

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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COMMISSIONERS PRESENT:

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## 1 P R O C E E D I N G S

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

4 Welcome to our guests in the audience.

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

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

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

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

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

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

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

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

22 The goal in CED is to provide access to services

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

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

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

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

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

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

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

14 Following publication of the study's finding in  
15 2003, Medicare revised its coverage policy to cover all  
16 patients who matched the characteristics of patients in the  
17 trial, who experienced a survival or quality of life  
18 benefit. Since then, use of the surgery has remained low.

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

1 information collected via a coverage with evidence  
2 development effort.

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

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

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

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

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

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

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

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

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

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

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

1 funding has been obtained.

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

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

17           So this concludes my presentation.

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

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

4           MR. HACKBARTH: Thank you, Nancy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 this so far, right?

2 MS. RAY: Yes, about 10.

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

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

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

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

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

1 different from outside of CED.

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

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

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

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

18 MS. RAY: Yes.

19 MR. BUTLER: Right, with a new category.

20 MS. RAY: Yes.

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

1 the other didn't?

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

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

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

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

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

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

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

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

1 statement.

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

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

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

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

1 a little bit of an overlap here.

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

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

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

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

1 information nationally.

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

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

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

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

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

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

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

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

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

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

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

19 MR. HACKBARTH: Where is that occurring, Karen?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 I mean CMS has changed, has modified its legal

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

6 MR. HACKBARTH: Yes.

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

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

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

21 DR. MARK MILLER: You got it.

22 MR. HACKBARTH: One other clarifying question, we

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

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

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

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

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

20 Okay, round two. Let me see hands.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 Does that make sense?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 lot to learn from there.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 MS. NEPRASH: We also asked the panel to whom  
15 should assistance be targeted, and this question was  
16 motivated by two things: limited resources and wide  
17 variation in the quality of care. For instance, spending on  
18 30-day readmissions for CHF in high resource use hospitals  
19 is nearly four times that of spending at low resource use  
20 hospitals. Hospital mortality rates for surgical patients  
21 vary twofold.

22 The literature on quality improvement also

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22           Other parts of the federal government have also

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

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

22 Let me also just provide a little background on

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

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

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

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

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

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

10           Another important piece of background is that in  
11 2006 the Institute of Medicine convened a panel to evaluate  
12 the QIO program, and in the course of its work, it found no  
13 conclusive evidence that QIOs were effective. Clearly, it  
14 wasn't impossible that they were; it was just hard to prove  
15 that they were. And that is the case for a lot of these  
16 types of quality improvement programs. But threaded through  
17 their report and another one commissioned by HHS are some  
18 findings that suggested that management and design of the  
19 program was flawed and in need of improvement.

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

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

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

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

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

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

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

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

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

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

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

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

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

3 So let us see hands for round one clarifying  
4 questions.

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

12 [Laughter.]

13 MR. HACKBARTH: Yes.

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

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

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

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

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

1 address those disparities.

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

5 MS. NEPRASH: Have not but can.

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

9 MS. NEPRASH: I can also get you that.

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

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

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

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

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

8 MS. MUTTI: Right, right.

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

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

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

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

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

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

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

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

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

5 MR. HACKBARTH: AHRQ.

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

9 MS. MUTTI: CMO.

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

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

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

10 PARTICIPANT: Yes, you are right.

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

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

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

1 in need of dance lessons?

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

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

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

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

9 MR. HACKBARTH: So both dance partners need  
10 lessons.

11 [Laughter.]

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

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

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

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

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

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

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

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

3 My question really is: Is there within any of  
4 these resources an explicit focus on the psychological, the  
5 motivational side of quality improvement? Because those  
6 like the Michigan Hospital Association who have got great  
7 results to show in a short period of time say that that is  
8 80 percent of the battle, not the technical side.

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

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

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

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

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

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

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

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

13           MS. MUTTI: Absolutely.

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

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

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

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

8 MS. MUTTI: We can report back.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 [Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1           Thank you.

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

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

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

1 market.

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

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

1 through it more safely and more effectively.

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

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

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

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

11 Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 yellow segments of each bar.

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

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

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

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

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

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

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

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

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

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

22           Not shown in the chart, the difference in the

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

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

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

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

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

1 care.

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

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

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

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

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

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

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

22 I just want to assure people that is not the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 Also, something similar is the idea that the

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

3 DR. DEAN: Yes.

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

6 DR. DEAN: Right.

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

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

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

22 DR. DEAN: Right.

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

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

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

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

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

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

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

22 DR. DEAN: Okay.

1 MS. NEUMAN: But when a hospice --

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

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

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

19 MR. HACKBARTH: Round one clarifying questions?

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

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

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

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

22 There was the nursing home situation, where

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

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

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

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

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

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

1 liberal view on sort of who could qualify.

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

7 Peter?

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

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

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

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

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

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

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

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

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

1 but I can do that.

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

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

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

13 [Laughter.]

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

15 DR. STUART: And the other --

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

18 DR. STUART: For the --

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

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

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

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

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

4 [Laughter.]

5 MS. NEUMAN: Why don't I get back to you on that?

6 The general rule is, and this may be an exception, that if  
7 it's for the palliation of the terminal condition, that it's  
8 within the hospice's payment that it has to be funded out  
9 of. There may be some technicality here that I'm not aware  
10 of --

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

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

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

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

1 Those are difficult questions.

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

9 DR. STUART: For palliation.

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

13 DR. STUART: That's correct.

14 MS. NEUMAN: Got it. Okay.

15 MR. HACKBARTH: Okay, round two.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 So I would say an expeditious movement on it.

2 The other thing is more in the form of a question.

3 I have inferred from both the background paper and your  
4 presentation that the U-shaped pricing is the majority part,  
5 or the biggest part of the fix that we would want to make.

6 You mentioned some follow-up studies, but just in trying to  
7 listen to you, it seemed like the follow-up work would be  
8 good things to do for later on, but they shouldn't impede  
9 us. We're not missing any big amount now. Is that  
10 assumption correct, that we're not missing anything if we  
11 said immediately to go to the U-shaped payment mechanism?

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

18 MR. BERTKO: Thanks. That was my impression.

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

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

9 MS. NEUMAN: Sure. So CMS is going to be having  
10 additional claims data beginning in January of 2010, and  
11 that will include visit time information as well as  
12 information on a broader set of visits -- therapist visits  
13 and also social worker phone calls. So there will be  
14 additional data that will be available starting in January  
15 2010.

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

18 MR. HACKBARTH: Right.

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

1 we had thought could accommodate the incorporation of both  
2 pieces.

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

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

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

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

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

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

11 [Laughter.]

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

16 [Laughter.]

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

18 [Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 MR. HACKBARTH: Any other round two comments?

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

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

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

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

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

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

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

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

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

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

15 MR. HACKBARTH: Of course, that's the tricky part  
16 --

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

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

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

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

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

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

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

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

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

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

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

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

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

6 So Craig is going to go on.

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

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

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

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

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

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

22           The VA also has some important features that

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

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

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

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

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

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

10           Now, a lot of these projects are funding  
11 additional GME positions in the VA, and they are expanding,  
12 potentially expanding by about 2,000 FTE residents, about  
13 \$250 million in additional funding. And a lot of this  
14 expansion is also allowing more time for residents to take  
15 an opportunity to take time for some of these educational  
16 endeavors that may take away time for clinical time. So the  
17 residents' time is -- so the net resident time in the  
18 facility is about the same in terms of the labor and  
19 productivity that comes out of the total residents. So it  
20 gives them time for those residents.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22           It concentrates federal support to hospitals with

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 Thank you.

8 MR. HACKBARTH: Thank you. Thought-provoking.

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

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

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

21 DR. BORMAN: Yes.

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

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

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

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

13           MS. BOCCUTI: Overlooking some --

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

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

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

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

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

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

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

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

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

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

11 Thank you.

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

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

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

1 we can take on.

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

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

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

17 MR. BUTLER: It could be an important companion.

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

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

4           MS. BOCCUTI: They do it differently.

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

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

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

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

22          MR. BUTLER: So my question second is very

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

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

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

1 DR. BERENSON: Could you go to slide 12, please?

2 I just want to clarify. Maybe I didn't hear it. But the  
3 Medicare piece of that, theoretically, I guess, or the logic  
4 of all of this is that the IME portion that goes for  
5 inadequate or for higher inpatient costs could or should go  
6 directly to the hospitals and not go through this mechanism.  
7 And so this would be the direct GME which is supporting  
8 residents, or -- I mean, anything is up for grabs, but isn't  
9 the logic that the portion that's not really -- that is  
10 there to really pay for the inadequate payments would not be  
11 in this scheme at all.

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

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

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

1 that be distributed accordingly.

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

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

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

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

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

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

18 DR. BERENSON: All right.

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

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

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

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

8 MR. HACKBARTH: It could, right.

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

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

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

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

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

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

18 MR. LISK: That currently is below that amount  
19 from a Medicare perspective. Medicare is paying about  
20 \$100,000 per resident.

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

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

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

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

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

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

22 MS. BOCCUTI: Yes.

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

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

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

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

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

21 DR. MILSTEIN: Thank you.

22 MR. HACKBARTH: Just a clarification on that.

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

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

8 MR. HACKBARTH: Right. Okay.

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

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

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

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

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

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

19 Okay. Round two --

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

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

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

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

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

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

7 Round two comments?

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

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

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

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

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

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

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

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

1 unimportant point.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 taken the compromise road.

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

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

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

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

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

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

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

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

17 MS. BOCCUTI: Sure.

18 MR. HACKBARTH: Okay.

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

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

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

1    come out of hospitals, I think is it just on average about  
2    50 percent or so in that given range that are Medicare  
3    beneficiaries? In that vicinity, so --

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

6            MS. HANSEN: Right, the public dollars.

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

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

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

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

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

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

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

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

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

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

4 DR. MARK MILLER: [Off microphone.]

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

7 [Laughter.]

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

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

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

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

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

1 basically stay within the same system.

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

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

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

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

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

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

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

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

4 DR. CHERNEW: [Off microphone.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 MR. HACKBARTH: Thank you all for --

17 MR. BUTLER: Strike that from the record.

18 [Laughter.]

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

20 MR. BUTLER: Strike that from the record.

21 MR. HACKBARTH: Just one concluding process point.

22 As Peter alluded to, we've got sort of an awkward transition

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

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

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

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

3 Thank you, Cristina and Craig.

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

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

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

1 information in a future chapter.

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

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

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

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

22           The conflicting incentives also may lower quality

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

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

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

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

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

15           Another issue to resolve is how to counter the  
16 incentives to stint on services furnished. Rewarding  
17 entities that provide good quality of care would make it in  
18 their financial interest to furnish it. Quality measures  
19 that are relevant to the dual eligible population are key to  
20 rewarding the right providers.

21           Many managed care entities will be challenged to  
22 effectively coordinate the care of dual eligible

1 beneficiaries. Many Medicare Advantage plans do not have  
2 experience with the services funded by Medicaid, in  
3 particular long-term care. Conversely, any Medicaid managed  
4 care plans do not have experience with Medicare benefits.  
5 Managing the care of dual eligible beneficiaries will  
6 require managed care entities to develop expertise in  
7 services, staff roles, and tasks that their staffs may not  
8 have much experience with.

9           Now let's look at the variation in spending,  
10 because it could shape the initiatives to coordinate  
11 beneficiary care. As a group, dual eligible beneficiaries  
12 differ considerably from their non-dual counterparts. They  
13 are more likely to be young and disabled, have three or more  
14 limitations in their activities of daily living, to be  
15 living in an institution, have less education, and be  
16 mentally impaired. These characteristics shape the amount  
17 of services dual beneficiaries require, the mix of providers  
18 serving them, and beneficiaries' inclination and ability to  
19 seek timely care.

20           Using MCBS data, we characterized dual eligible  
21 beneficiaries into the groups on this slide. First, we  
22 sorted beneficiaries into disabled and aged groups based on

1 their eligibility for the program, and then we used a  
2 hierarchy to design beneficiaries first into mental  
3 impairment groups and then into physical impairment groups.

4           Looking at some spending variation, there are two  
5 main points to take away from the analysis of the variation  
6 in spending, and there's more in the paper, but I'll  
7 illustrate by comparing four different groups. The first  
8 main point is that there's about a four-fold variation in  
9 combined Medicaid and Medicare per capita spending across  
10 the subgroups. You can see this by comparing the height of  
11 the bars on the far left with the far right.

12           The second take-away is that high-cost groups for  
13 Medicare and Medicaid are different. Starting from the  
14 left, comparing the first and second subgroups, the aged not  
15 physically impaired and the developmentally disabled, while  
16 the combined per capita spending for the second group is  
17 higher than the first group, the Medicare spending is  
18 actually lower. If we were to select subgroups to focus on  
19 based on Medicare spending, the second group might not get  
20 identified, even though it has higher combined spending.

21           Now, let's compare the second and the third  
22 groups, the developmentally disabled and mentally aged

1 groups. While the combined per capita spending for the  
2 third group is much higher, this is mostly due to higher  
3 Medicare spending. The Medicaid spending is about the same.  
4 This group has the highest per capita Medicare spending, but  
5 modest Medicaid spending.

6 The last bar, the aged with dementia, has the  
7 highest combined per capita spending, driven by very high  
8 Medicaid spending and high, but not the highest, Medicare  
9 spending.

10 There was also considerable variation in the mix  
11 of services furnished to beneficiaries in the different  
12 groups. Here, we see spending as a percent of the total per  
13 capita spending. The group on the left, the aged and the  
14 not physically disabled, had relatively low combined  
15 spending, and that spending was concentrated in hospital,  
16 physician, and prescription drug services -- that is the  
17 blue, the green, and the gray areas -- most likely  
18 reflecting community-based care with acute and chronic  
19 conditions that required hospitalization.

20 In contrast, high-cost groups tended to have a  
21 high share of their spending in facility-based care --  
22 nursing homes, intermediate care facilities, and skilled

1 nursing facilities. For example, the middle group, 64  
2 percent of its spending was on nursing homes, ICF, and SNF  
3 care. That is the yellow bar.

4 Another high-cost group, the aged mentally ill,  
5 shown on the right, had a lower share of facility-based  
6 spending, but one-quarter of its spending was on hospitals.

7 As we consider possible approaches to coordinate  
8 care, we will want to target policy options and program  
9 initiatives to different subgroups of dual eligible  
10 beneficiaries. We may also decide to focus on select  
11 subgroups, such as those with the highest per capita  
12 Medicare, Medicaid, or combined spending. We may want to  
13 focus on groups with the largest number of beneficiaries.

14 Alternatively, we may want to look at other  
15 metrics, such as where potentially avoidable  
16 rehospitalizations occur, and select initiatives that have  
17 the greatest potential to lower them.

18 The wide variation in spending and service mix  
19 will warrant different approaches to care coordination.  
20 Clearly, different strategies should be used for subgroups  
21 whose care is essentially facility-based compared with those  
22 whose care is community-based. For dual eligible

1 beneficiaries who are typically institutionalized, care  
2 coordination would likely be based at the facility, but we  
3 might want to consider whether having an outside  
4 practitioner act as a care coordinator would ensure access  
5 to needed services.

6           For beneficiaries with mental impairments,  
7 strategies will need to accommodate a limited ability to  
8 understand instructions and adhere to them.

9 Institutionalized or cognitively impaired beneficiaries may  
10 benefit from different provider arrangements than those  
11 established for dual eligible beneficiaries who are not  
12 impaired and living in the community. Managing care for  
13 dual eligibles whose care is community-based will require  
14 coordinating care across a wide array of providers, which  
15 will present its own challenges.

16           Over the next several months we will examine  
17 Medicare and Medicaid spending for dual eligible  
18 beneficiaries using claims data from both programs. These  
19 data will include information about chronic conditions for  
20 dual eligibles and allow us to report spending by various  
21 clinical groups. These analyses will further refine the  
22 beneficiary characteristics that may be important in

1 designing integrated programs to manage the care for these  
2 beneficiaries.

3           A second strand of work will review several  
4 initiatives that have attempted to manage the care for dual  
5 eligible beneficiaries. These include the PACE, Special  
6 Needs Plans that target specific subgroups of beneficiaries,  
7 and demonstration programs that capitate Medicaid and  
8 Medicare, such as the one in Minnesota and Wisconsin. This  
9 review will consider if these programs' features are well  
10 suited to managing the care for specific subgroups of dual  
11 eligible beneficiaries.

12           We would like to get your input on the following  
13 questions. First, should we focus on certain subgroups of  
14 dual eligible beneficiaries, and if so, which ones? And  
15 second, and related to that, how should we select the  
16 subgroups? Then the next area we'd like your input on is if  
17 there are programs or plans that you would like us to  
18 specifically look at as we look at initiatives that have  
19 tried to manage the care for duals.

20           And with that, I'd look forward to your  
21 discussion.

22           MR. HACKBARTH: Okay. Thank you, Carol.

1           Can I see hands for round one clarifying  
2 questions? Mike, and then Jennie.

3           DR. CHERNEW: I have two quick questions. The  
4 first one is on Slide 11 -- it could have been Slide 12.  
5 Are the dollar numbers you are showing us here and  
6 throughout inclusive of dual eligibles in Medicare Advantage  
7 plans, or are they just dual eligibles in traditional  
8 Medicare?

9           MS. CARTER: I think they are just traditional  
10 Medicare, because the way -- their claims-based spending.

11          DR. CHERNEW: All right, so --

12          MS. CARTER: Yes.

13          DR. CHERNEW: Do you know what fraction of the  
14 dual eligibles are in Medicare Advantage plans already, like  
15 --

16          MS. CARTER: I think it's about -- is it six?

17          DR. CHERNEW: And is that because -- is the reason  
18 you get such a small enrollment because they're dual  
19 eligible, the Medicaid program is essentially paying for a  
20 lot of the deductibles and other benefit holes, so there's  
21 not an incentive for you to join the Medicare Advantage plan  
22 if you're a dual eligible now?

1 MS. CARTER: That's my understanding, right.

2 Would you agree with that?

3 MR. BERTKO: That's part of it. The other part is  
4 the cost to them, and if it's not contracted with the State,  
5 the money from Medicare alone is not enough, so in some  
6 places it's enough and then they'll just put them in. In  
7 others, there's a dual contract. But those are more rare,  
8 and then there are only certain plans which specialize in  
9 Medicaid managed care which might have that kind of dual  
10 eligibility. So there's a subset of Medicare Advantage  
11 plans that can really deliver this kind of care across both  
12 programs.

13 MS. BEHROOZI: Or it's directly related. In the  
14 paper, there's a chart that shows the per capita spending.  
15 It's on page 14 of the paper. And for dual beneficiaries, I  
16 guess it's the average per capita spending is a little over  
17 \$25,000, and it breaks it down by Medicare, Medicaid, and  
18 other, and the "other" is nearly \$4,000. Given what you  
19 said about Medicaid covering the holes, I just wondered what  
20 the "other" was.

21 MS. CARTER: It includes -- most -- the biggest  
22 portion of it is out-of-pocket, and there is some private,

1 but -- it varied a little bit by the subgroups, but it's  
2 out-of-pocket, mostly out-of-pocket.

3 MR. BUTLER: Just quickly, remind me again -- I  
4 couldn't find it in here -- the total number of dual  
5 eligibles and the aggregate dollars as a percentage of  
6 Medicare spending of dual eligibles.

7 MS. CARTER: It's about 16 percent of the program  
8 is enrolled in -- are dual eligibles, and I think they  
9 account for --

10 MR. BUTLER: It must be 30 or something, if  
11 they're spending twice as much per capita --

12 MS. CARTER: Yes. I think it's actually higher  
13 than that. I think it was 40. Let me look. I think I have  
14 it right here.

15 MR. BUTLER: I wanted to look at the size of the  
16 problem or opportunity, depending on how you look at it.

17 MS. CARTER: It's 24 percent of Medicare spending.

18 MR. BUTLER: Okay.

19 DR. KANE: Yes, Carol, this is great. One thing I  
20 just am curious about is how did you find the data, because  
21 that was one of the hardest things, as I recall, was getting  
22 Medicare and Medicaid data linked up. Do we now have a

1 national data set?

2 MS. CARTER: We do have a national data set, but  
3 we are in the process of processing it. So these actually  
4 use survey data from MCBS, which surveys beneficiaries and  
5 then the claims get pulled for those beneficiaries.

6 DR. KANE: So what size sample -- so the survey,  
7 would that tend to favor the beneficiaries who are able to  
8 deal with surveys? I am just --

9 MR. BERTKO: No, this is the panel survey. So I  
10 believe, what, 70,000 people total, but across all types of  
11 people. So I'm guessing it's the 12 percent or so that are  
12 Medicare that are in the MCBS, because it's statistically  
13 valid and then it's a subset of that. So it's one-eighth,  
14 nine, ten thousand beneficiaries, of which this dual  
15 eligible subset has got to be that smaller subset of that.  
16 I don't know what your "n" was on that, Carol.

17 MS. CARTER: I'd have to look it up and get back  
18 to you. I don't have it right here.

19 DR. KANE: So this is just the claims on the  
20 people who have responded who are dual eligible --

21 MR. BERTKO: No, they're not claims. They're  
22 actually services, because it's the MCBS --

1 DR. KANE: It's the survey. It's what they  
2 remember using --

3 MR. BERTKO: It's actually they go in and they  
4 reach in and they talk to doctors and say, what did you  
5 charge? I mean, it's a very complete survey. I mean, it's  
6 incredibly rich.

7 DR. KANE: But do we have a good sense that it's  
8 pretty representative of the dual eligibles in these  
9 different subclasses, or -- I'm just curious. This is  
10 excellent, but I know it's really, really hard to get that  
11 kind of data, so I was just kind of trying to find out how -  
12 -

13 MS. CARTER: I don't know how representative it is  
14 of the subgroups that we then categorize people into. We'll  
15 have a better sense of that when we actually use the  
16 Medicaid and Medicare claims data, which we should have in  
17 the spring.

18 DR. STUART: One question that might come up on  
19 this point is the aged mentally ill and if they're  
20 responding to the survey. Well, the answer to that is that  
21 MCBS takes a lot of effort once they select an individual to  
22 be in the survey to actually make sure that that person's

1 information is collected. So if the person is unable to  
2 respond, then they will seek to find a proxy who can make  
3 that information available. That doesn't affect these  
4 numbers, which are claims-based, as I understand it, for A  
5 and B, and that's just taking the claims that were incurred  
6 on behalf of that group and then just displaying them by  
7 their characteristics.

8 MR. BERTKO: Carol, I think I misspoke, because I  
9 was mixing the MEPS with the MCBS, and the MCBS is, what,  
10 12,000 or so in the panel? My fault.

11 DR. MARK MILLER: So I think, just to connect  
12 these sets of conversations, MCBS goes out and surveys  
13 Medicare and picks up some of this population, too. Then,  
14 as Bruce described, it is a significant effort to keep track  
15 of what has gone on with the patient either directly or  
16 through proxies, and then says for the people in this panel,  
17 extract all of their claims and put them in a file. So it's  
18 a way to think about it --

19 MR. BERTKO: [Off microphone.]

20 DR. MARK MILLER: Yes. But what we're trying to  
21 build now is actually more what you started with, which is  
22 is there a national data set of combined Medicare and

1 Medicaid claims, and that's what we're trying to do now, and  
2 there will -- probably not for this conversation -- there  
3 will be some caveats attached to that, I believe.

4           And just to push this broadly, there is going to  
5 be caveats, like in this instance where we're using MCBS and  
6 then using it to disaggregate or to look at small  
7 populations, which it's not specifically designed to over-  
8 sample on, even when we construct a national data set, we're  
9 going to have to be very clear with you guys about what the  
10 caveats are going to be because this is a very difficult  
11 exercise and I think there will be some limitations in what  
12 we end up with. Is that right?

13           MS. CARTER: Right, and --

14           DR. KANE: It has prescription drug in it, so I  
15 knew it couldn't be Medicare alone.

16           MS. CARTER: Well, the prescription drug  
17 information was survey information that then gets adjusted  
18 for sort of the systematic underreporting.

19           MR. HACKBARTH: Clarifying questions?

20           MR. GEORGE MILLER: If I remember correctly, and I  
21 don't know if you address it or if it applies, but if I  
22 recall correctly, Medicare will -- one of the two, Medicare

1 or Medicaid, will not allow a patient to be in observation  
2 status. It wouldn't pay for that. But the opposite, either  
3 Medicare or Medicaid would. Is that taken into  
4 consideration in any of this analysis, or is that a  
5 statutory issue or a regulatory issue that we have got to  
6 deal with in trying to solve some of these problems, or is  
7 that --

8 MS. CARTER: You're talking about a patient that's  
9 in a hospital but in an observation bed?

10 MR. GEORGE MILLER: Right. If they're in an  
11 observation bed, either -- I can't remember which, I  
12 apologize -- but Medicare or Medicaid wouldn't pay for it  
13 for one program, but would pay for it in the other program.  
14 I apologize for not remembering which one. But did you run  
15 into that issue in dealing with this? And there are some  
16 other examples. I know my CFO would always tell me there  
17 are examples of conflicts between what Medicare would pay  
18 for and Medicaid wouldn't, or vice-versa.

19 MS. CARTER: Well, this spending would include  
20 whatever the respective programs paid for that, and so if  
21 one program doesn't cover it but another did, then the  
22 spending will include that.

1 MR. GEORGE MILLER: Because they're dual  
2 eligibles.

3 MS. CARTER: Right.

4 MR. GEORGE MILLER: So that's not a factor? That  
5 was really my question, if that's a factor.

6 MS. CARTER: Well, the spending's included in  
7 here. If there's a conflicting incentive in terms of sort  
8 of which program is --

9 MR. GEORGE MILLER: Just overall captured. Okay.

10 MS. CARTER: Yes. If there's sort of a gap there,  
11 then that's a separate issue, then, the spending.

12 MR. HACKBARTH: Other clarifying questions?

13 MR. BUTLER: I'm still struggling a little bit  
14 with the profile. On Chart 10 -- let's see -- can you put  
15 up 10 there? There we go. In the text, it says that half  
16 are mentally impaired, you know, with a third being mental  
17 illness and 11 percent having dementia. This is less than  
18 this.

19 MS. CARTER: Well, the dementia --

20 MR. BUTLER: How do you get to the --

21 MS. CARTER: -- is one plus ten, so across the two  
22 broad groups. Under disabled, there's one percent, and then

1 there's --

2 MR. BUTLER: Oh, I see. You add both, then, the  
3 columns?

4 MS. CARTER: Yes. Yes.

5 MR. BUTLER: Okay.

6 MS. CARTER: Yes. And so then mentally impaired,  
7 I think I included the dementia, the mentally ill, sort of  
8 adding all of that up, those four -- maybe all six. I can't  
9 remember.

10 MR. BUTLER: And then over 45 percent, it says,  
11 have three or more chronic conditions. That's not on this  
12 one --

13 MS. CARTER: That's not on this one.

14 MR. BUTLER: But it does suggest the care  
15 coordination, or you couldn't begin to do an episode of  
16 illness. You'd have to manage at a capitated level, I  
17 think, to coordinate the care of this kind of population.

18 MS. CARTER: I'll be curious when we start looking  
19 at it, because the data that we're getting have condition  
20 flags for, I think, about 20 or 25 conditions, and I'll be  
21 curious to see how many flags and then sort of if there's a  
22 neat typology that we can develop to really get at that,

1 because I think there's going to be many beneficiaries with  
2 multiples, and sort of how do you think about that.

3 MR. HACKBARTH: Other clarifying questions?

4 DR. CHERNEW: Can I ask about this chart?

5 MR. HACKBARTH: No.

6 [Laughter.]

7 DR. CHERNEW: [Off microphone.] If you're under  
8 65, not physically impaired, and you're not in one of the  
9 mentally ill bins, if you're disabled under 65, what is your  
10 impairment if it's not physical impairment and you're not in  
11 the mental --

12 MS. CARTER: I don't know. I mean, I know how  
13 each of those categories was created, so it's possible that  
14 somehow in the coding we didn't pick up exactly how somebody  
15 became eligible for the program. So they somehow became  
16 disabled for the program, became eligible for Medicare  
17 through disability.

18 DR. CHERNEW: Right.

19 MS. CARTER: Now, why they didn't sort of group  
20 into a higher bucket, I don't know.

21 DR. STUART: I think the answer is the way you  
22 classify people as being physically impaired, and that does

1 not link up to the reasons for entitlement for disability  
2 insurance. And actually, you can do it, and I'd encourage  
3 you to do it. The MCBS is linked to administrative records  
4 for the disabled that will indicate the reason for the  
5 disability. And so that information is available to you.  
6 Now, that's not going to help in terms of trying to find  
7 people who were not physically impaired aged because they're  
8 duals because of age, and so you're going to have a  
9 disconnect. I think you're right. You want the same  
10 measure of physical impairment for both the disabled and the  
11 aged. But it does kind of hang out there -- I noticed this  
12 when I first read it -- of saying, okay, well, if you're not  
13 impaired either mentally or physically, then what are you  
14 doing on the disability list?

15 MR. HACKBARTH: Other clarifying questions? I've  
16 got sort of a round one-and-a-half question. I'm struggling  
17 to get my arms around this. So our core problem is that for  
18 this population, we've got money coming out of two pockets  
19 and that creates weird incentives to shift costs and those  
20 incentives, in turn, may be destructive in terms of getting  
21 the patients' needs met and getting them met efficiently.

22 So it seems to me if that's a core problem, there

1 are two general directions that you can go. One is just for  
2 the whole population, say let's do away with two pockets and  
3 have it funded out of one. And then the other general  
4 direction is that -- and this is one we've tried in various  
5 ways in the past -- is to say, well, we can create special  
6 programs that the beneficiaries can opt into that will then  
7 integrate whether it's a PACE program or it's a SNP program  
8 for dual eligibles or a social HMO. But that second path of  
9 special program, it seems like we've tried that path a lot  
10 and there are issues about getting everybody into that and  
11 the incentives may not be strong for people to opt into it.

12 I'm just not sure why we keep reinventing the  
13 wheel here and trying to come up with ways to create special  
14 programs to deal with this incentive problem. Why haven't  
15 those other approaches worked, and some of them have worked  
16 well at the ground level, but they haven't spread widely  
17 through the program. It sort of makes me wonder whether the  
18 other track isn't the track that you need to think about,  
19 which is for all of these patients, get rid of the  
20 bifurcated funding. So that's an issue that I'm just  
21 struggling with.

22 MS. CARTER: And I'm sure you know -- no, I don't

1 know the answer, but people have thought about that for  
2 about 15 years, whether it's federalizing or moving the  
3 funding under one umbrella, either under Federal or State.  
4 I mean, people have talked about that.

5 MR. HACKBARTH: You know, obviously, federalizing  
6 the funding for these patients raises difficult issues in  
7 terms of, you know, finance and political feasibility, et  
8 cetera, and I don't mean to give light to that at all. I  
9 guess my real question is, why are we going to be any more  
10 successful this time in developing a new programmatic  
11 response with a new name that overcomes the core problem?  
12 Am I missing something, or am I --

13 MS. CARTER: No, I think you -- I mean, without  
14 mandatory enrollment, it's tough to get enrollees, and I  
15 don't know how you -- I mean, it's possible that you could  
16 do more to facilitate enrollment at the State level so that  
17 when beneficiaries enroll in Medicare, if they're eligible  
18 for Medicaid, you could make that an easier process. But  
19 that still doesn't mean you'd have entities to manage their  
20 care. You could, I guess, make -- I think beneficiaries  
21 undervalue care coordination services, so if they became  
22 more aware of what that really would mean for them, maybe it

1 would be more attractive. But this is a recurring problem  
2 with voluntary enrollment.

3 MR. HACKBARTH: Okay. Round two questions,  
4 comments.

5 MS. BEHROOZI: I'm still surprised by that chart  
6 that shows that the average dual beneficiary is spending  
7 \$4,000 out of pocket and the non-dual beneficiary is  
8 spending \$6,000. So \$4,000 on a Medicaid-eligible level  
9 income is quite a lot of money out the door for that person.  
10 I mean, that's quite a high percentage of their income, and  
11 it seems that it wouldn't be a bad thing, maybe, to do it on  
12 an opt-out basis, as you said, you know, make it mandatory,  
13 and then have the Medicaid dollars used to really cover  
14 everything for that beneficiary so that they can really  
15 receive all of the benefits and, yes, have programs  
16 accessible everywhere. I mean, this kind of indicates that  
17 maybe programs aren't accessible everywhere, because I just  
18 can't imagine that people would, quote-unquote, "choose" to  
19 spend \$4,000 if they were really aware of what was going on.

20 So I think -- I understand what you're saying,  
21 Glenn, about creating new problems, but it just seems like  
22 there hasn't been enough of a push, a thrust, behind really

1 getting folks into these programs, not just about how the  
2 dollars are best spent, but these people are getting --  
3 they're getting financially messed up. Their care is messed  
4 up. It just really seems like a good time to say that  
5 options are limited here. We've got to require people to be  
6 in programs.

7           But then you have to make sure that the programs  
8 are carefully selected and contracted, obviously, with the  
9 State and Medicare or whatever. It's not a free-for-all  
10 that you're going to just shove people into any willing  
11 provider kind of thing.

12           DR. CHERNEW: I agree with Mitra, and I was going  
13 to say that in order to do that -- to keep it voluntary,  
14 it's going to be hard. To make it mandatory requires you to  
15 have real comfort in the quality and the performance, and  
16 that's really an important issue. So I think we need to  
17 move quickly along with measurement in some of these areas.  
18 And the question in part is what do we do in the interim,  
19 because I don't think it is a feasible policy option now to  
20 recommend that everyone be forced into a dual managed care -  
21 - I just don't see that as happening. We have a way to go  
22 with measurements.

1           And I think one of the challenges we have here is  
2 the States, and maybe the Federal Government, I think more  
3 so the States are playing a game to get as much from  
4 Medicare as they can, and it's this difference in rates and  
5 difference in rules that allow them to game. And so I think  
6 the question, which I don't know the answer, is are there  
7 easy fixes that one might be able to put into the system to  
8 prevent some of the -- it's bad care in many cases, but it's  
9 also a cost shift to get more Medicare money coming out.

10           So that suggests in some ways -- I could think of  
11 ways, I'm not sure if they're good, of sort of having  
12 minimum Medicaid payment rates for Medicare beneficiaries so  
13 you keep that gap within some bounds so you avoid the  
14 incentive to churn people through, because I think what's  
15 happening is Medicaid setting low payment rates, paying sort  
16 of very much on the margin and relying on somewhat more  
17 generous Medicare payment rates to kind of make up the  
18 difference. And in order to make that work, given the  
19 rules, they have to do some of this churning and the other  
20 things you've talked about.

21           So I think if we could find administrative rules  
22 that might minimize some of that short-term inefficiency,

1 that might be a way to go, because I don't see the other  
2 system working in the near term as well as I would like.  
3 Maybe someone can figure out a way to do it.

4 MS. CARTER: And when you -- I just have a point  
5 of clarification on my end. When you talk about  
6 measurement, do you mean like performance measures or what  
7 do you -- okay.

8 DR. CHERNEW: [Off microphone.] -- put everyone  
9 into a Medicare -- if you want to put everyone in a dual  
10 eligible SNP-type plan and force them in -- see, the problem  
11 is forcing. Now, you can have an opt-out situation, but if  
12 you were going to try and really force them in, because  
13 otherwise you don't have strong incentives, you really have  
14 to worry that they get into something that they just really  
15 don't like or they can't force them into something that's  
16 really not providing good care. So you have to have good  
17 enough safeguards, I think, before you could go that route.

18 MS. CARTER: Mm-hmm.

19 MS. HANSEN: Yes, thank you. First of all, Carol,  
20 thank you so much for doing this. This focus, as you know,  
21 has been an area of not only both interest and history for  
22 me, but I just think that this population is going to grow

1 quite astronomically over time, just because of people's  
2 lowered income status and they fall into the category of  
3 being a dual primarily because of income more than anything  
4 else.

5           And thanks, Glenn, also to your forbearance on  
6 this. You know that I've brought this up probably from the  
7 time that I came on, because these are the same people. And  
8 the tough part is our statutory focus is on Medicare, but  
9 it's the same individual who happens to qualify for two  
10 programs and then this bouncing back and forth occurs.

11           I guess the questions, one is specific to, Carol,  
12 the ability to take a look at the current population. Since  
13 we have done readmission work in terms of the cycling back  
14 of people into hospitals, you know, every 30 days or 90  
15 days, have we ever looked at the particular cut on people  
16 who are dual eligibles as a subset of that churn?

17           MS. CARTER: No, but we have the data to do that.  
18 I did look at the share -- and I don't remember the numbers,  
19 but I remember that I looked at the share of the repeat, and  
20 I think we -- I forget, did we use three or more SNF  
21 hospitalizations within a two-year period, and duals were  
22 disproportionately represented in that, but I don't know

1 that I looked at sort of what was their pattern of  
2 readmissions.

3 MS. HANSEN: Right, because I'm thinking if we're  
4 going to narrow it for the time being to Mike's point, is  
5 are there kind of tighter things that we can do in the  
6 meantime while this is a very complex issue, as Mitra points  
7 out, and there are not always a lot of good, capable  
8 resources to handle this, what do you do in focusing and  
9 targeting in the meantime.

10 The other trend question I have is we talk about  
11 the level of people in institutional care that goes on.  
12 This now relates back to our work in nursing facilities,  
13 licensed facilities and other kinds of facilities where  
14 people go to, especially where it's the mentally ill or the  
15 people who use custodial institutional settings. Is there -  
16 - I forget now what the growth pattern, capital growth  
17 pattern in those facilities are, because that itself becomes  
18 a factor of resources down the pike, that these non-  
19 institutional options for this growing population is going  
20 to have to be dealt with because these people are still  
21 coming down the track, how we take a look at existing  
22 metrics based on the data that you've looked at, but then

1 projectively, what are some of the issues that we're going  
2 to face.

3 MS. CARTER: So you're asking about sort of the  
4 supply of ICFs and nursing homes?

5 MS. HANSEN: ICFs and SNFs, yes, because I thought  
6 that there has been, at least from looking at it for us, we  
7 see that there's not a whole lot of new building going on.

8 MS. CARTER: Yes. That's what I would say, also.

9 MS. HANSEN: So if that's the case, the compelling  
10 urgency of making sure some systems are in place, programs  
11 in any form are ready to receive this population, because  
12 otherwise they will churn that much more into the hospital  
13 environment. So that's something to anticipate.

14 MS. CARTER: And, of course, you know better than  
15 I that some States have been much more aggressive about home  
16 and community-based service provision to try to at least not  
17 initially institutionalize folks that maybe don't quite need  
18 it, probably delaying institutionalization.

19 MS. HANSEN: Right. So it would be great to -- I  
20 know this is not the focus of our work, but just those are  
21 the ways that this Medicare population is going to be  
22 dealing with it in the future.

1           And then finally, just as a resource, possibly you  
2 already know about it, but AARP just came out with a report  
3 focusing on three States, New York, I think Minnesota, and  
4 New Mexico --

5           MS. CARTER: Yes.

6           MS. HANSEN: -- as to how States are beginning  
7 themselves to look at it. And so it's really about their  
8 incentives, and my understanding is if they were paid a  
9 little bit more, to Mike's example, they would have some  
10 greater incentives in some ways to kind of keep the system  
11 appropriately whole rather than this bounce back. So  
12 certainly I just want to make sure that everybody was aware  
13 that we're looking at this on the State level right now.

14          DR. MARK MILLER: Jennie, when you said paid a  
15 little bit more, to whom, by whom?

16          MS. HANSEN: Possibly some -- the States -- let's  
17 see. The note I have is that they would like to be paid up  
18 front for avoidance of nursing facility costs. So they just  
19 -- so in other words, since their pay is so low right now,  
20 there seems to be kind of -- not by aggressive intention,  
21 but the ability to have the safety, the valve released by  
22 having people go back into Medicare for a while. So if they

1 had an incentive to kind of keep it steady state, covering  
2 their costs on the front side, they would not be -- their  
3 incentives to be more aggressive of keeping them in a  
4 constant state in the facility might be enhanced.

5 DR. MARK MILLER: [Off microphone.] And it's a  
6 Medicaid rate?

7 MS. HANSEN: Correct. Thank you.

8 MR. HACKBARTH: Okay, round two?

9 MR. BERTKO: This is just a question, Glenn.  
10 Since I think your first door of federalizing in any way or  
11 shape is not only closed, locked, and painted shut, we might  
12 want to focus our own thinking on only the second door, and  
13 as several people have said here, I think that we need to  
14 face up and say whether -- just forget about voluntary.  
15 Have an opt-out rather than an opt-in kind of mechanism, and  
16 there needs to be some choice along there. It seems to have  
17 worked to some degree. If you look at the LIS in Part D,  
18 even with the complex problems they had, most LIS members  
19 are covered for Part D.

20 Secondly, access in Arizona for Medicaid managed  
21 care seems to work on a mandatory basis. I think we have  
22 some lessons learned there. I would point out, though, that

1 design and management of these programs, of where they go,  
2 is really important. There are about five or six Medicaid  
3 managed care plans that I know of that work pretty well, and  
4 I think there are others, I think a couple of them in Boston  
5 that I don't know much about probably work well. The SNPs  
6 are too loosely allowed to qualify, in my mind, for what's  
7 done there, not that they couldn't become some, but they  
8 should. Jennie, your On Lok program as well as Evercare, I  
9 think, are other good models.

10           But we might need to have an assortment of models  
11 by State, because from my limited background on this, these  
12 populations are very, very heterogeneous, and so we might  
13 need to have four kinds of programs per State to get in  
14 there. And with some opt out, allowing you to have a  
15 remnant maybe back in this uncoordinated system, but with  
16 the vast majority opting in -- not opting in, enrolled in  
17 with only the ability to get out. To me, that seems a more  
18 productive approach rather than for us to meet -- this is at  
19 least the fourth time in five years or six years that we've  
20 talked about this and kind of wrung our hands as opposed to  
21 make stronger recommendations.

22           MR. HACKBARTH: I agree with much of what you say,

1 although an opt-in model for Medicare beneficiaries is a  
2 radical change in the 40-year philosophy of the program.

3 MR. BERTKO: It's time, though. If Jennie is  
4 correct on saying the growth in this is going to be large --

5 MR. HACKBARTH: I think I incorrectly said opt in  
6 when I meant opt out.

7 MR. BERTKO: Yes.

8 MR. HACKBARTH: It's an opt out model that would  
9 be a radical change.

10 MR. BERTKO: That's right. But if the growth is  
11 large and these people are very high-cost, maybe double --  
12 not double, but 50 percent more than the average Medicare  
13 beneficiary, we've got to think about more radical  
14 solutions.

15 DR. CROSSON: Just two comments. Carol, you were  
16 looking for places to look, and you may or may not know  
17 we've had for 40 years or so a social HMO in our Oregon  
18 region, which I think is the longest running if not the  
19 biggest one and has been successful, although difficult for  
20 all the reasons you talk about in terms of enrollment and  
21 then the mix of capabilities that are required. But it has  
22 continued to work and folks up there like it, both from the

1 perspective of the caregivers, the plan, and the enrollees.  
2 So you might take a look at that.

3 The second question is -- it sort of goes back to  
4 the previous topic discussion and, you know, do we want to  
5 soar like eagles or peck around in the barnyard for --

6 [Laughter.]

7 MR. HACKBARTH: That's an image that's going to --

8 [Laughter.]

9 DR. CROSSON: So I figured if we're going to take  
10 on reforming graduate medical education, why can't we batter  
11 down the locked door of at least raising and discussing the  
12 issues about federalizing, if that's the term, but sort of  
13 unifying the payment stream here and figuring out what would  
14 be required?

15 Now, I mean, some of the more politically astute  
16 and experienced here may be laughing either inside or  
17 overtly at me, like Bob is --

18 [Laughter.]

19 MR. HACKBARTH: The people who are really expert  
20 at pecking around.

21 [Laughter.]

22 DR. CROSSON: But I think at least since we have

1 had visions of soaring here today, I'd have to raise the  
2 question of why, in this particular case, we are not going  
3 to do it.

4 DR. BERENSON: I'm not answering that question.  
5 No, I'm going to -- I think there's -- I'm struck by sort of  
6 a disconnect in the discussion. Glenn, I think, correctly  
7 laid out the two doors and then pointed to the fact that we  
8 haven't been very successful in the second door, even though  
9 that seems the one that's politically available to us, so  
10 what are we going to do this time.

11 And then we had a discussion about how the problem  
12 is we need to develop an opt out so that we assign people.  
13 But what are we assigning them to, is my problem. I mean,  
14 I'd like to have four models in each State available, but  
15 what we have is PACE, which, what is it, we're up in the  
16 tens of thousands now, up to 30,000 or something total in a  
17 decade in which PACE has been proved. We had hundreds of  
18 thousands in SNPs, but we don't think that that works very  
19 well.

20 So I just don't think that we've got the models  
21 yet, I guess is my problem. I'd like, I guess, if we're  
22 going to do fruitful work in this area, because I -- you

1 know, your slide that lays out the rationale for why a  
2 managed care plan receiving capitation makes perfect sense  
3 to me, and yet it hasn't worked, or these are so tough that  
4 I think we need to really understand what the models would  
5 be and some reason to believe they'd be successful before we  
6 would go anywhere near sort of saying, now we're ready to  
7 restrict the choices of beneficiaries because we know what's  
8 good for them.

9           So that's my problem here, is understanding a  
10 little more why doesn't SNP work and can that just be  
11 tightened up in some ways so that it would, or are we really  
12 dealing with just such difficult issues that it's just  
13 really hard.

14           DR. KANE: I want to go back to something that  
15 Arnie brought up about the hospice benefit, that perhaps  
16 there's a time when we need to open up a third option or a  
17 gray area. So there's a zone where people are non-duals,  
18 but they're one acute episode away from becoming a dual, or  
19 one chronic condition exacerbation away from being a dual,  
20 and I'm wondering if we can't use this new data -- which I  
21 am delighted to hear we were trying to -- use this new data  
22 to say, okay, let's back up on the people who become duals

1 and see if there's some pattern of care or pattern of  
2 illness or pattern of utilization that puts them at a high  
3 risk of becoming a dual zone, but they're not yet there, and  
4 see if we can't open up the benefit package to be more like  
5 the Medicaid community-based, trying to prevent them from  
6 becoming a dual.

7 I mean, some of the stuff going on in Boston is  
8 around that, is trying to reach people before they actually  
9 hit the spend-down and trying to keep them in the community,  
10 and they're often identifiable. I mean, they're frail  
11 elders who are just barely hanging on and suddenly they  
12 become dual in a year and then you can see what they're  
13 spending. But I think there's a lot of people who are not  
14 quite duals who would really benefit from having community-  
15 based coverage and some of the types of services that they  
16 can't get under Medicare and they can only get once they're  
17 in Medicaid.

18 So that may be one way to get at this issue, is  
19 try to prevent the dual rather than manage the duals,  
20 because I agree. We have tried. I mean, it's very hard to  
21 get people to willingly go into a managed care program, but  
22 they might like to say, well, if you look like this profile,

1 we will open up the benefit package to you.

2 MR. HACKBARTH: In a funny sort of way, that's  
3 federalization for people in advance. The Federal  
4 Government's going to offer a benefit package that includes  
5 the Medicaid element.

6 DR. KANE: It would save Medicaid money, because  
7 people would never become dual. But it also is much better  
8 care for the beneficiary. So it's really -- I know. I  
9 mean, it's -- but it's not total federalization. It's just  
10 partial.

11 MR. HACKBARTH: Right. Right.

12 MR. GEORGE MILLER: Just a quick question. We  
13 have expert panels all the time and they've been very  
14 beneficial. Have we convened a panel with dual eligibles to  
15 ask them what would work and if we could -- if they would  
16 redesign a good system for them, what would work? Get their  
17 feedback, what works and what doesn't work for those who  
18 could participate?

19 MR. HACKBARTH: Well, we have not. In fact, we've  
20 not done a patient panel for any issue. To the extent that  
21 the issues here are financing issues, obviously, that  
22 wouldn't be their vantage point on it. So what they would

1 speak to is models. But the core problem is a paucity of  
2 models for them to relate to. Oh, I tried this one and it  
3 was really good compared to that one. You know, it's sort  
4 of like a catch-22.

5 DR. CASTELLANOS: I guess what bothered me on this  
6 in reading this is that this food fight that's going on  
7 between Medicare and Medicaid, it really bothers me. You  
8 know, I don't have a good answer, but I think, Glenn, you  
9 brought it up, and Chernew, you really talked about pecking  
10 and so on. I think if we could just form a safety net for  
11 these type of patients and then do a means test to make sure  
12 they do really qualify and then consider for that group of  
13 patients looking into maybe federalizing their Medicaid  
14 benefits. You know, somehow we have to address that, and I  
15 would hope -- I think we should look into it, at least.

16 DR. STUART: This is in response in part to points  
17 that were raised by Michael and Nancy, but also yours, Ron,  
18 and it's more in the way of problems and adding more to the  
19 rationale for why this has been an issue for so long, and  
20 I'll be brief.

21 The first part is that when you talk about people  
22 coming into the program, almost half of the aged duals are

1 duals who aged into the aged part. In other words, they  
2 started out as disabled beneficiaries and then they become  
3 aged. There is no disability above 65. You're suddenly  
4 cured. You're just aged. So there isn't very much of that,  
5 but there is a lot of movement back and forth in terms of  
6 entitlement for Medicaid.

7           It's not just once you get -- you're one acute  
8 condition away from eligibility. It has to do with if  
9 you're in States that have medically needy programs. In my  
10 State, you have to be certified four times a year, and so  
11 what you'll have is that you will have some people who will  
12 have, for whatever reasons, will be eligible for three  
13 months, will be off, and then will come back on. So you've  
14 got a lot of this churning that's going on within that  
15 population.

16           The other part, and this gets back to Mike's issue  
17 in terms of raising price, one of the reasons that the  
18 Medicaid programs traditionally had -- well, maybe now, too  
19 -- have low reimbursement is that they get out of covering  
20 Medicare cost sharing. So if a State pays below 80 percent  
21 of Medicare then it doesn't pay the 20 percent cost sharing  
22 for physician and other Part B services. So if you're

1 talking about raising the price, it's not just raising it  
2 for the Medicaid services. It's also raising it for the  
3 cost share part.

4 I hate to end on such a note of kind of despair,  
5 but the more you know about these, the tougher it gets,  
6 which I think gets back to Bob's point about what kind of a  
7 model do we have here, because the model has got to adjust  
8 to all of these things.

9 DR. CHERNEW: I agree with that completely and  
10 want to point out in addition, one of the problems of, say,  
11 like federalizing this to get rid of some of the  
12 efficiencies, which is appealing in many ways, is, for  
13 whatever we don't like about what the Medicaid programs are  
14 doing, they're spending less because they pay a lot less.  
15 The budget implications of bringing it all into the higher-  
16 paying system are non-trivial for reasons that you read, but  
17 even just the straight reason that we just pay more. And so  
18 if we put at the higher rate, it might smooth things out,  
19 solving one problem, but it creates other problems.

20 DR. MILSTEIN: I think it would be helpful to make  
21 a distinction between federalizing the program and coming up  
22 with a coherent program that jointly manages the Federal and

1 State contributions. I think that's an important  
2 distinction.

3 I spent a lot of -- for ten years when I was in  
4 practice having a disproportionate fraction of patients in  
5 this group. I would say even if they didn't cost the  
6 Medicare program a dime more, they are hugely more  
7 vulnerable. Many of them are relying on county welfare  
8 workers to figure out all the administrivia. It is very  
9 challenging. Often their care does suffer due to the fact  
10 that you've got two uncoordinated payers.

11 So purely based on the fact that these patients  
12 are much more vulnerable than any other class of  
13 beneficiaries that we try to do well for, I would say on  
14 that basis and on the basis of opportunities to prevent  
15 health crises through more coherent management, I think  
16 there is a case to be made for a single coherent benefit  
17 plan, separate and apart from whether it's fully Federally  
18 funded or funded through a combination of current -- some  
19 pro rate distribution based on State and Federal  
20 contribution. But I think there's a quality of care case to  
21 be made here separate and apart from improving efficiency of  
22 the program.

1                   MR. HACKBARTH: Okay. I'm feeling really bad for  
2 Carol here.

3                   [Laughter.]

4                   MR. HACKBARTH: We've dealt her a difficult hand.  
5 Why don't you put up your questions slide.

6                   MS. CARTER: They are easier than the issues you  
7 raised.

8                   MR. HACKBARTH: Right, they are. But that's why  
9 I'm putting them up, because I'm hoping that maybe we can at  
10 least give you a little guidance on your narrower --

11                   DR. MARK MILLER: I mean, the kind of things I  
12 could come away from with this conversation is I think we  
13 probably should, just like anything else that we do, we  
14 should continue to make sure that we understand these  
15 populations at some level of detail. We tend to speak of  
16 dual eligibles, but they aren't all the same. There are  
17 some very different -- so I think it's probably worth  
18 continuing down that road.

19                   Another way to take comments here about where,  
20 well, we seem to have tried these models, these mixed models  
21 and have failed. Why aren't we talking about the  
22 federalization approach? And that's really the point of

1 this conversation, is to ask you guys what you want to do.  
2 We could go through the history of -- or some of the  
3 history, not in detail -- what people have proposed on the  
4 federalization side or the State versus federalization side  
5 and at least acquaint ourselves and yourselves with some of  
6 the ideas that have been talked about in the past.

7           It's probably important to keep in mind when we  
8 talk about those models of understanding what the impacts  
9 are at a budgetary level and that type of thing because  
10 you'd have to get into things like clawback from the State  
11 and that type of thing, which are always really pleasant  
12 conversations to have. But at least we could work both  
13 sides of the street, these models, and also review again --  
14 because you guys already went to it and immediately brought  
15 this back up. So this means that the Medicare issue of kind  
16 of freedom of choice for this population would have to be  
17 compromised if you go with one of these models. And so we  
18 could crank through all of that and have somewhat more of a  
19 precise conversation of what each of these conversations  
20 involve and supplement that with building this data set and  
21 trying to figure out what this population looks like,  
22 because it also may be that you might want to target which

1 way you go with these populations as opposed to just saying  
2 it's everybody, although maybe in the end it is everybody,  
3 but just understanding.

4 That's a couple of things that we can do, and  
5 that's how I was telling Carol she'd be spending her  
6 weekends.

7 [Laughter.]

8 MR. HACKBARTH: And just to pick up on that, if we  
9 end up rolling out the federalization door and saying that  
10 we're going to develop new models, and then whether it's opt  
11 in or opt out, another question that would interest me is in  
12 more successful programs where we've had some organizations  
13 that have done a good job organizing the care in an  
14 efficient way, high-quality way, why haven't more patients  
15 opted into those models? What does it look like? And maybe  
16 this is sort of George's question. You know, what does it  
17 look like from the patient's perspective? Why aren't they  
18 clamoring to enroll? I think we have had a few successful  
19 experiments, and why haven't they drawn more patients? Is  
20 there something that we could do to make it more enticing  
21 for the patients to elect that model?

22 I think that the opt out is a real tough road

1 politically, and so maybe we can figure out how to make opt  
2 in more attractive from a patient perspective.

3 DR. BERENSON: Just to modify your question a  
4 little bit, is the problem that patients don't want to  
5 enroll or that we don't have an infrastructure out of a few  
6 specific places because it's tough to manage these programs?  
7 So if they were available, it might be that people would  
8 choose them, but they're not available. I don't know that.  
9 I think it would be helpful to sort that out.

10 MR. HACKBARTH: Okay, Carol -- Bruce, last  
11 comment.

12 DR. STUART: I'd just like to add something on the  
13 other end of the spectrum. I mean, we were talking about  
14 capitated programs, coordinated care within those programs,  
15 all the problems associated with it. At the other end of  
16 the spectrum is something that Medicaid programs actually  
17 have been doing for 40 years, and that's case management.  
18 Now, they may not do it very well, but one could think of a  
19 benefit that would be case management that would, in fact,  
20 require that some of the coordination problems that we  
21 talked about would actually be part of that benefit. You'd  
22 pay to have somebody do that on an individual basis. I'm

1 not advocating that, but I think that if we're looking at a  
2 spectrum of alternatives, that deserves to be there because  
3 there is some history with that.

4 MR. HACKBARTH: Thank you, Carol.

5 Okay. We are to our last topic for today, and  
6 that is looking at the variation in home health agency  
7 margins.

8 MR. CHRISTMAN: Hello. Really, today, we're going  
9 to cover two separate topics. The first is to give you an  
10 overview of the factors affecting the financial performance  
11 of high and low margin home health agencies. The second is  
12 related but separate topic regarding the accuracy and  
13 payment integrity issues raised by the way Medicare pays for  
14 home health outlier episodes.

15 For some time, the Commission has reported  
16 variations in the margins of home health agencies. The  
17 question for the Commission is how much of this variation is  
18 due to differences in cost or provider efficiency and how  
19 much is due to inaccuracies or problematic incentives in the  
20 payment system. Examining the characteristics of high and  
21 low margin agencies will allow us to begin to answer this  
22 question and possibly identify areas of the payment system

1 that need further analysis or refinement.

2 Briefly, let me review the variation we have  
3 reported.

4 For the last 4 years or so, there has been a  
5 consistent spread of about 23 percentage points between the  
6 agencies at the 25th and 75th percentile of the Medicare  
7 margin distribution, as reflected in the data you see here  
8 for 2007.

9 Now we see this variation in other payment  
10 systems. For example, there was about a 26 percentage point  
11 spread between the 25th and 75th hospital in the IPPS in  
12 2007. So the magnitude of the variation in home health is  
13 not unusual, but it is still a useful tool for examining the  
14 payment system.

15 We divided our agencies into quintiles based on  
16 their Medicare margins, and here you see the margins and  
17 characteristics of the top and bottom quintiles. The  
18 agencies in the low margin group had an average margin of  
19 about negative 9 percent while those in the highest margin  
20 group had an average margin of about 37 percent.

21 There was little difference in quality when  
22 measured using our composite measure of about two dozen

1 performance measures from the OASIS. The urban and rural  
2 shares of episodes provided were about equal among the high  
3 and low margin providers.

4 Now, it's not on this table, but the most  
5 significant difference in service area was within the types  
6 of urban areas that providers served. Low margin providers  
7 delivered more episodes in the urban areas with populations  
8 greater than one million while high margin providers  
9 delivered relatively more episodes in urban areas with  
10 populations of less than one million.

11 Next, we compared the ownership and cost  
12 characteristics of high and low margin agencies. If you  
13 look at the second line on this table, nonprofit agencies  
14 tended to be a greater share of the low margin group and a  
15 smaller share of the high margin group.

16 Now, if you look down at the next line, high  
17 margin agencies delivered about 25 percent more total visits  
18 in a year, and high margin agencies averaged about 28,000  
19 visits compared to 22,400 for the low margin agencies.

20 This combination of high margins and larger size  
21 suggests economies of scales, and the trends in agency cost  
22 support this, if you look at the next set of lines down.

1 High margin agencies had a cost per episode that was 40  
2 percent lower than low margin agencies, and they had this  
3 lower episode cost for two reasons. They had lower cost per  
4 visit and fewer visits per episode. Of these two factors,  
5 lower cost per visit appears to be most significant. High  
6 margin agencies had a cost per visit that was 34 percent  
7 lower than low margin agencies, and high margin agencies  
8 provided about 2 visits fewer, or 10 percent less visits,  
9 per episode.

10 Finally, the average payment did not vary much  
11 between high and low margin providers.

12 Overall, this table suggests that high margin  
13 agencies have lower costs because they are larger and can  
14 achieve economies of scale that reduce their costs.

15 Next, we compared the patient severity and  
16 services used for high and low margin agencies on a number  
17 of metrics. This table is a little busy, so let me point  
18 out the main conclusions and then say a little bit more  
19 about a few of the metrics.

20 If you look at the first and fourth lines, the  
21 ones in yellow, this is home health case-mix and HCC risk  
22 score. The latter is the factor used to risk-adjust MA

1 payments. On these two measures, the high margin providers  
2 have higher values, indicating that they serve more severe  
3 patients than low margin providers.

4           However, if you look at the fifth and six lines in  
5 orange, you can see that on two measures, functional  
6 impairment and chronic conditions, we did not find any  
7 difference between these two groups.

8           So, in total, across the four measures, we get a  
9 mixed picture: Two, including the case-mix, suggest higher  
10 severity for high margin agencies, and two suggest no  
11 difference. Specifically, the home health case-mix alone  
12 suggests that high margin agencies serve more severe  
13 patients, but two other measures disagree with it. These  
14 inconsistent findings make it hard for us to conclude  
15 whether the difference in severity suggested by the case-mix  
16 is accurate.

17           Further, the findings on case-mix and margins  
18 suggest that agencies with better margins had higher case-  
19 mix. Higher margin agencies have higher case-mix because  
20 they provide more of two types of episodes with higher  
21 values. They provide more episodes that had 10 or more  
22 therapy visits, which qualified for extra payments, and they

1 provide more episodes that are in the 2 highest categories  
2 of clinical severity as measured by the PPS.

3           The correlation between high case-mix and high  
4 profitability suggests a bias in the payment system where  
5 the high case-mix episodes appear to be more profitable. To  
6 understand this further, we analyzed the relationship  
7 between case-mix and episode cost in a multivariate  
8 regression. The regression had a result that was consistent  
9 with the trends on this table for case-mix. It found that  
10 it tended to overpay for episodes with high values.

11           These results lead us to two conclusions generally  
12 about the home health case-mix. First, it appears that the  
13 case-mix may not be accurately measuring severity. The  
14 inconsistent results across our four measures do not depict  
15 a consistent trend, and more analysis is needed to  
16 understand why. Second, while there may be issues with the  
17 case-mix's sensitivity to severity, the correlation between  
18 higher case-mix and higher margins suggest that, as  
19 constructed, the system overpays for high case-mix episodes.

20           So, based on this data, we have a few preliminary  
21 findings and some plans for further work:

22           First, size appears to be an important factor in

1 margins. Agencies that are larger have lower cost per  
2 episode and better Medicare margins. The difference in cost  
3 per episode is greater than the difference in average  
4 payment, case-mix or any other factor we examined.

5           There is no significant difference in the share of  
6 urban and rural service areas of high and low margin  
7 agencies, and there is no difference in quality based on our  
8 composite measure.

9           The results on our patient severity measures are  
10 mixed. It is not clear how accurately the case-mix is  
11 capturing severity.

12           That said, whatever limitations it may have, the  
13 case-mix in effect in 2007 appears to overpay for episodes  
14 with higher case-mix values.

15           Based on these findings, there are some areas we  
16 plan to pursue. First, CMS implemented refinements in 2008  
17 that changed the case-mix significantly. We will need to  
18 look at the new case-mix to determine the impact. We also  
19 may examine additional patient characteristics such as home  
20 health diagnosis, additional facility characteristics such  
21 as specific quality measures like hospitalization or ER use,  
22 and beneficiary characteristics such as dual enrollee status

1 or the availability of informal care.

2 We are also interested in any additional areas  
3 that you believe are appropriate.

4 That completes the discussion of the variation in  
5 home health margins, and next I want to brief you on a  
6 second topic, issues with the accuracy and integrity of home  
7 health outlier payments.

8 Differences in outlier costs could affect an  
9 agency's financial performance, but that difference appears  
10 to be small in practice. In our examination of agency  
11 financial performance, we found that outliers equaled about  
12 3 percent of episodes for high margin agencies and 5 percent  
13 for the low margin agencies.

14 The difference is not large, but because of the  
15 way Medicare pays for home health outliers it may be  
16 undercompensating agencies with high outlier costs and  
17 overpaying those with low outlier costs. Let me explain  
18 why.

19 In the home health PPS, costs are measured using  
20 standardized cost factors based on 1997 cost reports. These  
21 standardized factors are used to estimate the cost of the  
22 visits in an outlier episode.

1           These standardized costs are used even if the  
2 provider's costs vary from them significantly. Providers  
3 with costs above these amounts are underpaid, and, in the  
4 case of agencies with costs significantly lower than what  
5 Medicare assumes, outlier episodes could even become  
6 profitable.

7           This became evident in 2007 when an aberrant level  
8 of outlier payments were made to agencies in Miami-Dade  
9 County. Agencies in this area accounted for about 60  
10 percent of outlier payments for the nation, and the number  
11 of visits in an outlier episode in Dade was about double the  
12 average for the rest of the country. The high proportion of  
13 cases was obviously suspicious and suggests that some  
14 agencies were pursuing outlier episodes because they were  
15 profitable. This can occur when agencies either do not  
16 provide the services they bill or, again, have lower costs  
17 than the benchmarks Medicare uses when it computes payments.

18           CMS took some steps to address the fraud issue but  
19 did not change how it pays for outliers. Most importantly,  
20 they continued to use the standardized cost factors to  
21 compute outlier payments.

22           This example shows the problem the current system

1 creates: If a provider delivers 157 visits in a 60-day  
2 episode -- again, this was the average for Dade in 2007 --  
3 Medicare would assume the episode costs about \$12,700 based  
4 on its standardized factors and would make a payment of  
5 about \$9,500 to cover both the base payment and the extra  
6 outlier payment that the episode qualifies for. Based on  
7 Medicare's calculations, the provider would have lost about  
8 \$3,800 on the episode.

9           If the provider had costs that were lower than  
10 what Medicare assumed, the lower example in this case -- 30  
11 percent lower is what I've used for this example -- Medicare  
12 would have made the same payment of about \$9,500. But  
13 because the costs are lower than what Medicare assumes, the  
14 provider would have made a profit instead of a loss.

15           As long as Medicare does not use providers' actual  
16 costs to set outlier payments, low cost providers could use  
17 the system to make these episodes profitable. In addition,  
18 high cost providers get a smaller payment than they would  
19 get if actual costs were used.

20           This brings me to an option the Commission may  
21 wish to consider. Other PPSes use actual costs when  
22 computing outlier payments, and home health is an exception.

1 Using actual costs would raise payments for high cost  
2 agencies and lower them for low cost agencies. The payments  
3 would more closely match providers' actual costs.

4 The changes CMS has proposed for 2010 do not  
5 address this issue, so these inaccuracies remain. For these  
6 reasons, the Commission may wish to consider a  
7 recommendation for the Secretary that would change outlier  
8 payments to use actual costs when calculating payments.

9 This completes my presentation. Please let me  
10 know if you have any questions on outliers or the variation  
11 in margins work.

12 MR. HACKBARTH: Thanks, Evan.

13 Let me ask a question about the first part. One  
14 of the things that you found we have heard before, and  
15 that's larger agencies tend to do better, tend to be more  
16 profitable, which has always puzzled me. I associate  
17 economies of scale with industries that have high fixed  
18 costs, and so you're able to spread your fixed costs over a  
19 larger base, and that reduces your average cost per unit of  
20 service.

21 Home health is not an industry that I associate  
22 with high fixed costs. Any idea what's going on there?

1           MR. CHRISTMAN: I mean I guess one thing when  
2 we've looked at their costs generally, the break between  
3 sort of direct and indirect costs -- and generally thinking  
4 more of indirect costs as being those back-end things -- has  
5 been around 35, 40 percent and not terribly different from  
6 other providers. So they do have some home office costs  
7 that they do incur, and there are some things that home  
8 health agencies invest in, such as IT systems, that may  
9 offer some economies.

10           I guess I'd say that's something we could probably  
11 get a better handle on.

12           MR. HACKBARTH: Okay, further clarifying  
13 questions, we'll start on this side.

14           DR. CASTELLANOS: Can you turn to Slide 9, please?  
15 This is for clarification. I do not live in Miami-Dade  
16 County. Thank you.

17           MR. GEORGE MILLER: I just want to understand on  
18 10, what you talked about, the payment for low providers  
19 versus high providers. Are you suggesting this only for low  
20 cost agencies or would it be a policy change for everyone,  
21 that you go to the providers' actual costs?

22           MR. CHRISTMAN: The way we've done it is for all

1 agencies. So the payments, this example shows a lower cost  
2 provider. Again, this is just an option.

3 MR. GEORGE MILLER: I understand.

4 MR. CHRISTMAN: We would look at the providers'  
5 actual costs, and those with higher costs would get an  
6 outlier payment based on that, and those with lower costs  
7 would get an outlier payment based on that. So you can kind  
8 of see how they're payments would change.

9 MR. GEORGE MILLER: I'm a little surprised because  
10 wouldn't that benefit the more profitable agencies much  
11 more, if you change?

12 MR. CHRISTMAN: I don't believe it would, I think,  
13 because what would happen is that if you look at the  
14 information we showed earlier the low cost agencies are the  
15 higher profit agencies. So what this would effectively do  
16 is it would lower payments, outlier payments for low cost  
17 agencies and raise them for high cost agencies, which in  
18 this case would more or less be consistent with saying that  
19 we would be lower them for highly profitable agencies and  
20 raising them for less profitable agencies.

21 MR. GEORGE MILLER: Okay. Thank you. I got it.

22 MS. KANE: Yes, I have a couple questions. In

1 keeping with Glenn's question about why there might be  
2 economies or why higher, it's not that much higher,  
3 actually. I'm wondering, is there a difference between the  
4 free-standing and chained agencies, where they're sharing  
5 overhead more, or do we know anything about that?

6 MR. CHRISTMAN: We haven't looked at chain, and  
7 that's an option that we could pursue. The difficulty with  
8 that is that the chain data that is available is notoriously  
9 inaccurate. So that's definitely something we could look  
10 at, though.

11 MS. KANE: My other question is on the written  
12 document where you talk about quality scores being the same,  
13 but these are composites on 24 items which could cancel each  
14 other out. I'm just wondering, within the individual 24,  
15 are there any noticeable quality differences that might not  
16 show up when you do a composite so that everybody looks the  
17 same?

18 MR. CHRISTMAN: I think that's sort of a next lap  
19 we wanted to take on this. This composite score was based  
20 on a methodology the Commission developed about three years  
21 ago when we looked at approaches for examining home health  
22 pay for performance.

1 MS. KANE: So you can break that out from the 24?  
2 It would be useful to see that.

3 MR. CHRISTMAN: Yes. I'm sorry. Yes, I want to  
4 be clear. I think we see that as a next step. The two  
5 things we definitely think are kind of on our list are  
6 hospitalizations and ER use and looking at those rates  
7 specifically, and the other stuff. I think the adverse  
8 events stuff is at the top of our list.

9 MR. BUTLER: So, sometimes we soar like eagles and  
10 do things like the Medicare Advantage recommendation.  
11 Sometimes we peck in the farm yard.

12 This outlier thing, like Dade County, is almost  
13 like pecking below the farm yard level. When you get 60  
14 percent of the outlier payments in 1 county and we're  
15 handling what looks like a very technical thing, somebody  
16 fix it.

17 Is this partly because -- and I'm just kind of  
18 curious. Do these things fly under the radar because it's  
19 home health, and CMS only has so many resources, and these  
20 things just kind of get lost in the shuffle or am I missing  
21 something? We're entering this discussion at a pretty  
22 detailed lower level.

1           MR. CHRISTMAN: There are parts of your question I  
2 can't really answer. But I think just to put some  
3 perspective on this, I believe the number I saw was that  
4 Medicare does prepayment review of like half a percent of  
5 all home health claims. So the kind of work that might have  
6 uncovered the outlier stuff was not really possible until  
7 Medicare had paid. It's not necessarily ideal, but that's  
8 the way things have been.

9           MR. HACKBARTH: I would point out that some of our  
10 best work has been in the barn yard. Yes, we've made some  
11 really specific, but important, recommendations on issues  
12 like this. So it's detailed, but it can be significant in  
13 its impact.

14           The thing that strikes me about the outlier is  
15 that the system was set up from the beginning different than  
16 all the other PPS systems. I wonder what the history was  
17 behind that and why they would opt for a different model  
18 that, incidentally, would have pretty predictable  
19 consequences. It's not like this is a surprising result.  
20 It's what you would expect.

21           MR. CHRISTMAN: Anecdotally, the only thing I'm  
22 really aware of is that I believe in moving to PPS Medicare

1 has tried to use approaches that minimize its reliance on  
2 the home health cost report. They don't audit these cost  
3 reports. So I'm not entirely sure that that's exactly why  
4 they did it, but it's definitely consistent with that  
5 motive.

6 DR. BERENSON: That was one of my questions. I  
7 have two left, one on Slide 6 and 5, on trying to reconcile.  
8 You emphasized on Slide 6 the different case-mix with the  
9 high margin which looked fairly substantial. On Page 5,  
10 though, you show a payment per episode differential of only  
11 4 percent. Are those consistent, that that kind of case-mix  
12 difference and more therapy episodes, et cetera, only get  
13 you that small amount of payment difference?

14 MR. CHRISTMAN: The payment per episode is a  
15 payment for all episode types, and so it includes episodes  
16 that are paid outside the case-mix. For example, episodes  
17 with fewer than five visits are paid on a per visit basis,  
18 and outlier payments obviously will have an extra on top of  
19 the standard case-mix payment, the case-mix adjusted  
20 payment.

21 DR. BERENSON: The last question is, and others  
22 probably know the answer to this, do we have a number for

1 what percentage of revenues for home health agencies come  
2 from Medicare?

3 MR. CHRISTMAN: It varies, and I can get that.  
4 The last time I tried to pull it off the top of my head, I  
5 did it wrong. So let me get back to you on that.

6 DR. BERENSON: Okay.

7 MR. HACKBARTH: Clarifying questions?

8 DR. DEAN: The case-mix calculation, as I read  
9 this, it seemed to me it's drawn directly from, almost from  
10 the amount of service that's provided. Is that so you can  
11 sort of generate your own case-mix severity by how many  
12 visits you decide to make? Is that accurate? I mean it  
13 didn't quite make sense to me.

14 MR. CHRISTMAN: Let me clarify. Maybe I overdid  
15 it, but one of the points we wanted to make in the paper is  
16 that when it comes to episodes with therapy visits, the  
17 number of visits you provide can drive your payment.

18 Now, remember there's three commonly provided  
19 types of visits -- nursing, therapy and home health aide --  
20 but it's only the therapy visits that if you do more you get  
21 a higher payment.

22 The system in effect until 2008 had 1 therapy

1 threshold. If you hit 10 or more, it basically doubled your  
2 case-mix. You can think of that as doubling your payment.  
3 Less than 10, obviously, you can see the effect.

4 So the new system that went into effect in 2008  
5 has a more gradual series of thresholds. We're just  
6 starting to get data to see how that works out, but I want  
7 to be clear that even under the new system it operates in  
8 some respects like a fee schedule -- the more visits you  
9 provide, the more your payment will go up.

10 DR. CHERNEW: Can you describe how a current  
11 outlier payment system works and how responsive to more or  
12 less visits, or more or less intense visits.

13 MR. CHRISTMAN: Okay. I guess what I would say is  
14 remember that the outliers decide to pay for high cost  
15 episodes. They lay aside 5 percent of total payments, and  
16 they set a threshold of cost based on their estimates of how  
17 much, what the distribution of cost looks like, so that the  
18 amount of payments that they'll pay out will be equal to the  
19 5 percent pool. That's the way they sort of ration the  
20 payments.

21 For an episode that exceeds that threshold, they  
22 pay 80 percent of those costs.

1           Again, remember, all of these costs are computed  
2 using the standardized factors that CMS uses, and not the  
3 providers' actual costs.

4           DR. CHERNEW: So, if I have an outlier in my  
5 agency in the current formula, and I give an extra visit, or  
6 five, I don't get any more money.

7           MR. CHRISTMAN: After you've exceeded this  
8 threshold, you will get 80 percent of the cost of those  
9 extra visits.

10          DR. CHERNEW: Of my costs?

11          MR. CHRISTMAN: No, using the standardized  
12 formula. Right. So they take those five visits, and say  
13 they're nursing, and say the standardized visit says they're  
14 \$100. You do 5 visits, you get \$500. They only pay 80  
15 percent of that, so that you get a payment of \$400.

16          DR. CHERNEW: The reason I'm asking, the problem I  
17 have with all actual cost payment systems is they tend to  
18 give incentives to do more of the particular things, and I'm  
19 trying to figure out how this compares to the existing.

20          MR. CHRISTMAN: Let me point out two features that  
21 get at what we're talking about. One is remember we're not  
22 paying. In theory, we're not paying all of the additional

1 costs when we make an outlier payment. It only includes the  
2 80 percent of the costs above the threshold CMS has set.  
3 So, in a marginal sense, they're not supposed to be getting  
4 the full cost of the additional service they're providing.

5 A second place they're supposed to lose money is  
6 that this threshold is greater than the base payment, and  
7 Medicare makes no payment between the base payment and the  
8 threshold. So there are two places they're supposed to be  
9 losing money.

10 So that was what was most striking about the  
11 experience of Dade.

12 These outliers would balance the incentives for  
13 efficiency, which you mentioned, and selection, and these  
14 outliers are only supposed to pay a portion of the  
15 incremental costs of these episodes.

16 When we saw a lot of agencies pulling down these  
17 payments, it raises the issues that I tried to sort of  
18 underline on this slide, which is that if you have costs,  
19 you can do this two ways. You cannot provide the visit and  
20 just be outright fraudulent. But, legitimately, if you have  
21 costs that are lower than what Medicare assumes --

22 DR. CHERNEW: [off microphone] Eighty percent of

1 what Medicare assumes.

2 MR. CHRISTMAN: Right.

3 DR. CHERNEW: [off microphone] Now I understand.

4 MR. HACKBARTH: [off microphone] Round two.

5 DR. CASTELLANOS: I'd like to focus in a little  
6 bit on therapy. I fully recognize that physicians order the  
7 therapy. Somebody has to have the power of the pen. I also  
8 recognize that this is in the same bailiwick as any fee for  
9 service -- the more you do, the more you get.

10 I guess what I'm asking is, and I'll tell you  
11 where I'm going with that, what's the criteria for these  
12 visits, for the different forms of therapy -- physical  
13 therapy, occupational therapy, speech therapy -- and what's  
14 the appropriateness?

15 I guess where I'm going on this is, like what we  
16 did in hospice, we kind of tightened down on who would  
17 recertify that. Is there any mechanism we have that we can  
18 perhaps look at the appropriateness of therapy and how it's  
19 ordered?

20 MR. CHRISTMAN: I guess I would just briefly say  
21 that, one, the patient -- and this is not a small thing --  
22 the patient has to be eligible for home health. So they're

1 only going to be getting these services in the home if  
2 they're homebound and if they have a need for therapy or  
3 nursing.

4           Now, among the types of the services, it's simply  
5 going to be a joint discussion between the physician  
6 ordering the service and generally whoever is doing the  
7 assessment, looking at the patient's needs. I would say in  
8 this area I don't know that there's a lot of agreement right  
9 now on any sorts of best practices or clinical protocols  
10 that people follow very widely.

11           I guess another way of answering that question is  
12 that under the old system, remember we made these extra  
13 payments at 10 visits. It was surprising when we looked at  
14 one run that showed Medicare episodes by their sequence --  
15 the first episode in a spell, the second, the third, the  
16 fourth. When you looked at those episodes that just had one  
17 or more therapy visits, the mean number of visits was 10.  
18 It didn't matter if you were in the first episode of your  
19 home health spell or the seventh. By some measure of  
20 chance, it came out to about 10 visits.

21           Definitely, it appears that some folks have  
22 reacted to what's gone on in the payment system.

1 DR. MARK MILLER: And, of course, it's not chance.  
2 It's where we set the threshold that drove it.

3 I think the way I'm hearing your point, Ron, or  
4 I'm going to ask you, am I hearing you say that as we think  
5 about this issue perhaps we should adopt some of the  
6 strategies that we adopted in hospice, about looking at some  
7 of the high end and asking for a medical record review or  
8 some additional amount of certification on the part of the  
9 physician or whoever else is making this, in order to see if  
10 we can't drive some of the tail?

11 DR. CASTELLANOS: Exactly.

12 DR. MARK MILLER: Yes, that's what I thought I was  
13 hearing.

14 MR. HACKBARTH: Other round two questions,  
15 comments?

16 DR. BERENSON: Yes, on this outlier issue, I sort  
17 of share Peter's view that we're into the weeds on this one,  
18 but I guess my question would be if we think that what's  
19 going on here is there's an opportunity for gaming the  
20 system.

21 I guess my concern is there's an opportunity also  
22 for gaming cost reports. If we do not have a history of

1     auditable cost reports that have ever been used, sort of  
2     assuming that we can just get that up and going and that  
3     some creative person in Miami, who is not Ron, would not see  
4     that avenue for gaming us as opposed to doing unnecessary  
5     visits. I mean I'm not sure where we're going, but I would  
6     certainly be looking at the infrastructure required and the  
7     oversight needed to start moving to auditable cost reports,  
8     I guess.

9             DR. CROSSON: Well, sort of the other side of that  
10    is I would assume if we were going to do cost reporting for  
11    outliers, a home health agency would have to do cost  
12    accounting for all their patients because they wouldn't know  
13    who is going to be an outlier, right?

14            If what we already have is a situation where the  
15    very largest organizations, presumably with the most assets,  
16    have the highest margins, they would be the organizations  
17    more likely to be able to absorb the cost of doing the cost  
18    accounting, whereas the smaller organizations would not. So  
19    it would seem to me in addition to determining what  
20    resources CMS might have to put to this and whether it's  
21    doable and auditable, we also might want to think about, try  
22    to understand what the burden would be and whether that

1 would have a magnifying impact on the relative margins that  
2 we've looked at.

3 MR. HACKBARTH: So just to pick up on this theme,  
4 if you're really concerned about abuse of the outlier  
5 payment system, there are two paths that you can go down,  
6 and they're not mutually exclusive.

7 One, you can alter the payment formula which may  
8 add some burden to the system, may create a new  
9 vulnerability.

10 Another approach, to pick up on Ron's comment, is  
11 to say this is what we have an IG for. Let's just flag the  
12 people who have these very suspicious patterns and say go  
13 get them.

14 It may be that the latter is the most practical  
15 solution, at least worth thinking about. Of course, we have  
16 to fund enough IG people for the scale of the problem.

17 Other round two comments?

18 DR. DEAN: As Evan knows, I've been concerned  
19 about this issue and it's been very troubling because I've  
20 gotten a lot of complaints from people in our area that the  
21 small rural home health agencies are closing. In fact, just  
22 before I came to this meeting, I got a report from the

1 hospital association saying there were three more in our  
2 area that have closed, and yet it doesn't show up in these  
3 data. I'm struggling to figure out where the disconnect is.

4           One of the things, and I think it may respond a  
5 little bit, Glenn, to your questions about economies of  
6 scale, one of the economies of scale is the reporting of  
7 this OASIS instrument, which is apparently a very demanding  
8 thing. Several of them have told me that unless the nurses  
9 are doing this very frequently it's going to take them a  
10 long time, and then they probably still won't get it right.

11           I know the home health agency in my hometown was  
12 pulled out because they said the staff simply were not being  
13 accurate or complete or whatever it is, in completing that  
14 instrument, and they needed to have people. They were  
15 willing to send people from a central agency 50 miles away  
16 to do the visit simply to make sure that this got filled out  
17 completely.

18           So, like I say, I'm not quite sure if that's a  
19 fair comment or not. But for some reason we seem to be  
20 seeing a decline in access to Medicare home health coverage,  
21 and yet I realize it doesn't show up in these data. So I'm  
22 not quite sure where the problem is, but that may be one of

1 them.

2 MR. HACKBARTH: Yes, to me, this is one of the  
3 more important, more urgent questions on the table. In the  
4 past, we've tried to look and see if by cutting the data  
5 various ways, urban/rural, et cetera, whether there is a  
6 group that looks to be really suffering, and we've never  
7 been able to find that. Now, with more analysis, we still  
8 can't find it.

9 Yet, on the other hand, I know people on the Hill  
10 are hearing what you say, that there is some group of  
11 agencies that is really suffering. Obviously, this is  
12 important in the context of our recommendation, which the  
13 Hill has been interested in, to cut the home health base  
14 payment.

15 If there's some way, something that we might be  
16 missing, if there's some specially defined group of home  
17 health agencies that truly is greatly disadvantaged, boy,  
18 I'd like to know because what I'd like to do is suggest a  
19 solution that's appropriate to that problem, not the  
20 alternative which is well, let's keep the rates high for  
21 everybody across the board.

22 DR. DEAN: That makes perfect sense.

1           One of the issues, and maybe it's impossible to  
2 do, but part of it is how you define rural because the ones  
3 that are having the most trouble in South Dakota are the  
4 ones we call the West River area, which is western South  
5 Dakota where these agencies are probably going to be 100  
6 miles apart. Their average travel time is huge. So they  
7 have progressively reduced their area they're willing to  
8 cover simply because the amount of travel time, in addition  
9 to being very small volume and having these administrative  
10 challenges of getting the questionnaires filled out  
11 appropriately. I think it's some combination of those  
12 issues that is causing the problem.

13           Yet, if you define rural as just non-metro, you've  
14 got a fairly large contribution of places where the  
15 population is still fairly dense as opposed to western South  
16 Dakota where you've got probably less than one person per  
17 square mile, probably way less than one person per square  
18 mile in parts of it. So I suspect it's somewhere in there  
19 that the problem is.

20           DR. MARK MILLER: Can I just ask a couple things  
21 before we jump on, either to Jim or Evan? So, when we cut  
22 the data by urban and rural, didn't we use the more detailed

1 urban and rural breakout?

2 MR. CHRISTMAN: We did. We used what are called  
3 the rural/urban continuum codes, and it has nine steps. It  
4 takes the rural areas and splits them into five steps.

5 And I looked this up. Wessington Springs, it's in  
6 the very, it's in the least populous bucket that this system  
7 has.

8 DR. DEAN: [off microphone] Where I live is  
9 densely populated [inaudible] --

10 MR. CHRISTMAN: I guess what I would say is that  
11 we appreciate that these splits between urban and rural may  
12 be too big to get at some of these issues. So we did make  
13 an effort to look at it with a more granular set, and we  
14 didn't find anything.

15 DR. DEAN: [off microphone]

16 MR. HACKBARTH: To be more specific, what do you  
17 mean by we didn't find anything?

18 MR. CHRISTMAN: I'm sorry, when we looked at the  
19 share of episodes provided by high and low margin providers  
20 in those very rural areas, the share was not that different  
21 between. The share of episodes provided in those areas was  
22 not that different between high and low margin providers.

1 So you could be a high margin provider and serve people in  
2 the most rural areas or a low margin provider appeared to be  
3 equally possible.

4 DR. DEAN: [off microphone] [inaudible].

5 MR. HACKBARTH: What I'm told, it may be  
6 important.

7 DR. DEAN: [off microphone] That was a key thing.

8 DR. MARK MILLER: Tom, when you were saying that  
9 you got notice of some more agencies that had closed, does  
10 this mean that there's now no one in the area that takes  
11 beneficiaries for home health or does this mean that there's  
12 fewer home health agencies in your area? Do you have any  
13 sense?

14 DR. DEAN: I should go back and check, but I think  
15 they were probably the only providers in the area. I don't  
16 know that for certain.

17 DR. MARK MILLER: Because I mean remember there  
18 was, and I don't know your area although apparently Evan  
19 does, there was an uptick in numbers of agencies in the last  
20 few years. There has been very aggressive growth in number  
21 of agencies. So the question is sort of are you coming down  
22 and there's no one there to serve or is that now instead of

1 five, there's two? I think that's the question.

2 DR. DEAN: Well, I'd have to go back and check,  
3 but I don't believe that that's the case.

4 DR. MARK MILLER: We can check as well, but I  
5 think this is the question.

6 DR. DEAN: Because we have essentially no for-  
7 profit providers. In fact, I can't think of any in our  
8 area. They're all agencies that are run out of small rural  
9 hospitals, and they've just somehow made this decision they  
10 can't afford to do this anymore because outside of the two  
11 population centers, Sioux Falls and Rapid City, I don't  
12 think there are any for-profit agencies anywhere else in the  
13 state. I don't believe. Again, I'm not 100 percent sure.

14 DR. MARK MILLER: Once everybody has finished  
15 their comments, I have sort of a sense of where we might  
16 look next and how it might circle back around to some of  
17 this, but I've talked enough.

18 MR. HACKBARTH: I think we're close to the end.

19 MS. BEHROOZI: The yin to Tom's yang, I get the  
20 same kind of complaints from providers in New York City.

21 You talked, Evan, about in terms of areas for  
22 further analysis, looking at facility and beneficiary

1 characteristics. You mentioned looking at dual status  
2 beneficiaries. One of the things that they've raised is  
3 could you look at it by zip codes and socioeconomic status  
4 by zip codes.

5           Some of the different services, completely  
6 different services that they feel like they have to provide  
7 that are not compensated, that are not accounted for in the  
8 payment system, put them at a disadvantage when it comes to  
9 margins.

10           I wish Bill were here because I think he would say  
11 something along the lines of just looking at the claims  
12 data, the numbers, isn't informative enough, I think in this  
13 context because we don't really know enough about what the  
14 benefit is supposed to be.

15           I wonder if we're kind of getting to the point  
16 where you're looking for all these different ways to slice  
17 and dice the data, and you can't really come up with the  
18 truly explanatory factors. Is it time to do a focus group  
19 among agencies to interview the high margin, the low margin,  
20 the urban, the rural high margin and low margin?

21           MR. HACKBARTH: I think we want to be sensitive to  
22 paying fairly for agencies in all circumstances, but let me

1 draw a distinction between New York City and South Dakota.  
2 It's important. We shouldn't be trying to set up a payment  
3 system where every single agency is profitable across the  
4 board. The issue would be are we paying adequately to  
5 assure adequate access to care for Medicare beneficiaries in  
6 all parts of the country.

7 If a particular agency goes out of business in New  
8 York, there may be alternatives. Now, if it's VNS and Carol  
9 Raphael, that would have obviously broader implications, but  
10 I don't think Carol is going out of business.

11 MS. BEHROOZI: But I think it's about what the  
12 benefit is. I mean they think that providing a quality  
13 benefit requires them to put resources in that they're not  
14 being compensated for, and they think that the quality of  
15 the benefit will ultimately suffer if they are forced to  
16 operate at a negative margin all the time.

17 MR. HACKBARTH: Yes.

18 MS. BEHROOZI: I didn't say we were the same. It  
19 was just sort of like opposite arguments on the continuum.

20 It is troubling that we can't explain the  
21 variation, and I just wonder if it's time to look beyond the  
22 numbers and talk to --

1           MR. HACKBARTH:  When Carol was on MedPAC, which  
2 has been a number of years now, as you know, the issue was a  
3 little bit different.  In fact, it was more akin to the SNF  
4 issue.

5           Carol said, yes, we make money on Medicare.  We do  
6 reasonably well, but we need that to offset the poor payment  
7 that we get from Medicaid, et cetera.

8           You know what my response was on that.

9           Now again, just for the record and for people,  
10 that was a number of years ago, and we're talking about a  
11 different payment recommendation here.  We're talking about  
12 potentially cutting the rates, and so I don't want to  
13 pretend that Carol would say the same thing to this.

14          Okay.  I don't know about anybody else, but I'm  
15 running out of steam here.

16          DR. MARK MILLER:  Just a couple things on this,  
17 and I'll be brief.  The model I would carry in my head, or  
18 I'm carrying in my head -- you guys can do that if you want  
19 -- is we had something of this same discussion on SNF, and  
20 we spent some time trolling around and ended up finding out  
21 that there was some cost that we didn't think the system was  
22 particularly capturing well.  When you started to adjust

1 that, it started to back into things like redistributing  
2 money to hospital-based SNFs.

3 So one of the things that I took away from this,  
4 looking at the case-mix measures and particularly the case-  
5 mix for certain non-therapy episodes, is that if our case-  
6 mix is overcompensating at a certain level and there are  
7 providers who have figured that out, that may be the source  
8 of what we need to look at.

9 Now the other things I was going to say, you  
10 already said. We're going to continue to look at the other  
11 things, dual eligibles, services that are offered.

12 And to your point on focus groups, we've had some  
13 real focus groups. We have gone to their meetings, and they  
14 have come to us, and we have had some extensive  
15 conversations with the industry. I don't know if you want  
16 to rest assured, but you should be assured that we have  
17 talked to them, and they keep pointing. Each time we say  
18 the data doesn't show us this, they say well, then please  
19 look here. That's really what we've been trying to do for  
20 the last several months.

21 MR. HACKBARTH: Okay. Thank you, Evan.

22 Let's see. Before we do the public comment

1 period, let me just let the commissioners know that C-SPAN  
2 will be here tomorrow. So wear your best clothes, your  
3 bright tie or whatever.

4 Now we'll have our public comment period.

5 Hearing none, we're adjourned until 8:30 tomorrow  
6 morning.

7 [Whereupon, at 5:23 p.m., the meeting was  
8 recessed, to reconvene at 8:30 a.m. on Friday, November 6,  
9 2009.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, November 6, 2009  
8:30 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair  
FRANCIS J. CROSSON, M.D., Vice Chair  
MITRA BEHROOZI, J.D.  
ROBERT A. BERENSON, M.D.  
JOHN M. BERTKO, F.S.A., M.A.A.A.  
KAREN R. BORMAN, M.D.  
PETER W. BUTLER, M.H.S.A.  
RONALD D. CASTELLANOS, M.D.  
MICHAEL CHERNEW, Ph.D.  
THOMAS M. DEAN, M.D.  
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N  
NANCY M. KANE, D.B.A.  
HERB B. KUHN  
GEORGE N. MILLER, JR., M.H.S.A.  
ARNOLD MILSTEIN, M.D., M.P.H.  
BRUCE STUART, Ph.D.

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## 1 P R O C E E D I N G S

2 MR. HACKBARTH: Good morning. We are going to go  
3 ahead and start.

4 For the benefit of the C-SPAN audience, this is  
5 the Medicare Payment Advisory Commission, and we are an  
6 Advisory Commission to the U.S. Congress, a nonpartisan  
7 Commission that advises the Congress on an array of Medicare  
8 issues, payment policy in particular. And we make  
9 recommendations periodically, publish two reports -- a  
10 report in March and one in June -- and then, in addition to  
11 that, special reports as requested by the Congress.

12 Our first topic this morning is, in fact, a report  
13 specifically requested by the Congress and will include  
14 votes on recommendations. John?

15 MR. RICHARDSON: Thank you, and good morning,  
16 everyone. Carlos and I are here to discuss the  
17 congressionally mandated report on how to improve  
18 comparisons of the quality of care between Medicare  
19 Advantage and fee-for-service Medicare and among MA plans.  
20 Today we will present a set of eight draft recommendations  
21 for the Commission's consideration and voting.

22 As a reminder of the provisions of the mandate,

1 Section 168 of the Medicare Improvements for Patients and  
2 Providers Act of 2008 directed the Commission to study and  
3 submit a report to the Congress on how quality measures can  
4 be collected and reported starting in 2011 to allow  
5 comparisons of the quality of care between Medicare  
6 Advantage and fee-for-service Medicare and among MA plans.

7 The MIPPA provision directs the Commission to  
8 address technical issues such as potential new data  
9 requirements and benchmarking measures. The report is to  
10 include any recommendations for legislative or  
11 administrative changes as the Commission finds appropriate.

12 Before we go through each of the recommendations  
13 one by one, we think it will be helpful to provide a road  
14 map of all the recommendations together. As you can see on  
15 this table, the eight draft recommendations are arranged  
16 chronologically from top to bottom in terms of when the  
17 proposed recommendation action would feasibly be  
18 implemented. The two columns, headed "MA-to-MA Comparison"  
19 and "MA-to-FFS Comparison," indicate which of the two types  
20 of comparisons the draft recommendation applies to. As you  
21 can see, two of the draft recommendations -- the first and  
22 the last -- are cross-cutting and would affect both types of

1 comparisons.

2           Also note that some of the draft recommendations  
3 have been revised and reordered somewhat to reflect  
4 Commissioners' feedback at and after our October meeting.

5           The first draft recommendation would call on the  
6 Secretary to define the forthcoming criteria for the  
7 meaningful use of electronic health records, or EHRs, to  
8 support the storage and reporting of the data elements  
9 specifically required for the computation of a comprehensive  
10 set of quality measures with robust risk adjustment. The  
11 ready availability of clinical record data will  
12 significantly improve the quality of the quality comparisons  
13 that Medicare can use. This draft recommendation is  
14 presented first because, while the Medicare subsidies for  
15 EHR adoption by physicians and hospitals will not start  
16 until 2011, CMS is planning to publish draft meaningful use  
17 definitions by the end of next month and issue final  
18 regulations in early 2010.

19           The second draft recommendation addresses the  
20 issue of the appropriate geographic unit for reporting and  
21 benchmarking all types of quality measures. The draft  
22 recommends that the geographic unit for quality comparisons

1 should be the same as the geographic unit that MedPAC has  
2 recommended for MA payment areas, which generally are  
3 smaller geographic areas than currently used in quality  
4 comparisons. This draft recommendation could be implemented  
5 by 2011, and by that date would allow for MA-to-MA plan  
6 quality comparisons using current Healthcare Effectiveness  
7 Data and Information Set, or HEDIS, measures and the current  
8 Consumer Assessment of Health Care Providers and Systems, or  
9 CAHPS, patient experience survey instrument. For MA-to-FFS  
10 Medicare comparisons, it should be feasible to measure and  
11 report CAHPS results for the proposed smaller geographic  
12 units by 2011.

13           The third draft recommendation would apply only to  
14 MA-to-MA plan comparisons and require that data collection  
15 and reporting underlying certain quality measures be  
16 consistent across all types of MA plans -- HMOs, PPOs, and  
17 private fee-for-service plans -- which currently is not the  
18 case. This draft recommendation could be implemented to  
19 improve quality comparisons among all MA plan types by 2011.

20           The next three draft recommendations form a set of  
21 additional quality measurement improvements that would come  
22 online in 2013.

1           Draft recommendation 4 would require the Secretary  
2 to develop for fee-for-service Medicare a version of a  
3 quality measurement tool that is already in use in MA called  
4 the Health Outcomes Survey, or HOS if the Secretary  
5 determines that this instrument can be used to meaningfully  
6 differentiate health outcomes between MA and fee-for-  
7 service.

8           Draft recommendation 5 would direct the Secretary  
9 to add a set of outcome measures to the quality comparison  
10 toolbox for both MA-to-MA and MA-to-FFS quality comparisons.  
11 These measures can be calculated using administrative data  
12 such as fee-for-service claims or health plan encounter data  
13 -- data that the draft recommendation would require the  
14 Secretary to obtain from MA plans in sufficient detail for  
15 the calculation of these outcome measures.

16           Draft recommendation 6 would direct the Secretary  
17 to use a limited subset of HEDIS administrative-only  
18 measures for MA-to-FFS comparisons if the Secretary  
19 determines that such measures can be used to make valid  
20 comparisons between the two sectors.

21           So to briefly recap the big picture thus far,  
22 draft recommendations 4, 5, and 6 together, along with draft

1 recommendation 2, would require Medicare by 2013 to begin  
2 using patient experience outcomes and some process-of-care  
3 measures to compare quality between MA and fee-for-service  
4 and among MA plans and to do so in most areas at a smaller  
5 geographic level.

6           Then draft recommendation 7 would recognize that  
7 the clinical process and outcome measures in use today need  
8 to be further developed to cover more segments of the  
9 Medicare population, such as beneficiaries over age 75 and  
10 under age 65, and to measure quality of care for clinical  
11 conditions, such as mental illness and geriatric conditions,  
12 for which there are currently few quality measures.

13           Draft recommendation 8 recognizes concerns about  
14 the potential budget implications for CMS of the draft  
15 recommendations and whether the Congress should dedicate  
16 funding for the implementation of these activities to ensure  
17 that any quality comparisons between MA and fee-for-service  
18 and among MA plans are executed with sufficient resources to  
19 be as accurate as possible.

20           Now I will go on to the individual  
21 recommendations.

22           Most of the quality measures used today in all

1 public and private health insurance programs rely on  
2 administrative data services, such as medical claims or  
3 encounter data, and in some instances, also medical record  
4 review samples. However, for many providers engaged in  
5 clinical care, the validity and actionability of quality  
6 measures today is fundamentally limited by the absence of  
7 detailed medical record information in calculating these  
8 measures. This information could be used to accurately  
9 compute the measures and to appropriately risk-adjust the  
10 results to reflect the relative probabilities of achieving  
11 the desired outcome given clinical factors such as  
12 municipality co-morbidities and contraindications that often  
13 are not captured in administrative data.

14           Many quality measurement experts today believe  
15 that electronic health records hold significant promise to  
16 provide detailed clinical data for quality measurement and  
17 risk adjustment much more efficiently than is currently  
18 possible. New Medicare payment incentives authorized by the  
19 American Recovery and Reinvestment Act of 2009 are expected  
20 to accelerate the adoption and use of EHRs by hospitals,  
21 physicians, and integrated delivery systems starting in  
22 2011. The central policy question in this process will be

1 the definition of what constitutes the meaningful use of an  
2 EHR to qualify it for the Medicare subsidies.

3 Earlier this year, an HHS Federal Advisory  
4 Committee developed an initial set of recommendations for  
5 defining the meaningful use criteria, but the final  
6 definition of "meaningful use" will be set forth by CMS  
7 through regulations expected to be issued by the end of  
8 December 2009 and finalized in early 2010.

9 In our October discussion with you, several  
10 Commissioners supported an initial draft recommendation that  
11 the forthcoming meaningful use criteria should require  
12 qualifying EHRs to have the technical capacity to efficient  
13 store and report the data elements needed to allow  
14 comprehensive quality measurement with robust risk  
15 adjustment for both MA-to-MA and MA-to-FFS quality  
16 comparisons.

17 We also discussed the importance of EHRs being  
18 able to contain and report patient demographic data, such as  
19 race and ethnicity, which would allow quality measurement  
20 reporting to examine disparities. As Bill and other  
21 Commissioners noted in our previous discussion, the source  
22 of the demographic data in an EHR may most appropriately be

1 seen as administrative records. We have revised the  
2 previous draft recommendation to allow for this flexibility  
3 in the meaningful use criteria while also recognizing that  
4 some relevant demographic information, such as finer  
5 distinction in race and ethnicity, may be more feasibly  
6 collected during patient encounters and included in EHRs.

7           So the current draft recommendation reads: "The  
8 Secretary should define EHR meaningful use criteria such  
9 that all qualifying EHRs can collect and report the data  
10 needed to compute a comprehensive set of process and outcome  
11 measures consistent with these recommendations. Qualifying  
12 EHRs should have the capacity to include and report patient  
13 demographic data, such as race, ethnicity, and language  
14 preference."

15           To be clear, the intent of the second sentence in  
16 the recommendation is not to require that patient  
17 demographic data necessarily should be collected by  
18 providers during patient encounters, only that any EHR that  
19 qualifies for the Medicare subsidy payments should have the  
20 capability of storing demographic data and reporting it as  
21 needed to compute quality measures for specified patient  
22 populations.

1           The implications of draft recommendation 1 are as  
2 follows: For CMS administrative spending, we do not  
3 anticipate any additional costs for the agency beyond the  
4 administrative costs already assumed in the agency's budget  
5 for developing and implementing the EHR meaningful use  
6 criteria. I should note here that we are not providing  
7 ranges of estimated budget impacts for the draft  
8 recommendations throughout the report because MedPAC  
9 typically does not make estimates of the impact of draft  
10 recommendations on Medicare administrative costs.

11           The implications of draft recommendation 1 for  
12 beneficiaries, and also for policymakers, is that more  
13 comprehensive information on the quality of care would be  
14 available with the capability of more feasibly reporting on  
15 quality by race and ethnicity, gender, and age group. For  
16 providers, we estimate that there would be no additional  
17 costs as a result of implementing this draft recommendation  
18 beyond any net costs that providers are already projecting  
19 for the acquisition and deployment of the HR systems that  
20 meet the meaningful use criteria.

21           Carlos will now go through draft recommendations  
22 2, 3, and 4.

1           MR. ZARABOZO: The second draft recommendation is  
2 relevant for both the MA-to-MA and MA-to-FFS comparisons.  
3 The current collection and reporting of most quality  
4 measures in MA occurs at the level of the MA contract. Some  
5 MA contracts cover very wide geographic areas. For example,  
6 plans in California that cover much of the state, the entire  
7 state, report one set of statewide HEDIS results even though  
8 different parts of California have very different health  
9 care markets and the provider characteristics in each  
10 geographic area can be very different in both fee-for-  
11 service and MA.

12           For the purpose of informing beneficiaries about  
13 the relative quality of MA plans and the quality of MA plans  
14 as compared to fee-for-service, quality comparisons should  
15 pertain to a specific geographic area in which beneficiaries  
16 are making choices among different plan options and between  
17 plans and fee-for-service. This will enable beneficiaries  
18 to know which plans are better than others and how fee-for-  
19 service compares to available MA plans.

20           For CMS in its role as the entity monitoring the  
21 quality of plans and seeking improvements in plan quality,  
22 it is also important to evaluate the care that each plan

1 provides in different geographic areas in which the  
2 organization operates and how each MA plan compares to fee-  
3 for-service in its market area.

4           The Commission has already recommended changing MA  
5 payment areas from the current county-based payment system  
6 to one based on metropolitan statistical areas and health  
7 service areas. Consistent with that recommendation, draft  
8 recommendation 2, therefore, reads: "The Secretary should  
9 collect, calculate, and report quality measurement results  
10 in MA at the level of the geographic units that the  
11 Commission has recommended for MA payments and calculate  
12 fee-for-service quality results for purposes of comparing MA  
13 and fee-for-service using the same geographic units."

14           This recommendation affects both the MA-to-MA and  
15 MA-to-FFS comparisons as of 2011. HEDIS measures that MA  
16 plans report can be aggregated and reported at the  
17 appropriate geographic level as of 2011. And CAHPS results  
18 for both MA and fee-for-service Medicare can be determined  
19 for smaller geographic areas if there is an expansion of the  
20 sample sizes for this beneficiary survey.

21           The implications of this recommendation are that  
22 CMS will require significant additional resources to collect

1 the necessary information and report it for each of the  
2 smaller geographic areas. This would require a significant  
3 level of resources because systemwide reporting is not  
4 currently done for the Medicare fee-for-service sector, and  
5 there would be more detailed reporting for MA results.

6 For beneficiaries, the change would allow better  
7 comparability of quality measures. However, the number of  
8 beneficiaries being asked to participate in surveys will  
9 increase. Many plans would face additional burden and costs  
10 because of the increased number of reporting units that  
11 reflect the recommended geographic areas.

12 The particular draft recommendation also has a  
13 number of consequences affecting the reporting of data on  
14 quality. For example, if a measure for a given reporting  
15 unit is based on a review of a sample of medical records,  
16 expanding the number of reporting units would require more  
17 medical record review.

18 As we have mentioned in the past, there is also a  
19 small numbers issue. In going to smaller geographic areas,  
20 you are dealing with fewer enrollees and sometimes too few  
21 to yield valid results. The Secretary would have to develop  
22 alternative ways of evaluating reporting on quality in such

1 cases, for example, by using three-year rolling averages.

2           Draft recommendation 3 pertains to the MA-to-MA  
3 comparisons. Currently, not all MA plans report their  
4 results on the same basis. HMO plans can include  
5 information from medical records when they report their  
6 performance on some of the HEDIS measures, while PPO plans  
7 and private fee-for-service plans are permitted to use only  
8 administrative data for reporting on the same measures. In  
9 addition, a statutory provision provides that PPOs and  
10 private fee-for-service plans need only report on the care  
11 rendered through network providers, even though  
12 beneficiaries in such plans are free to use non-network  
13 providers. This results in a lack of comparability of  
14 measures across different plan types within MA.

15           Having all plans report on the same basis would  
16 enable a valid plan-to-plan comparison across all HEDIS  
17 measures, including for important measures such as  
18 intermediate outcome measures. The plan should also report  
19 on all the care that its enrollees receive whether or not  
20 providers are under contract.

21           Draft recommendation 3, therefore, reads: "The  
22 Secretary should have all health plan types in MA report on

1 the same basis, including reporting measures based on  
2 medical record review, and the Congress should remove the  
3 statutory exceptions for PPOs and private fee-for-service  
4 plans with respect to such reporting."

5 The additional reporting that we are talking about  
6 can begin by 2011. This particular recommendation only  
7 affects the inter-plan comparisons of HEDIS results in  
8 Medicare Advantage, that is, the MA-to-MA comparison, as we  
9 are calling it.

10 The spending implications of draft recommendation  
11 3 are that CMS would incur costs in processing more data  
12 than would otherwise be reported. For beneficiaries and  
13 providers, this recommendation would improve beneficiaries'  
14 ability to compare plans and systems. Non-HMO plans would  
15 incur additional costs in reporting on measures requiring  
16 medical record review and for reporting on non-contracted  
17 providers.

18 One of the sources of information on the outcomes  
19 of care for Medicare beneficiaries enrolled in MA plans is  
20 the Health Outcomes Survey. Currently, this kind of survey  
21 is only conducted among MA enrollees. We have discussed  
22 issues regarding its use in MA and whether CMS is able to

1 report results in a way that shows more distinction among MA  
2 plans. In your mailing material, we discussed how the  
3 public reporting through the Medicare.gov website differs  
4 from other reporting of HOS results. The Medicare.gov  
5 website shows more distinctions among plans. In the mailing  
6 material, we also noted that CMS is examining the HOS  
7 methodology, and one of the factors the agency will look at  
8 is the degree of differentiation reported across plans.

9           At last month's meeting, part of the proposed  
10 draft recommendation called for CMS to undertake the  
11 equivalent of the HOS survey in the fee-for-service sector.  
12 The Commission discussed how the HOS information could be  
13 collected in fee-for-service Medicare and whether it would  
14 be reasonable to undertake a survey effort in fee-for-  
15 service if the results cannot show meaningful distinctions  
16 between the fee-for-service sector and MA.

17           Based on that discussion, we are suggesting that  
18 the Secretary examine the utility of a fee-for-service  
19 Health Outcomes Survey and undertake such a survey if it is  
20 found to be useful in making distinctions between MA and  
21 fee-for-service.

22           Draft recommendation 4, therefore, reads: "The

1 Secretary should collect and report the same survey-based  
2 data that are collected in MA through the Health Outcomes  
3 Survey for the Medicare fee-for-service population if the  
4 Secretary determines that such data can meaningfully  
5 differentiate quality among MA plans and between fee-for-  
6 service and Medicare Advantage. For this particular  
7 recommendation, results of the MA-to-FFS comparison would  
8 not be available before 2013.

9           The spending implications of this recommendation  
10 are that it could require substantial CMS administrative  
11 resources if the Health Outcomes Survey is expanded to  
12 accommodate reporting for smaller geographic units and if  
13 fee-for-service beneficiaries are also surveyed. For  
14 beneficiaries, it would improve their ability to compare  
15 plans and systems, but the number of beneficiaries being  
16 asked to participate in surveys will increase. Plans would  
17 face additional costs for expanded member surveys.

18           John will now discuss further steps that can be  
19 taken to improve the measurement of quality in MA and fee-  
20 for-service for inter-plan and inter-sector comparisons.

21           MR. RICHARDSON: Draft recommendation 5 concerns  
22 adding outcome measures to the array of quality indicators

1 that Medicare can use to compare quality between MA and fee-  
2 for-service and among MA plans. Outcome measures provide an  
3 integrated assessment of quality because they reflect the  
4 result of multiple care processes provided by all the health  
5 care providers involved in a patient's care. In contrast,  
6 process measures, such as HEDIS, often focus on a single  
7 dimension of care for one specific condition. Outcome  
8 measures focus attention on system-level performance because  
9 achieving the best patient outcomes often requires carefully  
10 designed care processes, effective teamwork, and coordinated  
11 action on the part of many care providers.

12 To this end, outcome measures may be key  
13 indicators of the value-added functions such as coordinating  
14 care for beneficiaries with chronic conditions that a health  
15 plan can perform to improve the quality of care for its  
16 enrollees.

17 In our study, we examined four types of outcome  
18 measures that can be calculated for fee-for-service Medicare  
19 using existing claims data and that could be calculated for  
20 MA plans using encounter data if those data are specified to  
21 include the necessary data fields. These outcome measures  
22 are: hospital admissions for ambulatory care-sensitive

1 conditions, which are an indicator of the quality of  
2 ambulatory care in a health plan or geographic area;  
3 hospital readmissions for conditions where clinical evidence  
4 suggests that appropriate discharge planning and post-  
5 discharge follow-up can prevent unplanned readmissions;  
6 potentially avoidable emergency department visits; and  
7 mortality within 30 days of a hospital stay for patients  
8 diagnosed with conditions such as a heart attack, heart  
9 failure, or pneumonia.

10 We anticipate that CMS will begin collecting  
11 encounter data from MA plans beginning in 2011. CMS has  
12 specifically stated that the encounter data to be collected  
13 would be used for quality monitoring and that the agency  
14 plans to specify the exact data submissions requirements for  
15 MA plans.

16 This leads us to draft recommendation 5, which  
17 reads: "The Secretary should expeditiously publish  
18 specifications for forthcoming MA plan encounter data  
19 submissions to obtain the data needed to calculate patient  
20 outcome measures. If CMS obtains encounter data with the  
21 requisite data fields for MA plan members in 2011 and 2012,  
22 it should be feasible to calculate the four types of outcome

1 measures we have described by 2013 and use the results to  
2 compare MA to fee-for-service and MA plans to one another on  
3 these dimensions of quality."

4           The implications of draft recommendation 5 are as  
5 follows: For CMS administrative spending, we anticipate  
6 that there could be some additional costs for the agency  
7 beyond what is already assumed in the agency's budget if the  
8 proposed encounter data specification and collection is  
9 significantly greater than what CMS is already planning to  
10 do. CMS would also incur costs from calculating and  
11 reporting the outcome measure results themselves, but we  
12 will get to that in a moment under draft recommendation 7.

13           For beneficiaries, information on important care  
14 outcomes would be available as indicators of the quality of  
15 care provided under their MA plan or by fee-for-service  
16 providers in the aggregate in a local geographic area.

17           Implications for providers and plans are that they  
18 would incur costs above whatever costs they have already  
19 assumed for the planned 2011 encounter data collection.  
20 That potential cost increase depends on how much more  
21 extensive the collection of inpatient claims data that are  
22 needed for the specified outcome measures is relative to

1 what plans are already assuming about the scope of CMS'  
2 collection effort.

3 Draft recommendation 6 concerns the feasibility of  
4 using a limited subset of HEDIS process-of-care measures  
5 along with the outcome measures we just discussed and CAHPS  
6 patient experience measures. The key technical issue we  
7 have discussed in previous meetings and mailing materials is  
8 whether it is possible to make valid comparisons between MA  
9 and fee-for-service using a limited set of HEDIS measures  
10 that relies solely on administrative data.

11 The administrative data available for fee-for-  
12 service Medicare -- that is, medical and pharmacy claims  
13 data -- is not as rich a source of information on patients'  
14 diagnoses and treatments as the broader variety of  
15 administrative data available from MA, which includes claims  
16 data, encounter data, and in some plans, EHR data. These  
17 qualitative data differences do not necessarily affect all  
18 of the potential administrative-only HEDIS measures, and in  
19 some cases, such as monitoring plan enrollees who are using  
20 certain kinds of medications, we've found that fee-for-  
21 service Medicare appeared to have better results, perhaps  
22 due to more complete reporting of pharmacy data through Part

1 D.

2 In the end, we conclude that there may be a subset  
3 of HEDIS measures that potentially could be used to compare  
4 MA and fee-for-service using administrative data only, but  
5 each measure should be carefully scrutinized to ensure that  
6 any resulting comparisons are valid and reflect actual  
7 differences in the quality of care, not differences in the  
8 quality of the data used to calculate the measures.

9 Therefore, draft recommendation 6 reads: "The  
10 Secretary should calculate fee-for-service results for HEDIS  
11 administrative-only measures for those measures that the  
12 Secretary determines can provide a valid comparison of the  
13 two sectors."

14 The implications of draft recommendation 6 are  
15 that CMS would incur administrative costs in computing and  
16 reporting the selected HEDIS measures for fee-for-service  
17 Medicare in each of the geographic areas specified by draft  
18 recommendation 2. Beneficiaries, as well as policymakers,  
19 would have a limited but still relevant set of HEDIS  
20 measures, adding another dimension of quality comparison to  
21 go along with the outcome measures discussed earlier and  
22 CAHPS patient experience measures.

1           This total package of measures should improve  
2 beneficiaries' and other stakeholders' ability to compare  
3 quality between MA and fee-for-service. As for providers  
4 and plans, there should be no additional costs to them since  
5 they already submit to CMS the data that would be used for  
6 these HEDIS measure computations.

7           Draft recommendation 7 addresses the issue we have  
8 discussed in prior meetings about whether the current set of  
9 available quality measures, specifically focusing on HEDIS  
10 and outcome measures, are sufficiently comprehensive. Among  
11 the HEDIS measures currently in use for MA plans, few  
12 measures other than those related to medication use apply to  
13 Medicare beneficiaries over age 75, those with geriatric  
14 medical conditions, or beneficiaries under age 65. Some  
15 existing measures of the quality of treatment for certain  
16 clinical conditions, such as mental illness, typically are  
17 captured for such small numbers of beneficiaries that they  
18 do not lend themselves to public reporting. There also is a  
19 need to develop measures for special categories of  
20 providers, such as those serving rural areas.

21           A few minutes ago, I presented four types of  
22 outcome measures that could be used to compare quality among

1 MA plans and between the two sectors, but each of them has  
2 limitations as well. Other types of outcome measures, such  
3 as changes in patients' functional status or the ability to  
4 perform activities of daily living, also may be appropriate  
5 for use in quality comparison, as long as they are valid,  
6 reliable, and feasible to implement.

7 Outcome measures are of particular interest to the  
8 Commission because they are important indicators of health  
9 care delivery system performance and indicators of the  
10 potential value-added effects of MA plan activities.

11 Therefore, the next draft recommendation, 7,  
12 reads: "The Secretary should develop and report on  
13 additional quality measures for MA plan and MA-to-fee-for-  
14 service comparisons that address gaps in current quality  
15 measures."

16 We anticipate that the Secretary would assess the  
17 technical feasibility and costs of using or adapting  
18 existing quality measures, including those used in fee-for-  
19 service Medicare, such as those used for Hospital Compare or  
20 the Physician Quality Reporting Initiative; the measures of  
21 the care for persons with disabilities used in State  
22 Medicaid programs; and measures developed by health services

1 researchers, such as the Assessing Care of the Vulnerable  
2 Elderly, or ACOVE, measures developed at RAND.

3           The implications of draft recommendation 7 are  
4 increased administrative costs to CMS for the research,  
5 development, and implementation of new quality measures;  
6 improved quality of information available to beneficiaries -  
7 - that is, more and more relevant measures of the quality of  
8 care received by a greater portion of the Medicare  
9 population; and increased provider and plan costs for  
10 collecting and reporting data needed to compute any new  
11 measures.

12           The final draft recommendation relates to the  
13 importance of making sure there would be sufficient funding  
14 for CMS to administer the other recommendations in the  
15 report. At our October meeting, several Commissioners  
16 agreed that CMS must be provided with and devote a  
17 sufficient amount of resources to executing the quality  
18 comparisons among MA plans and between MA and fee-for-  
19 service.

20           The result of trying to implement the  
21 recommendations we have just presented without additional  
22 administrative funding for CMS likely would be inaccurate

1 and unreliable quality comparisons, which would not only  
2 waste resources but be detrimental to the interests and  
3 needs of beneficiaries, plans and providers, and  
4 policymakers.

5           In light of these concerns, the Commission agreed  
6 with taking the unusual step of considering a draft  
7 recommendation to the Congress that would dedicate  
8 administrative funding to CMS specifically for the  
9 implementation of the other recommendations in this report.  
10 This draft recommendation, number 8, reads: "The Congress  
11 should provide the Secretary with sufficient resources to  
12 implement the Commission's recommendations in this report."

13           The rationale that I just went through underlying  
14 the recommendation is also on this slide, with the  
15 additional proviso that the Commission would expect the  
16 Secretary to submit a detailed budget proposal for the use  
17 of the funds that are dedicated to support implementation of  
18 the recommendations in the final report.

19           The implications of this recommendation are that  
20 any additional CMS administrative resources appropriated by  
21 the Congress would increase Federal discretionary spending  
22 unless the additional spending is offset by spending

1 reductions elsewhere in the budget. Beneficiaries,  
2 providers, and policymakers would have significantly  
3 improved ability to compare the quality of care among MA  
4 plans and between MA and fee-for-service.

5 That concludes our presentation of the draft  
6 recommendations. Thank you.

7 MR. HACKBARTH: Thanks, John and Carlos.

8 So this is the culmination of over a year's worth  
9 of work and discussions in the Commission. I think that  
10 John and Carlos have done a very good job of capturing the  
11 suggestions that we have made, answering the questions we  
12 have raised. And, of course, you have all seen these  
13 recommendations once already. We discussed them at the  
14 October meeting, and they're essentially the same, albeit  
15 reordered in the way that John and Carlos described.

16 So I think we are at the very end of this process,  
17 and rather than having our usual rounds of discussion, what  
18 I would suggest we do here is just go through recommendation  
19 by recommendation and give people an opportunity to make a  
20 statement or ask any clarifying question on each as we go  
21 through. And then once we have gone through the entire  
22 package, we will go through and vote on each other in turn.

1 Okay?

2 So why don't you put recommendation 1 up? In  
3 fact, maybe before I do that, why don't you put the table up  
4 that sort of presents the whole package, and let me just  
5 invite any questions about how we've reformatted the  
6 recommendations and the way we've structured it. People  
7 feel comfortable with that? Any clarifications needed?

8 [No response.]

9 MR. HACKBARTH: Okay. Put up recommendation 1.

10 DR. BORMAN: I am going to interpret this, and I  
11 think I heard you, John, use the word "interoperable." And  
12 I just can't stress how important that particular  
13 characteristic is. And I just wonder whether we say that  
14 enough here, whether we need to explicitly use the word  
15 "interoperable."

16 In reading this, I hope that is what it means. I  
17 am going to choose to assume that's what it means. But I  
18 see Dr. Dean shaking his head, and on the provider end of  
19 this, we are constantly confronted with a myriad of  
20 products, most of which will not speak to each other,  
21 whether it is in the offices, hospitals, or whatever. And I  
22 just really wonder, because the information technology is so

1 key to this process, whether or not the "interoperable" word  
2 should get added in here somewhere. Otherwise, it is very  
3 well stated.

4 MR. HACKBARTH: Maybe what I'd suggest, Karen, is  
5 that in the text explaining this we include that as a key  
6 concept. Keep in mind what we're doing here. We are making  
7 a recommendation pertaining to a particular aspect of the  
8 EHR implementation, the definition of "meaningful use,"  
9 which qualifies physicians and hospitals for the federal  
10 subsidies. And so there is a whole big operation to define  
11 what medical records will qualify for federal subsidies, and  
12 we are just sort of looking at a sliver of that.

13 So I think that it would be appropriate to have a  
14 contextual statement that sort of describes the overall  
15 effort, a key element of which is to move towards an  
16 interoperable system. Does that address your concern?

17 DR. BORMAN: [Off microphone.]

18 MR. HACKBARTH: Okay. Also on number 1, Tom.

19 DR. DEAN: Karen took the words right out of my  
20 mouth because that was the first thing I was going to say,  
21 too. It is a huge problem, and anything we can do to  
22 promote interoperability on a broader scale is important. I

1 realize that that is not the direct intention of this part  
2 of it, but anything we can do to emphasize the importance of  
3 that move, we need to do, often and loudly.

4 DR. MARK MILLER: John, you have been tracking  
5 this process. I assume that this has been a subject of  
6 conversation and there has been comment on this and --

7 MR. RICHARDSON: Yes, the HHS IT Policy Committee  
8 that has put forth some draft recommendations for CMS'  
9 consideration for the definition of "meaningful use"  
10 contemplates that for a part of what defines "meaningful  
11 use" is the ability of the systems to be interoperable. But  
12 for this specific purpose, I would say it's more implicit in  
13 the fact that since these measures -- the data that go into  
14 the calculation of the quality measures are going to have to  
15 be rolled up at some level that we have put before you for  
16 consideration a certain geographic level, there is going to  
17 have to be some standards and interoperability between the  
18 different EHR products that would qualify for the subsidies.

19 DR. DEAN: [Off microphone] So it's definitely a  
20 step in the right direction.

21 MR. RICHARDSON: Yes, and we can make that, as  
22 Glenn said, clearer in the contextual text around the

1 recommendation.

2 DR. MARK MILLER: The only other thing I would say  
3 is when we comment, you know, through comment letter on  
4 EHRs, we can make sure to reinforce this point each time we  
5 do that as well.

6 MR. BERTKO: My comment is probably, Glenn, to you  
7 and Mark and maybe following up on Mark's statement there is  
8 the timing of all this. I'm assuming this would typically  
9 come out as a recommendation in our March report, which  
10 might be after the close period on the comment letter. So  
11 do we envision as MedPAC releasing a statement or something  
12 that supports this recommendation within the appropriate  
13 time period?

14 MR. HACKBARTH: Well, my recollection, Mark, is  
15 that we've already provided a letter of comments consistent  
16 with this message. Now, what they publish in December will  
17 also be open to comments, will it not?

18 MR. RICHARDSON: That is correct.

19 MR. HACKBARTH: So that will be a second  
20 opportunity for us to comment. So I think rest assured that  
21 we've been sending this message and will send it multiple  
22 times before it gets to final publication.

1           Mark, anything you want to add on that?

2           DR. MARK MILLER: That's it.

3           DR. CROSSON: John and Carlos, I'd like to  
4 compliment you also. This, as you know from our multiple  
5 previous discussions, is a pretty complicated area, and what  
6 you have done here is to make it understandable -- probably  
7 not simple but understandable and clear.

8           I also like the chart that brings all the  
9 recommendations together, not just simply because we can see  
10 them all in one place, because it implies something that I  
11 think is important, and that is that all these  
12 recommendations work together. In other words, this is a  
13 coherent whole. It is not just eight separate  
14 recommendations. And I would point out that there are  
15 interrelationships among them.

16           For example, the one we are discussing now, number  
17 1, with respect to EHR use, at least in my mind is closely  
18 related to a number of them, particularly number 7, where we  
19 will talk later about the need for the Secretary to develop  
20 new measures.

21           When we looked some years ago in Kaiser Permanente  
22 at the ACOVE measures that you mentioned, when they first

1 came out, it looked to us -- we didn't do a thorough  
2 analysis, but it looked to us that about 50 percent of them  
3 could potentially be acquired over time for electronic  
4 medical records.

5 And so I think one of the fertile areas for the  
6 development of new measures will, in fact, be an analysis of  
7 what can be extracted or could be extracted over time for  
8 electronic medical records leading to the construction of  
9 much better quality measures.

10 MR. HACKBARTH: Any other questions or comments on  
11 recommendation 1?

12 [No response.]

13 MR. HACKBARTH: Okay. Let's move on to 2.  
14 Questions and comments on 2?

15 MS. BEHROOZI: Yes, thanks. Ditto on all the  
16 compliments on making this comprehensive and comprehensible.

17 In the paper, you had noted that an alternative  
18 approach to prescribing smaller geographic units for  
19 reporting would be to have CMS use the actual beneficiary-  
20 level data that the plans currently collect or that CMS  
21 currently collects through CAHPS. So I wonder if you could  
22 comment on why that didn't make it into the recommendation,

1 because I just -- you know, I mean, you're the data guys.  
2 You know how much more fun you can have when you have all  
3 the raw data available. Or would it not really provide any  
4 meaningful ability to sort of reorder the data in useful  
5 ways?

6 MR. ZARABOZO: The issue with CAHPS is, Is there a  
7 large enough sample size for the units that we are talking  
8 about? So that would be the change in CAHPS. I think the  
9 answer is no, right now there is not; based on talking to  
10 the people that know more about CAHPS, the researchers, you  
11 do need to add more people to the survey to have an  
12 appropriate result for the smaller geographic units.

13 The HEDIS measures, also you can -- the current  
14 HEDIS measures are reported on a person-level basis to CMS  
15 and, therefore, you can use that information to report in a  
16 different manner, you know, aggregate differently.

17 MS. BEHROOZI: Yes, I think my question really  
18 goes -- assuming that there is a broader and deeper basis of  
19 data, you know, a larger sample size, whether it needs to be  
20 sort of pre-aggregated in these reporting units before it  
21 gets to CMS. Or should you not necessarily be prescribing  
22 the reporting unit, just say give us more data but give it

1 to us raw? Since we are talking about CMS needing lots more  
2 resources to do all of this, anyway. Or does that not give  
3 you meaningfully more ability to analyze it?

4 MR. ZARABOZO: Well, I think on the CAHPS data, it  
5 is primarily a CMS function -- that is, the aggregation. So  
6 I think it is -- what your saying should happen is probably  
7 what's going to happen and probably is what happens now with  
8 the CAHPS data.

9 DR. CHERNEW: First, let me join the number of  
10 people complimenting you on the work you have done, and I  
11 think the report is very thoughtful and very good. I want  
12 to make one comment about the interpretation of some of the  
13 data that is related to this recommendation, but I am  
14 supportive of this recommendation, and that comment is that  
15 often when we think about things like comparing MA and fee-  
16 for-service plans, we treat them as if they are distinct  
17 entities where you have MA plans often someplace treating  
18 patients and fee-for-service plans somewhere else treating  
19 patients, when in reality the norm is that providers are  
20 serving both the patients in the fee-for-service system and  
21 patients in the MA system.

22 I think the most important implication of that for

1   policymakers and for people who are interpreting the data  
2   that comes out of this is that the observed differences  
3   between the MA plans and the fee-for-service plans are not  
4   the appropriate metric for measuring the value of the MA  
5   plans, because anything that the MA plan does to try to  
6   improve any of the measures that we're going to talk about  
7   later, existing ones that exist that we have talked about,  
8   anything the MA plans do to improve those measures for MA  
9   beneficiaries will almost surely spill over into improving  
10  the quality of care for the fee-for-service beneficiaries.

11           So if we, for example, got rid of all of the MA  
12  plans, we wouldn't expect the fee-for-service performance to  
13  be what it was when the MA plans were doing all the things  
14  that the MA plans may or may not have been doing.

15           And so I think while I support this recommendation  
16  and the recommendations that follow, I think in the report  
17  it is important to be clear about what we can or can't learn  
18  from a comparison of the MA and the fee-for-service plans.  
19  From the point of views of the beneficiaries, it might give  
20  you a good idea of what's going on, but, again, it's telling  
21  you about the plans in general, not necessarily your  
22  provider and things like that. I think that type of

1 language is important to help the interpretation underlying  
2 this recommendation.

3 MR. HACKBARTH: I think your point about spillover  
4 effects is a valid one. There may be spillovers the other  
5 direction as well. It is not all one way.

6 MS. HANSEN: Again, just the opportunity first to  
7 say thank you very much. Always reading it from more a  
8 vernacular standpoint, it still makes coherence and sense,  
9 even though it is complex.

10 I am just struck really by the recommendations. I  
11 really am supportive of all of this, and I appreciate kind  
12 of the added commentary about the impact to beneficiaries as  
13 a whole. But I'm struck by not only our chapter here, but  
14 some of the other chapters that relate to how beneficiaries  
15 will look at information and use information. And given the  
16 kind of general track record in other parts of the Medicare  
17 program as to how much people use this information to change  
18 plans and make decisions as such, it seems like -- and I  
19 would love for future work -- because it is cross-cutting as  
20 to how choice architecture or use of information, the  
21 Hospital Compare, all these things that are really geared  
22 for beneficiaries, and yet the net result is there is very

1 little, sometimes, change. And when we talk about  
2 prescription drugs later, even though things are more  
3 expensive or not necessarily best quality, people don't  
4 necessarily take the information and use it.

5 So I just don't -- so it's more of a question of  
6 how do we have things framed that become truly useful or are  
7 designed in a way that people can be guided toward probably  
8 their quality best decisions or their price best decisions.

9 So it is a broader issue that cross-cuts  
10 everything, but I just would appreciate that, but it struck  
11 me in reading the recommendations here as well as some of  
12 the other chapters.

13 Thank you.

14 MR. HACKBARTH: Okay. Other questions or comments  
15 about 2?

16 DR. MILSTEIN: This is really a comment related to  
17 the prior comment on, you know, can we really -- you know,  
18 when a physician who is serving both the fee-for-service and  
19 the Medicare Advantage population makes changes, doesn't it  
20 equally benefit the fee-for-service population? And it goes  
21 in both directions, as Glenn pointed out.

22 I think over the last five or six years, one of

1 the things we have seen in the MA industry is the use by  
2 health plans, but not Medicare fee-for-service, of these so-  
3 called gaps in care alert, where they basically say this  
4 patient is missing this and you need to order this if you  
5 want to bring them up to snuff with respect to quality  
6 standards. And I think for that reason the spillover effect  
7 is real, but it's by no means 100 percent. And I think that  
8 is one of the ways in which plans add value relative to fee-  
9 for-service. And so I think the fact that there is some  
10 spillover effect is still not -- it's not clear that that  
11 would nullify all the advantages that some of the plans that  
12 are more quality conscious have begun to apply.

13 DR. CHERNEW: I agree with what Arnie said, and,  
14 in fact, what I would think would generally be true,  
15 although I recognize spillovers go both ways, my general  
16 belief would be the Advantage MA plans would be bigger than  
17 the observed differences that you see, because you are going  
18 to see some differences because of what the MA plans do that  
19 directly touch their beneficiaries or touch the providers  
20 related to their beneficiaries. That is part of the  
21 difference. But you'll see another value of the MA plans  
22 that are spilling over.

1           So for whatever value might -- now, I understand  
2 they could go both ways, Glenn, so I admit that that is  
3 true. But I think if you were to ask me for my intuition as  
4 to what you're going to see, the general value of MA is  
5 going to be bigger, because every time the MA plan causes  
6 the provider groups to put in a program to prevent  
7 readmissions, to get people in for mammograms, that will  
8 often spill over one way or another to others. That's my  
9 sense.

10           MR. HACKBARTH: What we'll do, as Mike and I had  
11 discussed, is we'll include a passage in the text that  
12 addresses this issue. There are, I think, spillover effects  
13 both ways, and I would also agree with Arnie's point that  
14 some of the things that the plans do that add the most value  
15 may not be as inclined to spill over because they are  
16 building a unique infrastructure that doesn't apply on the  
17 fee-for-service side.

18           So it is a complicated issue. I think it is a  
19 valid point. We will include discussion in the text.

20           DR. STUART: I think it's also important to note  
21 that there is considerable difference in MA penetration  
22 across service areas in the country, and so in a sense, this

1 would provide the information as a test of this hypothesis,  
2 because in areas in which there is very low MA penetration,  
3 Mike's hypothesis would be the quality would be lower than  
4 in cases where it is higher. And this would be the first  
5 time that we would really have information to be able to  
6 make that conclusion.

7 MR. HACKBARTH: Other questions or comments on 2?

8 MR. BUTLER: So this is an interesting one to me  
9 because it's the first Congress asked for that is fairly  
10 technical, so I suspect we have a greater chance of having  
11 an impact of actually following through with some of these  
12 recommendations.

13 We also have had them out there for a month, so  
14 what I am curious about, this particular recommendation and  
15 others say there is a spending impact, for example, on  
16 plans, and we have opened up now to the public our website  
17 to say provide comments and issues, and so these  
18 recommendations that have been out there, it's almost like  
19 proposed regs effect if you will.

20 So I am just curious. Have we gotten anything --  
21 I know we got one letter, but it wasn't on the -- have we  
22 learned anything in the last month now that this has been

1 out here that would guide this at all? And one other  
2 comment and then I will let you answer.

3 This particular one says increased spending,  
4 although, John, I think you were the one that said last  
5 month reporting at this level, breaking it up, is not a real  
6 big deal for most plans. So when we say increased spending,  
7 we don't have a dollar, but I suspect this one isn't a real  
8 big deal.

9 MR. ZARABOZO: The biggest expense, what John was  
10 talking about, for example, as I mentioned, is with the  
11 HEDIS data. You can just reaggregate it in a different way.  
12 It is coming in on a person-level basis, so a plan that's  
13 reporting a statewide number, you can just report by county  
14 or whatever unit you want to report on. The problem is with  
15 medical record review, because let's say for the State of  
16 California, you are a plan and you cover the entire state,  
17 you use sample medical records, 411 medical records to  
18 report for that unit. If we say that California should be  
19 divided into eight markets, then you probably have to do 411  
20 medical record reviews for each of the eight markets. So  
21 that is the big expense from a plan point of view.

22 And in talking to the trade associations and to

1 plans, that cost can be large. We've got a range of from  
2 \$12 to \$70 per record for the review. So that would be the  
3 major cost associated with this kind of -- with this range.

4 MR. BUTLER: Well, my question, though, was, among  
5 others: Did anybody use our new tool to express, you know,  
6 their --

7 MR. ZARABOZO: Yes. Yes, we have received  
8 comments about the --

9 MR. BUTLER: Three? Five? Ten? I am just kind  
10 of curious.

11 MR. ZARABOZO: One comment, one commenter.

12 DR. BERENSON: I was going to ask this in the next  
13 one, but it's relevant to the conversation we just had,  
14 which is that in the discussion you've emphasized it would  
15 apply to all plans, and then say HMOs, PPOs, private fee-  
16 for-service. But are we also talking about SNPs, PSOs, HSAs  
17 that are out there, Legacy Cost Plans? I mean, does this  
18 apply to everybody? And the relevance to the recent  
19 discussion is that SNPs, for example, are a small-volume  
20 plan with the -- I mean, they don't have lots of people, but  
21 the idea is that they're going to have a great impact on  
22 them. Would there be any different kind of cost

1 implications for small plans or HSA-type plans that we  
2 haven't thought through?

3 MR. ZARABOZO: Well, actually, in the case of  
4 SNPs, there are two kinds of SNPs. Of course, there is a  
5 SNP that is part of a larger plan, but the SNPs are  
6 currently being asked to report additional data, so they  
7 already have an additional burden. And so an organization  
8 that has SNPs within the larger organization is reporting  
9 for the entire organization for the HEDIS measures, and then  
10 they also have to report for the SNP plans those numbers.

11 But, yes, this affects all plans, essentially, all  
12 kinds of plans, including cost plans, for example, that  
13 appear at the Medicare.gov website. So, you know, small  
14 plans would be affected.

15 DR. KANE: The SNP is reporting -- are they  
16 supposed to have a fee-for-service comparison? And if so,  
17 do we have some plan to pull a comparable fee-for-service  
18 beneficiary pool and segregate them out so that they can be  
19 compared appropriately to the SNP? Say it's a dual-eligible  
20 SNP or if it's got a specific purpose, is there going to be  
21 some fee-for-service comparable population that they get  
22 compared to? Because that would, I think, add quite a bit

1 of work to CMS, anyway.

2 MR. ZARABOZO: That is a good point. I think one  
3 way to answer that is with the person-level data, you can  
4 cut it a number of ways, and one of the ways to look at it  
5 is, for example, people with certain conditions, if it's a  
6 SNP serving people with these conditions, you can do that  
7 kind of comparison. You may not want to do it on a plan  
8 basis to the fee-for-service people in that area. You may  
9 want to do it on a certain more aggregate basis. But those  
10 kinds of comparisons can be done.

11 MR. HACKBARTH: I think that it may make sense to  
12 add a sentence or two to the text saying that SNP  
13 comparisons raise some special issues that need to be  
14 thought through and that we have not thought through.

15 Okay. Any other questions or comments on number  
16 2?

17 [No response.]

18 MR. HACKBARTH: Hearing none, let's move on to  
19 number 3. Questions or comments on number 3.

20 MS. BEHROOZI: On the same basis sounds fair; you  
21 know, it sounds like a level playing field. But I think  
22 when it comes to a PPO plan in particular, we might not be

1 getting accurate or full information if we have them report  
2 on all of their providers regardless of whether or not  
3 they're in network, because some of the tools that they have  
4 to improve care they might only really be able to exercise  
5 with respect to their in-network providers. So rather than  
6 saying they should be exempt in a special way, perhaps we  
7 could add a layer for them to also be able to report  
8 separately on their in-network providers so that, you know,  
9 beneficiaries really have an understanding, particularly if  
10 there is a difference for any given plan, whether you're in  
11 network or out of network, that, you know, perhaps they  
12 really could have a better quality experience if they stay  
13 within the network within that PPO.

14 MR. HACKBARTH: I think that that may make a lot  
15 of sense. We need the raw material, the information, the  
16 data, and then this is an important display issue that I  
17 think may add value to the Medicare beneficiary trying to  
18 make a decision; here is the in-network score versus --

19 DR. BERENSON: Can I just pick up on that, though?

20 MR. HACKBARTH: Yes, sure.

21 DR. BERENSON: I had thought of that myself, but  
22 there will be -- just like the outcome measures around

1 readmissions or admissions for ambulatory care sensitive  
2 conditions, the care might have been provided in and out of  
3 network, and that's where the breakdown is occurring.

4           So I don't think that -- I mean, I think it's  
5 another sort of we need to work through those issues and  
6 should say something, but that it's not just a lay-up that  
7 you can report your in-network experience. It just won't  
8 work that way.

9           DR. CHERNEW: I was just going to say what Bob  
10 said.

11           MR. HACKBARTH: Any other questions or comments  
12 about number 3?

13           [No response.]

14           MR. HACKBARTH: Okay. Let's move on to 4.

15           DR. MILSTEIN: This one was the only thing on the  
16 list that I kept coming back to, and let me articulate the  
17 basis of my concern.

18           My concern really relates to this idea that  
19 implicit in our recommendation is there is a need for an  
20 additional review as to whether or not, you know,  
21 comparisons with fee-for-service, you know, would be useful  
22 or meaningful. And I wonder if you could just elaborate on

1 that a little. I read the text in the chapter, but, you  
2 know, from my perspective, this comparison has already been  
3 done. It was done for the Medicare Plus Choice plan. It  
4 wasn't done, you know, relative to geography by geography.  
5 It was done relative to, you know, a fee-for-service  
6 characterization nationally.

7 But, in essence, through that comparison the  
8 feasibility of making the comparison I thought was  
9 reasonably well demonstrated. So, you know, there obviously  
10 is a cost in further delaying for reconsideration given the  
11 fact that such a comparison was shown to be feasible. We  
12 actually used it in our deliberations to, you know, draw  
13 some initial conclusions about how the different MA plans  
14 across the U.S., I guess Medicare Plus Choice plans in the  
15 U.S., as they existed before MA, how they were performing  
16 relative to a national fee-for-service standard. I  
17 personally found the results useful, revealing. I think  
18 many other Commissioners did.

19 So could you elaborate further on the need to  
20 incur another delay while the Secretary reappraises the  
21 meaningfulness of the comparison between fee-for-service and  
22 MA. It seems to me -- I wasn't sure that that delay was

1 justified, and if it was justified, I couldn't from reading  
2 the text, again, understand what the basis of the  
3 justification was.

4 MR. ZARABOZO: Well, I think it reflects the  
5 discussion at the Commission meeting last time where people  
6 were concerned that, given what is happening in MA, you  
7 don't see many distinctions among plans, in some years no  
8 outliers, as they call them. Would that be the case if you  
9 brought in fee-for-service also?

10 And on your question, one of the questions might  
11 be, well, can you do it at a small geographic level? Is it  
12 appropriate to do it in that way versus doing sort of a  
13 broader fee-for-service HOS kind of study and being able to  
14 do it at that level as opposed to going to the effort of  
15 saying for each geographic area we will, in fact, do a  
16 Health Outcomes Survey for the fee-for-service population,  
17 which may show that there are meaningful distinctions  
18 between MA here and fee-for-service in this area.

19 DR. MILSTEIN: I would ask that maybe we would  
20 want to reconsider this, because unless we think that  
21 conceptually, you know, there is some reason that a  
22 comparison that's more locally grounded would face some

1 major technical barrier, you know, I would say in some ways  
2 on the face of it, it would be a lot more meaningful because  
3 if I'm a Medicare beneficiary choosing between a plan or  
4 fee-for-service, it's the performance of the fee-for-service  
5 community in the location in which I would be, you know,  
6 making a selection other than Medicare Advantage that I  
7 think would be relevant. And so it seems to me that if  
8 validity is our concern, then this recommendation would only  
9 strengthen the likely value of the comparison.

10 MR. HACKBARTH: For my money, the issue that I  
11 thought was at stake here was the power of HOS as currently  
12 used to discriminate performance among plans. So it's the  
13 first issue that Carlos referred to that the vast majority  
14 of plans perform as expected and only small members better  
15 or worse. And so when I look at this recommendation, I  
16 think what we're doing is asking the Secretary to look at  
17 the tool and see if it can be adjusted so that it more  
18 effectively discriminates among plans in terms of their  
19 performance while retaining its validity as a tool for  
20 assessing value.

21 You know, we have got to balance those two things.  
22 We could say instead of using a 95-percent confidence

1 interval, we're going to use a much lower threshold, but  
2 then we need to consider whether, in fact, it is a true  
3 measure of performance.

4           And so rather than trying to answer that question,  
5 we're saying to the Secretary please explore that, and if  
6 you think it can be altered to be more discriminating and  
7 still valid, go with it.

8           DR. MARK MILLER: Yes, I would even go further. I  
9 felt like what we were trying to do -- and you guys should  
10 speak up, you know, if this is getting off track. I thought  
11 what we were trying to do is accommodate two of your  
12 concerns, one being that this tool wasn't, just as Glenn  
13 went through, distinguishing and could we drive the policy  
14 process to think about what those confidence levels were;  
15 and, two, to build it up on the fee-for-service side so that  
16 it could be done across fee-for-service and managed care.

17           So I thought we were actually addressing the  
18 issues you raised and drove through the Commission.

19           DR. MILSTEIN: I like what you just said, but I  
20 don't think that's --

21           DR. MARK MILLER: Am I missing something? That is  
22 what the reg is --

1 DR. MILSTEIN: An example, a way of putting the  
2 words that I think might better accomplish that objective  
3 would be rather than determines whether it can meaningfully  
4 differentiate but how the comparisons could be adjusted to  
5 better differentiate both plan to plan and plan to fee-for-  
6 service. That way it's not a question of, you know, should  
7 we go forward with this. It is we want to go forward with  
8 it, and we're directing the Secretary to focus on how the  
9 comparisons could be adjusted to create more  
10 differentiation, more distinctions. As worded now, it is  
11 framed as determining whether it is useful in  
12 differentiating.

13 MR. HACKBARTH: Let me ask Mike for his comment,  
14 but while I'm doing that, think of exactly what word change  
15 you would propose, Arnie.

16 DR. CHERNEW: My comment was going to relate to  
17 this, because I think Arnie's comment implicitly raises a  
18 bigger issue and assumption which I think is worth making  
19 explicit, which is in almost all of the recommendations,  
20 including this one, there is the cost portion that says this  
21 will require more resources, culminating in the last  
22 recommendation about the more resources to do that.

1           I believe and I think the Commission generally  
2 believes, although people could speak for themselves, that  
3 there is the presumption that the value of the information  
4 will vastly outweigh the costs of collecting it in ways that  
5 we might know, but even in ways that we don't know. And  
6 while I won't put words into Arnie's mouth, I think in  
7 October he said very explicitly that measurement is sort of  
8 the first step to this pathway of getting the whole system  
9 better, which I think, in general, at least I agree with  
10 that point.

11           What I had heard in October about this particular  
12 one is that specs of the measurement tool were such that we  
13 weren't sure of that assumption; we weren't sure that the  
14 tool, as currently devised, would pass that implicit cost-  
15 effectiveness threshold that we were assuming in all of the  
16 other cases. So our goal was before going out and imposing  
17 the costs of doing this, we were going to try and make sure  
18 that we would pass that cost-effectiveness threshold. And I  
19 think that for most of the other cases, we believe that  
20 we're sufficiently above that, although I haven't seen the  
21 numbers. This is a bit of faith. But I believe we're  
22 sufficiently above that not to worry. And this one I

1 thought we were, and I think it's useful to make sure that  
2 we don't seem like we're willing to spend anything to get  
3 any amount of information, that we are sensitive to the  
4 costs that are being imposed on the system. And I think  
5 this is good.

6 MR. HACKBARTH: And so you are making an argument,  
7 if I understand it, that is in support of conditional, "if  
8 the Secretary determines."

9 DR. CHERNEW: [Off microphone] Yes, I am.

10 DR. MILSTEIN: My comment here is that that point  
11 I completely agree with, but in no way is specific to this  
12 particular measure. If one begins to think about how one  
13 might conceivably define, for example, meaningful use of  
14 EHRs in order to know that they maximally populate all the  
15 quality performance measures we believe might be useful, you  
16 could get into equivalent questions about incremental cost-  
17 effectiveness of some of the -- I know Jay mentioned that  
18 using the system they're using at KP, you can get about half  
19 of the ACOVE measures. Well, if we want to -- do we want to  
20 go -- do we want all of the ACOVE measures? Implicitly,  
21 there is -- you know, Jay is, I think, making the point that  
22 it may not be cost-effective.

1           So this point that Michael is making I completely  
2 agree with, but from my perspective, it is not uniquely a  
3 hurdle that we ought to hold up explicitly for this  
4 particular measures.

5           MR. HACKBARTH: Well, what I would like to do is  
6 get to specific language, an alternative proposal and  
7 language. While Arnie is working on that, I think Jay may  
8 have some thoughts on how to do it. Let me invite any other  
9 questions or comments on recommendation 4.

10          DR. CROSSON: Well, yes, I just thought that we  
11 could maybe move a little bit in that direction by changing  
12 the wording to say, rather than "if," to say "unless the  
13 Secretary determines that such data cannot meaningfully  
14 differentiate quality among MA plans." And/or you could add  
15 to that, "meaningfully and efficiently differentiate."

16          DR. MILSTEIN: The first one I think is very good.  
17 If we're going to introduce the issue of cost-effectiveness,  
18 then we ought to apply it to the whole list.

19          MR. HACKBARTH: I'd like to avoid trying to do it  
20 item by item, and, you know, I'd be happy to add that as a  
21 broad consideration when we talk about cost. But let's not  
22 try to amend each one to include "efficiently." So read it

1 again.

2 DR. CROSSON: So then it would say, "The Secretary  
3 should collect and report the same survey-based data that  
4 are collected in MA through the Health Outcomes Survey for  
5 the Medicare fee-for-service population, unless the  
6 Secretary determines that such data cannot meaningfully  
7 differentiate quality among MA plans and between fee-for-  
8 service and MA."

9 DR. KANE: Just the word "meaningfully," I'm happy  
10 with the way Jay has rephrased this, but the word  
11 "meaningfully," I think the reason we didn't like the HOS  
12 originally was that it was statistically not helping us  
13 differentiate among plans. But there is another set of  
14 meaningful that I think Jenny brought up, which is do people  
15 act on that information if you present it to them. And I'm  
16 wondering if we shouldn't somewhere in the text somewhere  
17 describe what we mean by "meaningfully" to include not only  
18 a statistical significance at some meaningful cut-off point,  
19 but also whether there shouldn't be some exploration of  
20 whether it's meaningful to the users. If we are going to  
21 start getting into meaningful, I think we might need to have  
22 some kind of definition somewhere what "meaningful" -- what

1 the attributes of "meaningful" are, because the statistics  
2 may not be relevant.

3 MR. HACKBARTH: I'm not a statistician, but maybe  
4 a more statistical term would be "validly distinguish" or  
5 something like --

6 DR. KANE: [Off microphone] higher than that and  
7 bring in what Jennie was saying, which is do people really  
8 use this data.

9 MR. HACKBARTH: Again, we will try in the text to  
10 address more broadly the issue of meaningful comparisons. I  
11 think that spans a number of recommendations, so I'd like to  
12 try to not do it in individual recommendations.

13 So would you prefer to stick with "meaningfully"  
14 here or would you like an alternative word like "validly"?

15 DR. KANE: No, I'm happy with the word  
16 "meaningfully" there. I just meant we need to define  
17 "meaningfully somewhere in the text.

18 DR. MARK MILLER: For the text, statistically and  
19 the use of the beneficiary. We can get that wording for  
20 you.

21 MR. HACKBARTH: Okay. So when we come back to  
22 vote, we will once again read the Crosson amendment.

1           Let's move on now to recommendation 5. Questions  
2 or comments on 5?

3           [No response.]

4           MR. HACKBARTH: Seeing none, let's move on to 6.  
5 Questions or comments on 6?

6           [No response.]

7           MR. HACKBARTH: Okay. Let's do number 7.

8           MS. HANSEN: Well, I really appreciate this one  
9 just because we're really covering two populations, I think,  
10 in your parentheses of the description of -- actually more  
11 on page 22 when you indicated the kind of beneficiaries that  
12 oftentimes aren't as well covered traditionally with HEDIS  
13 measures, coupled with Jay's comments about the ACOVE  
14 measures. So one is that I really do support that.

15           My question is also about knowing that some of  
16 these measures right now are covered, say, in the special  
17 needs plans. But given the fact that MA plans and  
18 certainly, of course, fee-for-service, but other MA plans  
19 will have some of these populations who might age in place  
20 in their plans, I just wonder whether or not there was an  
21 intention that ultimately some of these measures be nested  
22 in all MA plans and collection for fee-for-service.

1           MR. RICHARDSON: In some of our earlier mailing  
2 materials, we had contemplated that very question, and we  
3 will bring that back into the text of the report, because a  
4 number of those measures seem logical to apply to any plan  
5 serving a Medicare population.

6           MS. HANSEN: Great. I appreciate that. Thank  
7 you.

8           DR. KANE: Just to follow up on our previous  
9 conversation, perhaps the word "meaningful" should be put in  
10 before "MA plan" so that we could refer that back to what we  
11 -- you know, in the text, the definition. So, "The  
12 Secretary should develop quality measures for meaningful  
13 plan to fee-for-service comparisons." Just to keep  
14 incorporating the standard that we would use.

15           MR. HACKBARTH: I suspect if we went back all the  
16 way to number 1, we could find additional places to insert  
17 "meaningfully." Again, what I would prefer to do is have,  
18 early in the discussion in the text, language about what we  
19 want as meaningful comparisons, even some language that's  
20 not as easy as it sounds to come up with meaningful  
21 comparisons for a beneficiary trying to make decisions. I  
22 prefer to handle it that way as opposed to try to go through

1 and insert "meaningfully" in all of the individual  
2 recommendations.

3 Other questions or comments?

4 DR. CASTELLANOS: Just a general comment, not  
5 specifically on that but on that.

6 First of all, I want to congratulate you. I  
7 thought it was great work that you've done, and it's been  
8 fun watching you over the year developing this, and I  
9 congratulate you. I think you did an excellent job.

10 I guess my point is, somewhat like Jennie's, that  
11 we need to make sure this information is somehow provided to  
12 the beneficiary in some meaningful way so the beneficiary  
13 has the benefit of this analysis. And it seems that we do  
14 such good work here, but it doesn't seem to filter down all  
15 the way sometimes.

16 The other point I would really like to make is  
17 that, first of all, I support these programs. There is a  
18 definite increased cost to the provider, to the medical  
19 profession, to the doctor, and this needs to be recognized.

20 Now, I understand and I think it's worth the cost  
21 of doing it, but I think we need to recognize that this puts  
22 a tremendous burden on a one- or two-man practice. They

1 have to gather this information either by hand if they don't  
2 have electronic records. That needs to be acknowledged,  
3 perhaps not in the text but hopefully all of us recognize  
4 that this is a burden to the provider, too.

5 MR. HACKBARTH: Other questions or comments on  
6 number 7?

7 [No response.]

8 MR. HACKBARTH: And let's move then to the final  
9 recommendation, number 8.

10 DR. BERENSON: Yes, first just a wordsmithing  
11 thing, and then a substantive concern.

12 In the second bullet, where you have the word  
13 "costly," in context it looks like it's the figurative use  
14 of the word "costly," not a literal word. And since this is  
15 all about resources and spending and funding, I think we can  
16 say the same thing with throw an adjective before  
17 "detrimental," like "extremely" or -- in other words, I  
18 would suggest taking the "costly" out unless you mean  
19 literally costly. That is a small point.

20 The more general point I have here is -- and it  
21 picks up a little bit what Jay was saying way back in number  
22 1, which is, are we viewing this as a coherent whole? I

1 mean, the language we have now, which is basically if you do  
2 this, dedicated resources are necessary, you need a  
3 sufficient budget. Do we even want to go further and say  
4 you really shouldn't proceed -- my concern is the budget  
5 will be whittled down, you get half of what you want and you  
6 go do half of this. Do we think that is acceptable? Do we  
7 want to say something about the importance of the coherence  
8 of this whole package?

9           My own view is that the most important thing we're  
10 doing here is number 5, which is introducing new quality  
11 outcome measures. But I don't know if we want to get into a  
12 process of deciding which have to hang together and which  
13 don't.

14           I guess I would like to see language -- but you've  
15 got more experience in how the Congress might receive it --  
16 about being even stronger on don't go forward if you're not  
17 prepared to support this adequately, or something like that.

18           MR. HACKBARTH: Let me just get a clarification.  
19 The four bullets would not be part of the formal bold-faced  
20 recommendation that we included in here because we thought  
21 that they were such essential elements of the text that goes  
22 along that we wanted to highlight --

1 MR. RICHARDSON: Exactly right

2 MR. HACKBARTH: All right. And so I think Bob's  
3 editorial suggestion is a good one. We'll just delete  
4 "costly and" and use "detrimental."

5 As to the broader suggestion, what I'd ask, Bob,  
6 is that you submit us some language for the text, and let me  
7 just check in with the other Commissioners. I share Bob's  
8 concern that it won't be half the money, it'll be less than  
9 half the money, and the expectation will be that all of it  
10 be done. And I do think that it's important to maintain  
11 some coherence here and that should be part of our textual  
12 message.

13 Now, whether we should take the additional step  
14 that you propose of saying, you know, this is the most  
15 important piece, I think that would be further than we have  
16 discussed --

17 DR. BERENSON: [Off microphone.]

18 MR. HACKBARTH: Yes, yes. Bruce, did you have a  
19 comment on this?

20 DR. STUART: I agree. I think that if we start  
21 getting in the business of prioritizing these, we are  
22 actually going to get to the point where somebody is going

1 to say, well, if it's only the eighth priority, then, you  
2 know, cut it off.

3 So I think I would argue that the cohesiveness of  
4 this is really what we're after.

5 DR. MARK MILLER: And just on that point, the  
6 Congress asked how should we do certain things, and this  
7 package is designed to address their request. So in some  
8 ways, I'm just trying to say that I think your comment is  
9 consistent with coming back to them and saying, "You asked  
10 us how to do this. This is how you do the thing you asked  
11 us to comment on."

12 MR. GEORGE MILLER: Yes, as a general comment kind  
13 of in support of what Ron was just mentioning, and I also  
14 want to add my congratulations for the work that has been  
15 done and very well done. But in the chapter, a comment was  
16 made, "No provider costs beyond baseline spending to acquire  
17 and use EHR systems that meets CMS meaningful use criteria."  
18 Like Ron, small and rural hospitals, I would say that the  
19 additional cost for support of EHR, so for staffing and for  
20 interpretation of data, it will be also costly, it is just  
21 not buying the EHR and plugging it in and pushing a button  
22 and letting it run. There are support staff and ongoing

1 maintenance that is beyond the initial cost. I just want to  
2 bring that point up as well for providers.

3 DR. DEAN: Just a quick comment. I would want to  
4 reinforce what Jennie and Ron have said about -- I think it  
5 would be useful to follow up on this, and I'm not sure how,  
6 but we are very much driven by data and consider factual  
7 information to be the defining determinant of how we make  
8 decisions. That doesn't happen in much of the general  
9 population, and I think we need to -- clearly, we need to do  
10 this, but I think it would be useful somehow to follow up  
11 and to see, you know, how is it received and how much impact  
12 does it have on the general public. Because my experience  
13 is that what a relative's experience is or some story in the  
14 newspaper or something tends to have a lot more influence  
15 than some of these nicely laid out charts or how many stars  
16 they get.

17 MR. HACKBARTH: Well, I think that's  
18 unquestionably true. I think what the Congress is trying --  
19 well, for those who are inclined to look for more objective  
20 sources of data -- actually, that's probably not a good  
21 characterization. Additional sources of information to  
22 complement what they can get from the relative or a

1 neighbor. Right now it's very difficult to get that sort of  
2 information. We are trying to fill a void for those  
3 beneficiaries who want it.

4 DR. DEAN: I'm not happy with that situation.

5 MR. HACKBARTH: Right

6 DR. DEAN: Because I think we need to definitely  
7 move in this direction so there is some objective data and  
8 try to familiarize and make our population comfortable with  
9 dealing with more objective criteria. But the reality is  
10 that that is a tough sell.

11 MR. HACKBARTH: Absolutely.

12 MS. HANSEN: Well, I appreciate the other  
13 Commissioners' support of this theme, and it seems to have  
14 some resonance. And one possibility is to go back to  
15 thinking about draft recommendation number 4 where it's  
16 looking at the Health Outcomes Survey. Since it's collected  
17 from the beneficiaries -- and I know it's the discipline of  
18 the rigor that we're trying to still get, but whether or not  
19 the meaningfulness to beneficiaries could be a part of that  
20 language up to the Secretary, in other words, having the --  
21 unless the Secretary determines that such data cannot  
22 meaningfully differentiate quality among MA plans and

1 between fee-for-service and MA, inclusive of beneficiaries.

2 MR. HACKBARTH: What I would like to do is have  
3 language in the text that discusses "meaningfully," and I  
4 think there are two distinct components to that. One is the  
5 statistical sense that you want valid comparisons, but the  
6 other sense, which you and other Commissioners are  
7 highlighting is that the ultimate goal of this effort is to  
8 provide information to beneficiaries that is useful, or at  
9 least one ultimate goal. As we've discussed in previous  
10 meetings, there are other potential uses of this information  
11 -- payment bonuses and the like. But one potential benefit  
12 could be to help guide beneficiary choice. Achieving that  
13 aspect of this is maybe the most difficult piece, and we  
14 need to recognize that in the text, and people will have an  
15 opportunity to review the chapter if they want.

16 DR. CHERNEW: I agree with that, and I just wanted  
17 to note there actually is an existing and somewhat growing  
18 literature on how individuals use information like there.  
19 There are empirical estimates. There are people that worry  
20 about how it affects plan behavior. I think there is a  
21 whole sequelae of benefits from the information. I wouldn't  
22 change any of the recommendations, although I do think that

1 it's useful to note in the report that whatever support can  
2 be given, to not just generate the information but to not  
3 only support its effective use by beneficiaries, but to  
4 support research to understand the factors that influence  
5 the performance. There's a whole bunch of reasons why we  
6 want to know how these plans are doing that extend beyond  
7 helping beneficiaries choose. And the more research we can  
8 support to understand it once the data exists, I think the  
9 better the system will be.

10 MR. HACKBARTH: Said like a researcher.

11 [Laughter.]

12 DR. CHERNEW: I held off. I held off for almost  
13 the entire discussion, and only waited until Jennie said the  
14 opening.

15 MR. HACKBARTH: Right. Okay. I am ready to vote.  
16 How about you folks? So let's put up Recommendation 1. All  
17 in favor of Recommendation 1, raise your hands, please? All  
18 in favor of Recommendation 1? I'm not sure I've got  
19 everybody's attention. We've got votes. All. Okay. Thank  
20 you. All opposed? Abstentions?

21 Okay. Number 2. All in favor of Recommendation  
22 2? Okay. Thank you. Opposed? Abstentions?

1           Okay. And, Jay, bump me when we get to the one  
2 where we have the amendment. It is 4, okay.

3           Recommendation 3, all in favor? Opposed?  
4 Abstentions?

5           Recommendation 4, and, Jay, will you read the  
6 amended language.

7           DR. CROSSON: So Recommendation 4 as amended would  
8 read: "The Secretary should collect and report the same  
9 survey-based data that are collected in MA through the  
10 Health Outcomes Survey for the Medicare fee-for-service  
11 population unless the Secretary determines that such data  
12 cannot meaningfully differentiate quality among MA plans and  
13 between fee-for-service and MA."

14           MR. HACKBARTH: Okay. You're jumping the gun.  
15 Okay. All in favor of Recommendation 4 as amended? Thank  
16 you. Opposed? Abstentions?

17           Recommendation 5. All in favor of Recommendation  
18 5? Opposed? Abstentions?

19           Recommendation 6. All in favor of Recommendation  
20 6, raise your hands. Opposed? Abstentions?

21           And Recommendation 7. All in favor of number 7?  
22 Opposed? Abstentions?

1           And, finally, Recommendation 8. All in favor of  
2 number 8? Thank you. Opposed? Abstentions?

3           Okay. Well done. John and Carlos, thanks for  
4 your work on this project.

5           The next item on our agenda is a status report on  
6 Part D.

7           Rachel, will you be leading or Shinobu?

8           MS. SUZUKI: Good morning. Part D is about to  
9 start its fifth year with nearly 27 million enrollees and  
10 over 50 billion in spending accounting for a big chunk of  
11 Medicare spending.

12           In this presentation, we're going to walk you  
13 through what we've learned from looking at Part D enrollment  
14 data, what plan sponsors are offering for 2010, and what the  
15 cost implications are for enrollees and Medicare program.  
16 Remember, the open enrollment season for Part D runs from  
17 November 15th through December 31st, so now's the time of  
18 the year when beneficiaries have the opportunity to switch  
19 plans if they choose to do so.

20           According to CMS, in 2009 about 90 percent of  
21 Medicare beneficiaries had Part D or another source of drug  
22 coverage that's at least as generous as Part D. At the

1 start of the year, nearly 27 million or 59 percent of all  
2 Medicare beneficiaries were enrolled in Part D. Of the  
3 59 percent, 39 percent were in stand-alone prescription drug  
4 plans that provide drug only benefit -- that's the green  
5 piece -- and the remaining 20 percent were in Medicare  
6 Advantage Drug Plan, where enrollees get both medical and  
7 drug benefits through a single private plan.

8           Focusing just on PDP enrollees, there are about 17  
9 and a half million beneficiaries enrolled in PDP, and 46  
10 percent, or nearly half, received Part D's low-income  
11 subsidy, which provides extra help with premiums and cost  
12 sharing to people with low income and low assets. That's  
13 the dark green piece. This is an important point to note  
14 because LIS enrollees tend to be sicker and tend to use more  
15 drugs.

16           In contrast, a little over 9 million beneficiaries  
17 are enrolled in MA-PD plans, and 19 percent of those in  
18 MA-PD plans receive low income subsidy; that's the dark blue  
19 piece. So about 1 in 5 MA-PD enrollees receive LIS, which  
20 is a much smaller share compared to PDP enrollees.

21           Data from 2007 show that demographic  
22 characteristics of Part D enrollees differ from overall

1 Medicare population. For example, Part D enrollees are more  
2 likely to be female and more likely to be minority compared  
3 to overall Medicare population. And there are also  
4 differences between PDP and MA-PD enrollees and between  
5 those who receive the low income subsidy and those who  
6 don't. Compared to PDP enrollees, those in MA-PDs were more  
7 likely to be Hispanic and less likely to be disabled  
8 beneficiaries under 65. This might be a reflection of the  
9 areas in which MA-PD plans are located. LIS enrollees are  
10 more likely to be female and are more likely to be  
11 minorities and disabled beneficiaries under 65.

12 Part D enrollment also varied across the country.  
13 In 2007, Part D enrollment ranged from 40 percent in Alaska  
14 to 68 percent in California. And remember, when MMA created  
15 the Part D program, it also set up a subsidy program for  
16 employers who continue to provide drug coverage to their  
17 retirees. So in the regions with high take-up rates of  
18 retiree drug subsidy, Part D enrollment tended to be lower,  
19 for example, in Michigan and Ohio.

20 MA-PD share Part D enrollment also varied across  
21 regions, ranging from 2 percent in Alaska to 56 percent in  
22 Arizona. This pattern was generally consistent with the

1 Medicare Advantage enrollment.

2           Finally, we looked up the share of Part D  
3 enrollees receiving low income subsidy, and also found that  
4 it varies from region to region, ranging from 28 percent in  
5 upper Midwest to 64 percent in Alaska. And participation in  
6 Part D's low income subsidy program, of course, can be  
7 affected by region-specific factors, such as poverty rates  
8 and health status.

9           So we've been following beneficiaries' choice of  
10 plans since the start of the program. There hasn't been a  
11 dramatic shift from year to year, but there are some notable  
12 trends. We have two charts here. The one on the left is  
13 for PDPs and the one on the right is for MA-PDs. Green and  
14 orange represent those paying deductibles. You can see that  
15 a much larger share of PDP enrollees pay a deductible  
16 compared to MA-PD enrollees.

17           In 2009, about half of PDP enrollees paid no  
18 deductible -- that's the light blue piece -- compared to  
19 over 90 percent of MA-PD enrollees paying no deductible.  
20 Many sponsors of MA-PD plans use some of the financing from  
21 the Part C payment system called Medicare Advantage Rebate  
22 Dollars to lower Part D premiums or to enhance the drug

1 benefits, and eliminating the deductible is a very common  
2 strategy used by MA-PD sponsors to enhance the drug benefit.

3 Another common way MA-PD enhance the drug benefit  
4 is by coverage on drugs during the coverage gap. Here,  
5 green represents those in plans with no gap coverage, while  
6 orange and blue represent those with gap coverage. Looking  
7 left to right, you can see that a much larger share of MA-PD  
8 enrollees are in plans but cover some drugs in the gap.

9 In 2009, only 7 percent of PDP enrollees were in  
10 plans that provided some benefit during the gap, while over  
11 60 percent of MA-PD enrollees were in plans that covered  
12 some drugs during the gap. But as you saw in the earlier  
13 slide, nearly half of PDP enrollees get extra help with  
14 premiums and cost sharing through low income subsidy, and  
15 this low income subsidy essentially fills in the coverage  
16 gap. So even though most LIS enrollees are auto assigned to  
17 basic stand-alone PDP with a gap in coverage, they have a  
18 more complete benefit because of this subsidy.

19 So the open enrollment season is about to start in  
20 just over a week, and here are some of the main changes in  
21 plan offerings for 2010. Unlike in the previous few slides,  
22 now, I'm talking about percentages of plans and not

1 percentages of people.

2           You can compare the PDP and MA-PD offerings down  
3 the two columns. There would be fewer plans available in  
4 2010, a 7 percent drop for PDPs and a 10 percent drop for  
5 MA-PDs. And some of the reductions were due to  
6 consolidations among plan sponsors as well as CMS' effort to  
7 reduce low enrollment in duplicative plans. But  
8 beneficiaries will still have access to many plans. In any  
9 given region, beneficiaries will have access to between 39  
10 and 53 PDPs and many MA-PD plans.

11           A big change I wanted to call your attention to is  
12 the drop in the number of PDPs with zero deductible. In  
13 2010, only 40 percent of PDPs have a zero deductible  
14 compared to 55 percent last year. A larger share of MA-PDs  
15 will continue to offer plans that have no deductible.

16           Finally, a smaller share of PDPs will be offering  
17 coverage in the gap; 20 percent in 2010 compared to 25  
18 percent last year. And slightly over half of MA-PDs will  
19 offer plans with some coverage in the gap, which is about  
20 the same as last year. And over 40 percent of those MA-PDs  
21 offering gap coverage will cover both brands and generic  
22 drugs.

1 DR. SCHMIDT: Part D premiums are up again, but  
2 the premium increases are smaller for 2010 than they were  
3 for 2009. On the far left, the average enrollee in a PDP  
4 paid about \$35 per month in 2009. If they remain in the  
5 same plan for 2010, enrollees can expect to pay \$39 or over  
6 \$4 more.

7 MA-PD enrollees pay a combined premium that covers  
8 both Part D benefits and their regular Part A and  
9 Part B -- and other medical benefits. If we just look at  
10 the portion of that combined premium for their drug  
11 coverage, the average MA-PD enrollee will pay about 14.50  
12 per month in 2010, and that's just slightly under what  
13 they've been paying in 2009.

14 You can see that the MA-PD premiums are a lot  
15 lower than the PDP premiums. On average, MA plans have  
16 lower bids for providing basic benefits, and some of them  
17 are doing a very good job of managing benefits. However,  
18 the difference you see also reflects the fact that MA-PDs  
19 can use rebate dollars from the MA payment system to lower  
20 their premiums.

21 Overall, the average enrollee pays about \$29 per  
22 month for Part D in 2009. And if they stay in the same plan

1 next year, their premium will increase by about \$3 or about  
2 10 percent.

3 Now, we know for certain that some beneficiaries  
4 will switch plans, particularly some low income subsidy  
5 enrollees will be reassigned to different plans. Last year,  
6 reassignments and voluntary switching led to an average  
7 premium that was about \$2 lower than if beneficiaries had  
8 stayed in the same plan, and this mostly affected the PDP  
9 average.

10 Part D's payment system relies on competitive  
11 bidding, and it's the risk to plan sponsors that enrollees  
12 might switch plans that you give them incentive to bid low.  
13 But over the past several years, we've only seen about  
14 6 percent of enrollees switching voluntarily from one plan  
15 to another.

16 Right now, it looks as though most PDP enrollees  
17 will see their premiums go up again for 2010. But once  
18 again, there's this open question of whether the premium  
19 increases for 2010 have reached the point that they will  
20 motivate more enrollees to switch plans.

21 The year-to-year changes in Part D premiums also  
22 affect enrollees who receive the low income subsidy. That's

1 because Medicare sets a maximum amount in each region on  
2 what it will pay for the premium for low income subsidy  
3 enrollees. So each year, there is some turnover in the  
4 plans that have zero premiums to LIS enrollees. If an LIS  
5 enrollee is in a plan with a premium higher than this  
6 threshold, and they haven't picked a plan themselves, then  
7 CMS reassigns them to a lower premium plan.

8           For 2009 and 2010, CMS changed the method for  
9 setting these thresholds in a way that they hoped would  
10 reduce the numbers of beneficiaries to be reassigned. After  
11 receiving bids for 2010, CMS estimated that even with this  
12 new method, there would be about 2 million reassignments.  
13 So they've decided to use general demonstration authority to  
14 set thresholds in a different way, omitting the Part C  
15 rebate dollars from MA-PD premiums before setting the  
16 thresholds. This change especially affects parts of the  
17 country where a larger share of LIS enrollees are in MA-PDs.  
18 The Office of the Actuary estimates that this demonstration  
19 will cost about \$110 million in 2010.

20           With this demonstration in place, nearly the same  
21 number of PDPs have premiums below the thresholds of last  
22 year, 307 compared to 308. CMS expects to reassign just

1 over a million beneficiaries. That's moving beneficiaries  
2 into a plan offered by a different sponsor with a different  
3 formulary. Another 100,000 enrollees would be reassigned to  
4 a plan offered by the same sponsor, and that usually means  
5 the same formulary.

6 CMS does not reassign beneficiaries who have ever  
7 picked a plan on their own, which now number about 2 and a  
8 half million people or about a quarter of all LIS enrollees.  
9 We're not yet sure how many of these beneficiaries are  
10 paying a premium, but it's likely that many, or perhaps  
11 most, are, and the most common amounts are in the 8 to \$10 a  
12 month range.

13 I mentioned that Part D's payment system uses  
14 competitive bidding, and in this chart, let's take a look at  
15 the year-to-year changes in average bids from plan sponsors  
16 for providing basic benefits. I want to call your attention  
17 to the red circle, the overall increase of 5 percent for  
18 2010 bids. That's better than last year's situation when  
19 the average bid increased by 11 percent. And 5 percent is  
20 roughly what drug trends are looking like for other private  
21 sector payers.

22 Another difference from last year is that, this

1 year, each of the components of the bid, individual  
2 reinsurance, the base beneficiary premium, and Medicare's  
3 directly subsidy or its monthly payments to plan, grew at  
4 close to the same rate.

5           Last year, I came to you and told you about a big  
6 jump in the reinsurance component of the bids or what plans  
7 we're expecting in the way of catastrophic spending by their  
8 higher cost enrollees. Remember that drugs to treat certain  
9 conditions, like for rheumatoid arthritis and multiple  
10 sclerosis, can be very high cost, and patients who use those  
11 therapies tend to move quickly through the coverage gap and  
12 into the catastrophic phase of the benefit, where Medicare  
13 pays for most of the cost through individual reinsurance.

14           This year, the increase in the average bid for  
15 that reinsurance piece was closer to the increases for the  
16 other parts of the bid. Although that's good news, we still  
17 need to keep our eye on that component of Part D spending  
18 because it's precisely those kinds of high cost drugs where  
19 plans are less able to negotiate with manufacturers for  
20 rebates on price.

21           Now, let's jump from how much it cost to provide  
22 basic benefits per enrollee to the bigger picture,

1 Medicare's aggregate spending for Part D.

2           Incurred benefits have grown from about  
3 \$43 billion in 2006 to 49 billion in 2008, and CMS expects  
4 spending to reach about 53 billion for 2009. That's an  
5 overall average growth rate -- annual average growth rate of  
6 about 8 percent.

7           There are a couple of things about this slide I'd  
8 like to call to your attention. First, the low income  
9 subsidy piece, the extra help with premiums and cost  
10 sharing, has grown to become the single largest piece of  
11 Part D spending. It's now bigger than the direct subsidy or  
12 Medicare's monthly payments to plans to subsidize the cost  
13 of basic benefits for all enrollees.

14           Second, reinsurance has been the fastest growing  
15 component of Part D spending, with an average annual growth  
16 rate of about 22 percent. Reinsurance covers most of the  
17 catastrophic costs for beneficiaries who have very high drug  
18 spending. And this second point reinforces what I just  
19 talked about on the previous slide, our concern about how to  
20 control spending for very high cost drugs and biologics.

21           MR. YANG: Every year, CMS collects data from a  
22 variety of sources to measure the performance of its Part D

1 plans. In this section, I'll describe those performance  
2 measures that it makes public on its plan finder tool on the  
3 medicare.gov website to enhance beneficiaries choice.

4           There are currently 19 measures available, divided  
5 into four categories: customer service, member complaints,  
6 member experience, and the last group combining drug pricing  
7 and patient safety. CMS rates sponsor performance for each  
8 of these 19 measures and then assigns star ratings for each  
9 of the four categories. Finally, it assigns a summary score  
10 to measure overall performance.

11           In February 2008, the Commission convened an  
12 expert panel on Part D performance that highlighted the  
13 importance of the development of measures that accurately  
14 measure cost, access, quality and customer service.

15           In comparison to these expectations, we find that  
16 the current set of metrics still focus largely on customer  
17 service and enrollee satisfaction, and still does not offer  
18 a direct measure of timely access to need and medication.

19           As for measures of clinical quality, in 2009,  
20 there was one measure available on the plan finder; that is,  
21 the percentage of elderly beneficiaries who are prescribed  
22 medication with the high risk of side effects when there may

1 be safer alternatives available.

2 For the 2010 benefit year, CMS has expanded the  
3 section to include one more measure; that is, the percentage  
4 of drug plan members with diabetes who also have high blood  
5 pressure were given a type of blood pressure that is  
6 suitable for people with diabetes. In addition, it also  
7 plans to put out two measures, one on drug-drug interaction  
8 and diabetes medication dosing on its website.

9 Next, we took a look at the distribution of  
10 summary score for Part D beneficiaries enrolled in  
11 stand-alone PDP plans. In this graph, the blue bar shows  
12 the percentage of non-LIS enrollees' need summary score, and  
13 the yellow bar shows the percentage of LIS enrollees.

14 If we take a look at the contrast between the blue  
15 and yellow bars in the lower score categories, that is 3 and  
16 below, we see that a higher percentage of LIS enrollees are  
17 with sponsors with lower summary scores. Half of LIS  
18 enrollees enroll with sponsors with ratings 3 and under as  
19 opposed to a third of the non-LIS population.

20 We're not sure what to make of this; that LIS  
21 enrollees are in lower rated plans does not necessarily mean  
22 that they receive a lower quality of clinical care. Because

1 the 2009 metrics focus largely on customer service and  
2 enrollee satisfaction, this difference may mean that they're  
3 in a lower premium plan that may dedicate less resources to  
4 customer call centers and other elements of customer  
5 service. We'll leave that up for discussion.

6 DR. SCHMIDT: So we'll leave you with a few issues  
7 to discuss. First, we pointed out that the low income  
8 subsidy is now the biggest component of Part D, and  
9 Medicare's payments for reinsurance are the fastest growing  
10 component.

11 Second, there's the role that plan switching plays  
12 in Part D. The prospect of enrollees changing plans and  
13 premiums that grow too high is supposed to give sponsors  
14 incentive to bid low. And likewise, the prospect of getting  
15 or keeping LIS enrollees is supposed to give sponsors  
16 incentive to bid low enough to keep their premium under the  
17 regional premium thresholds.

18 But we seem to have some ambiguous feelings about  
19 plan switching. Some analysts would like to see less of it  
20 because there are transition issues that come up for  
21 beneficiaries and providers when they change plans, but  
22 others might want to see more switching to make the

1 incentives to bid low more credible to plan sponsors.

2           Finally, there's the continued need for better  
3 quality measures in Part D. CMS has introduced some new  
4 measures on the plan finder for 2010 and has plans for other  
5 measures for the future. But there's still considerable  
6 room for new measures that reflect timely access to  
7 medications and clinical quality.

8           We'll take your questions now.

9           MR. HACKBARTH: Thank you. Nice job, some  
10 provocative questions I think.

11           We will use our usual procedure of multiple  
12 rounds, the first round being strictly clarifying questions.

13           DR. STUART: Thank you very much. This is one of  
14 those reports that could easily have been four times the  
15 size. And I think you've done a really good job in taking a  
16 lot of information and putting it together in a very usable  
17 fashion. So I want to thank you for that.

18           I have a question and then a comment. The  
19 question relates to slide number 2 or the comment relates to  
20 slide number 2. And I'll simply note that that orange bar  
21 on the top that says "No creditable coverage, 10 percent,"  
22 now that has been stubbornly 10 percent since 2006. And so

1 my question is, what's happened between 2006 and 2009, or  
2 projections for 2010, in terms of who's in that group?

3 One of the disadvantages of having a report that's  
4 a snapshot of each year is that it doesn't focus on changes  
5 within the population. And there are actually three groups  
6 that I'm interested in to think about. This will go in to  
7 part two, but I think it's important to put them on the  
8 record.

9 The first is LIS and the extent to what proportion  
10 of those people would be punitively eligible for LIs based  
11 on income and assets but simply don't enroll.

12 The second part that I'd wonder about would be  
13 individuals who are covered under RDS, the Retiree Drug  
14 Subsidy, and that spending seems to be flat over time, which  
15 might imply that, in fact, there are actually fewer people  
16 that are in that. So there's a question of whether there  
17 might be people who are actually not getting employer  
18 coverage.

19 Then the third part that I'm really interested in,  
20 because I've never seen it come up anywhere, which is the  
21 number of people that have enrolled in Part D in one year  
22 and then disenroll later on. So three dynamic population

1 questions.

2 MR. HACKBARTH: I think the rule book says  
3 somewhere that round one questions can never have three  
4 parts.

5 DR. SCHMIDT: Did you want me to give it a try?

6 MR. HACKBARTH: Yes. We'll give Bruce a waiver,  
7 this time.

8 DR. SCHMIDT: I think the short answer is we don't  
9 have a very good sense, frankly, of who all is in that  
10 10 percent. I think CMS comes up with these numbers each  
11 year after kind of looking at new versions of SIPP and CPS  
12 and other data sources that might be available to try and  
13 get a handle on what types of drug coverage people have.

14 In terms of how many of these people might be LIS,  
15 I think that CMS has been making some effort to try and  
16 reach out to the LIS population, providing more  
17 region-specific information about who is likely to be in  
18 this no coverage category or in a category of may be in the  
19 Part D plan now, but not aware that they're eligible for  
20 LIS. So that they have been making more detailed  
21 information available to SHIPs and other organizations to  
22 try and reach out to that population. But you're absolutely

1 correct. It's been a very stubborn 10 percent.

2 On the RDS, I think the numbers have declined  
3 slightly for that, so it's possible that some of those  
4 people are falling into that category, but I also think  
5 there may be some movement from employers into MA-PDs.

6 MR. HACKBARTH: Okay. Other round one clarifying  
7 questions?

8 MR. GEORGE MILLER: The way you looked at me, I  
9 can't ask a three-part question. I'll just make it one  
10 part.

11 I'm curious about our conversation yesterday about  
12 the dual eligibles, and if there's a link, and which block  
13 on this same slide would dual eligibles fall in.

14 Are they in any one of these three areas or do you  
15 have a correlation?

16 MS. SUZUKI: Sure. So, actually, this will be a  
17 better picture to look at. So on the right hand, we have  
18 the PDP population broken into LIS and non-LIS. And the  
19 majority of the LIS are dual eligibles, because a little  
20 over 6 million of the 9.3 roughly million LIS enrollees are  
21 duals.

22 So part of that dark green or the majority of that

1 dark green are duals, and then if you look at the MA-PDs,  
2 there are, again, a little over a million, I think, dual  
3 MA-PDs. And a big chunk of them we think could be duals,  
4 although we haven't analyzed them.

5 MR. GEORGE MILLER: Well, to follow up on Bruce's  
6 question, do any of them fall in that 10 percent category of  
7 no coverage or do you know?

8 DR. SCHMIDT: Well, the duals were automatically  
9 assigned into Part D in 2006.

10 MR. GEORGE MILLER: Okay.

11 DR. SCHMIDT: So it's highly unlikely.

12 MR. GEORGE MILLER: Okay.

13 MR. HACKBARTH: Nancy?

14 DR. KANE: On slide 15 -- I have two questions,  
15 but they're not one question two ways.

16 So are there no plans with a 5.0 or are there no  
17 beneficiaries -- I mean, I'm trying to understand.

18 What's the distribution of plans by rating?  
19 Because you've got the beneficiaries, but -- are there no  
20 plans with a 5.0?

21 DR. SCHMIDT: I think that there were extremely  
22 few.

1 DR. KANE: But there are no enrollees --

2 DR. SCHMIDT: Jae is trying to pull up the  
3 numbers.

4 There are absolutely no plans below 2.5; we know  
5 that for certain.

6 Jae, do you remember there are -- just a handful  
7 it looks like.

8 MR. YANG: Yeah, there are nine plans that were  
9 under the five star rating.

10 DR. KANE: And no enrollees?

11 MR. YANG: Well, this is looking at -- this is  
12 looking at PDP plans.

13 DR. SCHMIDT: So this is everybody.

14 MR. YANG: Yeah, this is everybody.

15 DR. SCHMIDT: I'm sorry. We don't have the  
16 numbers of PDPs that had five stars. We know that overall,  
17 across MA-PDs and PDPs, there were a handful that had five.  
18 But this particular slide is just related to PDP, and we  
19 don't have the answer as to whether or not there were any  
20 with a five star rating right now.

21 DR. KANE: Well, let's just say there were no  
22 enrollees --

1 DR. SCHMIDT: There are no enrollees, yes.

2 DR. KANE: -- in a five star PDP.

3 MR. HACKBARTH: So the implication would be that  
4 all the five stars are MA-PDs.

5 DR. KANE: Okay. So now I understand that.

6 Then the other question I had is on slide 9, which  
7 is the plans offered for 2010. And you talk about there  
8 being 10 percent fewer plans, and private payers, we're  
9 talking about one-third.

10 I'm just trying to -- is that -- the causes  
11 for the drop, is that related at all to what's  
12 going on with the MA payment? I mean, what's going on with  
13 the drop, and how many people are affected by the fact that  
14 we're actually losing MA-PD plans? What do they do instead?

15 MS. SUZUKI: So I don't know exactly why the  
16 numbers are dropping, but a couple of things. There are  
17 consolidations among the plan sponsors. CMS has been trying  
18 to reduce the number of plans because they were very low  
19 enrollment plans and they were also duplicative plans. So  
20 if you wanted to offer multiple plans, you had to make sure  
21 that they're different, meaningfully different.

22 MR. BERTKO: Can I add, Nancy, there is also a new

1 network requirement starting, I believe, in 2011, which  
2 means that certain kinds of sponsors, I think -- and I'm  
3 inferring this from public reports -- have determined  
4 they're not going to be in that business anymore. And so  
5 the -- I won't say the consolidation, but their exit from a  
6 market that they can't serve seems to be beginning.

7 DR. KANE: And you're referring to the private  
8 fee-for-service plans, which is the second bullet on the  
9 right-hand side.

10 DR. SCHMIDT: By one-third.

11 DR. MARK MILLER: Which are in markets where  
12 there are other plans available for people to go to.

13 DR. KANE: Do we know how many enrollees are  
14 affected when we lose plans?

15 DR. SCHMIDT: I think a CMS official put out a  
16 number recently. It was on the order of 600,000,  
17 thereabouts; 6 to 700,000 beneficiaries in predominantly  
18 private fee-for-service plans will need to move to another  
19 plan or reenter original Medicare and pick a PDP.

20 DR. KANE: I guess what I'm trying to get is, is  
21 this just a one time thing or is this a -- how unstable is  
22 the MA-PD option, I guess, is what I really want to -- maybe

1 I should get at.

2 MR. HACKBARTH: That will depend on the health  
3 reform legislation and the specific provisions included on  
4 payment for MA. And then even once that's settled,  
5 presumably, it will take some period of time for plans to  
6 make judgments and for it to have its ultimate impact. So  
7 we'd be several years, I would think, away from the stable  
8 situation that you described.

9 Peter?

10 MR. BUTLER: My question, I want to confirm  
11 something in writing, in your written material, not in this.  
12 And that is we said yesterday we don't typically do focus  
13 groups with beneficiaries or patients directly, but this is  
14 an example where you did. You did 12 focus groups with  
15 eight in a focus group, three on LIS, three on non-LIS.

16 What really struck me is on the non-LIS, you  
17 reported that there was only out of -- which means of about  
18 50 people involved, there's only one, you said, that did not  
19 change their behavior when they reached the gap. Everyone  
20 else reported that they changed from going to generics or  
21 asking for drug samples. You have a whole list of things.

22 Is that right?

1 DR. SCHMIDT: Yes, that's correct. And, actually,  
2 Joan and Shinobu presented on that back in September, a more  
3 lengthy discussion of it. But, yes, there is a lot of  
4 change in behavior in anticipation of the coverage gap.

5 DR. BERENSON: I want to pursue Bruce's question  
6 to one more group, if you could go back to number 2. And  
7 that is the distribution of beneficiaries in MA only versus  
8 MA-PD.

9 If you've got 20 percent on MA-PD and there's  
10 about 24 and a half or 25 percent total in MA, can I assume  
11 that about 5 percent are in MA only? Do we know that? Not  
12 necessarily?

13 I'm also interested, and Bruce, in sort of trends  
14 and sort of anticipating what might happen if there's a  
15 payment cutback or a bench mark cutback so that benefits are  
16 less generous. Is there a population that would essentially  
17 revert back to MA only? I'm interested in the dynamics  
18 between the two, if you know.

19 DR. SCHMIDT: I'm not sure I can get you a precise  
20 answer, but I think that there are some private  
21 fee-for-service plans that do not offer a drug benefit as  
22 part of their package. So some of those people would be

1 enrolled in PDPs.

2 DR. BERENSON: My understanding, and I may have  
3 this wrong, is that an MA has to offer a PD, but they also  
4 can offer non-PD products.

5 DR. SCHMIDT: Yes, that's correct.

6 DR. BERENSON: And so --

7 DR. SCHMIDT: Why don't I come back to you with a  
8 more precise number of the percent in MA only plans.

9 DR. BERENSON: And the trends in recent years, if  
10 you could.

11 MR. HACKBARTH: Additional round one clarifying  
12 questions?

13 DR. CROSSON: Yes, and I'll word this very  
14 carefully; there's a consequence.

15 I'm sort of trying to figure out with respect to  
16 the LIS population who's better off. The non-choosers who  
17 have somebody watching out for them from the perspective of  
18 how much they have to pay in premiums, but they have this  
19 problem of being disrupted in terms of the plan and then the  
20 formulary, potentially changing medicines, or the choosers,  
21 who in fact have the opposite situation. They have a stable  
22 formulary, but on the other hand they might be paying more.

1           So my specific clarifying questions are, on  
2 slide 11, where it says at the bottom, many of the choosers  
3 are enrolled in plans with premiums above the LIS threshold,  
4 do we have an idea, on the average, how many more dollars a  
5 month those folks are paying, in other words, for the  
6 stability -- let's say for the stability of the formulary?

7           DR. SCHMIDT: I think our rough guess -- but we  
8 need to do some further calculations on this -- is an 8 to  
9 \$10 a month range.

10          DR. BERENSON: Eight to ten dollars. Okay.

11          DR. SCHMIDT: Another piece to this puzzle is that  
12 CMS has done some early work trying to look at the effects  
13 of reassignment in your calculus of who's worst off or  
14 better off; what happens to reassignees.

15                 A study that looked just for the year 2007,  
16 comparing LIS enrollees, who stayed in the same plan versus  
17 reassignees, found no difference in health outcomes as  
18 measured by mortality, ER use and hospitalizations. So  
19 that's one piece of data out there about reassignments.  
20 But, again, that's just for one year, so it's perhaps not as  
21 complete a picture as we might like.

22          DR. BERENSON: So that, perhaps, is an answer to

1 the second part of the question, which relates to slide 15.  
2 And the question is, the different distributions there that  
3 you have, the distributions of the LIS enrollees, how does  
4 that compare to the distribution of the star ratings? In  
5 other words, are they, in fact --

6 Oh, did Nancy already ask that? I'm sorry. Sort  
7 of asked it, so I'm really asking it.

8 [Laughter.]

9 DR. SCHMIDT: So it if were not weighted by  
10 enrollment, you mean, what does the distribution of the  
11 plans look like?

12 DR. BERENSON: Yes.

13 MR. YANG: We don't have that right now.

14 DR. SCHMIDT: We don't have it for the PDPs here,  
15 I'm sorry to say. But it's, you know -- you'd see probably  
16 a bit more spread to it, but it's not that dissimilar.

17 DR. CHERNEW: I don't understand how you could  
18 have a 5 if you had no -- if you had a plan that was a 5,  
19 you have to have some enrollees in it; otherwise, you  
20 wouldn't know it was a 5.

21 DR. SCHMIDT: I'm sorry. It would not be more  
22 spread out. It's still within the range of a 2 to 4 and a

1 half.

2 DR. KANE: There's only MA-PD with 5's. That was  
3 what the answer was.

4 DR. MILSTEIN: Obviously, we have a program here  
5 that's founded on this notion of consumers disciplining the  
6 vendors and the vendors raising value as a result. My  
7 question is this.

8 It works a lot better for consumers if the burden  
9 associated with disciplining the vendors is low rather than  
10 high. Can you just update us -- because so far, I didn't  
11 see anything that addressed this -- update us on what, if  
12 anything, CMS has done over the past year to reduce the  
13 burden on beneficiaries of a) even knowing when there's a  
14 plan that would be a better value for them, given the drugs  
15 they're on, better value meaning you can get the drugs  
16 you're on, but in your total spending per month, but  
17 estimated out of pocket plus premium, would be lower.

18 So that's called the burden of  
19 ascertainment -- what has CMS done to reduce the burden of  
20 ascertainment for enrollees? And then secondly, what has  
21 CMS done to reduce the burden of actually making a switch?  
22 So it's a seamless switch, kind of analogous to what the FCC

1 did in asking the cell phone companies to allow you to keep  
2 your cell phone number in order to reduce the switching  
3 costs associated with switching cell phone carriers.

4           So in the last year, what progress has CMS made,  
5 if any, on reducing these two facets of burden, that, if  
6 reduced, could make a big difference in consumers' ability  
7 to discipline the vendors?

8           MR. HACKBARTH: Let me just add on this. I  
9 consider this a round two issue. But since Arnie mentioned  
10 it, I think this is a critical, conceptual point about the  
11 program. And I'd just add that here we have a model that is  
12 premised on consumers disciplining the marketplace. The  
13 choices are quite complex, and we're talking about  
14 relatively small premiums. So the dollar gain for going  
15 through the effort may be relatively small, which puts a  
16 real premium on simplifying the decision making in the  
17 switching or the whole house of cards falls down.

18           DR. SCHMIDT: I'm not sure I have a very complete  
19 answer for you, and I may need to return with a bit more  
20 information. But I do know that there's been some academic  
21 work looking at if you notify beneficiaries that there may  
22 be lower cost options available to them, does that affect

1 their behavior, and there's some indication that it could.  
2 And I think that CMS has been taking a look at this  
3 literature. It was taken in the form of letters to  
4 beneficiaries and that sort of thing.

5 DR. MILSTEIN: So it sounds like there has been no  
6 material progress other than investigating relevant  
7 research.

8 DR. SCHMIDT: There is each year an effort to say  
9 to beneficiaries, it really behooves you to get out there  
10 and look at your options, but I would say that's -- that's  
11 what I know of the extent to it, but let me research that  
12 further and update you.

13 MR. BERTKO: This is a related question about  
14 future work. If you go to slide 13, I think some of you  
15 mentioned in the presentation about the concern about the  
16 growth and the reinsurance portion, which, again, is  
17 inferred by me to be mostly -- partly driven by the really  
18 high-class drugs, the biologics and such.

19 With the Part D data that I think we're getting  
20 access to, will be able to disaggregate the difference  
21 between growth and unit classed utilization and intensity in  
22 terms of new drugs, more people having drugs? I mean, is

1 that in your future work plan?

2 DR. SCHMIDT: Ideally, yes, depending on what all  
3 you have for us to do. We are able to look at utilization,  
4 and we have 2006 data now. We're hoping to get 2008 data  
5 perhaps later this year or early next year. But, yes, I see  
6 that as something that should be part of our agenda.

7 MR. BERTKO: My editorial comment is I think parts  
8 of healthcare reform legislation do have that pathway to  
9 biologic types of drugs that might be in here, and we might  
10 as a commission want to be on top of that.

11 MS. HANSEN: This is also on the same slide. It's  
12 just a question about the employer subsidy. If you could  
13 just refresh my mind about was this a temporary piece of  
14 subsidy in the legislation and will go away? And if so,  
15 will that have, obviously then, some impact on the  
16 distribution of the total spending for Part D?

17 MS. SUZUKI: It's not a temporary thing; it's a  
18 permanent subsidy that's available to employers who are  
19 offering actually equivalent coverage to Part D or more  
20 generous.

21 DR. DEAN: On page 14, slide 14, I was interested  
22 in the measures of clinical quality. You mentioned that

1 there was one drug they were concerned about, then they  
2 planned to release some more requirements.

3 Do you have any more specifics about what those  
4 are?

5 DR. SCHMIDT: Well, the one measure that was  
6 available for the 2009 benefit year was a measure of the  
7 percent of elderly members in each plan that were taking  
8 high risk medicine. So something --

9 DR. DEAN: The famous Beers list.

10 DR. SCHMIDT: I don't know if it's precisely the  
11 Beers list, but it's something equivalent.

12 DR. DEAN: I mean, that's a very controversial  
13 area --

14 DR. SCHMIDT: Right.

15 DR. DEAN: -- and some of us have great skepticism  
16 about the Beers list.

17 DR. SCHMIDT: Right.

18 DR. DEAN: That's why I wondered if that's what  
19 they were using.

20 DR. SCHMIDT: I will come back to you with more  
21 detail on that.

22 DR. DEAN: Okay, thank you.

1           Well, I just was going to say, just to Bruce's  
2 point -- because I was interested in the group that are not  
3 covered. The reality is that there are a certain number of  
4 people that just simply don't take drugs and don't perceive  
5 a need. And I suspect that that's a part of the group. I'd  
6 be interested to know how big it is.

7           DR. KANE: So when you look at the LIS population,  
8 does CMS make an effort when they reassign? If they have  
9 LIS enrollees who are going to blow right through the  
10 coverage gap and into the catastrophic, to put them in plans  
11 that will minimize their catastrophic crisis, or do they  
12 just say, well, if it's -- so there's no effort by CMS to  
13 protect Medicare from the rather substantial what they call  
14 reinsurance piece of this for the LIS -- I mean, CMS is  
15 reassigning LIS people at times, but they're not saying,  
16 well, you look like you blow through the coverage gap  
17 regularly or you hit the coverage gap. But there's no  
18 effort to minimize Medicare's ultimate cost because of the  
19 reassignment.

20           MS. SUZUKI: That's correct. It is randomly  
21 assigned.

22           DR. SCHMIDT: And a sense of whether there are

1 opportunities to protect Medicare a little bit, if the  
2 reassignment did incorporate the cost profile of the LIS.

3 MR. HACKBARTH: The implication I'm hearing is  
4 that there are some plans that would be better at preventing  
5 people from going into the reinsurance category.

6 DR. KANE: Or may have better prices so that the  
7 overall total is lower or some way manages that cost.

8 MR. HACKBARTH: For the expensive drugs. Okay.

9 DR. MARK MILLER: Actually, Rachel, I think you  
10 should pull in pretty fast here. We went through this  
11 discussion, I want to say, a year ago --

12 DR. SCHMIDT: A couple of years ago and continued  
13 to work last year, too. That was the perspective of the  
14 issue of beneficiary centered assignment. So you  
15 remember -- I think you raised this issue before, Nancy,  
16 which was a related issue of can you try to think about  
17 whether there are opportunities to put people into plans  
18 more intelligently, based on their past utilization of drugs  
19 and trying to minimize either the beneficiaries' cost  
20 sharing, or their formulary coverage, or those kinds of  
21 things.

22 NORC in Georgetown did some work for us on that

1 issue. It seems like there is a bit of a trade off between  
2 minimizing government costs versus minimizing beneficiaries'  
3 cost sharing or coverage of drugs on a formulary.

4 DR. KANE: For LIS people, it's actually just  
5 Medicare that you'd worry about.

6 DR. SCHMIDT: Well, except that there is the  
7 breadth of a formulary to consider as well because if a drug  
8 is not covered on it, then a person may be stuck paying for  
9 the entire thing themselves and may stop taking that certain  
10 therapy. And we I think decided or commissioners --

11 DR. MARK MILLER: I mean, the punchline -- we got  
12 pretty -- I mean, for analysts, we got pretty jazzed up  
13 about this and thought that there was something here that we  
14 thought we could come away with. But when we got deeper  
15 into it, the trade off was less clear cut, and exactly how  
16 to execute it I think got somewhat difficult.

17 DR. SCHMIDT: I think also, some of you  
18 commissioners raised some dynamic issues over time that  
19 there could be some unintended consequences if we were to do  
20 that; that certain plans might get the majority of LIS  
21 enrollees that take certain drugs, which might affect their  
22 bidding for a subsequent year. It might raise their -- it

1 might have the result of raising their premium and might  
2 actually lead to further reassignment. So that was one  
3 point of view that I think Bob Reischauer had, for example.

4 MR. HACKBARTH: Is there any way of knowing to  
5 what extent the beneficiaries who go into the reinsurance  
6 are there because they're using single source drugs, where  
7 there would be no price variability; it's basically the drug  
8 maker's name and the price?

9 DR. SCHMIDT: It's possible to do that through  
10 claims analysis, but it's not a trivial thing to do.

11 MR. HACKBARTH: Yes, okay.

12 Bruce?

13 DR. STUART: I take this as an incredibly  
14 important area that requires that we examine it  
15 holistically. And the reason I say that is that there are  
16 at least four dimensions that I can think of in terms of how  
17 you'd want to evaluate particularly the random assignment.

18 I mean, one came up in terms of what Jae's  
19 comment was on slide number 15, is that if the LIS  
20 population is predominantly in low star plans, and there is  
21 an annual reassignment that is truly random, that means that  
22 they're going to look like -- that may actually help them

1 out or it may not. So, I mean, that could go both ways.

2 As far as trying to map the choices of individuals  
3 according to what the prices are on the drugs that they use  
4 makes a very, very strong assumption that they're on the  
5 right drugs to begin with. And I think that is probably  
6 something that would not hold up if you were to look at it.  
7 And so, I think that's a second thing.

8 The third is about reassignment in terms of the  
9 reinsurance rate. You're right. It could be because of a  
10 single source drug, and that would be worth looking at, but  
11 just because the product is single source and doesn't have a  
12 competitor doesn't mean that there aren't therapeutically  
13 equivalent products that would be arguably as good if not  
14 better.

15 So I guess what I would suggest is if we're going  
16 to go along this route, we really should have some criteria  
17 about how we're going to make judgments about what's good or  
18 bad for assignment of enrollees that would include cost of  
19 the program as well as benefits to beneficiaries across a  
20 variety of areas, including satisfaction as well as drug  
21 quality.

22 MR. HACKBARTH: Ron?

1 DR. CASTELLANOS: In your final comment, you  
2 questioned about the better quality measurements. From a  
3 practical viewpoint and from a physician viewpoint,  
4 compliance on the patient's part is so important. I know  
5 we've talked about it before.

6 Is there any new data on that or are there any  
7 studies that we could do? It's going to impact on the cost  
8 of the Medicare system, especially with readmissions, et  
9 cetera.

10 DR. SCHMIDT: Patient adherence to their  
11 medications is a perennial problem. And, actually, the  
12 Pharmacy Quality Alliance has been developing some measures  
13 of medication use that focus predominantly on adherence.  
14 And I think over the longer term, CMS is hoping to introduce  
15 some of those measures into the ones that it uses for  
16 clinical quality.

17 That is really at the stage right now of -- the  
18 PQA's been road testing some of those measures. They're  
19 just now getting some of the results in from that. So it's  
20 a little bit farther down the road. One issue is that you  
21 could argue, from the standpoint of being a PDP sponsor,  
22 look, I'm running just the drug benefit; why should I care

1 about adherence?

2 Our past expert panels that we've had internally  
3 at the Commission, the thought has been, well, maybe you  
4 should hold PDPs to some of those measures, even though  
5 there are problems with patient compliance and even though  
6 it's not running an entire medical benefit as perhaps a  
7 pay-for-performance type of measure.

8 DR. CASTELLANOS: Thank you.

9 MR. BUTLER: So we typically look at these things.  
10 And then aggregate Medicare spending is 53 billion or a  
11 little over 10 percent, I guess of the Medicare budget, but  
12 its collateral impact on other spending is probably really.  
13 really important, and growing. So I think this is really  
14 important.

15 I had a thought. We typically in the Commission  
16 look so much at this aggregate spending from the Medicare  
17 point of view versus the beneficiary point of view, and  
18 we've increasingly looked at the impact of not only  
19 out-of-pocket spending here, but in Medigap and what happens  
20 to downstream Medicare spending as a result of these  
21 implications.

22 I'm wondering, maybe it doesn't belong in here,

1 but even in a context chapter, if we look at the typical  
2 Medicare beneficiary through his or her eyes and say the  
3 annual out of pocket is X dollars for the Part B premium, X  
4 dollars for the Medigap, X dollars for out-of-pocket drug  
5 expenditures, something like that would help us  
6 understanding, through their eyes, the levers that they're  
7 looking at annually in terms of the choices they're making.  
8 And if we had that and say, what does it look like to them,  
9 and recognize not everybody is average, I think it'd help us  
10 a little bit more on some of these trade offs and choices  
11 and where we might start to impact the benefits side versus  
12 just the expense side, and how do we contain \$53 billion in  
13 spending.

14 DR. BERENSON: Just a couple of thoughts about  
15 quality measures. On the issue of drug adherence, it does  
16 seem to me there's a theoretical advantage of an MA-PD,  
17 which has the delivery system as part of it, or at least  
18 it's closer to the delivery system than a PDP. So it does  
19 seem to me it's an area that we should be able to see some  
20 differences across MA-PDs and a difference with PDPs.

21 I'm particularly interested in the polypharmacy  
22 issue. And if the Beers list is no good, we need to make a

1 good one because I think, for the most part, we do have  
2 unique issues with the Medicare, the old, old population  
3 that Medicare has, which has gotten little attention in most  
4 of the FDA and other kinds of evaluations of drugs. So I  
5 think something -- I would like to work in that area and  
6 improve what is out there in terms of medications that are  
7 problematic in seniors and then on the polypharmacy issue.

8 DR. MILSTEIN: A couple of suggestions. One is  
9 just a direct consequence of my prior round one question,  
10 which is, I think a very useful area in which we could  
11 potentially be very useful would be to include within this  
12 topic as we proceed, an examination of what's being done  
13 elsewhere by what we consider exemplary within the health  
14 industry to help connect consumers with "better", whether  
15 it's a better plan, better provider. For example, some of  
16 the real strides that have been made in connecting patients  
17 who need organ transplants with the highest value, quality,  
18 outcome and cost organ transplant provider and an individual  
19 drug selection.

20 Obviously, our unit of selection here is PDP plan,  
21 but I think many of the lessons that the exemplary  
22 organizations that have made progress on reducing switching

1 burden and enabling switching to be highly discerning would  
2 be relevant. And if we mobilized it and put it into a  
3 finding, I think it might be very useful to either CMS or  
4 Congress.

5           There's been progress in applying, I call it  
6 choice burden reduction, good choice burden reduction, as it  
7 pertains to health care. And I think to the degree we have  
8 the resources to summarize it, mobilize it, and think about  
9 how it might be applicable to this particular program, which  
10 is very much formulated on optimizing consumer decisions, I  
11 think we could make a real contribution.

12           MR. HACKBARTH: And as I said earlier, I agree  
13 with that.

14           Have we, in previous reports or previous  
15 presentations that you've done, looked at the literature on  
16 switching behavior and health plans outside the Medicare  
17 Part D area, how much price difference is required? I'd be  
18 particularly interested in the switching behavior of  
19 seniors. My assumption would be -- I don't know if it's  
20 valid or not -- is that there's a bit more inertia and a  
21 little bit more reluctance to switch.

22           DR. SCHMIDT: We have not really reported on that,

1 but I know that the academic literature bears that out, the  
2 studies I'm familiar with, that they are more reluctant to  
3 switch.

4 MR. HACKBARTH: There are two sides to this. One,  
5 how strong are the signals motivating switching, and then  
6 how easy do we make it for beneficiaries to choose new  
7 options. As Arnie says, they're fundamental to the design  
8 of this program.

9 DR. SCHMIDT: Another piece of data that may be  
10 interesting is that the proportion of switching that's  
11 occurring voluntarily in D is about the same as in FEHBP,  
12 which is kind of interesting. There are some younger people  
13 in that population.

14 MR. HACKBARTH: That's important information, and  
15 if we could just do a little bit more context so we can put  
16 these numbers in a broader context, that would be good.

17 John?

18 MR. BERTKO: I'm going to open up a can of worms  
19 here, which is do drugs indeed reduce cost in A and B. And  
20 when Bill Scanlon and I were on the panel, Americare's  
21 trustees' technical panel in '04, we asked that very  
22 question. And my recollection is that the people from OACT

1 and CBO said can't find any evidence either way.

2           We have here potentially a natural experiment of  
3 turning on drugs in '06-07, and I'm not sure I'm ready to  
4 assign that to our team, that is MedPAC staff. But is there  
5 a possibility that we could monitor and work with some  
6 variety of people that would study that thoroughly, and then  
7 I'd go down to Mike's direction of a value-based insurance,  
8 which is to be able to know the subsets of drugs that really  
9 work and encourage those in one form or another.

10           So not a big thing, but I'm just saying can we  
11 throw that on our agenda?

12           DR. CHERNEW: The best site on this is a site by  
13 Yuting Zhang in the New England Journal of Medicine. So  
14 they've done it in one plan.

15           I think -- my take on the literature is it is  
16 undoubtedly true that drugs reduce spending in Part A and B.  
17 It is unclear whether they reduce spending in Part A and B  
18 as much as you spent on the drugs. I believe that in some  
19 cases, for some drugs and for some patients, they do. In  
20 fact, in some cases, for some patients, they more than pay  
21 for themselves. In other cases, as your question alluded  
22 to, there's great heterogeneity in that.

1           I want to go strongly on record as saying, saving  
2 money should not be the purpose of the Part D drug program,  
3 and we have to be careful that we don't set up this bar that  
4 we should only do it if it saves money. But it is true that  
5 the overall cost of Part D is somewhat less than the 53  
6 whatever it is; how much less remains to be seen. And I'm  
7 sure it will be a lot more work quantifying that, and I do  
8 think we could do a better job in evaluating the plans if we  
9 took into account some of the heterogeneity issues and the  
10 benefit design things that you said.

11           I was going to make a part two comment on this  
12 point, but maybe I'll wait until it's my turn.

13           DR. KANE: [off microphone] -- have to ask whether  
14 it's better than having had Medigap.

15           MR. BERTKO: And here is the natural result. I  
16 mean, we've seen the benefits of the switch from brand to  
17 generic, which has happened rapidly over this. I think  
18 there's another switch that Mike only alluded to, but I  
19 would describe more explicitly as saying, some drugs  
20 obviously work. Those are the high value drugs. Other  
21 drugs would seem to be wasted and, one way or another,  
22 emptied into toilets later as people take them but never has

1 any impact. And knowing more about that should serve us  
2 because who else is better to look at this particular  
3 question. There are other parts of the industry that have,  
4 if no incentive, even perverse incentives to keep this  
5 information unknown.

6 MS. HANSEN: Yes. My comments really amplified  
7 that of what Bob's already brought up relative to that  
8 population, and I've oftentimes also brought up in the past.  
9 Since older individuals tend to oftentimes take as many as  
10 anywhere from 15 to 20 drugs. That set up right there is  
11 just ripe for understanding that.

12 The second point that relates to that, that,  
13 again, we've done other work in the past, too, is to just  
14 look at the Medication Therapy Management Program that's  
15 nested into the Part D and how we can kind of put this  
16 together.

17 I know that there are changes in 2010 in terms of  
18 making sure that this will be perhaps a little stronger, but  
19 I would like to just see if we can kind of look at this in a  
20 composite way relative to MTM and the polypharmacy as it  
21 relates to the MA vis a vis PDPs, because I know that PDPs,  
22 again -- as you point out, the incentive, but does that have

1 meaning. And to Arnie's point, are there some best  
2 practices where it is used that are shown to be somewhat  
3 effective, hopefully, in the effective use of that MTM.

4           The last thing is on the quality issues of  
5 drugs -- excuse me, not the quality issues of drugs, but  
6 just the quality issues that need to be looked at. And if  
7 the Beers method is understandably not widely accepted but  
8 there are some, already I'm sure, research on sentinel kinds  
9 of drugs that have such dangerous impact -- many older  
10 people take blood thinners, for example, and that's high  
11 risk in the hospital and very high risk outpatient. So if  
12 there's some way to really focus on those things that  
13 oftentimes are the prompter for hospitalizations, and if  
14 that could be really looked at a little bit more carefully  
15 from the clinicians who would identify that.

16           MR. HACKBARTH: Okay. We're down to our last few  
17 minutes here.

18           Tom?

19           DR. DEAN: I just wanted to comment on the Beers  
20 list again. The Beers list, for the people that are not  
21 familiar with it, is a list of drugs that was published a  
22 few years ago under the heading of Drugs That Should Never

1 Be Used in the Elderly.

2           The dilemma for us as clinicians is that I would  
3 absolutely agree that everyone of those drugs has major  
4 complications and major problems. On the other hand, there  
5 are certain situations where we don't have any other  
6 alternative, and there are situations where the use of drugs  
7 on that list are extremely beneficial. They have to be  
8 monitored, they have to be used carefully, but to say they  
9 should be never used really produces harm because I've got a  
10 list of people that are on those drugs because we didn't  
11 have alternatives, and who tolerate them, and who are  
12 getting benefit from them.

13           So that's the dilemma. I mean, they're high risk  
14 drugs. I mean, I don't argue with that. But,  
15 unfortunately, they usually are published under a heading  
16 that says "should never be used," and that's just way too  
17 simplistic.

18           DR. SCHMIDT: I think in CMS' defense, they're not  
19 using that heading, and I'm not even sure that's the exact  
20 measure that they're using. They label this as high risk of  
21 side effects in the elderly.

22           DR. DEAN: And they are.

1 DR. CHERNEW: I just want to finish up briefly  
2 where I think John was going, which is, first let me say, I  
3 do think it's important to hold PDPs accountable for the  
4 adherence to the certain types of medications that their  
5 beneficiaries are taking. I agree with Bob's point that  
6 they have less of an incentive to do that than a MA-PD plan,  
7 although when we begin to look into this, I think what we'll  
8 find, I'm not sure, is that it's actually -- they're more  
9 similar to MA-PD plans than not because many of them are  
10 using similar formularies from the same organization. So  
11 you might find more connection than you otherwise would  
12 expect if you were just looking at pure incentives. But in  
13 any case, that's neither here nor there; it's an empirical  
14 question, and conceptually, we should hold them accountable.

15 I think one of the challenges here, when you look  
16 at some of the measures that you look at on reports like  
17 this is we see that people pay a deductible. We see that  
18 they have coverage or not coverage in the gap. But we have  
19 to ask ourselves is that good or bad. On one hand, you want  
20 them to have to pay something because you worry about the  
21 inefficiencies and you want there to be efficient use of  
22 medications in a whole bunch of ways. On the other hand, we

1 realize that we want to worry about their financial burden,  
2 and more importantly, the incentives they face to take the  
3 medications that are important, because they're important,  
4 and in fact there may be some spill over savings down the  
5 road.

6           But in any case, the problem is that cost sharing  
7 is both good or bad. So I think to the extent that we can,  
8 to the extent that CMS can, to the extent that other  
9 groups -- and I don't know what the Pharmacy Quality  
10 Alliance is doing -- can have more nuance benefits to  
11 recognize that there are some of these medications -- I  
12 think that blood pressure medication for diabetes is one of  
13 the classic ones that I use, which is clearly a high value  
14 medication, then I think -- we want to be able to develop  
15 those metrics and evaluate plans good or bad, based on a  
16 little more clinical sophistication and nuance than simply,  
17 oh, there's a doughnut hole, that's bad, or, oh, there's a  
18 doughnut hole, that's good.

19           There is some way in which we have to encourage  
20 the good but try and get efficiency within that. And that I  
21 think is hard, and I commend you for beginning to work on  
22 this. And the more we can bring in other work that you're

1 doing and others, I think the better.

2 MR. BEHROOZI: It might be a little related to  
3 what Mike said, but I think, too, what a number people have  
4 said, the extent to which -- and I know that you have been  
5 doing focus group work. The extent to which we can really  
6 get at the beneficiary's perspective, as Peter said, but  
7 remember the beneficiary's perspective is a prospective one  
8 when they're choosing plans. They're not looking back over  
9 how much they had spent. You know, it's not all totaled up  
10 yet.

11 So in terms of Arnie's comment about choice burden  
12 reduction or Glenn's comment about sort of what's the  
13 tipping point in terms of price difference, it might not  
14 just be a number. It might be where it hits them. It might  
15 be that it's the premium that's the most important thing  
16 because that's the first thing they're going to have to pay.  
17 Or it might be that it's the deductible because that looms  
18 large before they get to anything else. But then they are  
19 given the information about the fact that over the course of  
20 a year they will spend less in premiums, deductibles, and  
21 whatever because of the drugs that they're using.

22 Is it just that number or will they say, yeah, but

1 I can't even imagine how I'm going to pay the next three  
2 months' bills much less can I worry about what the total  
3 cost is going to be for the year. The immediacy of the cost  
4 or the immediate choice that they have just might not be  
5 capturable kind of by looking at retrospective data.

6 Like I said, you have started this work, and I  
7 would really encourage you to get into the head of a  
8 beneficiary, looking prospectively, and probably choice  
9 burden reduction I think is going to loom larger than just  
10 the dollars and the ultimate best choice that you might be  
11 able to make at the end of a period looking back.

12 MR. HACKBARTH: Okay. Thank you all. Well done,  
13 as always.

14 And our last session is on access to hospital  
15 services, and this will be sort of an initial step toward  
16 our hospital payment adequacy analysis. Much more will  
17 follow at the December meeting. Hannah, are you leading, or  
18 Jeff, or Zach?

19 MR. GAUMER: Good morning. Before we get started,  
20 I want to thank Jaeyoung Yang and Jeff Stensland for their  
21 contributions to this work. Hannah and I will present most  
22 of the material here.

1           In December, we will present the Commission with a  
2 variety of hospital payment cost and margin data to help you  
3 arrive at the annual hospital update recommendation. But  
4 we've decided to carve out the access component of the  
5 hospital update this year and talk to you about it this  
6 month because our analysis includes two measures, industry  
7 employment trends and the willingness of hospitals to accept  
8 patients with Medicare Select plans. Specifically, we view  
9 employment trend data as an indicator of capacity, and  
10 hospitals accepting Medicare Select patients as an indicator  
11 of hospitals' willingness to provide access to Medicare  
12 beneficiaries.

13           This presentation has two broad components. The  
14 first concerns hospital capacity to provide care, and the  
15 second concerns hospitals that accept Medicare Select  
16 patients who pay a discounted rate. Overall, we find that  
17 facility volume has grown, the scope of services has  
18 expanded, employment has grown, capital is available, and  
19 some hospitals are accepting patients in Medicare Select  
20 plans.

21           I will begin by talking about the capacity portion  
22 of the presentation and then Hannah will talk to you about

1 the Medicare Select analysis. Finally, at the end of the  
2 presentation, all three of us will be available to take your  
3 questions.

4 The number of hospitals participating in the  
5 Medicare program increased in 2008, in part because of the  
6 number of hospitals that left the program slightly  
7 decreased. This marks the seventh consecutive year in which  
8 the number of hospitals that opened have outnumbered the  
9 number of hospitals that have closed. Specifically this  
10 year, or in 2008, 52 acute care hospitals opened and eight  
11 closed. Those that opened were relatively small, and among  
12 those that closed, most were urban. Overall, approximately  
13 3,500 short-term acute care hospitals participated in the  
14 Medicare program in 2008. And it is important to note that  
15 hospital occupancy rates have remained relatively stable in  
16 recent years, at about 65 percent across all hospitals.

17 In addition to capacity growth, hospitals have  
18 expanded the services they offer in recent years.

19 DR. CROSSON: Just one moment. We've lost the  
20 slides.

21 [Pause.]

22 DR. MARK MILLER: [Off microphone.] We've got a

1 technical person coming. Everybody has handouts in front of  
2 them, the audience --

3 MR. GAUMER: Okay. So we'll continue with the  
4 beginning of Slide 4, if you want to flip to your hard  
5 copies.

6 In addition to capacity growth, hospitals have  
7 expanded the services they offer in recent years. Our  
8 analysis of hospital services reveals that from 2004 to  
9 2007, the share of hospitals and their affiliates providing  
10 most specialized services increased. For example, on the  
11 top row of the table you're looking at on your hard copies,  
12 we see that the share of hospitals offering palliative care  
13 programs increased more than any other service, at  
14 approximately seven percentage points. As a result, 42  
15 percent of hospitals offered palliative care programs in  
16 2007.

17 In contrast, there were only two types of services  
18 that were not offered by a larger share of hospitals from  
19 2004 to 2007, and on the bottom two rows of this table, you  
20 can see that trauma center services remained even at about  
21 42 percent and the share of hospitals offering urgent care  
22 centers declined two percentage points, to 33 percent. And

1 the five other services included on the table were included  
2 because they were among the fastest-growing services offered  
3 by hospitals from 2004 to 2007.

4 Service expansion occurred for both urban and  
5 rural hospitals from both 2004 to 2007, but was more rapid  
6 for urban hospitals. Services such as cardiac  
7 catheterization and open heart surgery, which are both more  
8 common in urban settings, continued to grow faster in urban  
9 settings. Rural hospitals also experienced service  
10 expansions, but generally at a slower rate.

11 The only notable departure from this trend was MRI  
12 services, which expanded twice as rapidly at urban  
13 hospitals. In 2007 overall, we can see that MRI services  
14 are catching up in rural settings, are catching up with the  
15 urban settings, where 79 percent of rural hospitals have  
16 MRIs and 92 percent of urban hospitals offered MRIs.

17 Slide 5 -- Bureau of Labor Statistics data reveal  
18 that as of August 2009, general hospitals employed over 4.4  
19 million individuals. Within the 24-month period that we're  
20 displaying on this slide, we see that general hospitals  
21 added approximately 170,000 jobs, growing approximately four  
22 percent from September 2007 to August 2009. Overall, this

1 growth rate is on par with the industry's ten-year average  
2 growth rate. However, you will note that hospital  
3 employment stagnated from roughly December 2008 to May 2009.  
4 And following this period of stagnation, the hospital  
5 industry appears to have resumed its longstanding employment  
6 growth trend.

7           Now, placing hospital employment trends in broader  
8 context, we see that hospital employment has increased at a  
9 relatively average rate for the health care sector. The  
10 hospital industry's four percent increase over the last 24  
11 months is displayed on the chart in yellow. Employment for  
12 the rest of the health care sector grew by five percent,  
13 which is represented by the red line, and it's important to  
14 note that that five percent line does not include hospitals.  
15 We've removed hospitals from there. However, the health  
16 care sector's trend line does include offices of physicians,  
17 which experienced an employment increase of about 5.5  
18 percent, more than any other health care provider during  
19 this 24-month period.

20           The green line on the slide represents employment  
21 for the economy overall during the last 24 months, and  
22 economy-wide employment inclusive of hospitals and inclusive

1 of the rest of the health care sector declined 4.7 percent,  
2 from September 2007 to August 2009.

3           The trend in spending on hospital construction  
4 suggests that access to capital remains adequate. Overall,  
5 the Census Bureau projects that over \$33 billion will be  
6 spent on hospital construction in 2009. Therefore, it  
7 appears that hospital construction will remain at levels  
8 comparable to 2007 and 2008. But as we look back, we see  
9 that construction spending steadily increased from 1999 to  
10 2007, culminating in over a ten percent annual increase in  
11 both 2006 and 2007. However, from 2007 to 2009,  
12 construction spending slowed, increasing just 1.5 percent  
13 per year.

14           Two additional indicators of hospital access to  
15 capital are, first, the trend in hospital tax-exempt  
16 municipal bond offerings, and also interest rates for  
17 hospital bonds. Based on data for the first nine months of  
18 2009, we see that the average monthly dollar value of bond  
19 issuances for 2009 were equal to the average monthly dollar  
20 value of bond issuances for 2007, at approximately \$3.4  
21 billion per month. Based on data from previous years, we do  
22 not anticipate a surge in bond issuances in the last three

1 months of 2009, which would bring those 2009 bond issuances  
2 up to levels observed in 2008.

3 Interest rates on tax-exempt debt have declined  
4 from one year ago. As of October 2009, the average interest  
5 rate on AA tax-exempt 30-year hospital bonds was 5.1  
6 percent, significantly lower than the 7.3 percent interest  
7 rate documented for similarly-classified bonds in 2008.  
8 This suggests that capital is more available to nonprofit  
9 hospitals than it was one year ago.

10 Hannah will now walk you through our Medicare  
11 Select analysis.

12 MS. NEPRASH: New to this year's analysis of  
13 access to hospital care is a discussion of Medicare Select  
14 plans. We could include this in the access to care  
15 discussion because it's one more piece of information on the  
16 relationship between payment rates and Medicare  
17 beneficiaries' access to care.

18 A Medicare Select plan is a type of Medigap plan  
19 in that it must provide beneficiaries with standardized  
20 benefits, identified by a letter A through L. What  
21 separates Medicare Select plans from other Medigap plans is  
22 that the Select plan charges a lower premium than the

1 identical Medigap policy, provided that the beneficiary uses  
2 in-network hospitals for non-emergency care. And for a  
3 hospital to be included in a Medicare Select carrier's  
4 network, that hospital agrees to waive all or part of the  
5 Part A inpatient deductible.

6           So how common are Medicare Select plans?

7 According to the National Association of Insurance  
8 Commissioners, there were 106 Medicare Select carriers in  
9 2008. These carriers offered Select plans in 45 States, but  
10 participation rates varied tremendously. Medicare Select is  
11 common in some States, like Florida, Alabama, Louisiana, and  
12 Illinois, and rare or nonexistent in others. Select plans  
13 represented roughly ten percent of all Medigap policies sold  
14 in 2008 and covered slightly over one million Medicare  
15 beneficiaries.

16           We analyzed the hospital networks of Medicare  
17 Select carriers in California and the five States with the  
18 highest reported Medicare Select enrollment. Focusing on  
19 the largest Select plans, we constructed a database of  
20 hospitals that participated in at least one Medicare Select  
21 network. We found that the share of the States' IPPS  
22 hospitals participating in Medicare Select networks varied

1 widely across States, ranging from only 14 percent of total  
2 hospitals in California to 97 percent of total hospitals in  
3 Alabama. On average, hospitals that participated in  
4 Medicare Select networks tended to have lower standardized  
5 costs per discharge compared to that of non-network  
6 hospitals. The lower costs resulted in higher Medicare  
7 inpatient margins at Medicare Select hospitals than the  
8 other hospitals.

9           Comparing quality of care at participating  
10 Medicare Select network hospitals and non-network hospitals,  
11 we found that the two groups of providers performed at  
12 roughly the same level. Likewise, the breadth of services  
13 at the average Medicare Select hospital appears to be at  
14 least equivalent to that of non-Select hospitals.

15           It's important to keep in mind that we examined  
16 all IPPS hospitals in six States where Medicare Select  
17 enrollment was sizeable and our information comes from plans  
18 that willingly shared their in-network hospitals with us.  
19 These are States where Medicare Select is relatively popular  
20 and not a representative sample of the United States.

21           With that caveat, the willingness of these  
22 hospitals to take lower rates for their Medicare patients

1 suggests that in the areas we examined, hospitals continue  
2 to see increases in Medicare patient volumes as desirable,  
3 and this is a positive sign for patients' access to care, at  
4 least in those markets.

5 So this concludes our presentation and we're happy  
6 to take questions, but two issues for the Commission to  
7 weigh in on include hospital capacity measures, as Zach  
8 discussed, and also if Medicare Select is a useful indicator  
9 of patient access to care.

10 MR. HACKBARTH: Okay. Why don't we start on this  
11 side, round one clarifying questions. Mitra and then Mike.

12 MS. BEHROOZI: When you were talking about the, I  
13 think it was the growth in specialized services, Zach, you  
14 referred to the difference between urban and rural  
15 experience. I wonder if, in general -- and I know that we  
16 do these analyses and we do the payment update and  
17 everything on a national basis, but I just wonder if you  
18 looked at regional differences, whether it was for growth of  
19 specialty care or any of the other issues, employment, and  
20 obviously it is an issue with respect to Medicare Select,  
21 but did you see regional variation? Did you look for it?

22 MR. GAUMER: We typically go down to the urban and

1 rural level and don't go further for that services analysis,  
2 but we can look into doing that.

3 MS. BEHROOZI: How about for employment or any of  
4 the other measures?

5 MR. GAUMER: Employment, we didn't go any further  
6 down because what we were trying to do was get a very broad  
7 assessment of employment trends.

8 DR. MARK MILLER: Does the data have the  
9 capability of doing that?

10 MR. GAUMER: Umm --

11 DR. MARK MILLER: Because this is the stuff that  
12 comes out of the BLS, right?

13 MR. GAUMER: Yes, exactly. So this is BLS data.  
14 I'm not exactly sure if we can go down. Usually, it goes  
15 down to the occupational level using a different data set.  
16 I can look into it. I don't think so, but I can look into  
17 it.

18 DR. STENSLAND: We can do regions on the overall  
19 employment.

20 DR. MARK MILLER: It's the region stuff. It's the  
21 big giant regions, right?

22 MR. GAUMER: Right.

1 DR. MARK MILLER: It may not be as -- that's what  
2 I was worried about, is how far down that data could go.  
3 We'll look at it. My sense is that it won't be as  
4 satisfactory as you might have been looking for there.

5 DR. CHERNEW: I just want to make sure I  
6 understand the Medicare Select market and what's going on.  
7 The hospitals that accept Medicare Select plans are in  
8 Medicare Select networks. They get paid the same amount as  
9 they otherwise would have gotten paid. The DRG payment is  
10 what the DRG payment is.

11 DR. STENSLAND: Well, they get the same amount  
12 from the government.

13 DR. CHERNEW: Right.

14 DR. STENSLAND: But then there is the patient's  
15 deductible.

16 DR. CHERNEW: Yes, right. No, exactly. So they  
17 get paid -- the government DRG rate is the same and they  
18 agree to waive the deductible from the patient, suggesting  
19 that they had a lower cost and they want to attract more  
20 patients.

21 DR. STENSLAND: Yes. Sometimes they waive the  
22 whole thing. Sometimes they just waive part of it. They

1 may say, okay, we will waive \$500 of the deductible for all  
2 the patients that come here from your Medigap plan.

3 MR. HACKBARTH: The inference -- I was going to  
4 ask about this, also. Are you finished, Mike?

5 DR. CHERNEW: No --

6 MR. HACKBARTH: I don't mean to interrupt.

7 DR. CHERNEW: Well, I -- so the insurer now, the  
8 Medigap plan was sort of only paying for the deductible. So  
9 now the premium is lower because now the insurer is not  
10 paying that. So basically what's happening is they get a  
11 very low premium because the hospital has agreed not to  
12 charge, and that's the --

13 DR. STENSLAND: So it kind of -- basically, the --  
14 from sort of the beneficiary's perspective, they talk to the  
15 Medigap plan and the Medigap plan says, maybe we'll give you  
16 \$500 off a year on your Medigap premium, okay, and they say,  
17 I like that. What do I have to do in exchange for that?  
18 Well, they say, you've got to be limited to this network of  
19 providers. So then the insurer goes to the providers and  
20 says, we're going to steer volume to you if you're willing  
21 to give us a waiver of the deductible or a reduced  
22 deductible, and then that's kind of the trade-off.

1 DR. CHERNEW: And so this only works -- follow the  
2 logic -- this only works if the hospitals themselves are  
3 low-cost and therefore have a high margin with which to pay.  
4 They don't need --

5 MR. HACKBARTH: Well, that's what I wanted to ask.  
6 So I think the inference that I would draw from this is that  
7 for a hospital that elects to participate, they believe that  
8 their net revenue per case is higher than their marginal  
9 cost of treating the additional patient, and they want  
10 additional patients because they've got unused capacity. So  
11 it wouldn't necessarily say that they're profitable. It's  
12 that the marginal revenue exceeds the marginal cost.

13 DR. STENSLAND: Right. Yes. So that marginal  
14 revenue might not exceed the total cost, but it exceeds the  
15 marginal cost, so they want those additional patients to  
16 fill a bed. It's better than an empty bed.

17 MR. HACKBARTH: And what is the conventional  
18 wisdom in the academic community and the literature about  
19 what proportion of hospital costs are fixed versus variable?  
20 I know that's a harder question --

21 DR. STENSLAND: There's a lot of disagreement on  
22 that.

1 MR. HACKBARTH: Right.

2 DR. STENSLAND: I think a lot of people would  
3 think at least a substantial portion are going to be fixed,  
4 at least somewhere on the order of 20 percent or something  
5 like that. Some people may say more, but there's kind of,  
6 like --

7 DR. CHERNEW: There's a long-run/short-run issue -  
8 -

9 MR. HACKBARTH: Exactly. You consider --

10 DR. CHERNEW: -- costs and --

11 MR. HACKBARTH: Yes. What's your time horizon for  
12 assessing what's fixed and variable, yes.

13 Okay. I've led us into non-round one questions,  
14 so I have Tom and then John.

15 DR. DEAN: On page seven, is there any measure, or  
16 do you have any data about how much of that spending is  
17 replacement and how much of it is really new beds or -- is  
18 the bed capacity changing, going up that rapidly? I assume  
19 not, but --

20 MR. GAUMER: In terms of bed capacity  
21 specifically, we've looked at some of the most current  
22 survey data out there and it seems like bed capacity itself

1 is staying relatively constant at about 800,000 beds across  
2 the country.

3 DR. DEAN: So the construction is replacement or  
4 outpatient stuff and --

5 MR. GAUMER: Umm -- yes --

6 DR. DEAN: Diagnostics --

7 MR. GAUMER: Yes. We believe so, yes.

8 DR. BERENSON: Clarification. On Slide 3, which  
9 is the number of hospitals opening each year, and maybe I  
10 wasn't listening carefully enough, but this looks like it's  
11 the number of hospitals open. Are all these hospitals, as  
12 far as you know, taking Medicare patients, as well?

13 MR. GAUMER: Yes. These are all participants in  
14 the Medicare program, right, or those that are no longer  
15 participating in the program.

16 DR. MILSTEIN: Do we know anything about what I'll  
17 call sort of effective availability of a hospital to a  
18 Medicare beneficiary with respect to whether or not some of  
19 the hospital-based physicians do or do not take Medicare  
20 assignment? I mean, some of the anesthesiology groups now  
21 or pathology groups that are the only -- the sole provider  
22 of the hospital, some of them are not offering -- that don't

1 take Medicare assignment, and so we have this new category  
2 of hospitals that are not effectively available to Medicare  
3 beneficiaries unless they have got a generous Med Supp plan.  
4 So do we track that? Do we have any information on that,  
5 because it certainly does affect the availability -- the de  
6 facto availability of these hospitals to less-affluent  
7 Medicare beneficiaries.

8 DR. STENSLAND: I don't think we've tracked that.  
9 Maybe that's something we could come back to you on when we  
10 talk about physician availability and how many are accepting  
11 Medicare patients next month.

12 DR. BERENSON: Yes, I just wanted to follow up on  
13 Tom. I think this is very useful information and I just  
14 think we should include the bed capacity trends that are  
15 happening because of the work we're going to want to be  
16 doing related to Paul Ginsburg's presentation last time  
17 about one of the strategies hospitals using of not expanding  
18 beds to have strategy. It puts this in some context. And  
19 by the same token, on the table that has the specialized  
20 services, I mean, there are others that I think are  
21 declining that you don't have, like mental health, substance  
22 abuse, maybe inpatient rehab, I don't know. I think it

1 would be very useful to get a real comprehensive list of  
2 specialized services, which helps us identify where the  
3 winners are and where the losers are. But it's very useful.

4 MR. BUTLER: Quickly, on construction costs. What  
5 gets you in that hopper, because somebody might do minor  
6 construction to meet code versus a big construction project.  
7 I see the source. I'm just curious what the definition is  
8 for construction costs.

9 DR. STENSLAND: My recollection is I think they  
10 look at the construction permits, and correct me if I'm  
11 wrong, Hannah. So you have -- both are in there. Like  
12 they'll have some, and they'll break it down into, okay, new  
13 buildings, major renovations, and they might also just have  
14 renovations within the hospital.

15 MR. GEORGE MILLER: On the four percent growth in  
16 unemployment, I want to come back to Mitra's point and try  
17 to flesh that out. I already heard the answer, but you  
18 don't know if there's been a shift to higher positions as an  
19 example of mid-level providers or the previous contract ED  
20 positions, as an example, or to Arnie's point that if the  
21 anesthesiologist no longer will accept Medicare, they either  
22 put the anesthesiologist on payroll and/or they subsidize

1 the anesthesiologist so they will take Medicare patients?  
2 So you don't have that bifurcation of that segment, because  
3 that could be part of the four percent growth in employment  
4 of hospitals.

5 MR. GAUMER: We did a little searching into the  
6 occupational changes that are taking place in employment --

7 MR. GEORGE MILLER: Right.

8 MR. GAUMER: -- and I don't think this exactly  
9 gets to your question, but we do see some changes in terms  
10 of RNs seem to be growing fast, imaging professionals seem  
11 to be growing fast. But we need to dig deeper into that  
12 issue about contracted versus employed physicians, if that  
13 answers your question.

14 MR. HACKBARTH: So what I hear you saying, George,  
15 is that --

16 MR. GEORGE MILLER: Do we know --

17 MR. HACKBARTH: -- growth in employment doesn't  
18 necessarily reflect a growth in capacity, but rather could  
19 just reflect a change in the relationship from a contract to  
20 an employment relationship and --

21 MR. GEORGE MILLER: Yes. Yes. And then on the  
22 Medicare Select, could it be, or did you do enough analysis

1 to determine if some hospitals may be choosing to accept  
2 those patients because -- or if your analysis determined if  
3 they're not collecting the copay or the deductible and their  
4 bad debt is high and this is a strategy to offset that.

5 DR. STENSLAND: Umm --

6 MR. GEORGE MILLER: If you're not collecting the  
7 copay and deductible --

8 DR. STENSLAND: Right. We didn't look  
9 specifically into that, but I could imagine something to  
10 that effect. The hospital could say, all right, there are  
11 certain people in my community that have a tough time  
12 affording their Medigap premiums, so I'm going to offer this  
13 Medigap Select policy to come to my hospital so they can  
14 afford a premium, so then at least they'll have a Medigap  
15 policy --

16 MR. GEORGE MILLER: Correct.

17 DR. STENSLAND: -- and maybe I'll at least get  
18 something from them. And if they didn't have a Medigap  
19 policy, maybe they wouldn't pay their deductible. It would  
20 be bad debt. And Medicare pays a portion of the bad debt,  
21 but they don't pay all of it. So I could see a conceivable  
22 story where that might flow into the decision making of

1 whether you'd want to accept Medigap Select patients.

2 MR. GEORGE MILLER: Okay. Thank you.

3 DR. MARK MILLER: When he was asking the question  
4 about the contractor to employee, you looked like you were  
5 almost going to say something. Did you have something to  
6 say on that?

7 DR. STENSLAND: Well, they also have contract  
8 employees that are going to show up as hospital employees,  
9 like if you're a hospital employee in that area contracting  
10 with somebody, they try to track that down, that they work  
11 in the hospital industry. So it's not so much that you are  
12 employed by the hospital, but you work in the hospital  
13 industry. So if I'm Manpower, Inc., and I contract with a  
14 certain hospital in Houston, BLS tries to count those  
15 Manpower, Inc. employees that are working in Houston as  
16 hospital employees in Houston.

17 DR. CASTELLANOS: I'd like to drill down on the  
18 employment issue, too. I think you need to really look at  
19 that. I don't think by hiring a whole bunch of doctors, and  
20 hospitals are doing that, it doesn't indicate an increased  
21 capacity.

22 The other point that Arnie made -- I think it was

1 Arnie -- about some of the doctors now not participating, it  
2 really has a significant effect on the beneficiary, because  
3 a lot of these doctors now are balance billing and the  
4 patients are getting surprised with an additional billing  
5 and that needs to be looked at.

6 And the other point that George made earlier and I  
7 made earlier is a lot of these patients -- I know I am  
8 hiring a lot more people, but to cover the regulatory side  
9 and not the capacity side. These unfunded mandates, and I  
10 hate to use that word, it's requiring myself, and I'm sure a  
11 lot of the rural hospitals and big hospitals, to hire  
12 people, not because they have increased capacity, but  
13 because of regulatory needs.

14 MR. HACKBARTH: I'm still thinking about this  
15 employment issue. But even if it didn't necessarily reflect  
16 an increase in capacity, it could have other implications.  
17 It could reflect a sign of financial health, that they feel  
18 that they can bring people onto the payroll that previously  
19 maybe were not on the payroll. That can play into market  
20 dynamics, as we discussed with Paul Ginsburg and Marty  
21 Gaynor. If a previously independent physician is brought  
22 into the hospital as an employee, that could alter the

1 competitive position of other hospitals who previously got  
2 referrals from that physician. I'm not saying that we know  
3 any of those things, but in looking at -- thinking about  
4 employment is an interesting way to look at this. It's a  
5 little tricky to figure out what conclusions to draw from  
6 the changes in employment, I think it's fair to say.

7 DR. BORMAN: I tried to think about this sort of  
8 at a rather high level and then a more detailed level. And  
9 so at the high level, I think the question that you've in  
10 part brought to us is that you've got two more potential  
11 measures of access, and are these helpful to us? Should we  
12 continue to look at them? And as I think about the other  
13 measures of access that we use, these certainly have their  
14 warts, but all those other ones do, too, so I personally  
15 find that having these additional measures is of some  
16 benefit, recognizing that they're imperfect, as are the  
17 other measures that we use. And so I would welcome  
18 continuing to use these and then the other payment adequacy  
19 assessments, potentially looking for other supplementary  
20 information that may be of equivalent value to us. And so I  
21 think that's helpful.

22 I think on the more detailed level, it sounds, if

1 I heard you correctly, that this Select group is relatively  
2 small and is somewhat geographically concentrated, and I  
3 would wonder -- one of the things we've not explored in that  
4 is are the relationships between these hospitals and post-  
5 acute settings different in this rather smaller group  
6 because could you potentially take a hit economically on the  
7 acute inpatient care with the expectation that you are more  
8 likely and more quickly going to some post-acute setting  
9 that may, in fact, balance your bottom line. And having  
10 remembered some of the maps we've seen about the non-random  
11 distribution of certain kinds of post-acute care, it does  
12 raise that question in my mind. So that if we were going to  
13 drill down on the meaning of and importance of the caveats,  
14 then that would be my question. Again, I'm not sure that  
15 that's the point of this exercise. It seems to me that  
16 perhaps more important is the notion that these are two more  
17 things that have some value and we just deal them into our  
18 composite measure.

19 MR. HACKBARTH: Okay. Round two. Arnie?

20 DR. MILSTEIN: This, you probably anticipated,  
21 based on my question. I think, on a going forward basis, or  
22 analysis of availability or access, we should think about

1 building this second measure in that uses the data that's in  
2 the Medicare claims database to identify hospitals whose  
3 hospital-based physicians predominately do not accept  
4 Medicare assignment. This could be -- I will defer to you  
5 in terms of -- but the obvious are predominant ER group,  
6 predominant anesthesiology group, predominant pathology  
7 group -- radiology, thank you, radiology group. So we could  
8 begin to have a sense, at least for non-affluent  
9 beneficiaries, have sort of a second measure of access that  
10 might be highly germane.

11           The third thing, and maybe someone -- maybe Mark  
12 or somebody knows the answer to this, but last month's  
13 presentation from Paul Ginsburg was obviously a very nice  
14 potential qualitative source for us, because they do this  
15 community tracking study where they're just continuously  
16 talking to providers. One of the things I think it might be  
17 good to get early readings on is whether or not that  
18 community tracking study is detecting any -- because they  
19 interview everybody in the community -- as to whether any  
20 hospitals are actually actively contemplating not  
21 participating in the Medicare program. That's something  
22 that we would be very well advised to get an early read on,

1 rather than have it explode two weeks before our December  
2 and January meetings and then we would be in a state of  
3 crisis.

4           So I think as long as we have that national asset,  
5 I think it might be helpful to use that as an information  
6 source for kind of -- like that early warning thing, you  
7 know, radar over the horizon to essentially detect that,  
8 because I think that would be something that if it were to  
9 spring on us unexpected might result in a level of panic  
10 that we'd prefer to avoid.

11           DR. BERENSON: Let me just comment, because the  
12 new round of site visits is going to be beginning in the  
13 very near future. Their initial meeting is in December.  
14 The problem is that we go to 12 communities and go to the  
15 large hospital systems in the 12 communities. So that only  
16 picks up, then -- I mean, I think it's unlikely that we're  
17 going to pick up what you're trying to pick up through that  
18 method. I think it's real important to do early sort of  
19 sentinel stuff, but it's a limited snapshot of hospitals who  
20 are not going to not see Medicare beneficiaries. They're  
21 not in the position to do that for -- I would be very  
22 surprised if the ones we go to would be the ones you'd be

1 picking this up on.

2 MR. HACKBARTH: You know, I would think, given the  
3 basic economics of hospital care, that this would be a  
4 lagging indicator, not a leading indicator, because so long  
5 -- they have fixed costs, and so long as the payment is  
6 exceeding their marginal cost, there's a reason for them to  
7 stay in if they've got excess capacity. But they could be  
8 at extreme levels of financial distress with inability to  
9 replace staff and equipment long before they get to the  
10 point where, oh, I'm going to drop out altogether. So I  
11 think of this dropping out of hospitals is probably more a  
12 lagging than a leading indicator. I'll let an economist  
13 address that.

14 DR. CHERNEW: Well, I think I'm going to say  
15 something slightly different, which is per our earlier  
16 discussion, a lot of different measures are all useful, but  
17 I think it's the primary measure for doing our primary task,  
18 understanding access from the beneficiary perspective is  
19 most important. And what I would worry about doing is  
20 setting up a set of measures that lead to a paradigm that  
21 makes us think that our updates have to be such that every  
22 beneficiary has access to every hospital in every setting.

1 I think that the more important thing is that every  
2 beneficiary have access to appropriate hospitals and  
3 appropriate care, even if some they can't go to.

4           So, for example, in the Medicare Select world, I  
5 don't mind using Medicare Select, or having it developed by  
6 the market, I might even add, to steer patients to hospitals  
7 that seem to be, based on your presentation, about  
8 comparable quality but likely cheaper. So I think that we  
9 run into a real risk of developing measures that identify  
10 one group of physicians or one group of hospitals or one  
11 group of something that are no longer in Medicare and  
12 thinking, oh no, access is reduced. We had better pay more.  
13 Because as long as we have the beneficiary perspective, I'm  
14 fine with some hospitals dropping out, some doctors dropping  
15 out, some -- particularly the ones that I think are high  
16 cost and not better quality. So that's --

17           DR. MILSTEIN: I agree with Michael. I think I  
18 was trying -- I wasn't addressing policy implications. I  
19 was simply saying, can we enlarge and enrich the dashboard  
20 that we build with respect to access measures, especially  
21 access measures affecting people who are not affluent enough  
22 to buy Med Supp. In terms of policy implications, I'm

1 probably with Michael in terms of how I would respond to it.  
2 But I think it improves the -- I think it gives us the  
3 ability to triangulate, and I think diversity of access  
4 measures would only benefit us.

5 DR. MARK MILLER: Just a very fundamental point.  
6 I mean, we do consult each year with Paul and HSC when we  
7 come up to our access analysis. However, again, to your  
8 point, it has mostly been focused on the physician side of  
9 things and what they're hearing there, and we can certainly  
10 cast the net more wide. But we talk to them each time --  
11 every year at this time of the year.

12 MR. BUTLER: Now we're in round two, right?

13 MR. HACKBARTH: Yes.

14 MR. BUTLER: Okay. First, the narrower question.  
15 You're looking for guidance specifically on information to  
16 help guide our update factor for next month. So on the  
17 Medicare Select, I'm not -- that's not my favorite and I'll  
18 tell you why. First, it is people that -- I'm not sure what  
19 -- it's a very small number right now, and I think people  
20 would forego the deductible primarily for increase in  
21 volume. That's not to say they'd do it for all Medicare,  
22 but more importantly, we already know in the Medicare

1 Advantage plans, where it's voluntary to contract, that  
2 hospitals are not doing it for the Medicare rate.

3           So if you want to use it for the Medicare Select  
4 argument, then you would have to use it for the Medicare  
5 Advantage, which we know is one of the reasons why Medicare  
6 Advantage in certain markets are high, because hospitals are  
7 not -- they're saying Medicare is not enough. I'm not going  
8 to participate at Medicare rates. So I think you'd have to  
9 look at that side, as well, if you want to look at an  
10 indicator of what hospitals would be willing to do, because  
11 they've already spoken on Medicare Advantage and they've  
12 said, I'm willing to walk away from the Medicare Advantage  
13 plan at Medicare rates.

14           Now, back to the bigger kind of picture. I agree  
15 with Glenn that employment is a good thing to have on the  
16 table. I don't think we want to draw too many quick  
17 conclusions, but it informs more just than the financial  
18 health of the institution, and let me just paint a little  
19 picture of kind of a barbell, the haves and have-nots, and  
20 what I think these numbers are telling us. Then I look at  
21 our own market ourselves.

22           There are those that are spending money on

1 capital, and by the way, knowing the IT piece would be an  
2 interesting piece of tracking capital because it's something  
3 we want. People are -- there are a certain set of  
4 institutions that are anticipating stimulus dollars. They  
5 are the same ones that the physicians are lining up who's  
6 going to win in my market, whether it's lining up for  
7 Kaiser, maybe, in a market, as easier to employ than before,  
8 or lining up with hospitals, those institutions that are  
9 going to have the IT support, the environment, the success.  
10 And so it is not just individual doctors. It is their  
11 staffs with them that are flipping into employment  
12 relationships. And it's not just hospitalists and ER  
13 doctors. It's physicians that are really, as we pointed out  
14 last month, that are lining up.

15 I know in our own numbers, that's where you would  
16 see the biggest increase of all. But it's also in the  
17 quality infrastructure in anticipation of whether it's  
18 readmission rates or -- I know our quality staff, that's a  
19 growth area. Our IT staff has grown. And so some of where  
20 you want growth -- in fact, some of these areas are things  
21 that you want hospitals to invest in in order to perform so  
22 that actually they can take costs out of the system. So if

1 I look at our own numbers, that's where the increase is.  
2 It's not the number of nurses at the bedside, that we're  
3 sloppy on productivity. It's in these other areas.

4 But contrast that to the other set of hospitals in  
5 our market that may look efficient, and, in fact, are  
6 efficient, but their capital spending is low. They're not  
7 putting money into IT. They're not putting money into the  
8 quality infrastructure. And yes, they may be able to do  
9 pretty well right now compared to Medicare, compared to  
10 others, but they're falling rapidly behind and they're kind  
11 of one stimulus dollar away from it. So when it comes  
12 December of next year, these are the same institutions  
13 largely that have been helped a bit by the stimulus dollars  
14 in the short run, but when that -- and has sped up some of  
15 the Medicaid payments that have lagged behind -- some of  
16 those have caught up in States, and in December of next  
17 year, you face another threshold.

18 So I don't know what all that is saying, but it is  
19 kind of reflective of what is happening in markets, I think,  
20 overall.

21 MR. HACKBARTH: I'd like to pick up on a couple of  
22 things that you said, Peter. First of all, what do we know

1 about the relationship between the rates that private plans  
2 pay versus Medicare? Is there any systematic information  
3 about that? We do that for physician services using a  
4 sample of private insurers. So that would be one question.

5           And then on this issue of the haves and the have-  
6 nots, so to speak, we've gone through our analysis that  
7 showed that institutions that don't have the luxury of a lot  
8 of high private payers can, in fact, lower their costs, but  
9 that's a static look at the issue. So long as the money  
10 keeps flowing into their competitor institutions that allows  
11 those institutions to do more stuff, their competitive  
12 position can erode even if they are profitable on the  
13 Medicare business, especially if the purchaser community is  
14 not really focused on buying value but people are just going  
15 to who's got the nicest atrium and the most whiz-bang  
16 programs.

17           So I wouldn't draw the conclusion that although  
18 those institutions that are constrained can break even or  
19 make a little money on Medicare, that this is a sustainable  
20 situation so long as all this money is flowing in from the  
21 private side.

22           MR. BUTLER: Some of your conclusions, I agree

1 with. I guess I'd probably state it in a different way.  
2 But there's fallouts in the market that could occur that are  
3 not necessarily in the places that you want it to have  
4 happen, and how we reflect that or get that into the pricing  
5 is a -- we all do these across-the-board things and,  
6 frankly, we'll be arguing about whether it's -- there's not  
7 a lot of money to hand out anyway, but it is an important  
8 question, if we could get around those leading indicators,  
9 as well.

10 And I mentioned IT spending. It would be very  
11 interesting to see on some of these places that we call  
12 efficient, are they advancing the IT agenda, for example,  
13 because if you don't have that, as we pointed out even in  
14 the previous sessions, you are going to be out of luck.

15 MR. HACKBARTH: On the issue of database, a way of  
16 more systematically comparing private and Medicare rates --

17 DR. STENSLAND: I think we can come back to you  
18 next month and have a little more breakdown on what the  
19 margins are for private payers between the private pay non-  
20 Medicare business that they get and then the margins that  
21 they get on their Medicare Advantage payments. I think we  
22 can do that on an aggregate basis. I think we can look into

1 last year's data, at least, and come up with that. But we  
2 don't have individual, by person, or even by hospital  
3 breakdown of that. It would have to be at a national level.

4 MR. HACKBARTH: Yes, I sort of suspected that that  
5 was the answer. So at the highest level, we have the  
6 aggregate information on private payment-to-cost ratios, but  
7 we have little ability to dig beneath that and say that the  
8 rates paid by Medicare Advantage plans or plans that have  
9 negotiating leverage because they have closed networks are  
10 these and they compare to Medicare.

11 DR. STENSLAND: I think we can look at Medicare  
12 Advantage plans as one big group, but we can't break it down  
13 to say Medicare Advantage plans in Chicago or what they're  
14 paying them.

15 MR. HACKBARTH: Yes, or closed HMO versus --

16 DR. STENSLAND: Right.

17 DR. MARK MILLER: Yes. Jeff, I was kind of  
18 surprised by that answer, the MA piece of it. We're pulling  
19 this off the cost report?

20 DR. STENSLAND: This is from the AHA survey, so  
21 AHA annually does a survey and they share some aggregate  
22 data with us. They kindly do that. So we don't get the

1 data directly. They get the data, they aggregate the data,  
2 and then we see the aggregate numbers. So we don't see any  
3 individual numbers from any individual insurer or individual  
4 hospital. We just get the national numbers from AHA.

5 DR. MARK MILLER: Okay. So this would be very  
6 different than Medicare allowable cost or anything like  
7 that?

8 DR. STENSLAND: Yes.

9 DR. MARK MILLER: All right. So we can take a  
10 look at this. There may be some caveats that will travel  
11 along with this.

12 DR. CHERNEW: There are databases, like the HCUP  
13 database is the most widely known database of hospital  
14 discharges. I just don't know -- in many cases we've been  
15 trying to get in other settings, it's considered proprietary  
16 what Plan X pays Hospital Y, and so in many of these  
17 databases, they will give you a cost number that is not  
18 actually what was paid but what is sort of a standard  
19 number. So I don't know what that is.

20 There are other places you might actually really  
21 get what was paid, although there might be some other  
22 issues. For example, Medstat has a database that includes a

1 lot of Medicare beneficiaries and actually does have in it  
2 paid claims amounts. So pending confidentiality issues,  
3 like you wouldn't release this was from one health plan or  
4 another, you might be able to access the actual payment  
5 rates from large claims databases like the Medstat database.

6 MR. HACKBARTH: Okay. We're down to our last  
7 little bit here.

8 DR. KANE: I mean, actually, there are some States  
9 that have all-payer data sets now that you can look at them,  
10 at the State level, anyway, differences in the payment-to-  
11 cost ratios by pretty specific payer types.

12 But I guess, just to react to the idea of how to  
13 measure access and adequacy of payment, it seems that the  
14 measures of employment and medical participation in Medicare  
15 Select, they just really seem like proxies that are much  
16 better measured more directly. So certainly, I mean -- I  
17 agree with the comment, I think it was Mike's comment, that  
18 don't we survey beneficiaries as to whether they have long  
19 wait times or can't get in for elective surgery? We do  
20 survey beneficiaries a lot, but don't we have some of the  
21 direct measures of beneficiary access, or even patient  
22 complaints? Given all the measuring we are doing about

1 plans and all these other things, there should be some good  
2 ways to measure beneficiary access. So that's one comment,  
3 that I think I'd rather see the direct measures than these  
4 indirect ones.

5 I do have a concern with the availability of  
6 trauma care, from what I've heard, that there's a lot of  
7 markets where there isn't adequate trauma capacity and that  
8 some places are still on divert and people wait for a long  
9 time. And I'm wondering if those might be better --  
10 something to consider for quality metrics, is what's the  
11 wait time from when you arrive with an emergency and when  
12 you get seen or get admitted. And I know that data is  
13 available. I know my State collects those kinds of things  
14 and maybe we should be looking at those metrics in terms of  
15 service capability and adequacy rather than these kind of  
16 very broad, it's available but is it open all the time? Can  
17 you get in?

18 And then, finally, on financial measures, I mean,  
19 that's what I do for a lot of States, is I do financial  
20 analysis. You know, we're looking at the tiniest piece of  
21 information we can, Medicare margins and total margins.  
22 There's much better, broader data sets out there around

1 financial measures, and including capital spending over a  
2 five- to seven-year period relative to the depreciation and  
3 age of plant and balance sheet stability for ability to  
4 invest in the future. I mean, there's many, many better  
5 measures out there that we all know how to use, but you just  
6 can't get it off the Medicare cost report because the  
7 balance sheet data there is pretty bad.

8 I did a report on this before I joined the  
9 Commission, but I do think if we really do care about how  
10 well hospitals are going to survive this big round of  
11 investment in infrastructure, it might be worth at least  
12 picking a few sentinel markets and going in depth and trying  
13 to see if the hospitals that are big Medicare beneficiary  
14 hospitals are likely to be able to be competitive with ones  
15 that may have much more commercial or a different payer mix.  
16 No, it doesn't have to be on everybody, but you could  
17 definitely develop some -- sort of like what the Ginsburg  
18 study does, but with more financial measures. That data is  
19 available. It's public, actually. Increasingly, you can  
20 download it off the municipal repositories for free.

21 I would just encourage you to try to think about a  
22 broader set of financial measures, because there's much more

1 useful stuff out there than margins.

2 DR. STUART: Just responding to the question about  
3 access to care, the Medicare Current Beneficiary Survey  
4 actually has two components, and you know this. The  
5 component that's relevant to Nancy's question is the access  
6 to care, and there are a battery of questions about various  
7 sources of care, primarily ambulatory, but it also covers  
8 outpatient hospital and it includes such things as how  
9 difficult is it to get an appointment, how much time it took  
10 to wait in the office, and there are some other kinds of  
11 things that could be correlated, at least with the  
12 outpatient side of hospitalization if not the inpatient  
13 side.

14 MR. GEORGE MILLER: Thank you. To the questions,  
15 I agree with Peter's comments and Nancy concerning these  
16 measures being a direct method. I believe they are  
17 indirect.

18 I want to deal with the Medicare Select issue. I  
19 have a concern with the graph and the numbers because three  
20 of those States are small, poorer States. They have a high  
21 percentage of low-income people, and three of them, Alabama,  
22 Kentucky, and Louisiana, have a higher percentage of rural

1 hospitals in those States. And some of those may be sole  
2 community providers, sole community hospitals, and therefore  
3 they, as I said earlier, may choose to waive the copay and  
4 the deductible. And in those States, I wonder about the  
5 wage index issue, if that doesn't factor into the reason why  
6 they may be willing to take Medicare Select, because they  
7 would get a better reimbursement thinking or figuring  
8 they're not going to get the copay -- not a better  
9 reimbursement, I'm saying, but thinking they would get a  
10 reimbursement, because again, they're not getting the copay  
11 and the deductible.

12 I don't know with six States you can draw a  
13 conclusion for the entire nation. I think there's about a  
14 million people in the plan. So I don't know if you plan to  
15 interpolate that for the entire nation, but I'd have a  
16 problem with that. It may be indirect measure. It may be a  
17 way to select it. But I think we need to peel back the  
18 onion and dig into it more for the reasons of the  
19 conclusions from this report. But I don't think you can  
20 interpolate for all hospitals across America based on that.

21 To the point about capital, Nancy mentioned about  
22 the balance sheet. Moody's, for example, downgraded more

1 hospitals this last quarter, which is another indication of  
2 the strength of hospitals, unfortunately, than they  
3 upgraded.

4           And to Peter's point about part of that capital  
5 being health information technology, not only do you have  
6 that capital cost, but you have got to hire more staff and  
7 that may relate to some of the growth capacity. So again,  
8 I'm not sure increase in hiring is an appropriate measure.  
9 It may be one tool, but an appropriate measure for capacity.  
10 I think there's others, as Nancy indicated.

11           DR. CASTELLANOS: Just hitting some of the things  
12 that have already been said, I agree. Hospital openings,  
13 closures, service, construction, these are proxies for  
14 payment adequacies. But the subject really is access to  
15 hospital services and I don't think we're addressing that.

16           It was somewhat addressed by Mike and Nancy and  
17 Bruce just recently on the patient side, and I think that's  
18 extremely important. We need to get that. But I think you  
19 need to also address it on the physician side. I want to  
20 know what services are available, ancillaries that are  
21 available, whether the hospital has IT available, the  
22 quality of the hospital I participate in, and the

1 infrastructure.

2           Now, I know on the physician side, you go out and  
3 do surveys. I don't know why we can't -- not for this  
4 section or this time period, but I think it would be  
5 important to go out and get some surveys, just like we do on  
6 the physician side, to the patient and to the physician to  
7 see where we stand. I think we're going to be surprised.

8           MR. HACKBARTH: Okay. We are at 12 o'clock.

9 Thank you, and we'll look forward to hearing much more about  
10 payment adequacy for hospitals next month.

11           We'll now have our public comment period for  
12 anybody wishing to make a comment.

13           [No response.]

14           MR. HACKBARTH: Seeing nobody approaching the  
15 microphone, we are adjourned. We'll see you in December.

16           [Whereupon, at 12:01 p.m., the meeting was  
17 adjourned.]

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