Dr. Chernew.

I also want to address the issue of severity, which was brought up in terms of the three o'clock discussion. Under general agreement we have regional variation exists and is not fully explained by prices or health status. The question of health status has been buried and is just as murky as the question of socioeconomic data, as far as I can see.

Again, the Wennberg Atlas refers back to a 2004 study by Wennberg by himself, which then refers back to a 1994 study by Lisa Iezzoni -- who happens also to be at Harvard -- who did studies on the severity of illness. And those studies are what Wennberg is referencing, the Iezzoni studies. And Iezzoni correlated severity of illness, particularly chronic illnesses with death in the hospital and correlating with discharge diagnosis. However, death in the hospital is certainly not a measure of anticipated health care costs.

So it looks to me like when Wennberg is talking about severity not explaining these issues, he's using the wrong measure. I understand that the measure that you use in the HCC includes Medicaid -- if a patient has Medicaid,

which is somewhat of an indicator of socioeconomic status. But I think a better measure was actually done in an analysis of the New Yorker article that I heard referenced here three or four times today, the Atul Gawande article.

The same data was looked at by Daniel Gilden, who runs Jen Associates in Cambridge, Massachusetts. And he used a severity indicator called his Fragility Index, which associates bill diagnosis in Medicare with things like vision problems, dementia, poor self-care. And with his fragility index, when you line up patients with equal fragility and compare them between McAllen, El Paso, and Grand Junction, the benchmark city that was in that article, they are identical except that the highest severity of fragility, in which McAllen was 10 percent higher, not 300 percent higher.

This article by Dan Gilden should be reviewed by your staff to see how he arrived at -- I have copies of it here if anybody wants to look at it -- see how he arrived at his Fragility Index, which just really undercuts this article in New Yorker, which of course President Obama was famous for having raised as this is what we have to fix, in a New York Times article describing his reaction to it.

So I just want to say that I think a little more careful look at socioeconomic and severity of illness variables may help to explain a lot of the variation that you've documented, certainly much more than is explained in the Wennberg Atlas.

And anybody who wants additional information, I have it here after the meeting.

Thank you.

MR. HACKBARTH: Okay, thank you and we are adjourned until 9:00 a.m. tomorrow.

[Whereupon, at 5:25 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, September 18, 2009.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, September 18, 2009
9:00 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, J.D., Chair
FRANCIS J. CROSSON, M.D., Vice Chair
MITRA BEHROOZI, J.D.
ROBERT A. BERENSON, M.D.
JOHN M. BERTKO, F.S.A., M.A.A.A.
KAREN R. BORMAN, M.D.
PETER W. BUTLER, M.H.S.A
RONALD D. CASTELLANOS, M.D.
MICHAEL CHERNEW, Ph.D.
THOMAS M. DEAN, M.D.
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
NANCY M. KANE, D.B.A.
HERB B. KUHN
GEORGE N. MILLER, JR., M.H.S.A.
ARNOLD MILSTEIN, M.D., M.P.H.
WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, Ph.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: Okay. Good morning. We have a guest this morning. Cristina, will you do the introduction?

MS. BOCCUTI: Sure. I'd be happy to. This morning we have Dr. Russ Robertson from the Council on Graduate Medical Education, which is COGME. This is a council set up by the Secretary of Health and Human Services -- I think out of HRSA, right? But he is going to talk more about what the organization is. But by way of introduction, he is also a professor and chair at Northwestern University in the Department of Family Medicine, and he has had a career of thinking about some of these issues. So we are happy to have him here this morning.

I'm going to let him stay here on his own so I do not jump in, but I will be right back if we want to have any other talk about the work going forward.

DR. ROBERTSON: Thank you very much. It is a pleasure and a wonderful opportunity to be able to be here.

Just before we get going, I just want to let you know what a wonderful staff you have. You probably already know that, but having had the opportunity to work with Mark and Cristina and Jim and Craig has been really helpful. And

I look at this meeting as really, for me anyway, a continued discussion that I think was able to start with MedPAC, or perhaps revive. As I look back on the previous Chairs of COGME, there had been interactions with MedPAC and its predecessor, and those had sort of gone fallow, so to speak. And it just really made sense, based on the overlapping missions that we have, to really revive the interactions that have been taking place. Kevin Grumbach was here, and I think that he probably commented on some similar issues. And so what I look at what we're going to be doing today is really a continuation of that discussion and hopefully engagement as we all go forward with regard to the missions to which we have been charged.

Just another quick comment I wanted to make is that, you know, I'm grateful to be a family physician, but I know at the present time there are certainly controversies or tensions that exist between specialties, and I'm really not here as a part of that today. If you could not think of me as a family physician today and perhaps think of me with my former career in mind as an elementary and junior high school teacher, not because you are at that level with regard to your education, but that's what I really like to

do. And that was a lot of what led me into medicine and what led me into family medicine, was that background. So hopefully, if that is an issue, I'd like to at least take that off the table.

So I'll jump into my slides here, and as I was saying, a complaint about having to wear glasses at this particular stage of my life. So just a little bit about what -- this is an overview, so I'll be talking about the history of the Council of Graduate Medical Education and its charge. And by the way, I'm going to try really hard to keep this to about 15 to 20 minutes because I'm aware that there's a lot of opportunity for discussion, and I don't want to do anything that would diminish the possibilities of doing that.

The council tends to take on issues sort of one at a time, and I think that seems to work best. Right now the issue that we are looking at is: Where are we as a nation with regard to primary care? Where are we with regard to educating the cadre of physicians that are going to be providers of primary care? And by way of explanation, we have a meeting coming up on the 17th and 18th or the 18th and 19th of November. I'm clearly aware that primary care

physicians are not the only physicians that are in short supply. We have the president of the American College of Surgeons, Dr. Russell, whom I've invited as a presenter for that meeting because there are clearly issues there. And I'm also aware that for certain internal medicine subspecialties, like infectious disease, rheumatology, endocrinology, there are shortages there.

So, believe me, there is a broad awareness that we have of that. But as we look at this from a priority-related standpoint, this seems to be where the council wants to go right now.

I'll talk a little bit about what's happening with graduate medical education and how it's growing in hospitals at the present, and then I'm going to go over some COGME recommendations specifically from the 19th report, and then we'll talk a little bit about -- there have actually been three reports that COGME has issued in the past that look at the issue of all-payer. So, with that, I'll jump in.

Just by way of me, as well, too, this is actually my second term on the council. I started in 2004 -- or 2003, and at the end of that term, I found myself as the Chair and was actually kind of enjoying it, so I asked

whether or not there would be the possibility for me to serve a second term, and that request was granted. And so I'll be on the council until 2011.

The council started back in 1986, but then it was called GMENAC, if anybody remembers that acronym, the Graduate Medical Education National Advisory Committee; and we sort of have continued to exist based on some periodic congressional reauthorizations. We sort of go on life support for a while, but nobody ever quite disconnects the ventilator, and we are able to continue to move along. And so those are the circumstances right now. We were in the major bill that was passed, so we are authorized through September of 2010. At the present time, we're supposed to provide an ongoing assessment of physician workforce trends, training issues, and financing policies, recommend appropriate federal and private sector efforts. We advise and make recommendations to the Secretary of HHS, the Senate Committee on Health, Education, Labor, and Pensions, and the House of Representatives Committee on Commerce. And those are our primary constituents to which we report.

We also have a very broad membership, and just as your membership has some statutory foundations, so does

ours. And so it's a wonderful mix of individuals, and so as a consequence, we really do represent a broad consensus. And I would also comment that all of the reports that I've been responsible for have all been approved by consensus. We do not necessarily take a formal vote, but the discussion is sufficient so that, whatever we issue, everybody has generally had an opportunity to have his or her opinions known.

I wanted to set the stage a little bit. We brought in a consultant from what is called the Altarum Group, a group of health care economists, to provide us with a context for where the nation is at it relates to primary care.

Right now, about 65 percent of all physicians in the U.S. are specialists; 35 percent are primary care physicians. Primary care, the definition that we use, is general internal medicine, general pediatrics, and family medicine. So those are the three specialties.

What the consultant did was looked at questionnaires from the 2008 graduates of all U.S. allopathic medical schools and osteopathic medical schools to assess what their interest was with regard to career

choice. Of that entire cadre of individuals, only 17 percent of them saw primary care, one of those three primary care specialties as their ultimate career choice.

What happens is, as a consequence of not everybody getting what otherwise their first choice was, about 27 percent of those students will end up in a primary care career. I think part of what we are talking about here are physicians are going to be taking care of adults, and so when you look at that 17 percent, probably about 5 percent drop out. So we're looking at around maybe 10 or 11 percent of current U.S. medical students that see themselves as primary care providers.

This was underscored in an article that was in JAMA last year that showed that 2 percent of U.S. medical students saw themselves as future general internists; about 4.9 percent saw themselves as family physicians.

When you look at other nations that have comprehensive policies with regard to universal access to health, the ratio of generalists to specialists is about 50/50. They also generally have a higher per capita number of physicians than we do, and so this is part of what is framing where we are with the second report.

So we are talking about where we are with regard to primary care. One of the statistics that is out there recently is that right now in Massachusetts it is a 66-day wait if you want to see a primary care physician. That is relatively recent information. So we've got concerns with potential supply, something I think looks like it may be happening with regard to health care reform.

Where are we with regard to the number of physicians that are going to take care of potentially 30 to 40 million new Americans? The AAMC has registered significant concerns about that. They project a physician shortfall of about 31,000, and that is across the board. That is not just primary care. A worry that we have is the potential for long waits, the potential for difficulty for access if there are an insufficient number of physicians to be able to do that.

There's probably going to be some increased reliance on -- the phrase is always difficult to use -- "physician extenders," physicians' assistants, advanced practice nurses. I think that the role that they are going to play, by intent or default, is going to continue to be a significant issue.

Some of the other things that are being talked about internationally, the World Health Organization put out a report last year entitled "Primary Care: Now More Than Ever." And one of the phrases that they reference is a phrase called "task shifting" and looking differently at the way that health care tasks are allocated and who does them. And one of the proposals that they have is that some of the tasks that specialists do could be moved to primary care physicians; primary care physicians to physician extenders or others.

There was an interesting article that was in the Annals of Family Medicine where it showed that as many as 70 percent of all visits to specialists currently in the United States are actually follow-up visits for chronic or routine care, and alleged that some of those visits could actually be performed by primary care physicians as opposed to specialists.

The other topic that's out there is there's a lot of talk about interdisciplinary care, interdisciplinary education. The three Title VII and the one Title Committee at HRSA have issued a report about that. We have been working on that collaboratively and where that might go.

When we think about the patient-centered medical home and those sorts of issues, I think that's something that's of import to consider.

Significant problems with regard to access for underserved populations and communities. There are some remarkable geographic maldistribution issues that are out there right now, and clearly the place where I practice in Chicago is in a medically underserved community, certainly shortages there. And I would imagine that you all are aware of some of the significant shortages that exist in rural settings.

One of the options that is being talked about is a proposal called "Teaching Health Centers," the notion that graduate medical education funds, instead of being given to a hospital, would instead be given to an ambulatory or community-based entity that would then be responsible for overseeing the educational process of primarily physicians who are learning and training in the ambulatory setting.

One of the things that's popping up now, for those of you who privilege physicians, is: How do you privilege a doctor in a hospital if he or she never sets foot in the hospital to practice? This is happening with family

medicine, with general internal medicine, with pediatrics, and with a number of other specialties. So the notion of the hospital as the nexus of graduate medical education certainly then should follow if we are having discussions about where physicians are or are not practicing.

I'll talk a little bit about Title VII funding. This is an issue for the primary care specialties. If there is sort of an analog to the NIH for departments that have an emphasis on primary care, you can certainly see that the trend curve is problematic. There was a Macy report that came out this year that shows a really strong correlation between Title VII funding and the production of primary care physicians. And what had happened in the previous administration is that there was a -- the way in which Title VII was scored, they were not able to document what they felt was a good value, and so, historically, the budget for Title VII was virtually zeroed out. And then, you know, with congressional intervention, there was some improvement. But there are a lot of novel GME-related programs that have been historically funded by Title VII that have been significantly depleted as a consequence.

I checked yesterday, and I don't know that there

is anything specific that has been done with Title VII at the present, but I think there's reasonable hope that there will be improved funding for Title VII funding.

This slide is based on an article that came out where Ed Salsberg from the AAMC and Paul Rockey from the AMA were lead authors, and we are looking at sort of what is happening right now with growth in graduate medical education positions. And there actually has been growth. You know, the cap, as you all know, was implemented in December, I believe, of 1996, and so there have been very few new Medicare-funded GME positions. But what has happened is hospitals have, in spite of that, chosen to fund graduate medical education positions, and during the period of time here, there has been about a net 8-percent increase in GME-funded positions, and they're in anesthesia, diagnostic radiology, emergency medicine, pathology, and psychiatry, and decreases in primary care specialties and OB/GYN specialties.

There has been about a net 37-percent decrease in the number of family medicine positions, and there have been similar but not quite as significant decreases in general internal medicine and pediatrics positions. So we have this

sort of interesting dichotomy where hospitals, you know, for very understandable reasons, continue to fund out of their own revenues positions in specialty areas, while at the same time, and for a couple of reasons that I'll go into in another slide, positions in primary care are diminishing.

Just a comment, too, about this slide is that there is a proposal now in current legislation that would redistribute currently vacant GME positions, and I think about 75 percent of those positions are projected to go into primary care and the other 25 percent into specialty care. On the surface, that sounds great. I think what would likely happen when you look at the cost of running different kinds of primary care settings -- and specifically family medicine programs are considerably more expensive to run than are general internal medicine and pediatrics. What we think would happen is many of those positions that would end up in general pediatrics or general internal medicine would perhaps unintentionally -- my choice of words -- still end up being a continued conduit for medical subspecialization. So I think that is a concern that I just wanted to raise.

Just a little bit with regard to what's happening in family medicine. This goes up to 2008. You can see the

positions have dropped considerably. By no coincidence, they were at their peak in the mid-1990s, and that was when managed care was looking like it was going to be the future, and there were a number of dynamics that really aligned at that time with significant interest in family medicine.

I have just two quick stories about how family medicine residency programs closed. One is a family medicine residency program in Racine, Wisconsin. This was a program that was administered by the Medical College of Wisconsin. By pure literal coincidence, I was interim chair of that department for a couple of years, and I moved that residency program from a hospital in Kenosha to the hospital that it found itself in Racine.

Racine is a town of about 200,000 people. Case is based there; Johnson & Johnson is based there. So, you know, it's a community that certainly is not on the ropes financially. And the way the residency programs work often in family medicine is that you end up, by default or intent, taking care of the patient population that the private physicians in the community would choose not to take care of.

And this particular residency program had a very

high percentage of its patients who were on public aid -- Hispanic and/or African American and underinsured and/or uninsured. And when you look at the sources of funding to run a residency program, you have the GME funds that the hospital makes available; you have clinical revenues; and in Wisconsin, actually the State of Wisconsin made money available from a legislative perspective to help support training programs.

But in this program, literally the bottom line was the bottom line, and when the hospital looked at the cost of running the program, there was pressure on the department; because the program was running at a financial deficit, the program was closed. And so all of those patients that were being cared for that were getting primary care in that setting were more or less left to fend on their own, and based on what we know, more than likely many of them will find their way to the emergency department and ultimately into the hospital. So what often looks like a short-term way to reduce an immediate and apparent loss is translated into higher costs. And from my perspective, the thing that I feel the worst about is people are unintentionally going to suffer as a consequence by lack of access to health care.

I think that really should be the driving issue.

The other story is a family medicine residency program that was based out of Wayne State University in Detroit. The Detroit Medical Center, which is not a part of the university or the medical school, made a decision, an explicit decision that they were not in the primary care business. And so when they looked at how they wanted to fund residency training slots, they had a very successful family medicine residency program that was located in a medically underserved section of Detroit, and they said, "We don't want it anymore." And the department chair was forced to look for another location for her residency program and ended up actually finding it in Rochester, Michigan, a suburb of Detroit.

They got the program started, and I will not go into a lot of details, but there was a CMS ruling that was made formally while that program was transferring, and they are currently struggling right now. They were a 24-resident program. They are looking at dropping to a 12-resident program and just frankly looking at surviving.

So those are two stories that are very contemporary with regard to what is happening with that.

Here is a slide that we have to talk about a little bit, and it is the whole issue of who is going into what and what are the motivations for why they're doing it. And there are a number of reasons. You know, I am not going to tell you here if you pay primary care physicians a half a million dollars a year, you'll solve the problem. I think that's an overly simplistic solution. And I think in some ways it's almost a little bit morally offensive, and I think that's not an area that we want to get into. But there are a couple of issues here, and a lot of this is supported by a Macy Foundation report that came out this year.

One of the problems is that there is what we say is a "hidden curriculum" in medical school. There's the formal curriculum and then there is what gets talked about in the hallway and which specialty you want to go into. And, you know, unfortunately, I will resurrect my role as a family physician, and what happens to a lot of us is what I truly believe are well-intended professors in medical school, when you say that you want to become a primary care physician or a family physician, "Well, you're such a smart person. Why would you want to invest your career in that specialty?" And that happens, and it's happening today.

It's just a reality.

Now, the other problem is that, particularly in academic health centers, students are exposed to the very best that specialty care can provide. They see absolutely phenomenal environments where literally cutting-edge care is taking place. And often the primary care physicians that they're exposed to -- general internists, general pediatricians, and family physicians -- are struggling. They're struggling economically. They're struggling from a lifestyle-related standpoint. And while they're doing their best to teach, that's not what the students are walking away with.

We had a program when I was in Wisconsin where we funded a summer externship for medical students, paid them $2,000, put them with a family physician in rural Wisconsin, and they came back with two distinct impressions: Dr. So-and-So is the most wonderful person I have ever met. He, or she, is a self-less individual, and no way do I want that lifestyle. And, unfortunately that is an impression, wrongly, that a lot of medical students have. There are some phenomenal things that are being done in primary care right now with the patient-centered medical home. But,

unfortunately, students aren't seeing them.

The other issue, still, it is the income gap. I think that's something that's out there. And based on, you know, people talk about loan or indebtedness as a driving factor for specialty choice. The AAMC says this and the Macy report says this, that loan forgiveness is a factor or debt is a factor, but it's not the key factor. The key factor, if you're looking at finances, is return on investment. And the difference between a primary care specialty and a procedurally driven specialty over the course of an individual's lifetime is about $3.5 million in terms of lifetime income. This is information from the Macy report. And so students are aware of that in the context of making their decisions as they decide what they want to do.

The other problem that the Macy report has brought up, and others, is medical school admission policies are problematic, that most medical schools, understandably, like to talk about their average MCAT scores, their average grade point averages. Well, the people who best fit that profile come from well-to-do, mostly suburban-urban settings. Those people do not want to go to a remote rural or a medically underserved setting in general. It's not because they're

bad people. It's just that that's the consequence of the environment in which they live.

There's explicit information out of the Robert Graham Center here in D.C. that shows that the number of applicants to U.S. medical schools from rural communities is a steady state number. They just don't get in. And when they do get in, there is real evidence that shows that they do return to the communities from which they came to practice, and they often go into primary care. So I think it's another issue that needs to be considered as we look at this particular issue.

So talking a little bit about the 19th report for COGME, we issued two reports about a year and a half ago, and we came up with four recommendations, and I'll just go into them in a little bit more detail. I think I'm doing pretty good time-wise here.

We had four recommendations: that we felt that graduate medical education should be aligned with future health care needs, and we recommended a funded increase in GME positions of about 15 percent to be able to accommodate that, and we felt that it could be accommodated through medical school expansion and through support directed

towards innovative training models which address community needs and which reflect emerging, evolving, and contemporary models of health care delivery.

The Teaching Health Centers proposal that I referenced really fits that to a T, but that has run into two fairly significant obstacles. First, when you talk to staff from the House Ways and Means Committee and then you look at the patient population that gets cared for in federally qualified health centers, which is what we're talking about, it's maybe 5 to 10 percent of those patients are Medicare-eligible patients. And if you apply Medicare GME rules to a 5- to 10-percent patient population, there is a way that you can fund them, but you'd be nuts to do it because there's virtually no money in it. And when you share this conversation with Ways and Means staff -- and particularly a phrase that I have picked up on is sort of the "pre-Medicare population." I mean, theoretically, you're training physicians that are going to take care of Medicare-related patients. They default to the standards that basically Medicare GME is to be allocated and paid for for larger percentages of Medicare patients, which is the hospital.

The other organizations that generally don't look kindly on this is the AAMC. The concern that they have expressed is that, you know, GME money should go to the hospitals, and that's basically the way it is. We've had some good conversations with the AAMC, and they have been really wonderfully engaging. And I think that there are some other ways to perhaps address this. But that's basically where we are with this.

The second recommendation somewhat really follows the first, and that is, broaden the definition of the "training venue." You know, again, where are physicians practicing today? You know, why should you have this potentially intensive inpatient hospital-based experience when you're going to spend the majority of your career practicing in a non-hospital setting? That really isn't recognized in any formal way with regard to the way GME funding is currently based.

The third recommendation is to remove regulatory barriers to executing flexible GME training programs and expanding training venues. There are some rules right now that CMS has that make it difficult. One of them is called sort of the community preceptor rule and the ability to fund

graduate medical education and to support the instruction and/or funding of faculty members who are working in non-hospital settings. I do not believe that CMS is purposely being not cooperative. We have a CMS member on COGME, and he is a wonderful person, a tremendous resource. And so this is not from my perspective an opportunity to complain about CMS. They have a number of other issues with which they're dealing, and I've been very grateful for the degree in which we have been able to communicate with them.

And the last recommendation is to make accountability for the public's health the driving force for graduate medical education. You know, basically this kind of calls the question: You know, what does GME exist for? Who are the people that are going to be the recipients of care that is funded by graduate medical education? And are we doing that right now, or is this an opportunity to look differently at the way we pay for graduate medical education and where the training is occurring?

We on COGME would argue that there's currently a significant disconnect with this, and I think that is where these four recommendations are derived.

Then the last thing that I wanted to talk about is

the issue of an all-payer approach to graduate medical education. When I went through the archives of COGME and then talked to Jerry Katzoff, who is our Executive Secretary, who has been there since the beginning -- he is sort of an archival presence as well as a wonderful fount of wisdom. Three times the Council on Graduate Medical Education has advocated for an all-payer system to support graduate medical education. We know that Medicare, through GME funding, is the primary source, but there also are Medicaid dollars that go into graduate medical education. The VA makes a major contribution to GME. We're aware of that, too. And we learned recently that actually the VA is looking at primary care differently and perhaps even willing to look at funding some sort of an approach to family medicine, which would be a substantial change for them. So in terms of people that are out there kind of wondering about what is going on, it is nice to know that the VA is looking at that as well, too.

You know, I am sure for reasons that we can all hypothesize, this has never really gained significant traction, and I will not go into a lot more detail because I think I'm beyond my 15 to 20 minutes. But in the COGME

reports that came up with this, there were a number of ways that this could be done.

One that already is being done right now is in Utah. Utah has a graduate medical education consortium where the GME slots for the state are addressed centrally, and then there's a group that makes -- they have a special waiver from Medicare to be able to do that. And the conversation -- and for the most part, I think, it has been something that people are pleased with. The question is whether or not something like that would work everywhere in the U.S. Utah has one medical school. States that are like that, I think it's easier to put together something along those lines. But one could argue that graduate medical education consortia could definitely be developed in smaller academic communities, but it would require, I think, an unprecedented degree of cooperation and collaboration to be able to do something like that.

The methods for funding it would be some sort of a surcharge on private insurance to be able to cover that. The reports did not go into any detail with regard to what that should be. But, again, you know, everybody sort of has a stake in what's going on right now, and I don't think it's

unreasonable to look at other sources or payers for graduate medical education.

One quick comment is Tzvi Hefter is the person who is on CMS that is on COGME, and I asked him what was happening to the growth in graduate medical education slots before the cap was placed, and they were growing at about 4 percent per year. And if you do some back-of-the-napkin calculations, right now there are about 25,000, 26,000 PG1 GME positions. If that had been allowed to grow at about 4 percent per year, I think I came up with something like 38,000 PG1 GME positions. You figure Medicare in spending about $12 billion a year on graduate medical education. Imagine what that would look like if we had not put the cap into place, and particularly if the continued predisposition of U.S. medical students to choose specialty care had been preserved in the context of that expansion. You can hypothesize this to where we might be with a health care expenditure perspective with that.

So I'll end my comments there and be happy to entertain questions.

MR. HACKBARTH: Thank you, Russ. That was terrific. We are still very much in the exploratory phase

here, learning about these issues, so I think we'll probably have lots of different areas that people want to explore with you. Our practice is to have several different rounds of questions, and the first round focuses just on clarifying specific points that you made.

So let me ask Commissioners, are there any clarifying questions for Russ?

DR. CASTELLANOS: We didn't have a lot of material to review before you came, but one of the points you made on the COGME was the third point about funding undergraduate education. I would imagine undergraduate may mean medical school education. We've struggled with this point before. We understand the graduate being funded. What direction are you doing to help fund medical school undergraduate education?

DR. ROBERTSON: Well, specifically, certainly that's not a charge that COGME has, and so we have not spent time or energy on that. So I don't have an answer for you other than that's not been a part of what our responsibility has been.

DR. CASTELLANOS: Thank you.

DR. CHERNEW: When they make their forecasts of

specialties and shortages, what do they assume about sort of the productivity, the number of patients that can be served by the existing physician base and new physicians?

DR. ROBERTSON: Who do you mean by the "they" that make the forecasting?

DR. CHERNEW: Well, you had a slide, for example, that talked about the different groups of projected shortfalls of -- I'd have to go back to see what the source of that was, but I've seen others as well.

DR. ROBERTSON: Well, I think generally we look at the patient population in the U.S. We compare what goes on here with countries that have taken a different approach to primary care, and that's where the 50/50 numbers come from. That's generally what you find in most Western European countries, and so that's where that projections comes from.

The other data that we showed is just real data with regard to what medical students are doing here in the U.S. and how their career choices are defining the direction that the specialty/generalist mix is taking at the present.

MR. HACKBARTH: Actually, my clarifying question was along the same lines. Do you make your own independent assessment of long-term needs? Or you are just reviewing

literature produced by other organizations?

DR. ROBERTSON: Well, for the last report we brought in the Altarum Group. They were the source of information that we built a lot of that one. But we're all, I think, relatively knee-deep in the literature that's out there, and so we try to follow that as well, too. So I think it comes from a variety of different sources. Again, we try to be relatively ecumenical in terms of the way in which we gather and process information.

MR. HACKBARTH: Okay.

DR. STUART: Could we look at Slide 9 again, please?

DR. ROBERTSON: Sure.

DR. STUART: Do you have any sense of what that line would look like or where family practice, rather, would be on that line if, say, through some magical intervention the average pay went from under $200,000 to $300,000? In other words, is there a sense of how important money is irrespective of all of the other things that you've talked about?

DR. ROBERTSON: There are two sources of information that we have for that. One is the Altarum

Group that did our projections, and the other is material that came out of the American College of Physicians.

The Altarum people said that they would recommend that if you could raise the incomes of primary care physicians to 60 percent of that of specialty physicians, that would make a big difference.

The ACP made a much more aggressive recommendation. They picked 75 percent as the threshold. And the dollar figure, nobody really wants to be real specific about that, but when we push, probably it's somewhere between the $200,000 and $250,000 per year salary.

Just a comment, too, related to that is at least in present legislation there is a recommendation for about a 10-percent increase in primary care funding through, I think, Medicare. The Robert Graham Group has done a study on that, and that nets out as about a $2,000 per year increase in the average salary of a primary care physician.

DR. STUART: Then a very quick follow-up. How long do you think it would take before there would be a response, a visible response in terms of students with graduate medical education going into primary care in response to higher pay?

DR. ROBERTSON: I think if you just said okay, beginning tomorrow we are going to make sure that every primary care physician in the U.S. makes between $200,000 to $250,000, it's going to take a while. The decision points for medical students are in their third year of medical school, so if they are going to choose a primary care specialty, it will be 4 years before they're practicing.

DR. STUART: Okay

DR. ROBERTSON: In general, internal medicine residency programs, there's theoretically a decision point there. But you still would have to do more than that. You would have to break through to the sort of medical school grapevine to be able to make that transition.

DR. STUART: Okay. Thank you.

MS. HANSEN: [Off microphone] I'm going to pass on this round.

DR. BERENSON: While you have that slide up, I was going to ask a question about it. You've emphasized -- and I appreciated the testimony. Thank you very much. Let me say that first.

DR. ROBERTSON: Well, thank you.

DR. BERENSON: What percentages of unfilled slots

with U.S. seniors are filled with international medical graduates, in general, and then for the primary care specialties?

DR. ROBERTSON: Well, the data that I know the best -- and I'll apologize in advance -- is what's happening in family medicine. Last year in family medicine, 49 percent of the slots were filled with U.S. medical graduates; 51 percent were filled with international medical graduates. And kind of what sort of happens is that if you are -- and the IMGs are both U.S.-born IMGs and foreign-born IMGs. And what I think ends up happening is that if these are individuals -- and there has been interesting work that has been done that for the foreign-born IMGs, their primary motivation is actually to enter into medical or surgical subspecialties. They have a much different perspective, and when they have the opportunity to do so, that's where you tend to find them.

I think what happens to some of the open primary care positions, they end up being kind of a point of access for people who want to practice medicine in the United States. It opens up a lot of cultural issues with regard to the physicians that you have caring for medically

underserved patient populations if the individual who is providing the care does not have some sort of cultural alignment with the recipients. So that's --

DR. BERENSON: That's where I was going with that. So is there literature that looks at the relationship between sort of where the physician comes from and cultural competence, racial disparities?

DR. ROBERTSON: Yes, there is.

DR. BERENSON: The second question I had had to do with geriatrics. You didn't mention geriatrics as a primary care specialty. Was that because they're too small to even think about? Or is there a principled reason why they're not in that category?

DR. ROBERTSON: Well, definitely they are, and it was on one of the slides. Actually, I have a certificate of qualification in geriatrics. I was a nursing home medical director for about 10 years, so I've, you know, greatly enjoyed caring for that patient population. But if you follow the literature, you know, there are lots of opportunities to do a geriatrics fellowship, but many of those fellowship positions go vacant. It is kind of the perfect storm analogy from a chronic disease population and

a reimbursement picture.

At a place that I was employed recently, we had a geriatrician who was just a remarkably talented individual, very passionate about the care that she wanted to render her patients. But the practice plan was basically an "eat what you kill" practice plan. So as a consequence, she was constantly well behind. She was not even generating her salary based on the patient population that she was caring for, and that is a significant problem in terms of a real shortage that we have of people willing to care for the elderly.

DR. BERENSON: You do consider them part of the primary care --

DR. ROBERTSON: Absolutely. Definitely. Absolutely.

DR. KANE: I had two questions. One is sort of similar to the income question, but has anybody thought about what the role of being a medical home might do to the supply of primary care practitioners? Would that appeal to them? Are they being trained into knowing how to do that? Or is this just going to make more people say, "Oh, my God, what a nightmare job"?

DR. ROBERTSON: You know. there are some really exciting things that are happening nationally around the concept of the patient-centered medical home. There is a project out of Family Medicine called TransforMED that's looking at this. This is one area where pediatrics, general internal medicine, and family medicine are really collaborating wonderfully. We were able to put together a meeting at the Brookings Institution in April of this year, and we brought a family physician from Virginia who was basically ready to quit practice. He was really just frustrated, and this was echoed -- I happened to be at a meeting at the AMA last week and sat next to Michael Maves. And one of the things that he commented on is: You have physicians that are, I will say, in my age category who theoretically ought to be at their peak earning years in primary care, and if anything, they are watching their incomes drop. They are spending their 401(k)s in order to remain viable.

This particular individual's name is Peter Anderson. He reorganized his practice along the lines of the patient-centered medical home, and the really exciting things that happened were that he was able to hit NCQA Level

3 from a quality-related perspective. Patient satisfaction went up. Employee satisfaction went up. And I would say not necessarily by coincidence but last in the order of priority is income went up by a third, and he is happier than ever being a primary care physician.

The literature that's out there on PCMH right now is still evolving, so there are some that are very successful demonstration projects that have been identified, and I think what I've been able to deduce is that the more senior a physician is, sometimes the more difficulty he or she has in making the adjustments necessary to transition.

Anecdotally, I was talking to the section chief for general internal medicine at Northwestern, and a number of the general internists at or around Northwestern, which, if you know where the medical school is, it's in a relatively well-to-do community, they're looking at doing malpractice reviews as a way to augment their income as opposed to continuing to grow their practice. So just another sort of real-world example.

DR. KANE: My second question is: You had mentioned the 66-day wait for primary care. How do people measure that? Is that a 66-day -- or how in general -- is

there a standardized way of doing that? Is that looking for a new doctor? Is that for an acute visit? Because it seems like there might be different ways to interpret that wait. If it's for a physical exam for a new doctor, that doesn't sound outrageous. But if it's to get in because you have something wrong, that's pretty --

DR. ROBERTSON: Well, I'm sure it's a combination, but I think basically what it means, you decide you want to see a primary care physician, you pick up the phone and you make a phone call, and you find out that unless it's a truly urgent or life-threatening condition, the wait is significant. I know that some of the early literature that came out of Massachusetts after they implemented the statewide insurance plan was that lots of physicians in the Boston area, literally their practices were closed, and patients could not find a doctor to care for them.

DR. KANE: Do you know if there is some objective and standardized way of measuring waits by specialty in geographic areas that you're aware of?

DR. ROBERTSON: There may be. I am not aware of it.

DR. MARK MILLER: Just as Nancy's spokesman, she

wanted to also follow up on when you said "income," you said they increase their income by a third in her first question. Could you just very briefly -- was that efficiency or revenue? Which way did that --

DR. ROBERTSON: It was real take-home money. This individual's pay went up from about $180,000 to $200,000 to over $300,000 from around 200 --

DR. MARK MILLER: [Off microphone.]

DR. ROBERTSON: Right. That revenue came because of much more efficient practice. He spent virtually all of his time engaged in direct patient care. A lot of the administrative tasks -- organizing referrals, writing prescriptions, following up for laboratory tests -- were done by staff. So as a consequence, he was not engaged in those activities. He was able to see more patients but, again, directly focus on direct patient care as the primary task.

MS. BOCCUTI: Plus when he got the NCQA 3, he got more reimbursement, right?

DR. ROBERTSON: Yes, definitely. There were a variety of other sources for that.

MR. HACKBARTH: I didn't hear that.

DR. ROBERTSON: When they got the NCQA standard, as well, too, there was certainly an income-augmenting aspect associated with that.

MR. HACKBARTH: Mm-hmm. Jay?

DR. CROSSON: Russ, thank you also for a very clear and to-the-point presentation. I have one specific question and it has to do with the recommendations on Slide 10, I guess. So this issue of the training venue and how flexibility might help in that area is one thing that we discussed last year. But I didn't quite get the distinction between the second and the third recommendations. Could you just go back over that?

DR. ROBERTSON: Sure. So the second is broaden the definition of training venue, and that essentially says, where is the best place to put a resident while he or she is getting the training that is hopefully going to sustain them for the remainder of their career, and that can be in the office in an ambulatory setting, but if you look at, for example, again, the rules that I know the best are the ones, the RRC Rules for Family Medicine, there is a very explicit requirement there for community-based training.

And so that could include school-based health

care. That could include going to a nursing home and providing care at a nursing home. That could include working with the city health department on a project with regard to sanitation, and a variety of other issues. So we are in the position sometimes where the RRC guidelines, the Residency Review Committee ACGME-authored guidelines, have specific requirements for training that are not necessarily currently recognized or reimbursed.

And I think that feeds into the following recommendation, because there are regulatory barriers. Basically, you can't bill a GME for educational activities that are taking place in settings that CMS does not recognize or authorize, and there have been a couple of situations in the family medicine world where hospitals have been fined by CMS and have had to make major reparations as a consequence of the unintentional violation of those rules.

DR. CROSSON: Thank you.

DR. MILSTEIN: This really builds on your answers to Michael and Nancy's and Bob's questions. You listen to this and your answers, then you look at the recommendations and I'm sensing a disconnect here. I guess, and I'll sort of jump to a conclusion embedded in my question. My

question is, how long -- how do we get to residency training experiences that illustrate sort of modern high-productivity life forms of primary care?

I mean, when you described as you send these poor people out to residency slots where these people are doing God's work, but it's with no benefit of any engineering flow concepts, no thought as to how one might go about better leveraging technology, nurse practitioners, medical assistants, community health workers, receptionists, all that, you know, Charlie Berger's sort of nationally cited practice in Maine, which is an illustration of this high productivity primary care practice. So in some ways, it's no wonder that -- but my intuition is that the residents in these programs are not being exposed to that model, and perhaps that in turn might be related to the nature of the faculty training them and what they know and what they can teach.

So how do we get -- and I didn't see that on your recommendation list -- to a group of faculty in training programs that actually understand the model and can teach it and can illustrate it in the training sites to which our primary care trainees are being exposed?

DR. ROBERTSON: I think that there are a number of ways to do that, and I think that's a very accurate assessment of the situation in which we currently find ourselves. The costs of practice transformation for the practices that elect to do that, and I think Kevin Grumbach quotes a statistic that around 60 to 70 percent of all primary care physician practices in the U.S. are basically onesies and twosies, so you are looking at individuals who have very little in the way of accessible capital. So even if they want to make a change, it's very difficult for them to do so. Certainly, some of the larger organizations, Geisinger and Kaiser and others, have been able to engineer these changes and, I think, provide wonderful settings that would be a fabulous experience for students or residents to participate in.

I'm not completely versed with this, but I know that there are demonstration projects that are being proposed in some of the legislation that's out there, funding that would be available, but it requires a certain degree of sophistication that often these individuals do not have in order to be able to identify and then apply for those kinds of funding sources.

So I don't think there is an easy answer to your question and I think it's problematic that we find ourselves in this particular situation without an easy answer.

DR. MILSTEIN: I'm sorry. My question really was, how do we get to a place where we have faculty that understand this model and therefore are in a position to teach it?

DR. ROBERTSON: I think that's a similar area that's transitioning. When you look -- again, I'll speak about my specialty. A lot of the people who are practicing family physicians and who become faculty members, they are individuals who are often community-based physicians who thought that they had some useful knowledge to offer in a teaching setting and so they move into a faculty position.

There are problems, I think, in primary care in terms of the degree of sophistication that our faculty members have and their capacity to do exactly what you are talking about. There is very little, unfortunately, in the way of peer-reviewed literature and/or competitive grants that come from certainly the family medicine world, is the one that I know the best. Unfortunately, there is some data that shows in studies that as it relates to research

aptitude, which isn't necessarily the direct question that you're looking at, but people who go into family medicine often are the least interested in those kinds of activities and so we, I think, unintentionally produce a cadre of faculty that are not in the position to do exactly what you were talking about.

MR. BUTLER: If we all agree, and we all agree here that we need increased capacity in primary care, I have a question of where to put our efforts. One would say the practice environment that the physician lives in and works in for his or her career is the most important element, and you have pointed out that compensation is a factor, but it's insulting if you think it's the only factor.

I think some of the support for that comment would come from your slide that says in the managed care heyday of 1992, when the primary care physician was not only maybe compensated more, but more of a gatekeeper or coordinator of care, was the kind of environment that felt better. So one way to go is to think that creating that environment would help attract additional primary care physicians.

The other is to tinker with the number of slots and the caps and the redistribution and the funding of GME

itself. As it's been said, about half of the positions are filled with foreign medical graduates as it is and not all of them are filled, period. So it makes me wonder about how much we are going to yield, we are going to get out of tinkering with the number of slots and how we're doing that process versus focusing on the ultimate practice environment.

So where would you put the -- obviously, I have a bias, but tell me what you think about the two. And you can't have both totally.

DR. ROBERTSON: Well, just to comment, I think that those of us in primary care made an absolutely colossal mistake in the mid-1990s by embracing the role of gatekeeper. There were some of us who thought, finally, we're no longer at the bottom of the totem pole. We're in charge. And we wrongly embraced that role in a way that I don't think we completely understood what all the implications of that were. We really recognize in retrospect that we should have much more warmly embraced the concept of coordination of care, and I think that's where people are right now. I think that's what undergirds the concept of the patient-centered medical home.

You know, again, I'm all with where you are, to tinker with reimbursement, to tinker with slots, whatever metaphor you want to use, the direction that we're heading right now is not necessarily a good one, and I think some of the discussions that are out there about bundling patient care, about providing care coordination fees, about demonstration projects, I think those are things that will begin to make a change.

But it's going to take a while and I don't know that there's necessarily a collective will to make that kind of a change. I think that's still a problematic issue as we look at some of the motivations of people who are involved in the graduate medical education discussion.

MS. BEHROOZI: This is still a round one question. In Slides 5 and 6, you referred to Title VII funding, and so even though the dollars don't look huge in the context of overall spending on GME, you identified it as an issue that related to the declining care for certain subpopulations. So can you explain a little more about what Title VII funding would be?

DR. ROBERTSON: Sure. There are, at least in primary care areas, there are three sources of funding that

Title VII has helped with. Undergraduate medical education, so funding medical school departments that are engaged in undergraduate medical education, so it actually gets a little bit to the question that Dr. Milstein raised. And so there were funds that were coming from that that medical schools were able to use, because often, if you are not generating the clinical dollars and if you're not generating the research grant funding, then you have to ask the dean for money and the dean sometimes will say yes, but more often than not, the question to that answer [sic] is usually no, and it's not because he or she doesn't support the educational process, but it's just, I think, a reflection of the number of challenges that the dean has. So there was a lot of money that was being spent and some really very novel undergraduate medical education experiences were in existence across the U.S.

The second source of funding was what are called academic administrative unit grants, so those were funding streams that helped support either the start of new primary care residency programs, and of note, there are still about seven or eight hospitals in the U.S. that do not have departments of family medicine, so there are some issues as

it relates to that.

And then the third are sources of funding that were to support graduate medical education, so to bring in funding that, again, would educate faculty members, that would strengthen the quality of the educational experience that residents were having. So when this drop took place, there were a number of departments across the country -- the University of Washington in Seattle is the first one that comes to mind. They had done a really good job of applying and spending Title VII money in a very meaningful way, and when the Title VII funds virtually dried up, then that really significantly undermined.

And as you pointed out, we're not -- a term that I picked up a couple of months ago was HOBODs, hundreds of billions of dollars. In terms of what's happening in the economy right now, I mean, this is pocket change, Title VII, and we were not able even to sustain a reasonable degree of funding there.

DR. DEAN: Of the people that enter primary care residencies, we know that in family medicine, most of those will end up in primary care, whereas pediatrics and internal medicine, it's a much smaller number. Do you know what

those numbers are or how many -- what proportion in pediatrics and internal medicine actually end up in primary care that enter those residencies?

DR. ROBERTSON: Well, sort of the most chilling data was the one that showed that two percent of all U.S. medical students see themselves as practicing general internists, so the other 98 percent are looking at becoming hospitalists or medical subspecialists. In pediatrics, the numbers of pediatricians that are subspecializing are continuing to increase. I'm going to pull a number that's a little bit out of the air, but I think it's getting close to 60 percent in terms of what's happening in pediatrics, and my understanding is that there are some significant shortages with pediatric subspecialties.

So again, I don't have a particular axe to grind as it relates to that, but I think the point that you make is that family medicine is a destination that will result in a primary care provider. There are certificates of added qualification in geriatrics, sports medicine, and now palliative care, but those individuals still by intent, if not by default, end up becoming lifelong primary care physicians.

MR. BERTKO: Russ, just a question on Slide 10, your third recommendation here. It's either to you and the COGME members or maybe even Herb or Bob. Is this, as far as you know, a barrier that could be changed by the Secretary at CMS, I mean, of HHS or the Administrator, or is it something we'd have to go to Congress on to recommend a change?

DR. ROBERTSON: My knowledge of the regulations is not that deep to be able to answer that question. I think those of us who are engaged in this would certainly look forward to working with CMS on that particular issue.

MR. KUHN: Russ, thank you. I'd like to kind of go back and revisit the issue of the numbers or some of the motivation behind those institutions that are training above the cap. You had talked about the growth prior to 1996, the growth since 1996. The numbers I remember reading in the past is about a third of all residency slots are training above the cap. Is that an accurate number, to your knowledge, and can you talk a little bit more about what is happening now in terms of new programs coming on, those that are training above the 1996 cap?

DR. ROBERTSON: Yes. I don't know -- the number a

third sounds large to me, when we put together a slide set for another presentation. Right now, again, I think Medicare GME funds somewhere in the neighborhood of 25,000 to 26,000 positions, and I actually have something that I could probably page through to try to find, but it would be not a good use of our time to be able to do that.

I think the net answer to the question is that if a hospital is looking at adding GME positions, they will find the money to do it, in general, if it's a specialty position and something that will support the specialists that are using their hospital. So maybe not the most specific answer, but it's the best one that I can come up with now.

MR. HACKBARTH: I'd like to go back and pick up on Herb's question and something that Peter said. It seems to me that the fact that there are so many positions above the cap, there's an important signal there, important information, and I'm trying to learn more about that. So I assume that most of those positions are in subspecialty areas --

DR. ROBERTSON: Yes.

MR. HACKBARTH: -- and that institutions, and

maybe you can help enlighten me here, Peter, that they choose to do that, are able to do it financially because those programs have good economics, unlike you mentioned family practice programs tend to be seen as not economically advantageous. So if that's correct, that raises a question in my mind about whether it's wise to direct Medicare subsidies to programs that are economically self-sufficient.

Now, I think Peter raised an important point, that the issue here isn't necessarily not enough family practice or primary care-related slots. We're just not getting people into them. But I guess the question I come to is, well, could redirect some of those subsidy dollars into the fee schedule or other ways that would more directly attract young physicians into primary care. It doesn't have to stay within the medical education financing area.

What am I missing? Am I missing anything?

DR. ROBERTSON: Well, I'll go ahead and try to touch on a couple of the points, and if I don't address them directly, please let me know.

One thing that actually I will bring up is that the presumption often is that, well, family medicine, it's a non-revenue producer. That have been two studies that have

been done, and I can't quote you the exact detail, but they look at downstream revenue based on referrals to hospital-based specialists and the use of ancillary supplies, or of ancillary services, and a primary care physician adds a tremendous amount to a hospital, and there are some systems that just basically choose to employ lots of family physicians and they don't necessarily -- or primary care physicians. They're not even really too worried about whether they make money on a dollar-for-dollar basis because they've done the analysis and they're aware of the potential for downstream revenue. So just in terms of addressing that argument.

In terms of what to do with the over-the-cap money, based on what I know about the amount of money that Medicare is spending on graduate medical education, I don't know that there's enough money there that if you redistributed it elsewhere that it would necessarily make the kind of difference that you're talking about, and I think part of what we've all been sort of addressing is the need for a systematic change in the way health care is funded, and specifically primary care.

MR. BUTLER: Well, I have a lot of reaction, but

just on the cap issue, I think, first of all, a third, I'm sure, isn't the number --

DR. ROBERTSON: I think that's too high.

MR. BUTLER: It's way, way over. I think it's at the margin, and I think most institutions, if you were to say -- I think, frankly, and again, my own experience, you get -- maybe you're recruiting a chair in a given specialty and there's a certain package that you're providing that makes his or her success critical. You might go over the cap a little in that specialty. But I think as a regular practice, teaching hospitals don't just blow by the cap and say, we're going to fund an extra 100 positions or whatever it is because they're worth it. So I think it's on the margin. I don't think it is something that is widely done.

DR. ROBERTSON: Just a comment, too, related to that. I want to be -- I mean, I think academic health centers are absolutely wonderful. They are essential. We need the specialists that they train.

I think the concern that I have is that when you sort of move out of sort of large academic health centers into other hospitals that are sort of technically not-for-profit, that's not necessarily the way in which they're

operating. That's not an area where I have a tremendous amount of expertise, but I'm not here to bash academic medical centers. I'm grateful to be at Northwestern. I have a great relationship with the hospital. They've been wonderfully supportive of our department.

I think one of the challenges that a lot of us in family medicine have, or in primary care, is to translate the value of what primary care brings to the table to people who often don't have a lot of experience with it, and that's been one of the fun things about what I get to do.

DR. BORMAN: Just a couple of things about some of the numbers and caps and things. Number one, roughly 30 percent of GME -- allopathic GME positions, roughly 30 percent are filled by other than U.S. medical graduates from allopathic schools. Okay, it's ballpark 30 percent overall, higher in family medicine, as you've heard, but that's sort of the ballpark-ish number.

Secondly, in terms of -- Peter is absolutely correct. Thirty percent over the cap, most places would be bankrupt, I think. The other thing you have to remember when you think about over-the-cap positions, there's a couple of factors. Number one, that the subspecialty people

who are by definition past their core residency are only getting funded at a half position at the most, so that when you go over with a fully funded residency slot as opposed to something for which you were only getting half anyway, kind of is a manipulation that is not reflected in the general statistics.

So, for example, if you were to add another gastroenterology fellow for whom you're only getting part anyway, it's not cost -- you would already be paying that half, so the increment that you're losing is less, if that makes sense. So there's a different -- the mix of what you have.

The other thing is that in the main, you can't just decide de novo to start a residency on over-the-cap stuff. You can, but generally speaking, that's not going to get done, so that the inherent bias is to grow the residencies that you already have because there's economies of scale in doing that. So if you already have an anesthesia residency, you're more likely to expand that than to take whatever dollars it would take to start a family medicine residency or whatever else it might be. So you need to be really cautious about interpreting over the cap,

and I think Peter's point that manipulating caps and numbers and things is probably not the most productive way to think about some of this.

MR. HACKBARTH: That's helpful. Craig has some information --

MR. LISK: Right. In terms of analysis that we did, and this would be, I think, based on 2004 data -- it may have been 2006, I can't remember -- but we counted about 8,000 hospitals in terms of Medicare hospitals with about 8,000 unfunded GME slots in terms of being over the cap by 8,000 that hospitals are funding, paying those without getting any Medicare GME or IME money. And actually, because some hospitals train both -- you know, it's actually an IME, so that's about 7,000 slots and 8,000 on the direct GME side.

MR. HACKBARTH: What is that in percentage terms? What's the base?

DR. BORMAN: [Off microphone.]

DR. ROBERTSON: Yes. There's 100,000 residents. I mean, in terms of Medicare hospitals, about 90,000 residents in Medicare-funded hospitals, so --

MS. BOCCUTI: [Off microphone.] Less than ten

percent.

DR. ROBERTSON: So it's less than ten percent, and that fits with the report out of JAMA that said, I think, 7.9 percent. So I think it very much aligns.

Just a quick comment, just based on Dr. Borman's statement. You can open a new residency program in what is called a virgin hospital, for lack of a better term. If a hospital has never had a GME training program, there is a way that you can apply to CMS to be able to get funded GME positions. The challenge that's associated with that is you have to fund all of the start-up costs of the training program from another source -- faculty salaries, resident salaries -- until the Medicare GME funds begin to flow. So it does happen, but not very often, and you usually need to find a source of income. It's generally, I would say, somewhere in the neighborhood of $1.5 to $2 million to be able to make something like that happen.

MR. GEORGE MILLER: Great presentation. I enjoyed it. On your recommendation number four about accountable for the public's health, I have a question, and you mentioned a little earlier about disparities. The Commission has done some work on disparities, and you made a

comment and I want to make sure I crystalize on the comment, that maybe some of the problems of disparity, if I have that correct, may be linked to foreign medical graduates and the competency issue. Did I hear that correct?

DR. ROBERTSON: There are several factors that feed into that, but I don't want to cut you off. Did you want to share anything else?

MR. GEORGE MILLER: My major question is, what will the Council's recommendation be to address the disparities overall, and what can you do in the medical school arena to try to eradicate disparities, number one, and then I'd like the first part of my question to be dealt with.

DR. ROBERTSON: Sure.

MR. GEORGE MILLER: Thank you.

DR. ROBERTSON: This is not a specific Council recommendation, but it's something that we've had some extensive discussion about and I think that there are certainly threads of that in this, and that gets back to what I was commenting on with regard to who gets into medical school.

You know, there have been some interesting studies

about organic chemistry, and that's the one class that usually trips people up. If you don't get a good grade in organic chemistry, the likelihood that you're going to be able to gain admission to medical school is drastically diminished.

Interestingly enough, there's an effort underway to reformat the National Board of Medical Examiners. Right now, there are two tests that medical students take, one at the end of their second year and one during their fourth year. There's a desire to fold those two exams into one exam which would then allow a significant transformation of the undergraduate curriculum that is now, some would say, excessively focused on the memorization of the arcane as opposed to practical information.

That process of changing the NBME has ground to a halt because most specialty, highly competitive specialty residency programs use Part 1 scores as a way to look at the candidates that they want to consider. So if you're looking at plastic surgery, looking at orthopedic surgery, you really don't have much to go on, because a lot of medical schools, their grades are pass/fail or a grade at medical school X is not equal to a grade at medical school Y, so you

use Part 1 of the Boards as the issue for that. So that is one of the problems.

The second problem is what I referenced with regard to who gets into medical school. Again, and I understand this, I have a daughter that just graduated from medical school, it's MCAT scores and grade point average. I think medical school admissions should look much more significantly at the background of the individual who is applying to medical school and that should be a factor.

One of the nice things about medical school, it's no longer look to the left, look to the right, and you'll be the only survivor. Medical schools have a variety of interests in keeping you there for the entire four years, not the least of which is the fact that you're paying a rather large amount of tuition that is going to be spent in the support of the administration of the medical school.

Last, to get at what you were talking about, there are real concerns about the culture of misalignment that takes place when you have individuals from two distinctively different cultures in an exam room trying to talk to one another. I was seeing patients yesterday. I work at a free clinic in the Chicago area. About three-quarters of the

patients are Hispanic, but a quarter are actually Polish and speak only Polish. So you rely heavily on interpreters. I think I'm a pretty good doctor, but basically, I'm a white guy taking care of people who come from a much different environment than I do and I know that there have to be things that people don't say to me, not because I'm doing anything wrong, but because I'm coming from a different background than they do.

MR. HACKBARTH: Let me see hands of people for round two. Okay. We're down to our last 15 minutes here, so I'd ask people to really be as concise as possible. Karen, did you have your hand up first? Why don't you go ahead.

DR. BORMAN: Just a couple of things and to blend some of what you've said with some of the stuff that I know or some data, related data in surgery.

I think that one of the things that comes out in the medical student literature about choosing specialties is that they're highly motivated by what they perceive to be the nature of the work and then also the influence of mentors. I think the influence of mentors goes directly to what Arnie has commented to --

DR. ROBERTSON: Absolutely.

DR. BORMAN: -- and I think that primary care specialties, just as general surgery has had to have to, to some degree, reinvent themselves as mentors and project the positive as opposed to all the griping that goes on in the physician lounge, and that's something that's internal to the specialty and not necessarily a government function or a funding function. So I don't know if there is specific data in the family practice literature, but I can assure you there are in a number of other specialties and general surgery learned that lesson.

I think one of the things you offered about the individual who restructured their practice really goes to the heart of this, and that's because the nature of the work does matter. And so you facilitated that individual to function as a physician. And so what I took from that, and you need to tell me if I've made a bad conclusion, was that a lot of what enabled him to do that was the appropriate reengineering of the practice and appropriate use of mid-level providers.

And so I think one of the issues here is if we assume that model of care, and this goes to Mike's question,

then what really is the physician need, because I think every time I ask, it seems like the projections we're making are made on the current model of care delivery. If that were the primary care dominant model, then perhaps the physician shortage is not as great. I will say that every time you go shopping in the mid-level provider store, it's looking increasingly empty and there are no sales.

That also sort of relates to a little bit of why sometimes hospitals are willing to fund over the cap, because even a fifth-year level resident is, by and large, cheaper than a MLP, a mid-level provider, because of all the associated benefits, their relative work hours, and a whole bunch of other things, and so I think that plays into it, as well.

I'd be interested -- the other piece is in pediatrics, I think they've had a lesser subspecialty trend, but it's because they more tightly control subspecialty positions, whereas I think probably now something around half of internal medicine residents, I think, go on into a second, or a subspecialization. I can tell you in general surgery now, the number is pushing 80 percent. So that's a huge factor. The pediatrics, we probably should be asking

what pediatrics has done because they actually have almost as many shortages in some subspecialties of pediatrics as they do in general pediatrics, and the comparison between pediatrics and others maybe could offer some lessons and that might be something that we want to explore to get some information out of.

And then, lastly, just again a general comment that there probably are some patient populations for whom their primary care is well delivered by someone who holds a specialist certificate, and so, for example, CHF, patients at a certain level may very well have a cardiologist as their primary care deliverer. So I think we want to be a little bit precise about when we talk about primary care services and primary care physicians, because it may not be entirely a one-on-one.

Have I gone way off base on any of that?

DR. ROBERTSON: No. Just real quickly, in order to give other people a chance to comment, interdisciplinary care has the capacity to increase capacity without increasing the number of physicians. I think that's something that's really important. Although if you look at what's happened in the PA world, and actually, we're in the

process of starting a PA program in our department, the reported data says only about 39 percent of PAs find themselves in primary care practices. My new program director tells me it's probably now closer to 20 percent, and so that 80 percent of PAs are practicing in hospitals in surgical and/or medical subspecialty settings. But I think there definitely are ways to dramatically increase capacity without necessarily increasing the number of physicians.

DR. CASTELLANOS: Two points, and I'll be as brief as I can. One is Arnie brought up this practice transformation, but we need an educational transformation. We need a new cadre of faculty members. And my point about undergraduate education, there's an economic principle. I'm not an economist. You've got to follow the money. So we need to put money into that,. I don't know if there's any basis for that today, but I think we really need to put money into educating a new cadre of faculty, not just for primary care, but throughout every medial specialty.

Second is the problem that we're seeing right now is the aging of the physician, and you have a well-educated group of doctors and we have a definite workforce problem. You know, you're not going to catch up for ten to 15 years.

You need to do something to incentivize the older doctor. Now, you made some comments about wearing glasses and apologized for it. Well, 14 out of the 17 Commissioners wear glasses. I'm an older doctor --

[Laughter.]

DR. CASTELLANOS: -- and you need to incentivize the older physician. And one of the examples you used was the hassle factor, your friend. If we can get rid of the hassle factor, I think we can keep a lot of the doctors in the practice, because we all enjoy what we do. We don't enjoy the hassle factor.

DR. ROBERTSON: Just a -- I mean, the AAMC has data on physician retirement and/or if they could retire, and I can't quote it in detail, but it's actually a fairly significant number of doctors who would. What's happening right now is the economy has certainly been an incentive for physicians to stay in practice, but clearly is not aligned with what you're talking about. And I think people who went into medicine a number of years ago, it was really fun and it was something that they looked forward to. Your work and fun sort of ought to be aligned and why can't we find a way to get back to that? So I agree very strongly with what

you've stated.

MS. HANSEN: Again, thank you very much for a great presentation.

DR. ROBERTSON: Thank you.

MS. HANSEN: And I come from a frame that's interdisciplinary. I worked with the PACE program, the original PACE program, for 25 years, so the whole use of the physician as a team member, coupled with the efficiency factor of allowing the physician to have fun, I think was a factor.

Secondly, your point about the place of reimbursing sites, because we trained residents, and I have a real technical question. When you said that, first of all, the penalties that oftentimes might occur if, say, funds flew to a clinical site, do you know if that's a regulatory, fixable, short-term thing before we deal with the bigger issue or not?

DR. ROBERTSON: Well, I think the short answer is probably yes, and just another comment. There's actually some interesting literature coming out right now about who are the teachers of physicians and why can't -- I learned a heck of a lot from nurses when I was a resident, but it

wasn't formalized. I think that there are ways to revise the medical education system so that there are much more formal roles for that. But the short answer is yes, but that's not an area that I have a tremendous amount of expertise.

MS. HANSEN: But using that final set, comments have been made along the way, and if I can reset this to, again, our responsibility for a Medicare population and the sheer numbers now, let alone in the shortages versus what's coming down the pike that we have, the question of the role of COGME relative to thinking about your recommendations on Slide 10. That really is about the population and where should the future go. And some discussion has been advanced relative to mid-level providers or other primary care providers.

How does the professional organization take a look at the responsibility of, say, the N, the numbers that are coming down? If we already have a shortage of people waiting 66 days in Massachusetts, how does the profession look at embracing a larger workforce to meet the need rather than trying to keep pulling? I think we still should make sure that the income is there, but rather than pulling

people in to change their specialty focus, there's a cadre of people who might deal with chronic disease management and others differently. So where has the organization itself stood relative to embracing this from a population-based approach rather than strictly a professional approach?

DR. ROBERTSON: In the 15th report, which was the one that we put out that said we needed 15 percent more medical students and 15 percent more GME slots, there was actually a draft recommendation that specifically addressed physician extenders, other non-physician providers, and this was my first meeting at the Council, so I was sort of trying to get my sea legs and the members struck that provision. We're now in the process of preparing our 20th report and we have an explicit recommendation that is exactly under development that references what you're talking about.

So part of what we want to be careful of is we don't want to get beyond what is our prescribed purview of graduate medical education, but I don't think you can have that conversation without talking about other providers. So it's something that I think will be revealed as we move forward.

MR. HACKBARTH: Are you able to stay overtime?

DR. ROBERTSON: Sure.

MR. HACKBARTH: Okay. It's now 10:25, and at this rate, we'll finish at 2:25, by my estimate, so I need to ask Commissioners to limit themselves, both in terms of the number of questions or comments and the length of them, because I really want to get all the way through one more time. So, Mike?

DR. CHERNEW: I'm new to this, and what I'm about to say might be heresy, but I find it curious that we spend a lot of time talking about how to pull more people into primary care as opposed to push more people out of specialty care. I don't have a position on that one way or another, but I could see the entire discussion going the other way.

DR. ROBERTSON: You know, there's a class that I teach right now at Northwestern. It's The Origins and Economics of Medicine. It's a class that's taught to second-year medical students to try to help them process exactly what we're talking about here. At their second year, they already get it in terms of what their future looks like. And when you talk to them about primary care, and I -- you know, one of the things I made very clear to the dean of the medical school is that I don't measure my

success as a chair by the number of people who go into family medicine. I have an academic obligation to expose them to the full range of what's there.

But under the present set of circumstances, I don't have a real good answer to that question. I think that some of the practice transformation that we're talking about, some of the potential to alter the clinical experience, I think, that Dr. Castellanos brought up, the experience that they have when they're in medical school and around primary care tends not to be the most positive. But then the really powerful roles of mentors. And if they're with a harried general internist who is complaining about his or her day, that acts as a pretty significant distractor, and unfortunately, it makes the issue that you brought up difficult to address.

DR. BERENSON: Are you aware of any medical schools in the U.S. or perhaps Canada that are specifically dedicated to producing primary care physicians and produce 40, 50 percent or more that might be models?

DR. ROBERTSON: There were a number that were created for that purpose -- Michigan State University. But a lot of the ones that did that, they've seen their numbers

drop. There actually is an osteopathic medical school, AT, still in Arizona that has almost a totally community-based educational structure for their medical students. I can't remember if they've graduated a class yet or not -- second year? What they have done is very groundbreaking and very much different than the way most U.S. allopathic schools are located.

One of the things that I did in preparation for this, and I won't read it to you, is there is this very specific information with regard to the atmosphere in which medical students learn. What it boils down to is that the medical school is basically a laboratory for them to make whatever decision that they want, and I don't think that many medical schools have a strong sense of obligation with regard to the cadre of graduates that they produce by specialty. I think that it varies across the country, but it still ultimately boils down to the student's individual decision.

DR. CROSSON: Russ, I'd like to turn again to the recommendation page, Slide 10, if we could. So one of the questions for us as a Commission going forward as we absorb all this excellent information is what actually should we,

can we do within our purview? And we have had discussions on this topic off and on over the last couple of years anyway and it seems we've focused on two things. One of those is what could we do, what could we recommend that would help improve the maldistribution of physicians by specialty. We've not made recommendations yet, but we have had some discussions about that -- specifically not made recommendations with respect to GME, that is.

Another area that we've touched on has been the question of the amount of IME payments that are made to hospitals, and we've talked about that from the perspective of whether or not value is being produced for the taxpayers, essentially, because there's some question about the level of payment. And we've had some discussions in that area, which have, I think, been just preliminary and not focused on any particular direction.

So as I look at the four recommendations, I think earlier, Glenn addressed a little bit about recommendation number one. While the impact of health care reform may very well produce a need for physicians across the board, I don't know that that's an issue that we have taken or are likely to. And it isn't also clear, as I think Glenn said, whether

simply increasing the number of GME slots by 15 percent is going to solve the primary care maldistribution issue.

With respect to numbers two and number three, as I said earlier, we have dealt with that and we have made some comments about perhaps CMS could consider creating flexibility in the venue area.

The one where I think you have a recommendation that dovetails a bit with discussions we've had is the last one, and that's making accountability for public health the driving force between GME payments, and in the context of the Commission, it would be -- I'm sorry, for GME, it would be GME payments. So I think we're probably going to discuss this question again and I wondered if you could elaborate a little bit on that. If we were to think about this question, given the level of payments, particularly the level of IME payments that are made, and if you're looking at it from the perspective of the public, the taxpayer, and the like, are there some things that could be done to increase the value that accrues as a consequence of those payments in improving public health, access to health services, or whatever value you have in mind with that recommendation.

DR. ROBERTSON: Well, you know, certainly recognizing that the process of training family physicians or primary care physicians, general internists is a -- it's a multi-factorial issue. We've talked about a lot of the push-pull factors that relate to that.

I think one of the challenges, and as a -- I was a residency program director for 12 years. Every year, you would negotiate with your hospital CEO with regard to the funding that was going to be made available to the residency program. It was always kind of a black box process. I mean, you never really knew how much money they were working with and you were just happy if you got what you needed to run your training program.

If there was something that could be done that would make that process explicit, transparent, and dollar for dollar so that the real costs of training -- faculty salaries, resident salaries, the salaries for the support staff, the rent for the clinic, the support for the different training venues -- if something like that were to be enacted, I think that we would be in a much better position with at least being able to fund the positions that we would want in order to produce the physician population

that I think that you're referencing.

But in addition to that, I still think that there are other issues that are system-based. But right now, most residency program directors, most department chairs, that's the kind of a discussion that they enter into, and unless you take an aggressive role, which ultimately really isn't in your best interest to file a Freedom of Information Act request so you can exactly learn what the GME support is the hospital is getting, both IME and DME, most of us would not be willing to do that because it would upset what I think needs to be a necessarily collegial relationship. But it, dollar for dollar, would make a big difference.

DR. CROSSON: Well, let me just ask you one specific question quickly. So one of the topics that has come up here is whether or not we, as MedPAC, should undertake to examine and make recommendations with respect to the nature of the training curriculum, or whatever you want to call it, the training program content for residents. Do you think that's an area that would be of value in improving the accountability of programs for public health?

DR. ROBERTSON: Well, certainly that's the purview of the Accreditation Council for Graduate Medical Education

at the present and that's an organization that I think takes its responsibilities pretty seriously. We're also, coincidentally, in the process of developing a new family medicine residency program. I look at them as the equivalent of the sort of Good Housekeeping Seal of Approval. The stuff that they put in there, it's there for a reason.

I don't know what kind of a discussion it would look like if you chose to interact with them. I think we know how to train who we want to train. I think the biggest challenge that we have is finding more transparent ways of funding it that don't put us in a position of having to look for other sources of support to be able to sustain what it is that we're trying to do.

DR. MILSTEIN: Let me try again on what I think Jay was driving at. I think what we've discussed before is, is there a pathway by which we could begin to do with our medical education dollars what we aspire to do with our health care payment dollars, that is shift onto a value-based method of allocating dollars. One element in such a process would be to make sure that the training content is kind of aligned with modern notions of efficient, high-

quality production of services in various specialties.

I think Jay's question, I think, also gets at a separate issue, which is -- and I don't think this is what ACGME is in the business of doing -- is as you're thinking about allocating monies across different slots, different specialty training slots, is there any -- what direction might -- is there any existing pathway that we might benefit from learning about that would allow some kind of a, I'll call it a value add analysis. In other words, if we produce an incremental dermatologist, there's a certain amount of value to the Medicare program, value to the U.S. health care system. If we produce an incremental primary care physician, trained in sort of the more advanced methods of primary care delivery we talked earlier, that might generate a different value add, in terms of the public's health, or even better, value, public's health divided by how much it costs us to attain that increment in the public's health.

If we wanted to move in that direction in terms of ceasing the distribution without conditions of Medicare medical education dollars, which is what we've been doing now, and begin to shift it onto a value-based allocation system, is there any existing information that we might

access to begin to think through the implementation of it? That is, how would one go about calculating the value add from training in a given type of specialty versus another, and also assessing the content of that training with respect to more advanced notions of how that specialty ought to be practiced?

DR. ROBERTSON: Thank you for the clarification. I apologize if I missed the original point.

There's a program out there right now. It's called TransforMED. This is something that has come out of the American Academy of Family Physicians. They opened up applications nationally to residency programs, specifically those were the targeted programs. They had funded to fund, I think, 14 or 15 projects. They had well in excess of 60 applicants for it.

So this is a process transformation approach toward undergraduate medical education that is being funded externally in addition to currently available Medicare GME funding. There are medical home projects that I believe the American College of Physicians is developing. So there are vehicles that are out there -- I think I'm getting at your question -- that would be able to, would welcome an

additional source of funding to effect that transformation.

DR. MILSTEIN: Thank you. I think that does address the second part of my question, but I'm still not sure whether or not we have a basis for ascertaining value add to Medicare or society from training an incremental dermatologist versus training an incremental primary care doctor.

DR. ROBERTSON: There's actually quite a lot of information that addresses that. I don't know that I can go into it in significant detail but there's tremendous amounts of information with regard to -- there was a statistic that I didn't bring. It was a DALE, Disability-Adjusted Life Expectancy. When you look at nations that have heavily invested in primary care specialties, the differences between where they are and the United States is absolutely dramatic.

So yes, there is a tremendous amount of information to support the difference between funding primary care physicians and/or specialty physicians.

MR. BUTLER: My comments are related to trying to envision what a deliverable next June, if we do a chapter, would do like. So I have six sections to this.

[Laughter.]

MR. BUTLER: It will be quick. It will be quick.

MS. BEHROOZI: Change your flight, Glenn.

MR. BUTLER: No, this is high level thinking about it.

The first would be what are the competencies that we want our physicians to have, regardless of specialty. ACGME gives us something to build upon. We could add to it the Medicare filter and kind of embellish it a little bit.

The second would be the training environment. I think we can build on our chapter we've already done that says linking to health reform. That's like what does the environment look like that would be overall what we want? It coordinates care, it has a focus on public health, it has IT, all of those kinds of things that says this is the setting that we ought to value purchase, if you will. Okay.

The third chapter would be on the mix and the number of specialties and say okay, what are the numbers that we need, of what kind.

The fourth would be a specific focus on diversity as we've kind of said ought to be in each chapter. And not just the numbers of types, but a better description of the

cultural differences emerging in our patient populations just to highlight that as a particular issue.

And the last would be, of course, is the financing, the sources. Where we begin with the reimbursement dollar and probably reinforce that still is a huge, huge driver in all of this. But then pick up on the $9 billion in DME and IME, highlight the Title VII dollars, the VA dollars, the stimulus dollars going to FQHCs, et cetera. Look at the sources. And then line that up with these other sections and say where would you use these dollars?

What I would advocate strongly is that the changes that we ought to kind of set in motion would be around that training environment and doing the DME/IME up or down in that bucket.

We could acknowledge the importance of tweaking the speciality and mix. I think already legislation in health reform is doing this, generally in the direction we'd like to see.

I would say in that section one bias is that splitting this up into all kinds of different settings is kind of counter to our integration strategy. So I worry a

little bit about having this free-standing entity have money and this -- when we're trying to create systems of care.

So I think we need to think about if we make all of these other people eligible for directly getting dollars, is it counter towards the integrated systems of care serving a community or not? It's just a concept.

But anyway, that's how I kind of think about the chapter and I think we really can make some directional good contributions in these areas.

MR. HACKBARTH: Thanks for the framework. That's helpful.

MS. BEHROOZI: It's really to pick up on George's point about disparities, though Peter also mentioned it as an issue that we should keep in mind. I would just urge you, maybe for the 21st report or the 22nd report -- since you'll be around for that -- to be actually more aggressive, I think, in looking at disparity of treatment and outcomes than just sort of cultural competency and recruiting more of the others who are currently not populating the medical profession, bring more of those others in.

I think it's really about focusing on who the professionals are and will be and will continue to be,

because medical school is going to continue to be expensive and the tests are going to be hard, all of those things. Because there is emerging data -- and actually the staff presented some to us this summer -- that disparities really come out most strongly when you're talking about a non-minority person -- I guess that would be a white person -- treating particularly -- in that case, I think it was evidenced with respect to African-American treatment outcomes.

And the African-American doctors were not responsible for disparities in the treatment of their patients by race.

So it's not just sensitivity and awareness. It's like really confrontation with that evidence and those facts and making it a very conscious part of training people who are going to be the providers, not just bringing additional people in to be the providers.

DR. ROBERTSON: Just a quick comment. To the AAMC's credit, they had a program that was called 3,000 by 2000. It was an aggressive effort to recruit minority medical students to medical school. They didn't quite hit the threshold but it was a very substantial activity that

they undertook and I think is very much aligned with what you're referencing. We need to do more of it and more of the same.

DR. DEAN: Thank you very much. This is obviously an area that is of great interest to me. I'm a family doctor who has practiced in a small rural community for 30 years.

It seems to me what I find very frustrating, and I appreciate your comments and I suspect that you may have some of the same feelings, is that where Medicare has leverage and where your mandate lies is at the end of the process. And it seems to me that where our problems lie is at the beginning of the process.

And you mentioned the problem with medical school admissions structures, which I've seen data -- probably some of the same data you've seen -- which show changes in the demographics of the people that are coming into medical school which don't fit with what we know we need, or don't predict very positively the kind of mix of specialists that we need to come out of.

I was very troubled by what you said about the national boards. I, too, just had a son who just graduated

from medical school and I was struck by what a negative influence that process is and how when I complained to medical school faculty that he was involved with, they tell me -- and I believe they're honest -- that their hands are tied basically because their students have to perform well on that board. And yet, it totally crowds out the kind of experiences that we would like to have students have to say there's a very positive future in primary care.

But instead, they have to learn the PKAs of every amino acid, which is totally useless, quite frankly.

[Laughter.]

DR. ROBERTSON: I couldn't agree with you more.

DR. DEAN: And then to deal with the things that you mentioned about the sort of negative influence that all too many students experience, with regard especially to primary care as they move through the specialty dominated inpatient experience that they have in medical school.

All of that, I guess the question, to get to the question, do you have -- does COGME or in your discussions or do you have any thoughts as to ways that Medicare could have an impact on the early phases of education which I see where our real problems lie.

Sure, there's a lot of things we can do to improve graduate education, but we still have lots of primary care slots that are going unfilled. And when you argue to the policymakers that we need to pour more money into graduate education, they say look, you're not even filling the slots you've got. And that's a fairly potent argument, even though it's obviously much more complex than that.

But it seems to me, in my career, I entered family medicine when there was a great deal of enthusiasm, right in the very beginning of the specialty. A lot of enthusiasm, a lot of very motivated, talented people coming into family -- then there was another burst of enthusiasm, like you said, in the mid-'90s. Now we hit a sort of a nadir. I think we're headed back up and I think the future is bright. But how do we communicate that to incoming students? And how do we create an environment early on that supports the choices of the specialities we know we really need?

DR. ROBERTSON: I think that medical schools get this. I don't think that they're an obstacle to what's going on. I don't think there's a conscious decision for medical schools to try to block people going into primary care. I think they're sometimes kind of stuck with the

environment in which they find themselves and it takes a long time to make a change.

Northwestern is in the process of completely revising its curriculum. We had a curriculum retreat a week ago today. One of the things that resonated throughout the retreat is we've got to find a way to get our students out of the medical center and into the community. That's where departments of primary care can make a big difference. Part of what I've done as chair is develop some really deep relationships with federally qualified health centers that are located in medically underserved communities and we're trying to find a way to function as a conduit to get students into those settings. And we have the support of the medical school's administration in doing that.

So I think those kinds of realizations exist.

In terms of what you can do from a Medicare-related policy, I think that again, in 1965 it made perfect sense to have GME policy directly aligned to hospitalized care because that's kind of where most of the care was being provided. The GME policy has remained virtually unchanged since 1965, and I think the challenge that you have and/or the opportunity is to look for a way to begin that

transitioning process without necessarily throwing hospitals into complete chaos.

I think this is something that can and should be done in a reasonably sequential manner to allow institutions to be able to plan. But we're also in a big hole right now. And I think that's the big concern, regardless of whether health care reform is passed, the numbers of physicians that we're producing who want to be adult primary care providers is still going in the wrong direction.

MR. HACKBARTH: I want to talk about Peters' Chapter 6 related to the financing piece of this, and use Mike's comment as a platform. So much of the discussion seems to be focused on how we draw more people into primary care as opposed to make the other alternatives less attractive.

At least implicitly, our model here has been sort of laissez faire, we'll be neutral in terms of what we fund and we'll let the system decide how many specialists we need of different types. That's not working, I think demonstrably it's not working.

So I'm fixated on Medicare and Medicare payment policy, and I know there are a lot of other very important

aspects of that, so forgive me for my fixation.

In Medicare, broadly speaking, we've got two types of levers. We've got our physician payment policy and broadly there's agreement that we have to increase the level of payment and perhaps change the method of payment for primary care. And correspondingly, we're going to have to tamp down payment for some of the subspecialty services. We may disagree on details but directionally I think we're all on board with that.

Now the other bit lever, Medicare lever, is the payment for graduate medical education. There we've had this very neutral policy, you decide what and we'll pay for it. We've got this situation where we know we need more primary care physicians but we don't have enough people wanting to go into them. So that's sort of pushing on a string there.

That leads me to the other obvious alternative, which is to say Medicare is not going to pay for as many subspecialty training spots and we're going to clamp down on that end.

Earlier I asked the question about whether the spots over the cap suggest that they're self-financing. The

answer I got back was persuasive, no, they're not. So the corollary of that is that, in fact, if Medicare squeezes on the number of subspecialty spots that we'll fund, that may have a significant effect. That lever may have power.

Reactions?

DR. ROBERTSON: Well, I think part of what happens right now, in terms of -- depends on the motivational direction that this ends up taking. Part of what I referenced earlier and what we got from the Altarum Report is that 17 percent of current students want to go into primary care but 27 percent actually end up going into primary care because they couldn't get the specialty slot that they thought that they wanted.

If you look at the expansion of medical schools in the U.S. right now, the COGME 15th Report I think projected or recommended a 15 percent increase. We're already at 18 percent so we've -- both by medical school expansion and, as well, as the creation of new medical schools. Central Michigan University now is going to start a medical school. Grand Rapids has now got a campus for Michigan State University. So this expansion is continuing.

So part of kind of what's happening is the gap

that exists between the number of U.S. medical graduates -- both allopathic and osteopathic -- and residency positions is beginning to shrink. And so by default, we'll end up filling a lot more of the primary care slots with U.S. medical students. And there's a brain drain issue that comes up with that. So that's one thing that I think is going to happen regardless, so long as the cap remains intact.

From a payment related standpoint, rather than looking at E&M codes, I'd rather see primary care physicians paid for the stuff that we like to do, which is the care coordination. I was the chair of the ethics committee at a community hospital where I was on staff. We spent lots of time with end-of-life issues. And 99 percent of the ethical issues for the ethics committee had nothing to do with medical ethics. It was all about the information that had been communicated to a patient and his or her family. But that takes two or three hours to do that. And right now there's really no way for that to be funded.

So those are the kinds of things that you could do that I think would make a difference. And these are the things that I think people who went into primary care for

all of the right reasons, they like doing that. They enjoy those conversations. They value the depth of the relationships that they develop with their patients and families.

MR. HACKBARTH: Thank you. As evidenced by the number of questions and comments, it was a very valuable presentation. We really appreciate the time.

DR. ROBERTSON: Thank you very much.

MR. HACKBARTH: Thanks, Russ.

Okay, we are substantially behind schedule but I'd like to assure Commissioners that we will end on time. Don't change your plane reservations.

So our next topic is comparative effectiveness and some results we got from some research on physician perspectives. And Joan and Nancy have graciously agreed to accelerate their presentation so we can get through this.

DR. SOKOLOVSKY: You really should not ask two New Yorkers to go fast.

[Laughter.]

MR. HACKBARTH: Right, right.

MS. RAY: Good morning. During this presentation we intended to first review the Commission's previous work

on comparative effectiveness and then describe the Recovery Act's funding for comparative effectiveness research initiatives, $1.1 billion to AHRQ, NIH, and the Secretary of Health and Human Services, as well as it also creates a Federal Advisory Council.

In the interest of time, I'm going to draw your attention, however, to one aspect of the Recovery Act's initiative, but I'm happy to take any questions that you may have about the funding to AHRQ, NIH, and the Federal Council.

The Recovery Act requested that the Secretary fund an IOM study on national comparative effectiveness research priorities. To fulfill this mandate, the IOM formed a 23-member committee of individuals from academia, physicians, payers, patient groups, and providers. Your mailing materials list the members.

Partly based on topics suggested by the public, the committee went through a three-round voting process to identify the 100 highest-priority CER topics, and the IOM released its report on June 30, 2009. The IOM committee organized these 100 topics into quartiles.

Your briefing paper includes a chart that shows

the distribution of the 100 topics by research area, so this is what I would like to draw to your attention, and it was a bit surprising to some of us. About half of the topics compare some aspect of the health care delivery system, such as comparing the effectiveness of comprehensive care coordination programs, such as the medical home and usual care, and comparing the effectiveness of accountable care systems and usual care on costs, processes of care, and outcomes. A third of the top 100 topics address racial and ethnic disparities, and about a fifth address patients' functional limitations and disabilities.

So, again, that concludes my part of the presentation at this point, but I am happy to take questions.

DR. SOKOLOVSKY: As we talked about yesterday, every year we conduct focus groups in different parts of the country with beneficiaries and physicians to hear from them about their recent experiences with the program. This year, with researchers from NORC at the University of Chicago and Georgetown University, we conducted six focus groups with physicians in July and August. Groups were held in Baltimore, Chicago, and Seattle, and participants came from

many different practice settings, including solo practice, small groups, multi-specialty group practices, and hospital-based physicians. About half were primary care physicians, and participants were ethnically diverse and included both men and women.

Although focus groups cannot have the precision or comprehensiveness of quantitative findings, they do enable us to gain more real-time knowledge of how the program is working for those people who are most directly affected. And they also supplement our knowledge by providing information that cannot be explained through claims, analysis, for example.

In 2007, as Nancy would have told you, the Commission concluded that there wasn't enough information for patients and providers to make many decisions about alternative treatment options for many common conditions and recommended more comparative effectiveness research. CER, however, will only be useful if physicians know about it and find it credible and easily accessible.

So this summer, we asked practicing physicians what they thought about comparative effectiveness research, and we found that physicians had a very diverse range of

opinions about comparative effectiveness. We found that, in general, the current initiatives are not well understood by practicing physicians. Some focus group participants opposed any comparative effectiveness research. While the majority welcomed more data, many had concerns about aspects of the research, and they also had a number of ideas about the best ways to disseminate CE information so that it would be useful to them.

I'm going to focus mostly on the concerns of those physicians who wanted more information but had some issues about the research. But I'd like to talk first about those focus group participants that opposed any comparative effectiveness research.

Those who were most opposed said they got all the information they needed from annual conferences, journals, drug company representatives, and their own experience. Some worried that CER would lead to mandatory guidelines from both the government and private payers and, as one said, "cookie-cutter medicine." They also worried that the research would only show the most effective treatment, on average, and ignore sub-populations. They believed that personal experience with a treatment was enough for them to

make treatment decisions.

For example, one focus group participant said, "I think the decision should be left up to us. We have our judgment. If we like something, if it works, great. If it doesn't, then we try something else."

On the other hand, those who were most supportive of CE said it would give them more information to decide best treatments for their patients. They said that despite all the information they got on a daily basis, they had very little access to head-to-head comparisons of drugs, devices, or procedures. Several said that the current guidelines from their specialty societies that they often consulted were frequently based on consensus-based -- were consensus-based because evidence enough simply did not exist.

Consensus-based guidelines could be shaped by professional biases and conflicts of interest. One primary care physician said, for example, "I take care of patients with cardiovascular risk factors, and I try to determine their risk with standard testing. And I get this consult, and I've never even heard of the thousands of dollars' worth of tests that they did. And I'm sure it's not evidence-based. It's just what they learned at a conference. And

I'm spending $30 of the patient's money, and they're spending $2,000 in this testing. Does it make a difference? Well, that should be answered objectively and in a centralized manner."

Although all participants said they would not use a treatment that didn't work for their patients, most didn't think personal experience was sufficient. For example, one physician noted that there were some things that an individual physician simply couldn't observe based only on their patients. He said, "The other issue is risk reduction or mortality rates. I can't see that in my practice. It's just not large enough."

Now I want to address some of the specific concerns mentioned by the focus group participants. They wanted to be sure that studies took into account not only outcomes but also the side effects of treatments, the patient's quality of life, and differences among groups. Some worried, on the other hand, that doing studies that took all of these important factors into account could require large sample sizes that would then make the studies prohibitively expensive.

Some worried about the effect of CER on

innovation. Again, we got very different views. Some said that manufacturers of drugs or devices that proved less effective than alternatives could be driven out of business, and that would slow innovations of new treatments; while others thought it would lead the industry to develop more innovative products because there would be a smaller market for "me-too" products.

A number of physicians linked CER to liability reform, one worrying that it could make them vulnerable to lawsuits if they used alternative treatments, even if they had good clinical reasons for doing so. But another believed that, in fact, it could be used to protect them from lawsuits if they were able to show that they used evidence-based medicine in their treatment decisions. And a few physicians said that this protection should be explicitly recognized in any comparative effectiveness program.

Physicians probably talked the most about how to ensure the most objectivity in the evidence they used. For example, nearly all physicians met with pharmaceutical company representatives. They said it was a good way to learn about new treatments, but that they had to take the

information they received with "a grain of salt." And if they were interested in a particular new treatment, then they would have to do more research to see if they were really interested.

Specialty societies seemed to be a generally trusted source of evidence, whether through conferences they sponsored, journals, or regular e-mail communications. People also cited NIH, FDA, and CDC as trusted sources.

In general, physicians believed that no source was completely without bias. Even the government could be biased towards less expensive treatments. So they emphasized the importance of transparency. Not only should researchers report any conflicts of interest, but also that credible CER information has to be transparent. Researchers must present their studies' research design, methodology, and particularly report all of the results so others could evaluate it for themselves.

Our focus group participants also discussed the best ways to make the information useful to them. They wanted CER findings to be concise and easy to read -- in other words, something they could look at quickly to see if it was relevant to their practice, and then dig deeper if

they were interested.

Results should be easily accessible. For example, some suggested getting brief information about something on their PDAs or through specialty society e-mails, which was a source that many were already receiving.

Several said that the priority should be high-priced new technologies with studies done before these technologies became widely diffused in practice. Another thought there should be an emphasis on studies that compared medical management with procedures for a given condition. Several also mentioned that, given the fast pace of medical science, it would be important to update studies frequently to take into account new evidence.

Well, I've discussed how the physicians who participate in our focus groups view comparative effectiveness research. To start your discussion, we'd like to hear about dissemination techniques that in your experience work best, and we're also interested in any other comments you may have about the other concerns physician express.

And, with that, I turn it over to you.

MR. HACKBARTH: Okay. Thank you, Joan and Nancy.

I would like to allot 10 to 15 minutes for questions and comments, and we'll just do one round on this.

This was useful information on these focus groups. It's pretty much what I would have expected, but, you know, it's useful to sometimes have that confirmed. It would be pretty much what I would expect both in the positive and some of the concerns raised.

Let me start with a question. Was there anything that really surprised you in the focus groups, anything that really stood out for you?

DR. SOKOLOVSKY: I suppose it was somewhat surprising to have people say, "We don't want any more information." I mean, the concerns did not surprise me, but the strength of the few people who were completely negative did surprise me.

MR. HACKBARTH: So even though that was a small number of people, that was surprising to you.

DR. SOKOLOVSKY: Yes.

DR. KANE: Did they all wear glasses?

[Laughter.]

DR. MARK MILLER: The only other thing I would have added to that, which is a little bit off of the focus

groups, is the IOM's priorities, at least when we went through them, we expected to see a lot more drug-drug, device-device, medical treatment versus surgical, that type of thing. And I was kind of curious as to what your reactions were to that as well, in addition to whatever happened in the focus groups.

MR. HACKBARTH: Okay. Let me see hands. Why don't we start on this side this time.

MR. KUHN: Thank you. I'm like Glenn. The result didn't surprise me. But I would just make the observation that, you know, every physician I've ever worked with in one way or the other attempts to practice evidence-based medicine. They've done that since day one, and somehow this issue has really taken on an interesting role because of the government's role here one way or the other.

Two questions -- one about the data. I noticed that you did these focus groups during a time of -- I think it was July and August of this year. That obviously was the same time when a lot of town hall meetings were going on around the country. Was there any kind of spillover that you could see from the activities that were going on and reported in the national press and the results you were

getting in your focus groups at all?

DR. SOKOLOVSKY: Not in a bad way. These were very kind of intellectually engaged, the people participating. People said afterwards what a good time they had discussing these issues. These were, in general, not high-passion. They were really thoughtful discussions.

MR. KUHN: Good. That's good to hear. The only observation I would just make on this is that obviously one of the clear messages we're getting here is that, you know, this issue of non-interference within the physician-patient relationship is loud and clear when you look at this data that's out there. And I think there will be some portability or some opportunities for us to discuss this further when we get into other topic areas in the future Commission work, such as shared decisionmaking and things like that. So I think it's one thing that -- there will be a number of interdependencies here on other things that we do. I just want to kind of point that out as we go forward.

MR. BERTKO: Just a quick question. On Slide 16 you mention here that they call for updates on new procedures and such. Was there any discussion in the focus group about using surveillance to see what happens after

procedures or devices get used a bunch of times?

DR. SOKOLOVSKY: They didn't talk about it. It was kind of interesting. We didn't want to define what these studies should look like, and it was very clear that people defined them based on their own experience, so that some people who were already engaged in clinical trials assumed that every one of these studies would have to be a clinical trial. Others did talk about meta-analysis. Nobody specifically mentioned things like registries. But others did talk about FDA, in fact, keeping track of what happened.

DR. DEAN: Thank you. This was very interesting. Obviously, this has been an interest of mine for some time.

In response to Mark's question, I had exactly the same response to the IOM list. I was really surprised at how vague or kind of non-focused some of the recommendations were, and I certainly expected much more in the way of much more specifics. At least from a clinical point of view, that's what we would need to make clinical decisions. From a policy point of view, maybe some of the other broader things.

In response to the focus groups, I guess I would

just respond that personal experience can be highly misleading, and I think that that's why the value of this. The most striking thing, just a month ago in the New England Journal there were two studies -- one from the Mayo Clinic and one from Australia -- about the treatment using vertebroplasty, which is a treatment for compression fractures of the vertebra, which is a very painful procedure, not a life-threatening procedure but the procedure that has been used and has come into wide use. They put a balloon into the collapsed vertebra, expand it, and then put the cement in to stabilize it. And the belief across, I think, the whole medical community is that that improved the outcome and shortened the recovery time. And in both studies -- one from the Mayo Clinic, one from a university in Australia -- these were well-done studies with sham procedures to compare for comparison. There was no difference with placebo. I mean, one study showed a very minor trend toward a shortened recovery time with the procedure, one showed no difference at all.

So here is an expensive participation that everybody believed worked, and when it was subjected to really hard-nosed scientific evaluation, it's not nearly as

good -- maybe it's not any good at all, but it certainly is nowhere near as good as people believed. That's why this kind of research is so important.

And so I think the important challenge is, first of all, we need to get the studies done. People fear how this data could be misused. And it could be misused, but any data can be misused. And I think we've got to get the data first, and if the powers that be become too heavy-handed in its applications, then that's a separate problem. But we cannot make good decisions if we don't have good data.

The dissemination is a challenge, and I guess my thought would be it would be helpful if CMS or NIH, maybe -- I'm not sure who the vehicle should be -- would develop some sort of a clearinghouse or website where you could consolidate all this information and you could have one source where, when we're looking for what really has worked, what does the research show in a concise form, we could go there and see what has been done.

We're never going to have perfect data. There's always going to be patients who have unique situations, and we have to make sure that our policies allow for that, and

that if we make good clinical decisions that don't entirely follow that, there has to be allowance for that. But, still, we need to figure out ways to make this data easily available.

MS. BEHROOZI: Just on the topic of the IOM list, it seems like a lot of the stuff is good stuff about public health kinds of issues, but it's really not the kind of thing where you would want there to be one answer. You would maybe want there to be sort of a ranking or here are alternative strategies or, you know, this works for 40 percent of the population and for the other 60 percent you have to do these other six things that have proven effective, as opposed to not even necessarily direct head-to-head things, but, you know, a more limited set of choices that a clinician might make among interventions. So they really seem to be kind of two different lists, almost, combined into one.

And just on the demographics, you know, the eyeglasses, as Nancy raised it, of the participants in the study, I imagine that the focus group is too small to really do a demographic analysis or specialty analysis or whatever. But maybe that is worth sort of at a next level of research

how do attitudes break out among specialties, you know, among ages, regions, whatever. That would be the kind of thing that I would think would inform the question of effective dissemination strategies. Again, you'd probably need multiple dissemination strategies to approach all the different groups of people you're dealing with.

DR. CROSSON: Just one comment on the dissemination strategy. I think you noted in the report that in the focus groups, a number of physicians had sort of a healthy skepticism towards all data that they use to make judgments, and I think that's entirely appropriate, particularly because I think there has been some concern in recent years about bias in research and the like. And I think in our own organization, our large medical groups, we see the same thing even, you know, within our own organization. And to the extent that we can generate clinical information about what we think might be the best direction or the other, sometimes we have physicians look at it with healthy skepticism also.

What we have generally found is that physicians tend to trust the judgments of individuals in their own specialty who have strong reputations for quality,

excellence, and independence of judgment. And so what we've tried to do over the years is to use those groups of individuals not just to promulgate information about what appears to be the best way to practice but actually to develop that information.

So it seems to me that there's something to learn from that in terms of the dissemination process, and that is, to both involve the key physician leaders in particular clinical areas in the development of these, which I'm sure is the intention, but then also to use similar groups of individuals -- expert panels, you might call them, or whatever -- in standing behind the recommendations, as the FDA does and other organizations do.

I think in the end it's very important. Often physicians turn right to the back page and say, "Okay, whose recommendation is this?" And they look for names that they can trust and, you know, based on reputation and the like.

DR. KANE: Yes. Was there anything in there about not just informing physicians, but also the patients and the broader community on what might be done with respect to informing, you know, the people who might really also like to know more about clinical effectiveness from the

perspective of the patient, and media, how to train the media on how to report on some of these kinds of things? Because it's often not well reported in the media, or, you know, people don't -- I know in public health risk ratios or odds ratios are very poorly interpreted by people who aren't trained to do that.

So is there any kind of thought about how to invest in both more broadly disseminating and then on how to train the media to talk about these things intelligently and objectively?

DR. SOKOLOVSKY: In terms of the focus groups --

DR. KANE: No. More in terms of all these other bodies talking about [off microphone.]

MS. RAY: Well, what I can speak to is that at least -- in AHRQ's announcement on projects that -- in AHRQ's general announcement on types of projects that it intends to use some of the Recovery Act's money, some of that will be on dissemination and translation initiatives. They didn't get into anything more specific about that.

At an AHRQ conference I just attended this past week, they noted that it is very difficult to try to disseminate -- to try to find effective dissemination

strategies to reach patients. So I think we will just have to watch and see how the Recovery Act's dollars are used to further dissemination strategies.

DR. BERENSON: Two points. One, since we're concerned about physician perspectives, I think it's important to point out that there was a letter signed by, I believe, 60 physician organizations that was very specifically supportive of the whole CER enterprise. So I think physicians are on board. I think we have to be careful about some of the concerns raised, but this is not an area where at least physicians are causing problems, so that's very reassuring.

The second point, to Mark's issue, I actually was the lead author on an article about a month ago in Health Affairs on a new technology -- not brand-new, but tele-health for ICUs, or the EICU, in which 10 percent of ICU beds now in this country are monitored by people in an external bunker. The people who have adopted this technology believe it reduces mortality dramatically, is the great thing since sliced bread -- not that sliced bread is that great, but that's what we say. And then there's most hospitals are quite skeptical. They don't think it's worth

the investment. They think their strategies make all the difference. And there's no objective data one way or the other.

So the whole hook to this article was that comparative effectiveness should not just study devices, procedures, and drugs, but that there should be some room for studying a delivery system or work process improvement.

And when the IOM came out, the paper got accepted, and we had to change it because there was the IOM saying that almost all of comparative effectiveness should be about delivery system and work process improvement.

I think probably there is a balance here that is closer to the original vision, which is drugs, devices -- clinical interventions, but that there should be room in the research agenda for the kinds of research that AHRQ does more so than just NIH research, which is what I think some of us were concerned that would tilt too far in that direction.

DR. STUART: There is another perspective on this. I, too, attended the AHRQ annual meeting just completed on Wednesday, and I direct one of AHRQ's Decide Centers, which is supposed to be preparing evidence on comparative

effectiveness. And one of the big deals that came out in this last session is the fact that in many interventions there is no particular reason to believe that the effect of the intervention, whether it's drug, device, or even behavioral, is going to be the same across different population groups. So this whole issue of treatment heterogeneity -- and Mitra focused on that -- is a real concern because there aren't clear boundaries upon where the heterogeneity goes and how close heterogeneity -- or what the variance is around some mean treatment effect according to different sub-populations.

So my question is: Is this reflected in part in terms of what you found in your focus groups? In other words, could it be that a physician says, "Oh, well, my patients respond to this particular treatment, and if they don't, I do something else," it really is a treatment heterogeneity effect as opposed to ill-informed personal opinion?

DR. SOKOLOVSKY: Certainly it was one of the concerns of physicians who wanted more comparative effectiveness research that we shouldn't assume that the same treatment worked for all populations, and they were

pretty clear about it. But the first group that I was talking about, in fact, didn't want any more information; they only wanted -- and, remember, this is a small minority. Most wanted more information but wanted to be careful that it took into account the heterogeneity of the population.

DR. CHERNEW: I have two very quick questions. The first one is: Do you have any sense of where the physicians or the focus group participants were getting their information about what comparative effectiveness research was? How did they come to what they were actually evaluating?

And my second question is: Is there anything that came out of the focus groups that might lead you to an opinion about where the detailed aspects of managing comparative effectiveness research -- not the board areas, but who decides I am going to study treatment A versus B within the sub, you know, gets done? And one would think, for example, that the system stuff might be best done in a place like AHRQ or an AHRQ-like place, and maybe some of the other ones might be done more at an NIH place. I know there has been a lot of discussion of the quasi-independent, sort of federal authorized whatever. And so any information

about how one might place all of parts of it would be useful, if there was any information that came out of the focus groups on that.

DR. SOKOLOVSKY: To your second question, I don't think that the knowledge of the different initiatives was clear enough that there was any useful information on that. In terms of where they got their information now, as I was saying, it seemed to be very much based upon their background so that there were physicians there who either now or in the past participated in clinical trials, and they had an NIH model of what clinical trials should be, and that's how they saw comparative effectiveness.

There were others -- and I want to say the primary care physicians were more interested in kind of looking across things and so talked more about meta-analysis. There were people who were familiar with Cochrane reviews.

One thing that -- I guess to Glenn's original question about was there anything surprising, one thing that was quite surprising and impressive to me, really, was that I am accustomed to hearing that physicians are overwhelmed with information and don't have time to read, for example. And we heard over and over again, we heard physicians

saying, "Well, if something's interesting to me, I want to go back to the original study and look at it." And I found that very both interesting and impressive.

MS. HANSEN: Great. I wonder, are there any plans to do focus groups on beneficiaries? Because there is so much -- you're talking about the climate of how people look at what's called comparative effectiveness. Or is, you know, AHRQ perhaps able to do that with some of the stimulus funds? And I know some of this then relates to work you've done on the informed decisionmaking that I think Herb brought up that this is another dimension of, but just how the beneficiary side gets represented.

DR. SOKOLOVSKY: Well, as you know every year we have a number of issues that we go out and talk to beneficiaries about. I have the feeling based on the lack of familiarity with the current initiatives by physicians, who were otherwise very kind of plugged in, that just going out and talking about that now to beneficiaries might not be the most useful thing we could talk to them about yet, although certainly down the road it's going to be really important.

MS. HANSEN: Sure. But is it something that we

can find out whether AHRQ is doing? Because, again, they are a process of that dissemination, and so how well that perhaps plugs into this side of the line of our working with the physician community. So I think if we could just somewhere, as we do some write-up on it, just to be able to get a fuller side as to what's happening.

And I bring up the same thing with just the health forums that have been going on, just the reaction, the idea that people don't want that, and they see that, ironically, as something coming between them and their physician. So there is some way to just bring a balance to that picture on the beneficiary perspective.

MS. RAY: You know, I don't have the details exactly in my head, but a couple of years ago, a California group conducted focus groups of patients and talked about, I believe, comparative research, and that's something that we could summarize and bring back to you at some point.

DR. CASTELLANOS: I'd like to take a little different viewpoint than what's been discussed. I think we all value the value of comparative effectiveness, so we're not going to -- we're not arguing that. I'd like to look at this issue, not just comparative effectiveness, but this

issue from 3,000 feet up or 10,000 feet up or however high you want to go.

I think the real issue here is -- and I'm not surprised by how the physician community reacted. Peter, you've been at hospital board meetings. Here, you have. George, you have. And this is not -- the physicians argue, they bring up issues. I mean, this is part of the physician mentality and education and intelligence.

What I think the point here is is that we need to think about not just strategies for comparative effectiveness, but strategies for all of the issues we've talked about, whether it be comparative effectiveness, whether it be, you know, design of a new -- dissemination of what we have wanted to do. And we don't have these good strategies for getting this useful information down to the practicing physician level or, as Nancy said, to the general public or to any of the communities.

I think, you know, with funding, I think we have the opportunity to better communicate these principles that we stand for and we've emulated. And I think as MedPAC we have the opportunity to be able to perhaps recommend some funding issues where we can get this information, not just

comparative effectiveness but other information that we think is valuable, not just to the physician community but into the general public.

MR. GEORGE MILLER: Thank you. Very interesting work from my perspective. I've got a question, just a technical question first, and you mentioned a little bit about a small minority. But could you give me the percentage of those who thought that CER shouldn't be done versus the majority who felt it should be done? Is it 10 to 90? Is it 30 to 70?

DR. SOKOLOVSKY: I don't really want to do that. I think it's hard to parse where the kind of line's drawn of, yes, I want more information, but I have so many concerns that, in fact, it's not possible to do it. So where do we draw that line?

MR. GEORGE MILLER: Okay. And I'm wondering if that line is because of the trust issue and what are the parameters for that trust. We've often heard health care is local, so where that information comes from -- and Ron just hit it, I think, in that. What is the entity that should effectively communicate for the physician community? And can you have one organization communicate to the physician

community about CER? Or should it be different avenues?

I was struck by the comment that some physicians relied on consensus versus CER, and I'm wondering what the basis of the research -- or what the basis of their consensus would have been. Or did they talk to you about that?

DR. SOKOLOVSKY: What they actually said was that the guidelines that their specialty societies use --

MR. GEORGE MILLER: Specialty societies, okay.

DR. SOKOLOVSKY: And, in fact, that seemed to be the most trusted source, if I could characterize it, would be the specialty societies. But some physicians said that, in fact, they thought that many of those guidelines that they relied upon were actually consensus-based not evidence-based, because the evidence didn't exist.

MR. GEORGE MILLER: I think it goes to Tom's discussion about the Kyphoplasty versus vertebroplasty. I remember being a CEO, and one of the greatest food fights I ever had was listening to that argument. And they would quote what I believe was at that time consensus-based information and not actual studies like you just quoted. And for someone who's trying to decide what resources to

invest in either, both, or neither, there has to be a repository of information.

So, again, my question centers around the communication. Should we as MedPAC make a recommendation? Should it be AHRQ or NIH? I think that's the challenge we have, and it sounds like that's the challenge of the physician community to deal with that issue. So it will be interesting to follow this.

I'm probably going to be a little bit off the subject, but I'm wondering if you had discussions in addition to CER, if discussions were in the vein of which specialty should do a procedure. Because, again, the food fight was over should anesthesiologists be doing a procedure or should it be a neurosurgeon, that type of thing. Did that come -- was that not part of it?

DR. SOKOLOVSKY: No, that really never came up.

MR. GEORGE MILLER: Okay. All right. Thank you.

DR. BORMAN: Fairly quickly, I hope. This is very nicely organized, and it's a nice juxtaposition of sort of some objective and then some subjective.

I, too, do not find the focus group comments surprising. I would hope that we do all remember that it is

a very small sampling of physicians, and while we all have a gut sense that it's emblematic, I think we need to be just a little bit careful about attaching too much weight in our thinking of what we take forward to that. So just as a caveat.

The second piece, just to comment on the linkage to the professional liability reform, and I think that's hugely important here for two reasons. One is that I think you can see that this is a carrot for embracing a process that we as a Commission have felt is important to take overall quality of care to another level. So I think, you know, it's a carrot; we need to understand the power of the carrot.

And then the second piece is that even separate from just the carrot of drawing people into it, as all certainly the physicians at the table will tell you, there will have to be a mechanism for peer review when guidelines are not employed. And you will never get meaningful peer review if you do not tie this in some way to professional liability considerations.

So that while the devil will be in the details and it will have to be appropriately crafted, that in order to

have this system have the downstream effect, there will have to be a peer review component, and it will have to offer protection to get that to happen.

Then, finally, in terms of what to focus on, with all due respect to the IOM and with respect to the fact that we do need to think about systems and processes, once again I think we can go to the high-cost, high-volume diseases and conditions, the high-cost drugs, some of the things we've already talked about here, high-cost element of biologics and, you know, what is going to be the appropriate use of those in relative diseases. And so I think that coming up with a list from the Medicare program's standpoint -- and I'm sure analogously the Medicaid program's standpoint or SCHIP in some combination -- could come up with the related pediatric issues for the segment that Medicare doesn't cover. I think identifying those will be a relatively easy place for at least some up-front good things.

MR. HACKBARTH: Thanks, Karen. Okay. Thank you very much, Joan and Nancy. Now we will move to our last sessions, an analysis of episodes of care and Jennifer is going to lead that.

So we are now at almost 11:40, so I'm going to be

shooting to wrap this up around 11:20 so we can allow 10 minutes for the public comment period. Jennifer has agreed to help us with that.

Did I say 11:20? We're actually going to go backwards, yes, and Jennifer is going to do that for us.

I meant to say we're going to finish at 12:20.

MS. PODULKA: And I'm going to try to go as quickly as I can, but being a Texan and not a New Yorker, it's going to be a little bit challenging for me.

I don't want to confuse people with the face and the episodes name because my presentation is actually going to take a look at the Medicare program in a way that the Commission has not traditionally undertaken.

Several Commissioners have asked over time for a cross-payment-silo perspective. Mike, you specifically suggested that we use our episode database for this purpose.

So as I mentioned, cross-silo perspectives, we're going to explore levels, growth and variation in Medicare spending using the episode database. Just to reorient you to that, the database is built using Medicare claims and the episode treatment groups, from ETG software from Ingenix, Inc.

Before I get into that, this is not an endorsement. As you will recall from our June report, we very strongly said that CMS needed to use an open, non-black box Medicare-specific episode grouper. But we have this data tool, and when we have a data tool we use it.

So the ETG software groups Medicare claims into clinically distinct episodes of care. These include about 500 clinically related groups called ETG base classes. These base classes are further split into more granular ETGs, such as diabetes with and without complication or with and without surgery, or some other smaller groups.

But for our purposes, we're using these as base classes. Think of these as very high level. To be non-confusing, I'm going to refer to these as episodes throughout the presentation. Think of these, you'll see soon, as diabetes, hypertension, things like that.

So basically, what we did was look at our usual levels in growth, but in a slightly different way. Here, the 20 clinical episodes that accounted for the greatest share of total Medicare spending on episodes in 2005 -- that's the high level -- together, these accounted for almost 60 percent of total Medicare spending on episodes.

I want to draw your attention the fact that our denominator is spending on episodes, not the entire universe of Medicare spending. That's consistent throughout. So numbers, spending, everything is episodes.

Of these 20 high level episodes, only two are for acute conditions: closed fracture of thigh, hip, and pelvis, and bacterial lung infections. The rest are chronic conditions.

Note, episode software splits all types of episodes into either acute or chronic. Acute you might think of as something short in duration, such as sinusitis. Everything else is similar between acute and chronic. It's all types of services -- doctor visits, hospitals. But acute ends when that service grouping ends.

Whereas chronic conditions, such as diabetes, tend to not go away in your lifetime. So for analytic purposes, what the software does is it creates annual chronic episodes.

Okay, the first set of numbers. Here you see the first 10 of the top 20 high level episodes. To orient you to the data, the first line, ischemic heart disease, ranks first in total spending, accounts for 14 percent of total

Medicare spending on episodes, and about 20 out of every 100 beneficiaries with at least one episode has ischemic heart disease.

If you look down those columns on the right-hand side, you see that we have a mix of both common episodes that are not so expensive, and rarer episodes that are rather quite expensive.

And to fit everything in, here are the next 10 of the top 20. Notice that these now account for about only 1 to 2 percent of total Medicare spending on episodes.

Moving from levels to growth, I'm going to show you on the next couple of slides. About half, exactly half of those 20 episodes that were high level are also high growth. But we set our definition for growth a little differently. We first limited our universe to those that accounted for at least half a percentage point of total spending on episodes. And in that universe, these 20 together accounted for almost 30 percent of total episode spending in 2005.

Again, coincidentally, of the 20 fastest growing, two are acute conditions, which are spinal trauma and then the UTI and similar episodes. All the rest here are chronic

conditions again.

So data here, the yellow lines represent ones that are both high level and high growth. Reading across, for the first line, joint degeneration of the neck grew the fastest. I want to note that that 19 percent growth rate is average annual. It's not total growth over the multi-year period.

Note, if you read down, that there were some Medicare coverage decisions during this time period that, of course, contributed to the growth. For example, coverage of breast and prostate cancer screenings.

To spend a little time, the next 10 of the top 20. Of course, when we talk about growth, the natural question is what's driving growth rate? So to help answer that question -- sorry, I tried to squeeze it all in so we could look at it all together. It gets a little small.

But basically, what you can see is that we broke out number of new cases and total change in spending annually. You can see that in all instances, the total spending -- the green bars -- grew faster each year than the number of new episodes. So both are driving growth but it's not all just new episodes.

Next, we ranked those high level and high growth episodes by 10 geographic areas. You see them here on the screen. Basically, they're a mix of high and low levels in growth. So they're designed to be illustrative.

So I'm going to take you through the words first. In each of these 10 geographic areas, the 10 episodes that account for the greatest share of total Medicare spending on episodes were pretty similar in rank -- rank in that local area -- to the national rank. So if you read across that first row for the most common condition, ischemic heart disease, it was consistently in first place across all 10 areas.

However, I'm going to give you a secret. You don't have to read anything. If you sort of unfocus your eyes and look at this as a pretty picture, think of it as mosaic, one -- the first level rank -- is the lightest color. Ten, the opposite end of the ranking, is the darkest color.

So if you kind of look at it, and of course, those blue cells are blank so there's no overlap between national and local, the pattern is a little mixed up by fairly consistent. Which means that national and local is very

similar in terms of level.

Not so on growth rate. Here the results are quite different. Again, maybe don't try to read if you're not interested, because they do get kind of small. But if you look at the picture, you can see that overlap between national and local looks really different here. It ranges from only one cell overlapping in Houston to six in Minneapolis. You'll notice lots of blanks where there's absolutely no overlap between national and local. And of course, it's very mixed up.

So you can draw lots of conclusions from this, but one that I offer is that any policy options that focus on the high growth conditions are probably going to have some differential impact by local area.

Next we took that local comparison and we looked by type of service spending. Of course, type of service spending differs by episodes. That's not a surprise. But we found that there were significant differences in type of service spending for the same episode in different geographic areas.

In other words, the exact same condition is treated quite differently in different cities. Of course,

if I really did this analysis it would be way to big to look at compared to the last one. So we drew some illustrative examples.

So if you look at this table, it shows notable or largest type of service ranges for the first five of our 20. You know that ischemic heart disease, the share of spending for the episode devoted to inpatient services ranged from a low of 49 percent in Miami to a high of 68 percent in Minneapolis. And we have notable ranges in all of these.

Next, we repeated this not for level but those high growth episodes. And note that this time we're comparing the total change over time by type of service. So let me interpret what that means. For a joint degeneration of the neck, the share of total episode spending devoted to post-acute care services declined by 4 percentage points in Indianapolis and grew by 15 percentage points in Phoenix.

In some instances, when you look past the five -- and this was in your paper but not shown on the screen -- there were fewer differences. But remember again, those fast growing -- we had fewer number of cells to draw from. But even still, some significant differences.

I'm going to skip future analysis because it's

understood.

Discussion questions. I offer this for your consideration. This analysis of fast growing episodes especially raises questions about the underlying incidents of disease. I grouped this into three possibilities. Does this reflect growing disease burden in the Medicare population? Or an increasing propensity among health care professionals to diagnose and treat? Or third, an increasing propensity among Medicare beneficiaries to seek treatment?

Of course, the next big bullet there, are there detailed analyses that you would like to see? It's a powerful dataset. Virtually the only limitation is the ability to present the information and our time to slog through it here, of course. But if you have ideas, please let me know.

And we've done top 20, top 10. But if you have an illustrative episode or two that you would like to really dig into, please suggest that, as well.

And thanks very much.

MR. HACKBARTH: Thank you, Jennifer. For a Texan, you talked pretty quickly.

Let me just say a word about the context for this. Mike has pointed out in the past that on the one hand we lament the fact that so much of Medicare is focused on silos and all that. But we fall into the trap of, in fact, talking mostly about the silos. So Mike suggested it would be good for us to spend some time looking at these things on a different plane. So this is a first effort to do that.

So Mike, I'm going to give you the first opportunity to react to this.

DR. CHERNEW: [off microphone.] I think this is stunning work.

MR. HACKBARTH: Would you hit your mic?

DR. CHERNEW: I think it's stunningly even more wonderful when I say it into the mic.

I guess -- I will just be very brief because I know we don't have time. I think that as we move forward to new sets of payment systems, it raises a whole bunch of ways of what we want to do. I think the first thing people would agree on is we'd like the Medicare system to be more than just paying bills, but be a little more clinically oriented. In order to do that, I believe we need data that's a little more clinically oriented. I think this is a wonderful start

at doing that.

I think there's a number of specific questions that arise. One of them which will come up, which we don't need to talk about now, how good are the groupers? What do we think about the episodes? There's a whole series of technical things about groupers that matter that are more than mundane questions in an era that might go towards some sort of episode-based payment. The details of that will matter.

Issues of how we would deal with updates, which is something we deal with a lot, in a world that has episode-based payments or under bundling, is crucial. So beginning to look at what episodes look like matter.

I know that there are several people -- I'm involved with a group at the Bureau of Economic Analysis and there's a group at Harvard run by David Collier that's been thinking about this a lot. So I think, as next steps, it might be useful to talk with some of those folks as to what's going on.

But I'll just stop by saying I'm thrilled that you did this, so thank you. I think there's more to be done in this area to make the health care policy questions focus

much less on how do we control spending in a silo and how do we make sure we're caring for people in certain clinical conditions better.

The data being oriented that way, I think, is one step to do that.

DR. SCANLON: One observation about the issue of looking at growth. I think that as I looked at this and I saw that about half or slightly more than half of the fastest growing episodes, in terms of share of spending, were less than the lowest of the top 20. I think there's this question that when something is small, a little bit of growth can be a big percentage change.

So thinking about different ways of looking at growth might be something that would be worth doing. What contributes most to the share of growth? Or among the top ones, which ones are growing the fastest? Because I think that if we do do policy, we want to make sure we have the biggest impact of the policy that we have.

MR. KUHN: Thanks. This is really fascinating stuff. I really enjoyed reading it, and the presentation.

A quick thing in terms of the groupers -- and it's been a while since I've looked in terms of the makeup of all

of the inputs into the groupers. But as MedPAC has opined in the past and CMS has begun to implement a number of ways to try to get pricing correct, MS-DRGs work in terms of some of the activities. I know the RUC is going through right now to look at procedures that are going up dramatically. CMS has picked off the top 100 that they have asked the RUC to look at.

So I'm curious about is there a way we can get a relationship, in terms of the ones that are growing fast, what part of the pricing of that particular procedure, of a part of that grouper, is helping drive that on a go forward basis.

So in a way we could group this together but then also kind of disaggregate them a little bit so we can see the relationship or the correlation between maybe mispriced procedures or mispriced activity and how much that's influencing the grouper, as well. Because as we try to think about new payment policies as we go forward, we still might have a foot in the old world and yet try to get a foot in the new world. And how those two relate to one another would be helpful for me as we continue to look at this.

MR. BERTKO: Again, good work, like everybody

said.

One of the things I guess I'd bring up here is the question of bundling. Arnie, in an earlier meeting, forced me to think about this yet some more. I think -- I noted the caveat here that your percentages there were percentages of episodes, which I assume is a subset of percentages of spending but a large subset.

So it brings up the fact that perhaps limiting ourselves on a practical basis to 10 episodes -- and I think I counted them -- would be 45 percent of the episode costs and somewhat -- a large percent of that. Because to actually run this out would be very complicated and begin to organize things.

The question I would ask as maybe a follow-up might be throwing water balloons of bundled payments at episodes might be different between the acute ones, obviously, and the long-term ones, chronic ones -- diabetes in particular. But are there ways, given the way the episodes are structured, that you could see some of the episodes being more practical than others? Diabetes being lots of comorbidities. Maybe ischemic heart disease being a little bit simpler. And the chronic ones, the fractures

being the simplest of all.

So it's more of a rhetorical question. Can you come back to us at some point with some response?

And like Mike, I think, there are other people working on the episode based types of stuff that you might want to check with also. Prometheus, as being a key example also.

MR. HACKBARTH: So a factor might be simply the number of physicians typically involved in each episode.

DR. DEAN: Just a quick question, which might make this even more impossibly complex. But the real question is who has it right, in terms of the spending and resource use. Is there any way to tie some of this data to outcome data?

I don't know if that's even possible. But with the variation we see, it's not all right. And is the -- are the high spending areas getting better outcomes? Or as we've seen frequently, they don't. I guess that would be what we'd need to decide the policy.

I don't want to try to construct the graph to present that.

At any rate, thank you. It's very interesting stuff.

MS. BEHROOZI: Yeah, it was great, and I appreciate your struggle to figure out how to convey things visually, because you've done such a great job with the stuff that you've chosen, and the squinting and seeing how the colors shape.

Can you turn it back to Slide 9? Because that was actually my favorite chart in the paper. It shows the difference between the growth in episodes and growth in spending, number of episodes and spending. And I just -- I don't know. I feel like there's a lot more to learn about that. I mean, how do you have spinal trauma -- okay, it's only responsible for 0.6 percent of spending. I looked that up. But that's kind of amazing, more than a 5-percent annual decline in number of episodes, yet over 3 years, if that's an almost 10-percent average annual increase, a 30-percent increase. You know, what explains that? Some of what you were looking at in terms of the types of procedures in various regions, some going up and some going down. But I guess I just would love to know more about what's behind consistently the costs are going up much faster than the episodes are going up, that spinal trauma, one, just being sort of the most -- the biggest spread or whatever.

MS. PODULKA: We can pick spinal trauma and a couple others and dig down and see what's going on there. I'm not prepared on any of them today, but we could certainly try and break out new treatments, more treatments, what's happening.

MS. BEHROOZI: Thanks.

MR. BUTLER: What I like about this is that yesterday we tried to look at Medicare Advantage plans versus fee-for-service, and this is the middle ground way of looking at things where all the action is. And if we don't make an impact here, we're not going to change the system. So I think it's the right unit of analysis that we ought to dive into.

Now, two suggestions on the additional analysis. You gave the dollar numbers, and not up on the slides, but the annual spending per episode, and I was shocked at how low some of them were. Of course, being a hospital guy more than others, you know, you quickly say, well, this is a mean for annual spending. And then I come to, you know, you can drown in a lake that is an average of 5 feet deep. And so I want to know where the depths are, and the mean doesn't tell me a lot in this. It doesn't tell me where to hunt.

The second is that the geographic variation is interesting, but I think at the heart of this still is to line up our silos and look at the variation across the segment, as you did a little bit of, to say what communities had high hospitalization use for an episode versus other components of care. But if you can do some of your slick magic on some of those charts that show the best in class for the components of the care across the silos, that would be very helpful.

DR. MILSTEIN: I think early on when I started at MedPAC, I think I complained to Mark and Glenn saying, you know, if you benchmark the information flow that we, Congress, CMS, you know, GAO have to go on in figuring out what we're getting for the money in the Medicare system, I said, you know, we're not even close to what goes on in other industries. And I said what we need is a -- you know, so we have to move toward a value-based dashboard navigation system so we can begin to, on a more timely basis, understand where we're having the biggest fluctuations in value -- that is, you know, quality, as Tom was referencing, divided by total cost of care.

As I was looking at your mosaic, I realized this

is the beginning of movement in that direction. It's like a glimpse into the future as to the kind of instrument panel that all those parties I referenced, including us, you know, need if we are going to better steer this big aircraft called Medicare and, perhaps with respect to comment, the health care system.

So this is for me -- and I think a lot of us were sort of mouthing or have said the word "wonderful," and I think that's right. Michael's comment is properly cautionary. This is an early instrument panel, right? This is like a vacuum tube. But this is at least a step in -- you know, a huge step in the right direction and I think, you know, it invites all kinds of interesting questions, like the potential utility of such a dashboard at different units of analyses, whether it's plans, accountable care organizations, health systems, provider -- physician groups, individual physicians, individual hospitals. There are just innumerable applications. But this is just a huge advance and a wonderful presentation, and I think a real glimpse into, you know, what could be a value-based navigation system for us, for CMS, and for the people putting money into these benefits.

DR. KANE: I think this is -- I am very excited as well. I want to reinforce what Peter mentioned, that the distribution of the variability within the episode would be very useful as well. I think, you know, if everybody is doing the same thing within even a highly occurring, highly frequent episode, maybe that is less something we should spend time on than something that has a lot of variability in the way the spending is within. So, you know, maybe tell us the standard deviation or the range as well as the frequency and the rate of growth.

I'm going to do my broken record routine and ask if drugs are in here.

MS. PODULKA: Unfortunately, this is an earlier time period, so for these data we don't have them.

DR. KANE: Yes, so at some point, obviously, we really want to see the drug piece be in here.

And then I wonder if -- so spending is one metric of what's going on in an episode, but so is utilization. And I'm not sure that spending, particularly for the inpatient component, is a particularly good, you know, proxy for utilization to what's going on inpatient, you know, the number of tests, procedures. I don't know if we have a good

record. I mean, the DRG payment is one amount, but what happens to the utilization within the hospital might be useful information, even length of stay and -- I don't know. But it might help understand what happens post-acute or help explain some of the variation. And it may be impossible. I don't know if we have good inpatient utilization types of information.

But it would be, I think, trying to eventually understand the variability within an episode, spending, you might want to have some type of utilization as well as just other spending data to understand that.

DR. MARK MILLER: I know we're behind on time, but is this standardized?

MS. PODULKA: That's correct, so the payments are standardized to remove geographic differences. So to an extent, we are co ming closer to like an RVU count with our dollars. So the differences aren't differences in input prices or something like that between the different cities. It really is differences in utilization.

I hear what you're saying about disaggregating what types of utilization. I'm not sure how much we can do that within the inpatient. But I'll explore what we have as

options there.

DR. KANE: Yes, and my understanding also even home health, isn't it episodes? We don't know how many visits. Some of the breakdown of what's actually happening inside that spending might be -- might or might not be available, but at some level, it might become useful.

And then the last thing that I think would be helpful and interesting and probably relevant and explain the variability within an episode would be whether the enrollee has supplemental coverage or not, or even if they're LIS, non-LIS -- I mean, some sense of the socioeconomic and coverage status of the beneficiaries, that that could be also linked.

So look at the distribution within an episode of spending and/or utilization, and then try to explain -- not adjust, but explain why that variability might be in terms of some of these basic things, and then the remainder might be, you know, clinical variation that we would want to look into and better understand. But I think it's great and I'm very excited.

DR. BERENSON: I will join that sentiment, but let me start with maybe a quibble and then ask a question. The

quibble has to do with my perception that everybody now is so convinced that all spending is related to chronic care, and that's the area that I work in, that I think people miss that there's a lot of acute events that happen in people with chronic conditions. And so when I see cerebral vascular accident labeled as a chronic condition, I sort of scratch my head. I mean, these are people with atherosclerosis who then have an acute event. Ischemic heart disease is a chronic condition. Acute myocardial infarction is an acute event.

I guess my question is: Does this grouper permit you to do it both ways? Can you -- well, you know the question.

MS. PODULKA: Right. That was actually in my expanded notes that got cut right before coming up here.

DR. MARK MILLER: [Off microphone] Why are you looking at me?

[Laughter.]

MS. PODULKA: Yeah, blame it on Mark.

Okay. So basically anyone -- and this is true of the software, but any researcher who is trying to split care into acute and chronic, some are going to be clear cut, and

some are going to be gray areas that fall in between. The way it works in the grouper, chronic conditions can absolutely have acute flare-ups, so you can have atherosclerosis and it can flare up into an event.

It seems to generally characterize it more as a chronic than to separate it out into a separate acute, which can be helpful from a research point of view to see the related care and see when it flares up. And, again, as I said at the beginning, these are the very aggregated base classes. I keep referring to them as episodes, but the actual episodes are much more granular than these so that you would see a heart condition with AMI being a specific episode; whereas, here you just see the heart condition.

So there is the ability to disaggregate these into the more is it chronic with a flare-up or is it chronic without the flare-up. And, again, these are the pros and cons. You're trying to create a schema to understand this without having everything completely disaggregated into little individual bits, and there's a trade-off to that schema.

DR. STUART: I agree with Bob, and I was particularly interested in terms of the impact of flare-ups

on lower back pain.

I have a couple of substantive issues here. One is when I look at this, it looks like we're focusing on all of the increases. Whether it is through acute or chronic, it's all looking at growth. And my guess is that some of this growth is really additive, but some of it really substitutes for other kinds of things. And so there may be a certain artifactual side to this where, because of the way certain procedures, maybe new technological interventions come in, is that you'd really like to see in cases where you see big increases, are these brand new or are they substituting for something else. And so if you had something to look both at increases and decreases, I think that might help increase the -- or it might help make the picture more holistic.

The second thing is -- and I think we have all faced this in one sense or another, and it has to do with how we interpret percentage change. Between last August and this March, I lost about 50 percent on my stock portfolio, and then between August and July, my stock portfolio increased by 50 percent. So, therefore, I'm even, right? Well, no. I'm down about a third.

So if you're looking at increases and decreases, and particularly if you're looking at increases from small bases, it would be useful to have an analytic technique that standardizes that. And economists actually have come up with one that looks at absolute change and then change in absolute change, and it's associated with something called arc elasticity. That's probably the most common application of this thing.

And so I would suggest that you look at this and think about how these things might change if you do them in terms of absolute rather than relative changes.

Then the third thing -- and it's been mentioned before -- I think this is potentially a way for putting the clinical piece into the large Wennbergian view of differences, geographic differences. And so I would really encourage kind of some thinking about how we take this and we marry it to what we see in the Dartmouth Atlas.

MR. GEORGE MILLER: Just a quick question. I'm very thrilled with this work and very excited. I thought that I would have a platform by looking at this information to deal with one of my pet peeves or concerns, and that is, if there was a correlation between specialty hospitals or

physician clinics. But I didn't see that correlation here. At least I haven't been able to draw that conclusion. I don't know if you plan to do that in any way, because these are not all procedure driven. I was a little surprised by that.

MR. HACKBARTH: George, you're looking at the part that's related to particular markets and just sort of making a guesstimate as to where --

MR. GEORGE MILLER: I'm just guesstimating, yes.

MR. HACKBARTH: -- physician-owned hospitals are most prominent.

MR. GEORGE MILLER: Yeah, and also with the previous slide, not only this slide but the previous slide, which is just counterintuitive to me, but that may be because I'm not a researcher at all. I'm just curious if that's going to take that path, if you think the large spending -- we've got a large increase in procedures in some cases and referral by physicians to their own practices. But I don't see that correlation here.

MR. HACKBARTH: Well, you know, in other data, other analysis that we've done, we have found a relationship between the advent of physician-owned specialty hospitals

and increased utilization with associated services.

MR. GEORGE MILLER: Right.

DR. BORMAN: Just to reiterate, great stuff. I think it's starting to take us in a direction that we all want to go. The question would be if we pick several things to dig deeper into, would we want to see if we could identify commonalities in fastest growing or in spending in terms of types of services, because that -- and whether that matches up with some of our other analyses about growth and various types of services.

MR. HACKBARTH: Okay. Just one comment. I agree with what everybody said about this being very interesting, and thank you, Jennifer, for your work on it. And like Mitra, I really liked the visual presentation. That was very effective.

One other reaction that I have is that while I don't really disagree with what Arnie said about the utility of a dashboard that includes better measures -- a dashboard for policymakers, CMS, et cetera -- my ideal world is where we've changed the payment systems so that it's the providers of care who are hungering for this data and trying to perfect it and figure out what it means and what they can

learn from other places. To me, that is nirvana, not having a bunch of feds pawing through it and trying to figure out what's best but providers wanting it. We have a ways to go before we get there.

MS. HANSEN: The one comment I would make -- first of all, this is fantastic. I didn't get a chance to say that. But I think to your point, Glenn, the ability to have this -- this is where the HIT side of this comes into place, and being able to use it at that local level so it's both, you know, individual kind of pure comparative and benchmark, the ability to constantly have that so that the evidence is about you in terms of what you're doing on behalf of care, but it's really framing it in terms of value from multiple levels, clinical effectiveness per se as well as, you know, whether there's a barrier so that only the administrative side looks at it, so that it's not finances driving it but the relativity at least gives you a sense.

MR. HACKBARTH: Thank you, Jennifer. Well done, and also thank you for helping hasten things along.

Okay. Actually, we are right on time. It is 12:15, and we are ready to begin our public comment period.

Dr. Rich has, once again, proven quickest to the

mic.

DR. RICH: I've lost weight.

MR. HACKBARTH: Let me just repeat the ground rules here. Number one, please identify yourself and your organization. Number two, please limit yourself to comments no more than two minutes. When this red light comes back on, that means two minutes is up and I'd ask you to bring your comment to a conclusion.

Once again, let me just emphasize, I know this is a short public comment period, but it is not the only way, or even the best way to communicate with the Commission. The absolute best avenue is to communicate with our staff, who will go to great lengths to listen to you and your information.

As I mentioned yesterday, we are also looking at ways that we might enhance opportunities for public comments and we'll have some more information on that at the October meeting.

With that, Dr. Rich?

DR. RICH: Thank you, Mr. Chairman.

My name is Bill Rich. I'm Medical Director of Health Policy for the American Academy of Ophthalmology.

I would just comment that I was very impressed with the last presentation, especially the slide showing the 20 areas of fastest growth. Frankly, the Commission should take credit for a lot of the answers to those questions are actually being answered now.

The Commission recommended that we look at area of growth. CMS submitted the 100 fastest growing services. The RUC actually put together four other screens: codes presented together, growth, change in site of services, and several others. Just looking at those, I can tell you, some of them are expanded patient populations, new technology, marginal technology, inappropriate coding. It's all over the place.

But the explanations are actually there. The granularity is there to explain those 20 -- this is a different way of looking at it. This is aggregate data. But looking at the subsets of growth, be it coding or volume change or change in the patient population, almost all of those things can be explained.

So I strongly encourage Jennifer to get in touch with Barb Levy at the RUC now. Just look at the simple one of rheumatoid arthritis. That's Enbrel. So that's a Part B

drug. So I mean, some of these things are very explicable and the data is out there now and actually being sent back to CMS. And a lot of them are explained by the 100 codes that Herb sent forward last year.

So I think this was very interesting. We're the little guys looking at the little pieces. But to see the aggregate was really very enlightening.

Thank you.

DR. LURIE: Good morning. I'm Dr. Peter Lurie with the Health Research Group at Public Citizens, an advocacy group here in Washington.

I have no conflicts of interest to disclose.

In your June 2009 report -

MR. HACKBARTH: Sir, could you make sure you stand close enough to the microphone. It's a little difficult to hear you.

DR. LURIE: Let me see if I can raise this. Is that a little better? Should I start again?

I am, again, I am still Peter Lurie, a physician at Health Research Group at Public Citizen. We're an advocacy group in Washington. I have no conflicts of interest to disclose.

In the Commission's 2009 June Report, you observed that "Medicare, with an enormous financial stake in health care and graduate medical education, has never specifically linked any of its direct GME or IME subsidies to promoting or fostering important goals in medical education."

I want to suggest one area that you might consider doing that in, one that did not come up at all in the COGME presentation this morning. That would be resident work hours.

You are helped here by a very recent report by the Institute of Medicine that concludes that "a robust evidence base links fatigue with decreased performance in both research laboratory and clinical settings." They review all the research in this area, including a randomized controlled trial conducted at Harvard that shows a 36 percent decrease in serious non-intercepted medical errors.

So I think that you're starting to have a scientific base there that is just really getting stronger with time.

Now all of you know that in 2003 the ACGME came up with new guidelines on just this question. Guidelines are well and good. Compliance is another matter all together.

Research looking at compliance objectively shows that it's really been quite poor so far. 84 percent of interns and 91 percent of teaching facilities had a work hours-related violation in the first year after implementation of these guidelines.

So I think we should not assume that this problem has been taken care of and certainly the IOM has made that point, as well.

I also urge you to think about what the public thinks of this question. It's easy for we physicians and others in this room to think that it's so important a matter that we can, ourselves, solve it. But actually, there's limited information on what the public knows and thinks about this. And what there is is very worrisome.

The public is very worried about this issue. In a 2002 national public opinion poll by the National Sleep Foundation, 70 percent of respondents said that they were either somewhat or very likely to request another doctor if they knew that that doctor had been working for 24 hours. Of course, the problem is they almost never know that. The patients don't know that. They would prefer another doctor. They simply aren't even offered the choice.

In a more recent survey by the Kaiser Family Foundation, 66 percent agree that reducing work hours of doctors to avoid fatigue would be a “very effective” way to reduce medical errors.

So that all said, I want to come back to the initial charge, really, to yourselves, the idea of linking reimbursement policies to important goals in graduate medical education. I’d like to suggest this is one for initial consideration. A reimbursement formula that takes into account compliance with the IOM report’s recommendations would be an important step forward.

Thank you.

MR. HACKBARTH: Any others?

Seeing none, we are adjourned. See you in October.

[Whereupon, at 12:22 p.m., the meeting was adjourned.]