

## MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

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

Thursday, November 4, 2010  
9:11 a.m.

## COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, JD, Chair  
ROBERT BERENSON, MD, FACP, Vice Chair  
SCOTT ARMSTRONG, MBA  
KATHERINE BAICKER, PhD  
MITRA BEHROOZI, JD  
KAREN R. BORMAN, MD  
RONALD D. CASTELLANOS, MD  
MICHAEL CHERNEW, PhD  
THOMAS M. DEAN, MD  
JENNIE CHIN HANSEN, RN, MSN, FAAN  
NANCY M. KANE, DBA  
GEORGE N. MILLER, JR., MHA  
BRUCE STUART, PhD  
CORI UCCELLO, FSA, MAAA, MPP

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1 P R O C E E D I N G S [9:11 a.m.]

2 MR. HACKBARTH: Good morning. We have two agenda  
3 items before lunch today. First is care coordination for  
4 dual eligibles, and then second is findings from rural site  
5 visits.

6 At the end of the morning session, as always, we  
7 will have a brief public comment period.

8 So first us is care coordination for duals.  
9 Carol?

10 DR. CARTER: Great. Good morning. Today we're  
11 presenting on coordinating the care for dual-eligible  
12 beneficiaries. Dual eligibles are enrolled in both Medicare  
13 and Medicaid. They make up one-sixth of Medicare  
14 enrollment, but account for one-quarter of program spending.

15 In June, we reported that not only does Medicare's  
16 fee-for-service payments include few incentives to  
17 coordinate care, but Medicaid and Medicare do not work in  
18 concert to manage these beneficiaries' care. This  
19 population is diverse, but compared to other beneficiaries,  
20 it is more likely to be disabled and to have poor health  
21 status. Combined Medicare and Medicaid spending on this  
22 population is highly variable, reflecting whether the

1 beneficiary has dementia, the number of chronic conditions  
2 they have, and the amount of nursing home care they receive.

3           The June report also described the programs that  
4 are fully integrated and noted that to manage the care for  
5 this population, programs needed to integrate both the  
6 financing and care coordination across the services covered  
7 by Medicaid and Medicare. We said that we would examine how  
8 these programs coordinate the care for that population.

9           Today we're reporting on site visits and  
10 interviews we conducted with state and program  
11 representatives about the care coordination programs. We  
12 interviewed officials from nine states and conducted site  
13 visits to three of them. We contracted with Mathematica to  
14 conduct these site visits and participated in all of them.

15           Among the programs, we selected a mix of  
16 approaches to care coordination, including a well-  
17 established, fully integrated program; a new medical home  
18 model; and a relatively new Medicaid managed care long-term  
19 care program with companion SNP plans.

20           We also talked with officials in states that tried  
21 and failed to implement an integrated program to learn what  
22 didn't work. We also spoke with three PACE providers and

1 visited two and spoke with many other stakeholders that are  
2 listed in the mailing materials.

3 We found that integrated state programs vary  
4 considerably. States have taken different approaches, some  
5 building out their Medicaid managed care programs, others  
6 relying on care coordination overlay to their fee-for-  
7 service system. States also vary in their readiness to  
8 integrate the financing and care coordination, some willing  
9 to assume full risk for dual-eligible populations and others  
10 not.

11 Programs vary in the range of services they  
12 coordinate. The North Carolina Primary Care Network  
13 coordinates only acute-care services. In contrast, the  
14 fully integrated programs coordinate all services, including  
15 long-term care. The lack of results from most programs  
16 leaves open the question of whether the models are effective  
17 at lowering spending and coordinating care.

18 Administrators agreed that ideally to control  
19 spending and to manage the care for this population, a  
20 program should be at full risk for the full array of  
21 services. Financial integration gives a program the  
22 flexibility to furnish services a beneficiary needs,

1 including those not covered by either program, such as  
2 installing grab bars in bathrooms or furnishing air  
3 conditioners to beneficiaries in the summer. Administrators  
4 also appreciated that to fully coordinate the care, they  
5 needed to manage all services.

6           Providers were not always on board, and in some  
7 states stakeholder opposition had limited the scope of their  
8 program. For example, in some states the nursing home  
9 industry was concerned about lower volume or lower payments  
10 that might accompany integrated programs. Some behavioral  
11 health providers prefer their own separate system of care.

12           But the states had several commonalities.  
13 Programs grew out of the states' circumstances and, in  
14 particular, their approach to the Medicaid-only population  
15 and stakeholder support. Programs typically had a champion  
16 to see them through what was usually a long development  
17 process.

18           We also found that programs define their  
19 populations broadly, including or excluding categories such  
20 as the nursing home certifiable, the Community Well, or the  
21 disabled.

22           Our analysis this past spring of spending patterns

1 had led us to consider designing programs around  
2 beneficiaries with certain conditions, such as dementia.  
3 Interviewees disagreed with this approach. They said that  
4 they think about the whole patient and that defining groups  
5 by condition ran counter to this approach.

6           Most interviewees thought that the care  
7 coordination activities would be similar across different  
8 populations. What would differ is the mix of services and  
9 providers that needed to be coordinated. For example,  
10 programs for the disabled might emphasize supporting  
11 independence and include a mix of social, fitness,  
12 community-based, and behavioral health services along with  
13 medical services.

14           The care coordination activities were pretty  
15 similar across the programs, with some variation depending  
16 on the scope of services covered by the programs. The care  
17 coordination activities that were similar are listed on the  
18 left-hand side and include things like assessing a patient's  
19 risk for hospitalization, development of an individualized  
20 care plan, and so on. These activities aim to avert  
21 hospitalizations, institutionalization, and avoiding ER use.

22           The intensity of these activities varied by

1 patient. Their care needs will shape the frequency of  
2 patient monitoring, the mix of services to be coordinated,  
3 and the providers, and the range of services and the ratio  
4 of patients to coordinator.

5 Interviewees had a number of suggestions to  
6 increase enrollment. These included more accurate program  
7 descriptions and marketing materials, expanded efforts to  
8 disseminate information about the programs, and technical  
9 and financial assistance to states and entities that want to  
10 develop integrated care programs. But interviewees were not  
11 optimistic that these suggestions would make a fundamental  
12 difference to enrollment.

13 Many interviewees supported an opt-out enrollment  
14 in which beneficiaries would be assigned to an integrated  
15 program with an easy way to either switch assignments or to  
16 opt out and to revert to fee-for-service care.

17 Some beneficiaries' advocates were supportive of  
18 opt-out enrollment while others were not. Opponents, which  
19 included an administrator of a fully integrated program,  
20 made three arguments:

21 First, beneficiaries would lose their freedom of  
22 choice and would likely have to switch their physicians.



1           Second, to be successful, these programs require  
2 beneficiary buy-in and adherence, which may be lacking if a  
3 beneficiary does not want to be enrolled.

4           Third, some advocates for the disabled oppose opt-  
5 out if it reduces the independence of the disabled.

6           Stakeholders told us that states are reluctant to  
7 develop integrated programs that mostly save Medicare money.  
8 Many state representatives we spoke with wanted their state  
9 to benefit from their investments that result in Medicare  
10 savings. Some states hope that better coordination would  
11 lower their spending on long-term care.

12           In implementing fully integrated programs, states  
13 and programs used a mix of incentives to win over  
14 stakeholder opposition. For example, to gain nursing home  
15 support, the industry in one state was offered incentive  
16 payments so that they continued to be paid for a certain  
17 period of time after a beneficiary was discharged to the  
18 community, and nurses were placed in facilities to increase  
19 their staffing. State officials underlined how important  
20 adequate payments were to maintaining a network of  
21 providers.

22           In sum, the programs vary in their approach,

1 scale, and scope of services included and reflected state-  
2 specific circumstances. Combined with limited results, it  
3 wasn't clear how replicable the programs would be. There is  
4 a lack of managed care plan, state, and federal experience  
5 in managing the full range of services, especially long-term  
6 care and behavioral health. And, finally, enrollment is  
7 unlikely to expand much without an opt-out enrollment.  
8 These observations brought us to consider how to build out  
9 existing approaches to care integration.

10 MS. AGUIAR: As Carol discussed, we learned from  
11 the site visits and interviews that integrated care programs  
12 are small in number and scale and are not likely to be  
13 replicated widely. The next step is to continue to examine  
14 the strengths and weaknesses of integrated care approaches  
15 and how these programs can be modified to serve more dual-  
16 eligible beneficiaries. Ideally, care coordination  
17 approaches would integrate all of the financing and care  
18 coordination for dual-eligible beneficiaries. There are  
19 currently two approaches that accomplish this. Under fully  
20 integrated managed care plans, a managed care organization  
21 integrates the financing and care coordination. And under  
22 the PACE program, the integration occurs through a provider.

1           Both of these approaches are jointly financed by  
2 Medicare and Medicaid, with the managed care plan or the  
3 PACE provider receiving capitated payments from each  
4 program. The plan or provider is then at risk for dual-  
5 eligible beneficiaries' acute and long-term care services.

6           Two other approaches -- medical homes and care  
7 coordination demonstration programs -- add care coordination  
8 activities to the existing fee-for-service Medicare and  
9 Medicaid payment systems. These care coordination-only  
10 approaches are limited because they do not integrate  
11 Medicare and Medicaid program finances, and they also  
12 maintain the incentives in the fee-for-service system.  
13 However, we include these approaches here because states  
14 that are not interested in a managed care approach may  
15 prefer a medical home model and because a number of care  
16 coordination models are being tested through CMS  
17 demonstrations.

18           The capitated and full-risk structure of  
19 integrated financing and care coordination programs gives  
20 the managed care plans and PACE providers the incentive and  
21 flexibility to intervene with medical and social services,  
22 including those that are not covered by either program.

1 These interventions can help beneficiaries avoid costly  
2 hospitalizations and nursing home placements.

3           Expanding fully integrated managed care plans and  
4 PACE providers will be challenging. Administrative barriers  
5 between the Medicare and Medicaid programs will have to be  
6 overcome. The Federal Coordinated Health Care Office is  
7 establishing a program alignment division to work on these  
8 issues. In addition, there is a lack of experience with  
9 managed long-term care. Only 13 states currently include or  
10 plan to include long-term care services in managed care, and  
11 most Medicaid managed care plans and Medicare Advantage  
12 plans do not cover long-term care services.

13           Further, enrollment in fully integrated care  
14 programs is low. For example, despite the success of the  
15 PACE program in lowering hospitalizations and emergency room  
16 visits, less than 1 percent of beneficiaries enroll in the  
17 program and less than 2 percent of dual-eligible  
18 beneficiaries are enrolled in fully integrated SNPs.

19           Medical homes and care coordination programs,  
20 routine fee-for-service, and add care coordination  
21 activities by receiving a per member/per month fee to  
22 coordinate a beneficiary's care. The medical home approach

1 has been implemented in North Carolina. Under this program,  
2 the state pays a network of primary care physicians, a small  
3 per member/per month fee to manage only the acute services  
4 for the dual-eligible beneficiaries.

5 Another care coordination-only approach is the  
6 Medicare care coordination benefit. A few care coordination  
7 programs such as the Independence at Home demonstration and  
8 the Community-based Care Transition program, will be tested  
9 as demonstrations under PPACA. Medical homes and a care  
10 coordination benefit could cover both acute and long-term  
11 care services and could be jointly financed by Medicare and  
12 Medicaid. However, the North Carolina program and the  
13 demonstration programs focus on managing acute-care  
14 services, but do not coordinate Medicaid services.

15 In addition, although medical home and care  
16 coordination providers could be at risk for some portion of  
17 their monthly payment, the providers are not at financial  
18 risk for acute and long-term care services, and their  
19 ability to control spending will be limited as a result.  
20 Further, because providers will continue to operate in a  
21 fee-for-service environment, fee-for-service spending  
22 incentives will remain, and providers will now have the

1 flexibility to offer their services that could contribute to  
2 a beneficiary's well-being but are not covered by either  
3 program.

4           The fee-for-service with care coordination  
5 approaches offer a way to begin to coordinate beneficiaries'  
6 care and may be a realistic step towards care management in  
7 many states and in the Medicare program. Compared to the  
8 integrated financing and care coordination programs, though,  
9 these approaches are less likely to be as effective at  
10 coordinating care and controlling costs. In addition,  
11 medical homes or care coordination entities would have to  
12 become at risk for acute and long-term care services in  
13 order for these approaches to transition to programs that  
14 integrate both financing and care coordination.

15           The next phase of work could focus on three main  
16 areas. For one, we could explore how the PACE program could  
17 be expanded. Because PACE already covers the full scope of  
18 Medicare and Medicaid services, we would explore the  
19 expansion of PACE along two dimensions: geographic service  
20 areas and dual-eligible sub-groups eligible for enrollment.  
21 The focus of the work would be to identify how the PACE  
22 model can be altered to expand geographically and to non-

1 nursing home certifiable beneficiaries without losing the  
2 critical elements of the model.

3 For example, we could possibly begin by looking at  
4 the experience of the 13 rural PACE sites. The information  
5 from this work would not only inform how to expand PACE, but  
6 it could also be used by other providers that are interested  
7 in developing an integrated financing and care coordination  
8 program for dual-eligible beneficiaries.

9 A second area of focus could be to explore how  
10 Medicaid managed care plans and SNPs could be scaled up to  
11 cover long-term and behavioral health services, serve more  
12 geographic regions within a state, and serve all sub-groups  
13 of dual-eligible beneficiaries.

14 Finally, we could focus on exploring ways to  
15 increase enrollment in integrated care programs. For  
16 example, we could explore opt-out enrollment and how passive  
17 enrollment to Part D plans worked for some states and not  
18 for others. An opt-out enrollment policy would need to  
19 consider protections for dual-eligible beneficiaries, such  
20 as choice among multiple integrated programs, the breadth of  
21 the provider network, and an easy process to switch  
22 integrated providers or disenroll back to fee-for-service.

1           We would appreciate Commissioners' feedback on  
2 these two questions. Are there priorities for the next  
3 phase of work? And are there additional programs or  
4 directions that we should focus on?

5           Thank you.

6           MR. HACKBARTH: Thank you, Christine and Carol.

7           So let me see hands for first round clarifying  
8 questions.

9           MR. ARMSTRONG: I think this is a clarifying  
10 question. I understand -- actually, I'm not that familiar  
11 with these programs, but I understand through the material  
12 and your presentation that results of the interviews and  
13 what we know led to some general comments about what we  
14 would expect the effectiveness of coordinated programs  
15 versus fee-for-service reimbursement and coordination on top  
16 of that to be. But do we have any data that would actually  
17 objectively describe outcomes for patients that live in  
18 those two different models?

19           MS. AGUIAR: The outcomes research is very  
20 limited. Of the existing integrated programs, which were  
21 the ones that we visited this summer, there are some  
22 evaluations of PACE. There were a few others of the



1 Minnesota program. There was a literature review done by  
2 Professor Grabowski at Harvard that we were looking at that  
3 really went through the evaluations of all of the state SNP  
4 capitated programs as well as the PACE program, and did find  
5 some problems with the way that the evaluations were done.  
6 And the results are somewhat mixed. They tended to find  
7 improvements in quality of care and satisfaction, and  
8 results on the cost savings were a little bit mixed. So the  
9 evidence we say is limited. It is a little bit thin.

10 For the care coordination programs, I would say  
11 probably the care coordination benefit and the medical home,  
12 I think probably the best look is the Medicare care  
13 coordination demos that have been going on. We have not  
14 looked at the results of that, but we are aware that there  
15 was a conference that CMS spoke at a few weeks ago where  
16 they said that the results on those programs are limited.  
17 So that result is a little weaker.

18 The North Carolina medical home model just really  
19 began in January. It expanded to duals in January.  
20 Previously it was just for the Medicaid-only population.  
21 And so the evaluation of that hasn't been done yet.

22 DR. CHERNEW: There are probably many slides on

1 which this question could be asked, but maybe on Slide 11 is  
2 where I first noticed it, which is where it talks about, you  
3 know, the payment being jointly financed by Medicare and the  
4 states through capitation. So I'm confused about how this  
5 relates to Medicare Advantage and the Medicare Advantage  
6 payment rates and how the states are setting up the rates  
7 compared to the Medicare component of the rates and what  
8 that integration actually means.

9 I had thought that SNPs were paid in an MA  
10 Advantage kind of way with Medicare funds.

11 MS. AGUIAR: That's correct. That is right. So  
12 the integrated plans that we're talking about is one managed  
13 care company that is both a Medicaid managed care plan and  
14 has a companion SNP. And so for the Medicare side, they  
15 receive the Medicare Advantage SNP payment rates. On the  
16 Medicaid side, they negotiate with the states for what the  
17 rates will be for those Medicaid benefits.

18 DR. CHERNEW: So when it gets capitated, do those  
19 numbers get added together and they're receiving -- from  
20 your answer, it sounds like there's two streams of money  
21 they're getting.

22 MS. AGUIAR: That's correct, yes.

1 DR. CHERNEW: And [off microphone] joint  
2 capitation.

3 MS. AGUIAR: Right, and I see -- I think your  
4 question is touching --

5 DR. CHERNEW: Jennie probably knows.

6 MS. AGUIAR: I think it's touching upon a common  
7 concern that these programs have had because they are  
8 getting two separate funding streams that are not  
9 commingled. And so that touches on some of the  
10 administrative barriers of operating these programs.

11 DR. CHERNEW: So it's actually not jointly  
12 financed in the sense of like coordinatedly financed.

13 MS. AGUIAR: Exactly. When we say jointly  
14 financed, we mean that both programs, Medicare and Medicaid,  
15 are giving capitated rates to one entity.

16 DR. STUART: When you read this chapter, you  
17 realize just how daunting this is, and that's only one of  
18 the problems. But I was taken by one of your site visits --  
19 I believe it was New Mexico -- where you indicated that the  
20 contractor was unable to identify half of all of the dual  
21 eligibles in that state. And I'm wondering. You'd think  
22 that that would be a no-brainer. And I guess my question

1 is: Why is that a problem? And then how widespread do you  
2 think it is?

3 DR. CARTER: I think there are two problems, one  
4 in New Mexico but we heard it in other states as well. One  
5 was just having a list of the dual eligibles. It seems very  
6 straightforward, but, in fact, states don't always have the  
7 resources even to put together a list so an entity knows who  
8 are the beneficiaries eligible for programs in their area.

9 The second thing we heard in New Mexico was once  
10 they even knew and had identified the beneficiaries, they  
11 simply couldn't locate them. And that problem, you'll see  
12 in the chapter it did diminish considerably over time, but  
13 it was a problem that they couldn't -- you know, this is a  
14 population that may move, that doesn't necessarily have  
15 telephone service, and so they were just hard to physically  
16 locate.

17 DR. STUART: Did you find this as an issue in the  
18 other sites that you visited?

19 DR. CARTER: No, we did not. The actual locating,  
20 right, no.

21 MS. KANE: Bruce was looking at my question, so he  
22 asked it.

1 [Laughter.]

2 MS. KANE: I'm not sure which round this should be  
3 in, but is there any place in the ACA or all these Medicare  
4 payment innovation pilots where Medicaid is considered a  
5 partner or is expected to play a role? I mean, some of this  
6 stuff would naturally fall -- I mean, if you were an ACO,  
7 are there any incentives in any of the acts to try to  
8 encourage Medicaid participation that might encourage more  
9 of this, you know, trying to manage the care as a system?

10 MS. AGUIAR: I don't believe in the ACO demo that  
11 that explicitly includes dual-eligible beneficiaries or  
12 Medicaid. That is something that Melanie Bella from the  
13 Federal Coordinated Health Care Office has said is a  
14 priority for them or something that they are interested in  
15 looking at. But it wasn't explicit in the legislation. At  
16 least I don't believe so.

17 DR. MARK MILLER: And I'll say this, and actually  
18 we can -- there's probably some more detail that we could go  
19 through and bring up on this on how demonstrations would  
20 work. But one thing to keep in mind on Scott's question and  
21 perhaps your question is the evidence here is really thin.  
22 And, you know, there's a lot of sense of people on the

1 ground, I think this can work for the following reasons and,  
2 you know, some logical arguments for it.

3 But one marker to put out in the distance as we  
4 think through this is whether what the Commission starts  
5 talking about is developing demonstration platforms where  
6 you can actually get both the evidence and much more of the  
7 integration. So down the line, but it's a marker to sort of  
8 think about it. If it turns out that there's not a lot to  
9 build on here, that's one thing that you guys can be  
10 thinking of as we go down the line.

11 MS. HANSEN: First, a disclosure, and that is, I  
12 was connected to the original PACE program for just about 25  
13 years, so in the course of that, I probably know some levels  
14 of detail that would be more specific. But my question  
15 right now is relative to talking to the states at the state  
16 level. Are there plans for checking in on how they manage  
17 at the state level with the dual contracting arrangement  
18 that they've set up? Because this is one of the things that  
19 relates to SNPs about how Medicare and Medicaid come  
20 together at the state level and also at the CMS level. So  
21 any plans for discussing what makes it possible to kind of  
22 get going? Or is that the 13 states that you're alluding to

1 that you'll have a chance to follow up a little bit more on?

2 DR. CARTER: We were thinking for the 13 states  
3 that -- I think that number is the number of states that  
4 have Medicaid long-term care, managed long-term care, right?

5 MS. HANSEN: I guess my question is, pulling back,  
6 some of the issues are really at how states that have chosen  
7 to embrace, whether it's PACE or something else, the full  
8 dual aspects of it, the ability to have some interviews at  
9 that state level to understand really what has led them to  
10 that ability and what was necessary to make it possible for  
11 them to come to a comfort level to kind of dive in to do  
12 that, so just understanding the mechanics. Because I must  
13 tell you, having dealt with many, many states, that's a very  
14 crucial part of the formula in addition to the outcomes.  
15 But even getting these off the ground is just absolutely  
16 important to identify what are the possible barriers and the  
17 success possibilities that make this platform of duals  
18 possible in a go-forward basis.

19 DR. CARTER: I felt like we did talk -- with the  
20 states that we interviewed, I felt like we got a flavor for  
21 that, and I know that the Office of the Duals is  
22 particularly interested and working -- but when you talk

1 about the barriers and sort of how long these take to get  
2 going, I know that that is something on the operations side  
3 that that office will be focusing on. I think her office is  
4 -- she's planning on splitting her office, and some of her  
5 staff will be devoted to ironing out really what we heard  
6 were multiple operations barriers. But I don't know that  
7 that office will -- part of what you're asking is sort of  
8 how do states sort of turn the corner and decide to kind of  
9 plunge in with both feet. And I think we got a little bit  
10 of a flavor for that. And certainly -- I mean, one of the  
11 things that I found frustrating about the site visits was  
12 the role of a champion, which really is important and pretty  
13 hard to replicate, and sort of a consistency at the  
14 governor's level and at the state agency level. And you  
15 don't have that in a lot of states either.

16 So those are sort of external to sort of even any  
17 kind of programmatic design that might be ready to go, sort  
18 of that continuity in personnel is something that you just  
19 really aren't going to have in a lot of states.

20 MS. AGUIAR: I would just add that also, you know,  
21 as part of this, as Carol mentioned, we spoke with two  
22 states -- Virginia and Maryland -- that had tried to develop



1 these programs and weren't able to, and largely because of  
2 stakeholder resistance and some other problems as well. You  
3 know, just from talking to some other states, as well that  
4 we were able to attend a conference with states and so to  
5 get some of their feedback, we definitely got the impression  
6 that the states recognize that the long-term costs are  
7 significant and that it is a problem that they want to  
8 address, but lack the resources, both financial and staff  
9 and expertise, to be able to do. And so I think there is --  
10 or at least the sense that I got is there's sort of a need  
11 for technical assistance to help states to really get off  
12 the ground. And other states just may not be really there  
13 or interested in really developing these programs. So I  
14 think it varies.

15 MR. GEORGE MILLER: I want to focus on the reading  
16 material about the caption, the right-sizing care  
17 coordination, and then from your sense and what I have read  
18 about right-sizing care coordination, if the opt-out portion  
19 is very critical for right-sizing coordination. Did I  
20 understand, or my conclusion from what I read is that if you  
21 had the opt-out portion included, then you could best deal  
22 with right-sizing. You mentioned numbers of between 200 and

1 500 participants in the paper. Is that the ideal set of  
2 circumstances to make right-sizing work with the opt-out  
3 option so that folks who would have to opt out and be able  
4 to deal with the problem you maybe had in New Mexico of  
5 finding all the beneficiaries? Is that the critical pathway  
6 to make this work in the States, from your perspective?

7 DR. CARTER: I don't think we have systematically  
8 looked at sort of what is the right ratio of sort of what a  
9 care team, how many enrollees or participants a care team  
10 can manage, and as the paper describes, I mean, the ratios  
11 in North Carolina are very different, but they're  
12 coordinating a very small section of the span of services.  
13 They're only coordinating acute care services. The PACE  
14 model uses, what, 2.5 FTEs for about 125, compared to the  
15 North Carolina model where one person is managing 4,000.  
16 That's a huge span. And we haven't systematically looked  
17 through the information that's available to get a sense, a  
18 better sense of sort of how you right-size those teams  
19 except to only note that, depending on what you are  
20 managing, obviously, and the frailty, because the PACE is  
21 very intensive because of the multiple conditions that those  
22 patients have and their level of frailty.

1           MR. GEORGE MILLER: Well, part of the reason I  
2 asked is because what is said under right-sizing, you want  
3 to try to keep those administrative costs under 12 percent,  
4 but then you also want to talk about the right ratio of  
5 providers to the population. So I just wanted to know how  
6 that played out and how you figured that out and how the  
7 States figured that out, and try to be prescriptive or each  
8 State figures it out on their own. It's more of a comment  
9 than a question.

10           DR. DEAN: Just to clarify, you said that the  
11 North Carolina program dealt only with acute care. Does  
12 that mean everything except long-term care or does it mean  
13 just hospitalization or -- I wasn't sure just what that  
14 covered. I mean, they've made a lot of claims over the  
15 years about the success of their medical home approach and  
16 their Medicaid group --

17           MS. AGUIAR: Right.

18           DR. DEAN: -- and I'm just curious, for what  
19 seemed to be very small investments, at least in their per  
20 member per month payments, but --

21           MS. AGUIAR: Right. So because it is a primary  
22 care physician practice based, it really is only touching on

1 the primary care, the primary and acute care, and the  
2 measures that they will be -- that the networks, the medical  
3 home networks will be evaluated against, because there is a  
4 shared savings component with Medicare, are really acute  
5 care focused. So looking at, like, hemoglobin A1C, diabetes  
6 measures, there is a preventable -- then there's a  
7 rehospitalization rate measure or preventable  
8 rehospitalization rate measure, so there is that one outcome  
9 measure, but they tend to be much more acute care, primary  
10 care focused, and it isn't within the purview of the program  
11 now for the PMPM that's to cover the care coordination  
12 benefit, does not cover Medicaid services. So they're not  
13 managing, as well, any Medicaid home health or Medicaid  
14 nursing home stay or Medicaid home and community-based  
15 services. That's not being managed within the program now.

16 DR. DEAN: But it would include hospitalizations  
17 and sort of routine outpatient care?

18 MS. AGUIAR: Yes.

19 MR. HACKBARTH: A question about the text box on  
20 States as the entity to manage Medicare funds. It says  
21 there are some States, five States, that are interested in  
22 this approach. Would that entail them taking responsibility

1 for all of the duals within their jurisdiction or is that  
2 envisioned as an opt-out sort of model, where it would be an  
3 option for Medicare beneficiaries but they could elect not  
4 to go into it?

5 MS. AGUIAR: Right. Those details, I don't  
6 believe, have been worked out yet. The States are in very  
7 preliminary discussions with the CMS about this model.  
8 Vermont --

9 MR. HACKBARTH: So it could go either way?

10 MS. AGUIAR: Right, and Vermont is interested in  
11 taking responsibility for all of the duals in the State  
12 whereas Massachusetts is looking, I believe, only at the  
13 under-65 population. So I think that the States are  
14 interested in different things and the specifics around that  
15 model haven't been worked out yet.

16 MR. HACKBARTH: But in Massachusetts, which is of  
17 interest to me, so in Massachusetts, is it all of the under-  
18 65s or would people have -- Medicare beneficiaries have the  
19 opportunity to say, no thanks, I don't wish to be part of  
20 it?

21 MS. AGUIAR: We don't know yet if --

22 MR. HACKBARTH: Okay.

1 MS. AGUIAR: -- if they've even discussed that  
2 with CMS or if it's been decided yet.

3 MR. HACKBARTH: Okay. Round two comments and  
4 questions. Karen, Scott, Ron.

5 DR. BORMAN: Do you have any sense of ability to  
6 project a future number of duals or a trending of duals? I  
7 think there's a lot of moving parts going on in the Medicare  
8 program with the baby boomers, things that have happened  
9 more recently in the past several years with our economy.  
10 Do we have any real projection of where this might be going,  
11 that is, that might intensify our interest, lead us to push  
12 things more quickly, or is this something that's kind of  
13 moving along at sort of a very measured, slow increase, or  
14 do you have a sense for that? That would be the first  
15 question.

16 DR. CARTER: We haven't looked at that. I mean, I  
17 assume the Medicare population is growing at a fairly low  
18 rate, but it's expanding, as we all know. And I don't know  
19 what States are doing -- and then, of course, the other  
20 question is eligibility on the State side for dual  
21 enrollment, right, on the Medicaid side. But we haven't  
22 looked at that.

1 DR. BORMAN: I'm just thinking about some of the  
2 21st century beneficiary work that we started down the road  
3 and trying to characterize that longer-term population. Are  
4 we looking to see an increasing number of very vulnerable  
5 people on the financial side or are we looking at a  
6 relatively stable number but a much more hard-lined gap  
7 between haves and have-nots? I mean, I think maybe best  
8 guess might give us a little idea about that.

9 MR. HACKBARTH: Well, to the extent that the  
10 oldest cohort of Medicare beneficiaries is growing in size,  
11 we have more of the very old Medicare beneficiaries.

12 DR. BORMAN: Right.

13 MR. HACKBARTH: Wouldn't there be a higher  
14 propensity in that group to be dual eligibles?

15 MS. AGUIAR: I think the --

16 MR. HACKBARTH: Because if nothing else, running  
17 out of resources --

18 MS. AGUIAR: Right, exactly. So they would be the  
19 spend-down population, the Medicare spend-down population.

20 MR. HACKBARTH: So that would accelerate the  
21 growth in this population to the extent that we're shifting  
22 to the --

1 DR. BORMAN: I'm just thinking here. We had a  
2 group in the original population when the program first  
3 started that perhaps didn't really have pension plans and  
4 certainly didn't have defined contribution plans. Then  
5 we've transitioned through several eras of retirement  
6 planning, and do we have a sense of whether that's really  
7 changed anything or do we just go with the basic assumption  
8 that we're going to have more people in this elder-elder  
9 group and therefore we will have bigger numbers? Just if  
10 there's any information on that, it might inform our  
11 thinking a little bit.

12 I guess another question would be, it appeared to  
13 me that you were starting to define or come in the  
14 conversation, there might be some things that we could  
15 define that would be basic elements of any care  
16 coordination, whether it was totally managed by the States,  
17 whether it was in some contracted entity, whether it was  
18 PACE, whatever it is. Is there some sort of way, if those  
19 could be defined, to translate those essentially into  
20 conditions of participation, if you will, to get the  
21 matching dollars? I mean, I think in terms of trying to  
22 look where is the leverage here, it would appear to me that



1 that's the place and that somewhere at a very early phase in  
2 this, the criteria obviously would be very simple,  
3 relatively low bar, but it would appear to me that we might  
4 look that we have to build over time and what is the  
5 leverage to make it stick.

6 I think Mark's point about demonstrations was  
7 wonderfully well taken because we've got a whole bunch of  
8 money, a whole bunch of folks, and no data. So rather than  
9 just entirely shooting from the hip, demonstrations and  
10 pilots would be helpful, but is there anything that up front  
11 could be built in with these things that are already key to  
12 success? Is there a policy lever to incorporate those?

13 MR. ARMSTRONG: First of all, I just want to begin  
14 by reinforcing the points that were just made. I think that  
15 that's right. I believe that, to your questions, we should  
16 explore ways to scale up managed care plans. I think we  
17 should explore strategies for enrollment, including  
18 understanding much more of the implications of the opt-out  
19 policies that you were talking about.

20 But having said that, I really do -- I have to  
21 say, I have never really known that much about this  
22 population of dual eligibles in my career, but I'm impressed

1 that 16 percent of our beneficiaries are incurring 25  
2 percent of the costs in this population alone, and  
3 particularly impressed by how little we really understand  
4 what's going on and what kind of sophisticated programs we  
5 have for advancing or improving our ability to manage this  
6 population. And so to build objective criteria for how  
7 these programs might look and some measures by which we  
8 would judge success in moving this forward, it seems to me  
9 it's time for us to be doing that kind of work.

10 The last point I would make is just an obvious  
11 one. It seems, just as our Federal payment and care  
12 coordination policies need to be coordinated with the  
13 States, we also need to make sure our policy agenda is  
14 coordinated with MACPAC, and I just kind of assume that we  
15 would be making sure that happens, too.

16 DR. STUART: First of all, good job. I really  
17 like the idea of you talking about care coordination.

18 The first question I have -- and there's two --  
19 one is -- really, one and a half -- care coordination is a  
20 universal problem. It's just not related to dual eligibles.  
21 And I guess if you -- it's just not related to this most  
22 vulnerable group of patients. I guess my first question is,

1 if you exclude managed care, the HMOs, and the PPOs, and  
2 exclude the demonstration projects, the home health ACOs and  
3 the North Carolina program, and so we're just talking about  
4 fee-for-service now, and I know that's -- how many programs  
5 are there available for care coordination in that group of  
6 patients, which is about almost two-thirds of the patients?  
7 Outside of managed care, outside of the demonstration  
8 projects, outside of that in the Medicare program, how many  
9 other programs are there for care coordination?

10 MS. AGUIAR: I don't know the exact number. I  
11 know that there are some more demonstrations that will be  
12 tested through the health reform law. But I don't -- and I  
13 don't know if this is probably a better question for John  
14 Richardson -- if any of the actual previous care  
15 coordination models that were demonstrated in the Medicare  
16 program actually became implemented. Do you know? I don't  
17 think they were, though.

18 DR. STUART: Well, I understand your concern,  
19 because I can't find any, either.

20 MS. AGUIAR: Yes.

21 DR. STUART: But, you know, one of the things  
22 we've always -- and I hope Tom emphasizes this, too -- one

1 of the things we always want to do is to try to help the  
2 primary care physician. I'm a specialist. You know, 40  
3 percent of what the primary care physicians do is stuff like  
4 this that don't get reimbursed. There are codes available  
5 in the Medicare system for reimbursing for this, but these  
6 codes are not financed. I think it's an issue that we need  
7 to think about, because this is not just a problem to this  
8 vital population. It's a universal problem.

9           And then one other issue where we could help on  
10 that is, and Tom and I talked a little bit about it this  
11 morning, in the consultation. When I used to see a patient,  
12 I'd do a consultative report and I would write a report to  
13 Tom and I'd say, I recommend this, this, this, and this.  
14 Well, we don't do consultations anymore. We do HIT, which  
15 is eight pages of stuff that you can't even read. Somehow,  
16 we need to change that. I'm not saying you have to pay for  
17 consultations, but somehow, we need to change that  
18 communication.

19           My second point is, I guess it's -- and George  
20 briefly mentioned on eight this opt-out enrollment. And  
21 Carol, you made some very good points. I'm very, very  
22 concerned about this because in this group of patients, and

1 I take care of this group of patients, I am telling you,  
2 they're very vulnerable. They're older. They have some  
3 significant family issues and medical issues and mental  
4 issues. And they're not capable of following this opt-out  
5 issue. And, you know, it's almost like we're pushing them  
6 into a system where maybe they're going to get pushed away  
7 from their family doctor. It's almost like -- and I don't  
8 like to bring this subject up, but it's almost like  
9 developing a two-tiered system, those that have and those  
10 that don't, and I'm really concerned about the opt-out issue  
11 in this population.

12 DR. CHERNEW: Yes, so I think there's two things  
13 about this topic that make it unique. One of them is that  
14 it has this coordination between the State and the Federal  
15 Government that many of our other things don't have, which  
16 is sort of unique and requires some thought. And the second  
17 one, it focuses on patients in a much more clinical way than  
18 we're normally used to thinking about. In fact, it can even  
19 do more. Some of the SNPs have particular conditions  
20 associated with them. That latter part, I think, is  
21 wonderful and I'm very supportive of all of these programs.

22 I think that in reading this, one thing that

1 strikes me that's very important is I think it is a mistake  
2 to think that we will do some research or some analysis and  
3 will decide this is a good way and this is a bad way. When  
4 I see this heterogeneity, what I think is there's probably  
5 different ways to be successful in different settings, and  
6 trying to figure out how you should do it this way because  
7 this worked well in North Carolina, or you should do it this  
8 way because it worked for New Mexico, is probably not the  
9 right paradigm for going in. I think it's more useful to  
10 think about how we might set up system structures to allow  
11 successful organizations to thrive, and that's complicated  
12 in this case more than other cases because of the State-fed  
13 coordination.

14 I do, in the spirit of what Ron said, worry about  
15 the opt-out part of it because I'm concerned that that is a  
16 bigger discussion. It's not that I'm necessarily opposed to  
17 opt-out per se. I don't think the evidence is strong enough  
18 to support it here, and I agree with Ron and his concerns  
19 about it. But as soon as you say we're going to do opt-out,  
20 you could see that going to Medicare Advantage more broadly.  
21 You could see a whole series of things where that is  
22 important -- where that could be applied, and that's really

1 a general issue.

2           So I guess my view is understanding how to do the  
3 bundled coordination, how to -- you mentioned in the text  
4 box, you know, some States apply to get a single capitated  
5 payment from -- per my clarifying question -- from Medicare  
6 and Medicaid. I think thinking about how that works is  
7 important, and thinking about when we say, for example, does  
8 it save money, if I understand, many of the studies you look  
9 at, they look at underlying costs. But if you had a  
10 capitated payment, it saves money or not based on how you  
11 set the capitated payment up or down. So if it saved a ton  
12 of money but the capitation payment was up here, it would  
13 save money, or capture that, or if they used a ton of money  
14 but they were still capitated, they'd all be at risk. So  
15 thinking through the right payment in this joint Medicare-  
16 Medicaid coordination and how it saves money is a little bit  
17 different than whether it affects utilization one way or  
18 another.

19           So as long as we have good measures of quality and  
20 we have reasonable strategies for bundling, I think that's  
21 really the first order activity, and I do think there's a  
22 lot of potential here and I'd hate for us to be a barrier as

1 opposed to a facilitator.

2 DR. BAICKER: This is, I think, intriguing in  
3 thinking about the implications for a broader array of  
4 policy decisions that we make, although it's focused on this  
5 particular group, and I think the opt-in, opt-out decision  
6 or implication depends also on the metrics by which we're  
7 judging these programs and how we're deciding what meets the  
8 criteria or not. And I agree with Mike's perception that  
9 it's going to be very hard to be prescriptive about here is  
10 the model that fulfills what we're looking for, but rather  
11 if we looked at whether or not it was achieving some quality  
12 metric goal, and however you can get there by coordinating  
13 care, that's great. If you can show that this particular  
14 method of coordination is going to improve coordination  
15 outcomes and not increase costs, great. Then do it that  
16 way.

17 Then I think we might be more comfortable with an  
18 opt-out model, where rather than going to a two-tiered  
19 system we're saying, we're putting you in the higher quality  
20 tier unless you opt out of it. Then it doesn't have the  
21 flavor of creating, for a population that might not be very  
22 good at choosing among these things, you're getting second



1 class care, we're saying the default is that you're getting  
2 what we consider the best coordinated care we can find. But  
3 if you prefer not, that's fine, too.

4 DR. STUART: There are two things that I'd like to  
5 follow up on. Let me address the opt-out and opt-in  
6 question first. The Part D Medication Management Therapy  
7 program, MTM, in 2010 moved from an option that the plans  
8 could either have opt-in or opt-out to an opt-out program,  
9 and so it might be useful just to look at that and see,  
10 first of all, what the arguments were for CMS to move to an  
11 opt-out, and then eventually to see what the impact of that  
12 was because Medication Therapy Management is part of care  
13 coordination.

14 And that's really the core of my question. And if  
15 you could move to Slide 11 -- 7, sorry, 7 -- when I read  
16 this chapter, and I understand that these are site visits,  
17 the real question I had is what's the scope of the inquiry  
18 that you have planned in this area, because it looks like  
19 you've got the beginnings of a taxonomy for how these very  
20 disparate programs might be both identified and evaluated,  
21 at least in the sense of identifying the elements of these  
22 programs. And so making that a formal question, are you

1 moving toward a census of these approaches and then trying  
2 to evaluate what seems to work and what elements seem to  
3 work?

4           And I'll just give you an example. There's a  
5 program that just started in Minnesota this year that is  
6 focused on Medicaid recipients who are in nursing homes, and  
7 it's a program designed to identify residents who would  
8 really like to come back into the community but for various  
9 reasons just don't. The program is designed to provide a  
10 mechanism by which these, at least a portion of these  
11 individuals can be returned to the community. And this is  
12 going to have, if it works, it's going to have obvious  
13 implications for Medicare as well as Medicaid. But it's  
14 just a Medicaid focus and has all of the elements over there  
15 in the core activities. Would that qualify for this as far  
16 as the scope of the inquiry?

17           DR. MARK MILLER: I think some of the reason that  
18 you're getting a pause here is that I think where we are --  
19 I think it's hard for us to answer that question, and if you  
20 guys think I'm on the wrong track, speak up. I think where  
21 we are in our inquiry, we went through all the data analysis  
22 that we did last time. Then we went out into the field and

1 this is what we found. And I think at this point, whether  
2 different models should be contemplated, I don't think we  
3 would be closing doors to any other kinds of models or  
4 ideas. I think the more difficult question is given how  
5 thin the evidence is, some of the barriers that exist, is  
6 there anything productive we can do to help here and move  
7 things along, if we even decide there is a direction to go  
8 in? You know, you're discussing an opt-out. That presumes  
9 there's something to opt out of, and we're not even sure  
10 what that is.

11 So I think in terms of the inquiry, I think some  
12 of the pause was, I don't think we're rolling out any ideas.  
13 I think we have even a more -- after visiting the field, I  
14 think we're seeing the complexity of the situation, how thin  
15 everything is out there, whether there's a platform, and are  
16 there mechanisms to help facilitate the platform. So I  
17 think the most narrow answer to your question is, I don't  
18 think we rule out any ideas. How we could build something  
19 to capture and build on those ideas, I think, is some of the  
20 difficulty we're facing.

21 Now, I cut in line here. If you guys wanted to  
22 give a better answer, I was giving you time to think of one.

1 [Laughter.]

2 DR. CARTER: I mean, we do plan to look at some  
3 care plans of some of the special needs plan to see what  
4 they are doing. My guess is, we're not going to come --  
5 there may be some things added to this list, but I don't  
6 know that we're going to be -- we don't have plans to survey  
7 programs for sure, and I think it's going to be hard for us  
8 to do any kind of hard data analysis of beneficiaries that  
9 are in these programs and how does their care, either cost  
10 or performance measure, other performance measures, compare  
11 to beneficiaries who are not. I just don't think -- we're  
12 not in a place to be able to do that kind of an evaluation.

13 DR. STUART: Right. No, I certainly understand  
14 that.

15 DR. CARTER: But some of what you were saying --

16 DR. STUART: But is there just a list of these  
17 programs? I mean, what I'm -- when I look at this, I can  
18 see we have certain programs that kind of fall in. There  
19 may be others that fall out. But unless you've got a list,  
20 then how do I know?

21 DR. CHERNEW: Can I say something? There's a list  
22 of the SNPs and there's a list of the PACEs, and then

1 there's a list of the MA plans that may have some components  
2 of these. So there may be other parts going on somewhere  
3 else, but to get the funding mechanism, you have to be an  
4 explicitly named whatever you are.

5 MS. AGUIAR: Right, and I would just -- sorry --

6 DR. STUART: Well, I can describe one that's not  
7 on that list, I guess is what I'm saying.

8 MS. AGUIAR: Right. Exactly. And I think, and to  
9 that point, when we started looking at this, we really, at  
10 least in the June chapter, we're looking at the programs  
11 that had the components that they were integrating both the  
12 financing and the care coordination. So we looked at that  
13 taxonomy and then that was the focus of the site visits, and  
14 that's why we focus on the States and the State SNP model  
15 and the PACE model. We've also done some interviews with  
16 Medicaid managed care plans which have a sort of smaller  
17 integrated -- smaller SNPs, smaller companion SNPs. But  
18 we've looked at some of those programs, too, that are just  
19 focusing on the Medicaid program, really sort of just trying  
20 to understand a little bit about how they are approaching  
21 this population, because if we ever get to the point of  
22 considering how to expand any of the programs to integrate

1 both the financing and the care coordination to other  
2 populations, there's a lot to learn from what Medicaid-only  
3 programs are doing. And so -- and also, then, on the care  
4 coordination, the medical home and Medicare side, while  
5 we're looking at that, too, is to see what are the lessons  
6 there that we can learn.

7           Again, we haven't ruled anything out at all, and  
8 so this is very helpful for us to know, that if there's a  
9 specific direction or program that you think that we  
10 definitely should be looking at, we're happy to do that.

11           DR. KANE: Yes. So I was on the board of a group  
12 that tried to manage this population. You know, I was on  
13 that board for about 15 years, so I learned a little bit  
14 about it. One of the biggest problems is that we don't have  
15 the provider capacity, the gerontological knowledge, the  
16 skill sets of how do you work on a gerontology team. So you  
17 can find a program that works, but you can't replicate it  
18 because there just isn't that expertise built into the  
19 education system right now. So I'm wondering if there  
20 wouldn't be a useful way to look into how do we train people  
21 to become -- and we don't have many gerontology programs  
22 anyway -- but how do we make people want to be

1 gerontologists and how do we foster these programs, and not  
2 just the physician side, but also the nurse practitioner and  
3 the pharmacist and the whole team.

4           So you can manage this population, but then you  
5 burn out and there's nobody there to pick it up. And so I  
6 think one of the fundamental problems is we don't have the  
7 capacity to provide adequate gerontological services to this  
8 increasingly older multiple chronic condition with dementia  
9 population. And the Medicaid managed care plans leave out  
10 the long-term care populations. They like to do AFDC, but  
11 they sure don't want to deal with long-term care. So I  
12 don't think we have the expertise. And the MA plans don't  
13 have the expertise. That's a benefit that gets cut off.

14           So I don't think we have the expertise to deliver,  
15 and I think that's one of our fundamental problems, and  
16 Jennie can help me think through that, but I think -- so one  
17 of the things we need to think about is what kind of  
18 infrastructure needs to be in place to even put the  
19 expertise out there more generally in society, and I think  
20 that goes to the education and training gap that we really -  
21 - it's a new population and they aren't used to thinking  
22 about how to train for that.

1           I guess another issue I have is one of the  
2 successful ways we marketed our services was to go to senior  
3 housing programs. So there's a whole lot -- we've moved  
4 from nursing homes to assisted living. So most people don't  
5 want to be in nursing homes, but they do go to assisted  
6 living and a lot of assisted living programs have to be  
7 subsidized because people are poor or low income and it's a  
8 huge -- you know, if you can -- so one way to look for these  
9 people, preferably before they have their Medicaid crisis,  
10 and actually even before they hit Medicaid status, is in  
11 these assisted living communities where there are tons of  
12 people right on the edge and you can actually keep them from  
13 going over the edge sometimes if you intervene early enough.  
14 So thinking about how to identify that at-risk population,  
15 they're right there in assisted living and they're often,  
16 you know, not as old as -- and not yet nursing home  
17 eligible, but they're right on the edge, and you can  
18 actually manage that population if you have the provider  
19 capacity to think about that. So I think looking at  
20 opportunities to work with the housing areas.

21           And now how does the private sector do this is  
22 another area. I mean, there's a lot of these CCRCs,



1 Continuing Care Retirement Communities. Now, granted,  
2 having a lot more income does help, but they do also have  
3 those populations that get dementia and get old and get into  
4 coordinated care. And so what are some of the private  
5 sector models. I guess this is where you start wishing we  
6 had an all-payer system once you get over 65, because if the  
7 real problem is Medicaid and Medicare just can't get along,  
8 maybe we just should stop having two separate silos here on  
9 the payment side and just maybe look at the private sector  
10 for inspiration, because people are, I think, doing better  
11 jobs sometimes in the private sector coordinating this care.  
12 So it would be a place just to look for some inspiration.

13 I guess on the opt-out thing, I'm very  
14 uncomfortable. I feel the same as Ron does. This is not a  
15 population that you should say, you're here and you have to  
16 opt out. That -- I just find that really disturbing. And I  
17 think it would be far better to just sort of try overall to  
18 expand the capacity of our provider system to take care of  
19 these people and for their primary care doctors to be part  
20 of the whole geriatric system rather than what's happening  
21 now. You know, you can't do PACE with non-PACE-trained  
22 providers because they don't know how to be part of the

1 team. It would be much better if we can get these non-PACE  
2 primary care doctors who are managing elderly people to be  
3 trained and credentialed to be a part of the team, as  
4 opposed to forcing the patient into something that we're --  
5 that doesn't -- that seems almost anti-American to me,  
6 despite the --

7 MR. HACKBARTH: The opt-out obviously is a key one  
8 here. And the rationale that I hear for considering opt-out  
9 is that there are some seemingly good programs, and  
10 enrollment in those is lower than we would like it to be,  
11 and so people are looking for a means to increase enrollment  
12 even in the limited number of good programs. So the idea,  
13 as I understand it, is to sort of nudge people, make the  
14 default that they get enrolled, but try to protect their  
15 freedom by choice by allowing opt-out.

16 Now as Ron indicated, there are some issues, given  
17 at least some portions of this population have significant  
18 problems. They have dementia or other mental disorders,  
19 that the idea of opt-out sounds a little discordant, and  
20 that's a fundamental problem I'm not sure how to deal with.

21 DR. KANE: They also have a historic relationship  
22 with a provider, and they don't want to give it up. And

1 that's why I'm saying it's that person we should be talking,  
2 that provider --

3 MR. HACKBARTH: Yes.

4 DR. KANE: -- rather than taking the beneficiary  
5 and say okay, now we're going to put you in with the good  
6 people who do know. They've been with those people for a  
7 while, and so they should be trained to be part of -- the  
8 people who should be not allowed to opt out are the  
9 providers who are taking care of those people and should be  
10 told they have to participate.

11 MR. HACKBARTH: Yes, and I agree with that. So I  
12 don't interpret this as disagreeing with that.

13 But you know ordinarily the way we think of giving  
14 people a reason to enroll in something that is good for them  
15 is give them a choice and allow them to share in the savings  
16 from it. That's the basic concept in Medicare Advantage.

17 Now here there are some ways that people can share  
18 in the savings. For example, they get the services that  
19 otherwise would not be covered -- transportation and other  
20 services that are highly valued. But as I understand it,  
21 the basic rules are you can provide additional services but  
22 not cash, if my understanding is correct, and that's been

1 sort of part of orthodoxy, that cash is an inappropriate  
2 inducement although for this population cash may be really  
3 highly valued.

4 I know this may not be politically correct, but  
5 rather than just sort of skip over that I think we at least  
6 need to think about whether that ought to be something  
7 that's considered as a policy option. I'm not endorsing it.  
8 It may, on examination, prove to be inappropriate. But if  
9 we're going to look at this, I think we ought to look at  
10 other inducements that people may find valuable.

11 DR. CARTER: We did hear from administrators of  
12 integrated programs that they wondered if their enrollment  
13 would expand at the margins with the cutbacks in state  
14 benefits on the Medicaid side, particularly for home and  
15 community-based services as those are targets of budget  
16 cuts, that there might be some folks who qualify to be  
17 enrolled in one of these programs, that might make them  
18 enroll because they want access. They want to retain access  
19 to services that they have been getting.

20 DR. MARK MILLER: I would add to this  
21 conversation, I guess two things. One thing on the provider  
22 side to keep in mind is that some of these arrangements

1 might be viewed as threatening to the provider, and so your  
2 ability to get the provider to come in and participate could  
3 be a hard row as well.

4           And then I guess in some of your discussions --  
5 and Jennie, you may have even specific experience on this --  
6 at least I thought I remembered in some of our conversations  
7 where you were running us through it, that there were  
8 situations where there's a lot of stakeholder resistance to  
9 these types of programs, but then once there is some  
10 coordination and you can see the actual benefit to the  
11 patient, that some of that view has come around. So I mean  
12 just keep that in mind too. A poorly run program, nobody is  
13 going to like but if there's actually something that  
14 provides social services, transportation, that type of  
15 thing.

16           DR. CARTER: Yes, I think we heard two things.  
17 One is benes who were enrolled in a program but had been  
18 reluctant to give up their physician, once they saw the  
19 benefits of coordinated care, actually liked it.

20           And the other thing we heard, and I don't mean to  
21 oversell this, but we did hear that beneficiaries don't  
22 necessarily have a longstanding relationship with a provider

1 in this population. So having them give up their primary  
2 care physician isn't true for all of these beneficiaries.  
3 They have gotten care from a number of different providers.

4 So your point is taken. I'm sure for some  
5 beneficiaries that's true, and for others we heard that that  
6 was not.

7 DR. KANE: No, that's for the ones who enroll, but  
8 I'm saying though if you're trying to get a population to  
9 enroll that haven't wanted to enroll, one of the common  
10 reasons is they don't want to give up their provider to join  
11 a different set.

12 DR. CARTER: I'm talking about people who had  
13 enrolled. Just in talking with folks in general about this  
14 enrollment option, we did hear that well, one thing you'll  
15 hear is that people don't want to give up their primary care  
16 physician. That's true for some people, and it's not true  
17 for others because this is a population that does not  
18 necessarily have a consistent set of providers that they've  
19 seen over a long period of time.

20 DR. BERENSON: Yes, two points. One I'll pick up  
21 on this opt-out discussion, and I guess I'm with Mike which  
22 is to sort of think broadly about a number of different

1 situations where we have tended to want to go one way or  
2 another way, and I'm worried about whether we're being  
3 coherent in our approaches. The ACA in the Independence at  
4 Home demo requires a positive enrollment for that.

5 And then at the other end, the ACA in an ACO, or  
6 shared savings ACO, has an invisible retrospective  
7 assignment which we found some objection to, but here we had  
8 some division about whether we thought that having an opt-  
9 out would undermine the purposes of the program.

10 So we have sort of a range of things, a range of  
11 approaches to get beneficiary involvement across different  
12 programs, and I think it would be helpful as part of this  
13 process to sort of think coherently about when, what are the  
14 sort of criteria for when you want a positive enrollment,  
15 how would an opt-out actually work for people with dementia  
16 or mental illness, sort of operationally and can it actually  
17 work, et cetera. So I think that's a fruitful area to do  
18 work in.

19 The second comment I would make relates to fee for  
20 service with care coordination. I am interested and a  
21 believer in the first group -- integrated financing -- but I  
22 think we're a long way from getting the majority of people

1 in Medicare, duals in need, into those programs. So in the  
2 meantime I think we should be doing work in the traditional  
3 Medicare program.

4           And I just raise one other area. I guess where  
5 I'd focus is on low-hanging fruit, and to me the lowest-  
6 hanging fruit in the traditional program is this phenomenon  
7 of patients in nursing homes going to the hospital for a  
8 urinary tract infection, for simple things, partly because  
9 of the inconsistency in financing with the desire to create  
10 a three-day hospital stay, to get a SNF payment rather than  
11 a nursing home payment, partly because of other inability of  
12 the nursing home to manage patients.

13           So I'm interested in exploring more if there's at  
14 least enough basic evidence to suggest success of the  
15 Evercare kind of model, sort of nurse case management  
16 assigned in the nursing home, very targeted care  
17 coordination, not a medical home taking care of patients'  
18 needs across the whole continuum but really focused on the  
19 patient in the nursing home and trying to prevent those  
20 hospital stays that really are avoidable, as one way to  
21 deal, as a sort of a Band-aid until we can figure out how to  
22 rationalize these funding streams.



1           So could you just say something about what we know  
2 about that and whether that's a fruitful area to do work in?

3           DR. CARTER: Well, I have presented in the past  
4 work that we've looked at -- what share of beneficiaries are  
5 repeats from nursing homes back to hospitals. So we know  
6 that that's a problem. We know that the payment systems  
7 encourage rehospitalizations to get the SNF payments.

8           The Evercare model has been evaluated. It shows  
9 that beneficiaries and their families, on the quality  
10 measures, definitely it's better than not having that model.  
11 And I think the cost comparisons were mixed. I think they  
12 were better than the control group that was beneficiaries  
13 enrolled in other nursing home, but comparable to  
14 beneficiaries enrolled in the same nursing home but not in  
15 the Evercare, which you'd sort of expect.

16           And I can look at other articles, but the ones  
17 that I have looked at show mixed on the cost side but  
18 definitely better on the quality measures.

19           But I think you're right. I mean that's an  
20 obvious target of opportunity, is to prevent  
21 rehospitalizations.

22           On the other hand, I don't want to have a

1 situation where patients are staying in nursing homes that  
2 aren't equipped to deal with patients. We have to navigate  
3 that carefully.

4 DR. BERENSON: [Off microphone.] [Inaudible.]

5 DR. CARTER: I want to make sure that nursing  
6 homes aren't penalized for rehospitalizing patients who  
7 really need to be rehospitalized, and so I understand. So  
8 we need to carve out the potentially avoidable, the UTIs,  
9 and that.

10 DR. BERENSON: No, I think that's right. That's  
11 right. My understanding is it's case management and if the  
12 patient needs to go, they go.

13 DR. CARTER: Right.

14 DR. BERENSON: It's not like there's a financial  
15 penalty to the nursing home.

16 But I just think that it's worth looking at that  
17 model, whether it's with an intermediary organization like  
18 Evercare or whether it's potentially directly that CMS might  
19 have the capability of doing some direct contracting in this  
20 area as well. I would like at that in a broad sense. I'm  
21 not endorsing it. I just think it should be on the array of  
22 things we look at.

1           MR. HACKBARTH: So let me see hands over here of  
2 people who have round two comments. We are about 10 minutes  
3 over already, so let me move quickly through these.

4           Jennie?

5           MS. HANSEN: I just wanted to answer a few  
6 questions that have come up, and then I'll also frame this  
7 and come back to the opt-out question.

8           I think the question, Mike, that you've raised  
9 about just the states and how the capitation works. You  
10 know there's a centralized Medicare approach to this, using  
11 HCC and frailty factors, and so that's a universal  
12 application of all the PACE sites because it's Medicare  
13 side. Because there are 30 states that do PACE now, they  
14 each have their criteria as to what anchor they tend to use  
15 to set their rates. So they're separately done, and they're  
16 known to each party, meaning Medicare and Medicaid, but it  
17 then goes to the provider to do the management of that.

18           And then I may as well cover the opt-in and opt-  
19 out since this has been brought up. I think one of the  
20 things MedPAC can do is highlight some of this discussion  
21 because it does speak to what the PPACA discussion options  
22 are that you outlined, Bob, about the full range of

1 voluntary versus retrospective. But how do we discuss this?

2           And I really picked up on the theme of what, Kate,  
3 you brought up that ultimately is the quality on this. That  
4 may be one of the ways to frame it. And then also patient  
5 satisfaction or family satisfaction, so there's a patient  
6 element, because people who get kind of railroaded in, I  
7 mean, will disenroll for the most part, especially if  
8 they're not the super frail population.

9           But I guess I would speak to the issue of the  
10 complexity of the people who don't know that they could  
11 benefit from this. And I think some of the examples you  
12 said, that once people are in it, then they suddenly realize  
13 it. They don't realize it how chopped up their life has  
14 become or how difficult their life has become and how it  
15 could be different. So that's why I have some mixed  
16 feelings about a group that could benefit from a much more  
17 coordinated system but perhaps don't even really know that  
18 right now.

19           Relative to the physician relationship and what  
20 the incentives might be, I know when I was even in San  
21 Francisco this whole idea of keeping their primary care  
22 physician if they had the primary care and still having the

1 central model be kind of the core engine with the  
2 competencies and then working gently, frankly, with the  
3 primary care physician in the community. So that's doable.  
4 I think it has kind of grown in that option. Some PACE  
5 projects are trying that now.

6 But there is, to speak to our MedPAC body of work  
7 that I think it does relate to, is what Nancy, you brought  
8 up for how does a group of people develop the competencies,  
9 the geriatric competencies in particular and the way of  
10 working with other team members to coordinate complex care.  
11 That is one of the areas I think is an opportunity to think  
12 back to our accountability for GME funding. You know that  
13 extra \$3.5 billion that we identified previously.

14 Because the population is growing and needing  
15 this, and people aren't really being prepared for it, is  
16 this one of the areas of policy linkage with other work that  
17 we're doing, to think about what needs to be expected as an  
18 outcome?

19 Not dictate curriculum because I know that's not,  
20 but what is that we will get ready in order to deal with  
21 multi-morbidity as well as issues of multiple pharmacies?

22 I think people think they know what to do with it,

1 but oftentimes that really is not the case. So I think it  
2 can link back to our GME work, to make sure that there is  
3 some linkage of Medicare.

4           And relative to the staffing numbers and the  
5 models -- I think, George, that you asked and that you  
6 answered -- is that here you have 1 or 2 people for 4,000,  
7 and then you have 1.5 or 2.5 people for 150, say. I want to  
8 make sure that we, perhaps in our texts when we publish,  
9 think about this as a targeted way to look at the  
10 population.

11           You brought it up, Carol, that this is a complex  
12 population that really needs a lot of touch points. Not all  
13 dual eligibles require that, as we know in some of the SNP  
14 models. So we should make sure.

15           I certainly don't agree that we should be  
16 prescriptive about this but understanding we're targeting  
17 populations, and so that's why there should be a panoply of  
18 programs, not one solution.

19           And I think about Massachusetts as the point of  
20 why they don't do the Medicare population. They have a very  
21 strong infrastructure of serving older populations in kind  
22 of coordinated programs. So now their focus on a statewide

1 basis would be the under-65.

2           And going back to targeting, the last comment I'll  
3 make on this one is I think it's important. Another example  
4 of showing it's apples and oranges, if you think about where  
5 the PACE population is best at, it is that multiple  
6 population whose average age has all these complexities.

7           The reason in your text that two to three million  
8 dollars is involved in this is I want to have the comparator  
9 be the right comparator because if we think about building a  
10 nursing home bed, what is the dollar amount on that as  
11 compared to thinking about two to three million for the  
12 wrong population. So I think it's apples to apples because  
13 right now even the staffing in a nursing home tends to be  
14 about -- my old data five years ago is like 1.1 or 1.2 staff  
15 to 1 resident.

16           So that's why, George, I don't think this could be  
17 lumped together. So I think we can compare apples to  
18 apples, and that would make it easier to see why there needs  
19 to be different programs.

20           So that's why I worry about one of the first  
21 questions which is should we stretch PACE a little bit for  
22 other populations? So long we're sure what the intervention

1 is and how the money flows, to make sure that the outcomes  
2 can be consistent with that design.

3           And the second question about the managed care  
4 aspects is that I think there's great opportunity with the  
5 SNPs and the managed care programs to perhaps think about  
6 how to deal with the early presentation of dual eligibles,  
7 so different groups have different opportunities. Thank  
8 you.

9           MS. UCCELLO: I'll try to be quick. People have  
10 already talked a lot about the opt-out/opt-in, so I'll skip  
11 that, but I will say that regardless of whether it's opt-in  
12 or opt-out there needs to be a better way to identify the  
13 people who could be eligible for these programs. So that's  
14 worth pursuing.

15           Also in terms of outcomes and there not being a  
16 lot of evidence right now, given some of the resistance by  
17 beneficiary advocates, I think it makes sense for some of  
18 those metrics for outcomes to include the things like the  
19 independence for the disabled population and those kinds of  
20 things that those groups are worried about.

21           And finally, this was mentioned in the text but  
22 not in the presentation -- the issue of sharing Medicare



1 savings with the states and not always being clear what  
2 states are doing with the money. I think that needs to be  
3 something that's monitored.

4 MR. GEORGE MILLER: Very briefly, and I agree with  
5 Jennie, the discussion for me was very rich, about the opt-  
6 out, and I want to be clear that I raised that issue because  
7 I wanted to hear a broad spectrum of opinions on it.

8 So I agree with Ron and what Kate said about the  
9 quality piece of it. There's no wrong or right answer for  
10 the larger population. There are some folks that probably  
11 would benefit by having an opt-in notion because they need  
12 the help. And again what Kate said about the quality piece,  
13 putting in that category makes a lot of sense, and others  
14 certainly should have that freedom, so not one answer.

15 Then I agree with Bob, that we should do nothing  
16 now about care management because the financial piece will  
17 take a longer time to have impact for us. So I agree with  
18 Bob.

19 MS. BEHROOZI: It was interesting to me how we got  
20 into the discussion of opt-out. You know the way you  
21 presented it was the reasons not to do it, the complaints  
22 that people have had about it, because in the paper the

1 title of that section is broad, but not uniform, support for  
2 opt-out.

3           And you raised the issue of people not having  
4 regular providers beforehand, and also the difficulty and  
5 the burden sometimes for seriously impaired people to go  
6 through this whole exercise of choice, I think actually.

7           And it does go to how you do it. I'm sorry, maybe  
8 Jennie or somebody raised the issue of how opt-out would  
9 work. It can be an opportunity that people don't have now  
10 actually, to exercise a choice. When somebody is  
11 registering or signing up for Medicare, if they are a dual -  
12 - and of course this depends on being able to identify that  
13 population -- at that point be able to tell them: Okay, so  
14 this is where you will be unless you choose this other  
15 thing. You may want to choose this other. You may want to  
16 stay in fee-for-service because your doctor isn't in this  
17 thing. But here's what the thing is and what it has.

18           And I'm not so concerned about two tiers because  
19 we are talking about the potential for people being in  
20 something. You know. Like you said, Bob, last time we were  
21 talking about ACOs and whether opting out should be an  
22 option because otherwise you would have people locked in.

1           And Scott, you talked about how interesting this  
2 area was because of the disproportionate spend associated  
3 with this subgroup, but there are other subgroups who also  
4 have disproportionate spends. Maybe there are certain  
5 chronic conditions where people should be in these  
6 coordinated care programs.

7           I mean opt-out for everybody. How about that?  
8 You know. Like whether it's an ACO, whether it's a targeted  
9 SNP kind of situation, whatever the locus of the care  
10 coordination and services more targeted to those  
11 populations' needs are, maybe we should be thinking about it  
12 more broadly.

13           But as Nancy said, there has to be something there  
14 to opt out of. People had a lot of interesting thoughts  
15 about all of that, but one of the things I thought might be  
16 helpful in organizing the work -- for me anyway, to look at  
17 the work that you're doing -- is maybe if you could take  
18 some of those operational barriers that you're talking  
19 about. I had written down low-hanging fruit, which Bob  
20 ended up saying also.

21           Some of the things that, something you identified  
22 in the paper is that the coordinated care programs in some

1 states where they really are doing the Medicaid and Medicare  
2 together. The SNP situations I think. They have to give  
3 different, they have to insert different language in the  
4 Medicaid section from the Medicare section, which ends up  
5 being nonsensical to the person who's reading it. So that  
6 seems like the kind of thing you could eliminate by  
7 regulation, or the whole thing of not getting data on  
8 Medicare services, like having access to claims data or  
9 things like that, maybe if there's a way that we could see  
10 what that list of operational barriers is and what could be  
11 eliminated by regulation or EHRs or whatever, those kinds of  
12 things.

13 DR. DEAN: Just a couple of points. First of all,  
14 I think it's really essential as this evolves that the care  
15 coordination activities have to be connected and integrated  
16 with the primary care activities. There has been a whole  
17 long list of case management demonstrations and so forth,  
18 most of which haven't shown very much, and the biggest  
19 problem has been that they haven't been coordinated with  
20 primary care. I've dealt with a bunch of them through  
21 insurance companies and so forth. For the most part they've  
22 been a pain in the neck because they're on one track, we're

1 on a different track, and to try to keep the communication  
2 going to make it effective has just been extremely  
3 difficult.

4 I totally support, agree, applaud all the things  
5 that Ron said because these things, the coordination  
6 activities are something we really try to do as much as we  
7 can, but it's over and above everything else that we need to  
8 do. You know I consider it part of my responsibility, and  
9 that's part of the frustration I think of a lot of primary  
10 care doctors. They're unhappy with their role because they  
11 don't feel they're able to do the things that really need to  
12 be done. So there's a big element of frustration that gets  
13 built in.

14 I think in Scott's program actually, the health  
15 affairs description, that was one of the first ones I saw  
16 where they really did it, and proved that it does make a  
17 difference and you can save money.

18 I mean we could talk about this a long time, but  
19 just as a final point, one of your core elements is a  
20 centralized electronic record. I would just tell you that  
21 is important, it's necessary, and it is extremely difficult.  
22 Today's EHRs, as Ron said, generate massive amounts of data.

1 They are very difficult to provide data entry for. They  
2 don't communicate with each other. We've got a multitude of  
3 systems in place across the country that won't communicate  
4 with each other.

5 So it's a great goal. It's an important goal.  
6 But we're a long ways away. We need to keep doing  
7 everything we can to move toward that goal.

8 MR. HACKBARTH: Okay, so let me conclude with a  
9 brief word about MACPAC. I think Scott raised this.  
10 Clearly, this is an issue in which MACPAC has an interest,  
11 as well as MedPAC. So we have an opportunity here to work  
12 across the two programs and integrate what we do.

13 So we are living this experience, and of course  
14 the staff have reached out to MACPAC and are sharing  
15 information about what we're doing.

16 I certainly believe that we would be much more  
17 likely to have an effect on policy, which is why I'm here,  
18 if we could agree with MACPAC on steps to recommend to the  
19 Congress. So that would be the goal.

20 Having said that, we're making this up as we go  
21 along. This is a new situation for us, working with another  
22 commission. We each have our own rhythms and cycles and all

1 that. So that's the objective. We'll have to figure out  
2 how to make it work. It's going to take some real effort on  
3 the part of our staff and theirs to make it effective, but  
4 we are not oblivious to the shared interest in this issue.

5 Thank you, Christine and Carol.

6 And now we move on to findings from rural site  
7 visits. This is, I think, the first session that we've had  
8 on this, preparing for a mandated report to Congress. This  
9 was, as you'll recall, one of the things included in the  
10 Affordable Care Act, and the due date is June 2012. Joan,  
11 are you -- or Jeff.

12 DR. STENSLAND: All right. Well, good morning.  
13 Today we're going to talk about a report that we're going to  
14 be doing on rural health care in rural America, and today  
15 we're starting out by talking on a series of site visits to  
16 rural communities, and this is going to be the first part of  
17 a broad study that we're going to be carrying out over the  
18 next year and a half on rural health care.

19 As part of the PPACA, Congress mandated that  
20 MedPAC conduct a study of rural health care, and  
21 specifically we were required to examine several issues. We  
22 need to look at access to care by rural Medicare

1 beneficiaries; quality of care in rural areas; the  
2 adjustments to payments to providers of services in rural  
3 areas -- these are Medicare adjustments to payments; and  
4 adequacy of payments in rural areas by Medicare.

5           The report is due on June 15, 2012, and so what  
6 we're going to talk about today is just the first  
7 installment in a long process over the next year and a half.  
8 And what's nice about that is we can raise some of the  
9 issues today and then over the next year and a lot of  
10 feedback from you as well as from the rural community  
11 researchers and advocates.

12           Just to give you a little brief outline of our  
13 research plan, to address those four questions that are  
14 raised in our mandate, we plan to conduct both qualitative  
15 and quantitative research.

16           On the qualitative side, we're going to start  
17 today by talking about how we went out to listen to  
18 beneficiaries, patients, and providers. Today Joan will  
19 report on our findings from beneficiary focus groups, and  
20 she'll also report on provider site visits.

21           On the quantitative side, we plan future analysis  
22 of services provided to rural beneficiaries. Now, this will



1 be similar to the work we did in our 2001 analysis of  
2 services obtained by beneficiaries in rural areas, including  
3 frontier areas. This time around we'll also be looking at  
4 access to pharmacy services and how beneficiaries in  
5 frontier areas fill their prescriptions.

6 We will examine quality-of-care metrics such as  
7 hospital mortality, readmission and process measures. We'll  
8 also look at obtaining recommended services and other  
9 metrics of quality for the various sectors, looking at rural  
10 and urban quality.

11 We'll also discuss special rural payment  
12 adjustments for hospitals, physicians, and other sectors.  
13 This is specifically part of our mandate. For example,  
14 we'll look at sole community hospital payments, low-volume  
15 payments to hospitals, and special payments to physicians  
16 such as rural health clinic payments.

17 And then after we look at all these adjustments,  
18 we will examine the adequacy of payments using the metrics  
19 that we traditionally use for payment adequacy in our  
20 December meetings.

21 And now Joan will talk about what we've learned on  
22 our site visits and focus groups.

1 DR. SOKOLOVSKY: So as a first step in our work on  
2 the rural report, working with researchers from NORC and  
3 Georgetown University, we conducted site visits and  
4 beneficiary focus groups in three states this summer. The  
5 states we went to were Montana, Kansas, and Alabama. We  
6 chose these states to get a multifaceted picture of the  
7 rural health care delivery system. The rural areas in  
8 Montana are often referred to as "frontier," with long  
9 distances between towns. Rural towns in Kansas are not so  
10 far apart, but the places we went to are still clearly  
11 rural. We chose Alabama because the health financing  
12 context is quite different there. While small hospitals,  
13 rural hospitals in Montana and Kansas are generally critical  
14 access hospitals, this is not true for Alabama, which has  
15 only a couple in the states. And I'll talk more about that  
16 later.

17 Here I just want to emphasize again that this is  
18 not the report, but it does help to generate ideas for us  
19 and for you to consider and help put in context the  
20 quantitative findings that we will have.

21 The beneficiary focus groups were conducted in  
22 small towns in each state. We met in places like motels,

1 churches, and in one case a bank. We interviewed providers  
2 in hospitals and clinics, and we also met with beneficiary  
3 counselors in their offices.

4           It's hard to sum up all that we learned in a few  
5 bullets, but here are the key findings. Beneficiaries in  
6 our focus groups did not report problems getting primary  
7 care services. Seeing specialists could be more  
8 challenging, and those needing specialized care like  
9 dialysis or chemotherapy generally had to travel to the  
10 nearest metropolitan area or rural referral center. Our  
11 interviewees agreed that recruiting primary care physicians  
12 was their most significant challenge.

13           We visited a broad range of rural hospitals,  
14 ranging from those that were largely emergency rooms with an  
15 average daily census of less than one to large rural  
16 referral centers providing services to a network of small  
17 hospitals in their general area. Although most hospitals  
18 and many of the clinics we visited had telemedicine  
19 equipment, we found that the use of it was quite limited.

20           So to talk more about access, beneficiaries in our  
21 focus groups did not report access problems, particularly  
22 for primary care services. Although they are quite aware of

1 the limited number of physicians in their local communities,  
2 they almost universally reported that they had a usual  
3 source of primary care. But many depend on nurse  
4 practitioners or physician assistants and seem quite pleased  
5 with the care they receive. A few, however, said they  
6 prefer to drive to the nearest metropolitan area or referral  
7 center to get care from the phenomenon. In general, when  
8 they need strategy or more complicated tests or diagnoses,  
9 they go to the nearest large city.

10           There were few specialists living in most of the  
11 towns that we visited. Obviously the larger hospitals were  
12 an exception to this. Local hospitals often had  
13 arrangements with specialists to provide periodic clinics on  
14 a regular schedule. It could be weekly, monthly, or some  
15 other variation. The type of specialists varied from  
16 hospital to hospital, but the ones we most often heard  
17 mentioned were cardiologists, general surgeons, and  
18 orthopedists. However, hospitals are not always able to  
19 find specialists willing to travel, and sometimes  
20 beneficiary, through choice or necessity, travel to cities  
21 or rural referral centers to see specialists.

22           We visited several communities where beneficiaries

1 needing specialized services like dialysis or chemotherapy  
2 had to travel more than an hour each way to get them.  
3 Beneficiaries in our focus groups seemed to generally accept  
4 this as part of rural life. We heard people say things  
5 like, "We have to travel to go shopping or go to the movies.  
6 Why should we expect health care to be different?" They  
7 said that they would depend on family or friends to get them  
8 to their appointments if they could not drive themselves.  
9 However, we heard from beneficiary counselors that  
10 transportation for people needing specialized services is  
11 one of the problems that they most encounter.

12 All the providers we interviewed said that  
13 position recruitment is their greatest challenge.  
14 Beneficiaries, too, seemed aware of the difficulty. Some of  
15 the challenges we heard about included physicians concerned  
16 about having to be on call all the time because they are the  
17 only physician in town. Next, we often heard about  
18 physicians leaving a rural area because they wanted to live  
19 in a larger city or their spouse couldn't find work.  
20 Additionally, rural areas are trying to recruit basically  
21 primary care physicians. As we've talked about so many  
22 times, the medical education system produces fewer primary

1 care physicians, and rural hospitals and clinics are  
2 competing for recruits from a smaller overall pool.

3           Additionally, our interviewees said that primary  
4 care as practiced in rural areas is different. They see a  
5 greater variety of problems and are less likely to refer  
6 patients to specialists. The physicians we talked to like  
7 that aspect of their work, but they did think that maybe  
8 others wanted a more predictable practice.

9           Hospitals and clinics try to address the  
10 recruiting problem in different ways. Sometimes they  
11 recruit physicians through the National Health Service  
12 Corps, or they recruit foreign physicians through the J-1  
13 visa program. But these physicians may leave after they  
14 have fulfilled their obligations. The most expensive  
15 alternative that we heard about was contracting with  
16 temporary physicians to fill their needs.

17           The places that we visited said they generally did  
18 not have trouble recruiting nurses. They were able to  
19 recruit locally because local colleges had nursing programs.  
20 In one of the larger hospitals we went to, we were told that  
21 the hospital would help employees improve their credentials  
22 by supporting them through post-graduate training programs.

1           Just as many of the places we visited were able to  
2 recruit nurses locally, many of our interviewees told us  
3 that one way to get physicians that will practice in rural  
4 areas is to grow your own. They told us that growing up in  
5 a rural area or doing a rural residency increases the  
6 likelihood that a physician will practice in a rural area.

7           In Alabama, we visited with organizers of a  
8 program to grow their own physicians. The program involved  
9 -- it was multifaceted, and it started with identifying  
10 young people living in rural communities in high school and  
11 in college. They would offer the students summer programs,  
12 hook them up with local physicians that they could shadow  
13 during their work. After colleges, they offered a course  
14 which included training in public health, but also would  
15 help students bring up their MCAT scores if necessary  
16 through science courses. They sponsor a rural residency  
17 program to give their graduates experience providing care in  
18 rural areas. And, finally, the program graduates that meet  
19 their commitment and go back to their community to practice  
20 will get the costs of medical school fully funded after four  
21 years of practice. They have recently started a similar  
22 program to identify minority students and encourage them to

1 practice in their home communities.

2 We met with a graduate of the Grow Your Own  
3 Program who is now practicing in his hometown, working in a  
4 two-person practice in a town without a hospital, and he  
5 told us he was very happy with his choice.

6 So we visited a range of hospitals from large  
7 referral centers to very small critical access hospitals,  
8 again, with an average daily census of less than one. Most  
9 of the hospitals we visited were small. In Montana and  
10 Kansas, these small hospitals were mostly critical access  
11 hospitals. In Alabama, they generally were not. Private  
12 payer rates were lower in Alabama, and they generally  
13 operated under strong financial constraints. The hospitals  
14 believed they had a positive margin for Medicare patients so  
15 they prefer the prospective payment system.

16 The smallest hospitals serve mainly as places to  
17 treat simple conditions and stabilize emergency cases before  
18 transferring them to a larger hospital. Many of the  
19 hospitals did not deliver babies, although a few did.

20 Some small hospitals add services like nursing  
21 homes, alcohol and substance abuse programs, or geriatric  
22 psych units. Many had good physical facilities. All of



1 them had CT capability, and about half had MRIs.  
2 Beneficiaries in our focus groups spoke of the local  
3 hospital as a very important community resource, but  
4 frequently went out of town for their care. They saw having  
5 the hospital as important in case of emergencies.

6           Physicians had mixed opinions of the importance of  
7 practicing in a town with a hospital. Just to give you a  
8 couple of examples, one practicing in a town without a  
9 hospital said that he appreciated the idea that he didn't  
10 have to be on call. Another said it was much harder to  
11 recruit physicians when there is no nearby hospital. And we  
12 heard of a couple who said they were concerned about the  
13 quality of care provided in their local hospital.

14           So to talk a little more about quality, we asked  
15 about quality of care in both our beneficiary focus groups  
16 and our provider interviews. Beneficiaries generally  
17 defined quality in terms of their physician's ability to  
18 communicate with them and know them as individuals. They  
19 generally liked the quality of care they received locally,  
20 although there were several who defined quality as the care  
21 they received in the nearest large city.

22           The providers we interviewed generally spoke

1 highly of the quality of care in their community, but some  
2 raised quality concerns. We heard that a few providers  
3 preferred sending their patients to a large hospital in the  
4 city, specifically because of quality concerns. Several  
5 nurses said that the challenge that their facility has  
6 recruiting physicians can affect quality of care.  
7 Administrators have difficulty firing physicians for  
8 questionable practices when they may be impossible to  
9 replace. And some nurses expressed satisfaction because the  
10 administration of their hospital had made the tough  
11 personnel decisions.

12           We found that the use of telemedicine in the  
13 places we visited was quite limited. Most hospitals and  
14 many clinics had telemedicine equipment, but some would say  
15 it was gathering dust. They identified some technical  
16 issues like the lack of broadband connectivity in the most  
17 rural settings. In general, the connections were less than  
18 ideal, and physicians would get frustrated trying to conduct  
19 a visit.

20           In addition, they often had difficulty finding  
21 physicians in urban hospitals who were willing to conduct  
22 visits through telemedicine. In two places, we found

1 telemedicine was being used for psychiatric consultations,  
2 including those involving patients dealing with law  
3 enforcement.

4           A rural referral center was using an eICU to help  
5 monitor the ICU. By having remote monitoring of the ICU  
6 available at night, nurses in the ICU could get immediate  
7 advice, including whether they needed to wake the doctor who  
8 was on call, and they could take care of one patient while  
9 knowing that the others were being monitored remotely.

10           Several interviewees talked very highly of the  
11 importance of using the equipment for teleconferencing.  
12 Clinicians were able to use the equipment to participate in  
13 continuing medical education and peer review sessions  
14 without having to leave their local communities. Physicians  
15 said that this use helped to reduce the professional  
16 isolation experienced by some rural doctors.

17           So, again, these site visits were just a first  
18 step in our work on the rural report. We're very interested  
19 in hearing your reactions and whether these findings trigger  
20 any additional questions, things we should be looking at.  
21 As you continue your deliberations, you may want to discuss  
22 some issues raised in the site visits, like physician

1 recruitment, access to services, and quality of care. And,  
2 of course, Jeff would be happy to answer any questions.

3 [Laughter.]

4 MR. HACKBARTH: Thank you. So we'll begin on this  
5 side with round one clarifying questions, and I'd ask people  
6 to be disciplined about clarifying in round one. So let me  
7 see hands for clarifying questions.

8 DR. DEAN: One quick one. How were the focus  
9 groups selected?

10 DR. SOKOLOVSKY: We worked with focus group  
11 facilities in the larger urban areas who have experience  
12 conducting site visits in rural areas and focus groups in  
13 rural areas. They have lists of potential people, and they  
14 have relationships with churches or with hotels where they  
15 can set up the equipment and recruit beneficiaries. We did  
16 a broad range of outreach to find these facilities, and that  
17 also was another factor in choosing where we went.

18 DR. DEAN: Well--[off microphone].

19 MS. BEHROOZI: In light of the finding, the  
20 evidence that hospitals in many of these communities are  
21 viewed as emergency care centers, you know, just triage or  
22 whatever it is in case of emergencies, did you see -- or did

1 you look at or could you look at, particularly in the  
2 communities where there was no hospital, whether there was  
3 an urgent-care facility or some replacement of the  
4 hospital's role for that particular function?

5 DR. SOKOLOVSKY: One of the sites where we did the  
6 focus groups was a community that had had a hospital and the  
7 hospital had closed. They had set up an ambulance system to  
8 provide urgent care and to get people to the nearest  
9 hospital. But when we went around, kind of the focus group  
10 always ends with sort of what's the most important thing you  
11 need or what's the biggest problem, every single person said  
12 they needed a hospital, and they all worried about,  
13 particularly in cases of emergencies, it not being there.

14 MR. GEORGE MILLER: In the presentation or the  
15 paper you sent out, you talked about quality a couple times.  
16 Did you balance some of your quality statements within the  
17 published literature, particularly from rural research  
18 centers, on quality and dealing with those? I realize some  
19 of the information you got was anecdotal, but my question  
20 is: Can you tie that anecdotal information to real factual  
21 information, research, particularly in rural areas on  
22 quality versus just their perception?

1 DR. STENSLAND: I think this was a report on what  
2 people were telling us out there, so this is all about  
3 perceptions. Certainly in the report we will tie it to  
4 outcomes data, and it is, you know, moderately consistent  
5 with some of what the rural health research centers have  
6 published. In terms of cases of the real small places,  
7 they've seen some higher mortality; we've seen higher  
8 mortality, more even on readmissions, some great problems on  
9 the CMS process measures.

10 MR. GEORGE MILLER: There's also some research  
11 that said there is better quality on both of those issues,  
12 too.

13 DR. STENSLAND: I'll have to get back to you.  
14 This is University of Minnesota stuff. Maybe there's  
15 another research center that's --

16 DR. DEAN: [Off microphone.]

17 DR. STENSLAND: Yeah.

18 DR. BERENSON: Yeah, in the paper you talk about  
19 CMS' definition of rural and then your own sort of notion of  
20 a continuum, and you went up to a commuting county that is  
21 located adjacent to an urban area which, if I had to put a  
22 word on that, I'd call suburban. Could you sort of

1 enlighten me about where you draw the line between rural and  
2 suburban in what you're looking at?

3 DR. STENSLAND: So the suburban areas are -- we're  
4 using just the MSA definitions for this analysis of --  
5 that's the broad definition. So the urban and the suburban,  
6 that's kind of the MSA. And then we're looking at outside  
7 the MSA. So there's --

8 DR. BERENSON: It's adjacent to --

9 DR. STENSLAND: Adjacent to the suburbs. Think of  
10 it that way.

11 DR. BERENSON: So it would have been more precise  
12 to say adjacent to a suburban-urban MSA.

13 DR. STENSLAND: Adjacent to the MSA.

14 DR. BERENSON: So you're not going -- because I've  
15 recently heard about some placements of national health --  
16 it sounds like National Health Service Corps people in,  
17 like, Arlington, Virginia, and places like that. And it  
18 makes me a little nervous that there may be a slippery slope  
19 and that we're really focused on rural here.

20 DR. SOKOLOVSKY: I always thought I lived in a  
21 rural area.

22 DR. MARK MILLER: Being from Arlington --

1 [Laughter.]

2 DR. MARK MILLER: But, actually, I want to remind  
3 all the Commissioners, remember also during the summer  
4 planning session we talked about a couple different ways to  
5 do the continuum, and so there are classifications that can  
6 be, you know, way out to frontier types of things, and we  
7 can go through all those kinds of things with you as we work  
8 through this.

9 MR. HACKBARTH: Round 1, clarifying question on  
10 this side?

11 [No response.]

12 MR. HACKBARTH: Okay. Round two questions and  
13 comments.

14 DR. DEAN: Needless to say, I have a number. I  
15 guess the reason I asked the question about the focus groups  
16 is I would be really cautious about generalizing from any of  
17 those responses, because quite honestly, they just don't  
18 gibe with my own experience. And part of it has to do with  
19 the definition problem that Bob brought up. There is a  
20 tremendous diversity in rural areas. I mean, you can have  
21 counties that are adjacent to Rochester, Minnesota, that are  
22 15 minutes from the Mayo Clinic, and you've got native



1 villages in Alaska where you have no professional provider  
2 within probably a couple of hours by air travel. And you've  
3 got everything in between.

4           So I think that we really need to be cautious  
5 about a few people's perceptions. And also I think  
6 perception of access is a very subjective thing, and if you  
7 talk to people in rural communities, their perception is  
8 what they've been used to. They know what they've had in  
9 the past, and they know what they're used to. Does that  
10 mean it's adequate or appropriate? And I would suggest  
11 that, for instance, do those folks understand that if they  
12 have an MI, their chances of getting to a facility that can  
13 do angioplasty within 90 minutes, which is the standard, is  
14 probably zero, or their ability to get to a major trauma  
15 center within the Golden Hour, the so-called Golden Hour, is  
16 virtually zero. I know it is in our area. Now, that  
17 doesn't mean that's something we can fix, but I think we  
18 really have to be careful about generalizing from some of  
19 these impressions.

20           Just to go down the list, certainly the recruiting  
21 problem is a major issue, and it's even more significant,  
22 and all the things that you said about that are certainly

1 true. One of the really worrisome things is that among  
2 entrants to medical schools, the proportion of people coming  
3 from those backgrounds is actually going down just when the  
4 need is going up. And so that is a particular -- I know the  
5 people, some of the people that are in the Alabama program,  
6 and that's a marvelous program. Unfortunately it's very  
7 isolated, and I don't think it has been replicated anyplace  
8 else. And I'm not exactly sure what their numbers are as  
9 far as their outcomes, but the people that are running it  
10 are wonderful people, and they're clearly on the right  
11 track. But no other state has really chosen to do that.

12           With regard to the number of -- the provision of  
13 specialty care by visiting specialists, that is an option.  
14 In our own experience, it's a declining option. We used to  
15 have about six or seven different specialties that came to  
16 our area. Now we have three. They have dropped off because  
17 they decided it wasn't financially feasible for them or  
18 acceptable, or whatever the proper term is. And so the  
19 availability of specialists that are willing to do that is  
20 becoming less and less. So as far as the future is  
21 concerned, I think it's a very questionable thing to depend  
22 upon.

1           I'll try and be quick here because I've got a long  
2 list.

3           With regard to telemedicine, telemedicine has been  
4 viewed by the technical community and some of the  
5 policymakers as the solution to all our problems for many  
6 years. I was on a governor's task force 20 years ago that  
7 was going to solve South Dakota's rural health problems with  
8 telemedicine.

9           Now, it has made great progress, and it is very  
10 useful. We use it quite a bit. But the problems are still  
11 problems of logistics, getting the specialists into the  
12 particular studio where they can do it, the time it takes to  
13 get the patient set up, the time it takes to do all the  
14 organization and so forth. For a while, there were  
15 significant reimbursement issues as well. Some of those  
16 have been overcome. But it still is an awkward mechanism.

17           Like I said, we use it a lot. I work for an  
18 organization that runs a network of small rural clinics that  
19 stretch out over a range of about 300 miles. And, for  
20 instance, we have a psychiatrist that comes to our clinic  
21 and does consults for the other nine clinics from our  
22 clinics. And it's an access to -- it's limited. It's not

1 enough. But it at least provides access to some services  
2 that weren't there up until just, you know, this last year  
3 or so when we were able to do this service.

4 Travel is a barrier, and, you know, I know your  
5 folks said that they could overcome it, but there's a lot of  
6 objective data that say the farther you move services away  
7 from people, the less likely they are to use them. There  
8 was a study that showed that even offering free mammograms,  
9 if the facility was more than 20 miles away from the  
10 patient, they didn't use it.

11 There were some really good studies that are now a  
12 bit dated that the University of Washington did on OB care,  
13 and what they showed, the more you centralize obstetric  
14 care, your costs go up and your outcomes get poorer because  
15 of the same issue. People just don't drive that far. They  
16 put things off. They wait until the last minute. They wait  
17 until they have a crisis, and then they go. And so your  
18 outcomes get worse.

19 I cringe, I have to -- maybe I'm just being  
20 defensive, but I would quibble with the issue that small  
21 rural hospitals deal only with simple conditions. I can  
22 tell -- I don't do it right now, but I can tell you about

1 the two patients that were in our hospital when I left  
2 yesterday, both multiple problems, very complex patients.  
3 They were on our swing bed program, but our experience is  
4 that oftentimes the patients in the swing bed program that  
5 have these complex chronic conditions -- one fellow had a  
6 bad stroke and had a whole lot of other complications. He  
7 couldn't participate in the official rehab program because  
8 he was too limited. So he comes to our swing bed program,  
9 and they require every bit as much care as any acute-care  
10 patient that we've had.

11           So maybe I should just stop. I also quibble a  
12 little bit with the implications of some of the statements  
13 about quality. Again, there is huge diversity, and there  
14 are studies from some of the rural research centers that  
15 showed that looking at MI care, for instance, there is a big  
16 range. There are some places that don't do it very well,  
17 and there are some places that do it just as well as any  
18 urban center given the fact of the limitations of what  
19 facilities have available.

20           So, again, I would be cautious about generalizing  
21 from any of these things. I'll take a breath.

22           DR. STENSLAND: We'll certainly look at the data,

1 and having looked at the data in the past, we've always said  
2 that there's a range of outcomes, and certainly -- and  
3 there's going to be some good, but there also might be some  
4 that have some room for improvement.

5 DR. DEAN: Oh, there's no question about that.

6 MS. BEHROOZI: Just very quickly, listening to  
7 Tom, I was going to cede all of my time to you, Tom, being  
8 from Brooklyn, and then to George.

9 [Laughter.]

10 MS. BEHROOZI: But it just occurred to me,  
11 particularly when you were talking about, you know, what  
12 people are used to is what they think they're supposed to be  
13 used to, or whatever, and then at the end talking about the  
14 quality issues and references in the paper to how people  
15 felt about their own little hospital as compared to the big  
16 city hospital. I realize that you're looking at comparative  
17 data as between urban and rural access and quality and  
18 things like that. But if you have the time and the money --  
19 and I know you've got a lot on your plates -- it might be  
20 interesting to do a focus group with urban beneficiaries as  
21 well and see how much they sound alike, because, you know,  
22 you'll have community-based hospitals in one part of the

1 city that the docs are all proud of, but they wouldn't send  
2 their own kids there. They'd send them to, you know, the  
3 big academic medical center across the river, or whatever,  
4 you know, in another borough of that same city. And just  
5 some of the things that people say, whether it's providers  
6 or beneficiaries, might sound a lot alike.

7 DR. SOKOLOVSKY: I just want to say that we, in  
8 fact, did -- we didn't talk about it for this presentation,  
9 but in each of the states we went to, we also did the focus  
10 groups in the urban areas and did ask them exactly the same  
11 questions and did hear very much the same issues about  
12 access. And, in fact, we've been doing that now for four or  
13 five years. So, yeah, we have been tracking that.

14 But the other thing I wanted to say was that at  
15 least in one of the rural hospitals, they asked us what the  
16 beneficiaries said in the focus groups about access, and  
17 when we told them, they expressed almost Tom's exact words:  
18 They think they have access, but they don't realize what  
19 they don't have. So I guess that's a tension.

20 MR. GEORGE MILLER: Yes, I'll be just as brief as  
21 Tom was.

22 MR. HACKBARTH: [Off microphone.]

1 [Laughter.]

2 MR. GEORGE MILLER: He said a lot of the things  
3 that I was thinking and would have said, so I'll try to be a  
4 little more brief and concise. As his statement said that  
5 people perceive that they have access to care, I think that  
6 is generally true because they get used to what they have.  
7 I was struck by the statement and your comment that, in  
8 general, beneficiaries do not report access problems in  
9 general. But then you said that you don't find that  
10 specialists live in rural areas. Well, that's to me an  
11 obvious statement because as the CEOs of the hospitals you  
12 talked to said they would bring them in one or two days a  
13 month for clinic services for those specialists. And as Tom  
14 talked about, and in my case -- I ran three rural hospitals  
15 -- we would pay great money to put the facilities in they  
16 want, the equipment, but there was the travel time between  
17 one of my hospitals and the larger hospital of about an hour  
18 each way. And so while they came for a while and got good  
19 patients, as their practices grew, for economic reasons they  
20 figured, Should I spend two hours a day driving one day a  
21 week to Jasper, Texas, or could I stay in Beaumont and  
22 generate more revenue? It became an economic issue. So our



1 patients didn't have to travel to them.

2           The other issue that -- and I'm glad to hear you  
3 say that you found some of the same issues in rural areas  
4 because I was going to make that very point. You said some  
5 physicians do not admit to the local hospital -- or one  
6 physician didn't admit to the local hospital. That is true  
7 in urban areas, that some physicians don't admit to certain  
8 urban hospitals. So my concern is do you make that part of  
9 the report, or is that just an anecdotal statement?

10           And the other side of that -- I was in another  
11 little West Texas town -- we put a physician off our staff  
12 for inappropriate quality of care. We couldn't tell anybody  
13 why he wasn't there. We couldn't say anything about it.  
14 But that physician would say, "Well, I don't admit to that  
15 hospital anymore." Well, there's a reason. If you don't go  
16 beyond the obvious reason that they just said it, there may  
17 be a reason behind that.

18           So, again, I understand why the statement was  
19 made. That's what was reported. But I'm concerned about  
20 the conclusions that could be drawn by that statement. And,  
21 again, as Tom mentioned, I ran a small rural hospital. We  
22 had babies that came and they couldn't breathe, and we would

1 revive them right there. We had a stabbing, 21 times  
2 stabbed. Our general surgeon came in with five minutes,  
3 cracked open the chest, used paddles to start that heart  
4 back, and that patient is alive.

5           So it's not a Band-aid -- rural hospitals are not  
6 Band-aid statements. We do some extraordinary work to save  
7 people's lives and stable until they can get to other  
8 places. And we do that in our hospitals to the capability,  
9 so you just can't make a broad-brush statement that rural  
10 are small, Band-aid statements, and -- you didn't say that,  
11 but I don't want that inference to be out there. So I just  
12 want to put the other issues on the table.

13           And, finally, on transportation, a study was done  
14 in a small town that I was in that transportation wasn't  
15 issue except for many of the families had one means of  
16 transportation. When the husband or other spouse took that  
17 one mode of transportation to go to work, then the other  
18 spouse did not have access to get to the hospital, which it  
19 could have been four, five, six, seven miles away, if they  
20 had an emergency with the spouse who was at home and the  
21 children. And so saying that there's not a transportation  
22 issue, you have to peel that onion back and really look at

1 the underlying issue. So if there's a car in the family or  
2 a truck in the family and they take that to go to work. then  
3 the rest of the family doesn't have transportation or access  
4 to health care at that point in time.

5 I could go on, too, but I'll yield the rest of my  
6 time.

7 MR. HACKBARTH: Well, I appreciate, George and  
8 Tom, both of you trying to help us deal with our time  
9 constraints now, but what you have to say is really, really  
10 important for this report. You both have firsthand  
11 experience that we need.

12 Tom, we've often talked by phone, had phone  
13 conversations to go through issues with you. I would urge  
14 both of you to help us in that way on this. You know, we  
15 only have so much time in the public meeting, but there's no  
16 reason for our conversations and your input into the report  
17 to be limited by that. So we need to hear more from you.

18 MS. UCCELLO: Just very quickly, I think as well  
19 that Tom and George have brought up some really important  
20 points that I know that you'll be pursuing, especially, you  
21 know, trying to find more data on the quality issues and  
22 that kind of thing. But as someone who's kind of new to

1 this topic, I really appreciated, you know, this  
2 perspective, and especially -- I don't know if it was our  
3 summer meeting or another meeting, just thinking about,  
4 well, what do people expect who live in these areas.

5 And so I think that's really important to include  
6 as well, so I want to thank you for those.

7 MS. HANSEN: Yeah, relative to the diversity of  
8 these settings, there's something there specific to the  
9 people who might be on dialysis or cancer treatments, which  
10 is a chronic condition that requires a lot of regular  
11 access. I wondered if there will be a little bit more  
12 coming to kind of think about this from what beneficiaries  
13 manage to do and perhaps whether there are creative ways  
14 that are being dealt with.

15 That leads to my second and final question about  
16 how we frame some of this since this is such a -- intended  
17 to be a comprehensive report. I do wonder if there are some  
18 almost best practice centers of different kinds of rural  
19 settings that have figured out a way almost transformatively  
20 to meet the needs of their communities in ways that are  
21 creative as a result of taking full advantage of, you know,  
22 basically what opportunities they happen to have, and just

1 to be able to kind of describe that a little bit more,  
2 because not only would they be helpful perhaps for rural  
3 settings, I think they could be instructive for urban  
4 settings as well as we think about, you know, when you have  
5 limited resources, how do you still achieve access, quality,  
6 and value?

7 MS. KANE: Just a couple things.

8 One is I guess it would be helpful, I think, to  
9 discuss what the goal is of rural access. You know, if you  
10 go hiking in the wilderness and have no cell phone  
11 reception, you're going to get one level of emergency  
12 assistance. And, you know, if you're walking around  
13 downtown Boston, you have another. So I guess, you know,  
14 what is our standard and what should we be using? Is there  
15 supposed to be parity with urban environments? And is that  
16 realistic?

17 I guess just more generally I'm not sure where  
18 we're going to set a standard. Certainly -- and I think the  
19 focus groups speak to this -- patient expectation might be  
20 the standard, you know, what are people expecting versus  
21 what they get. But I just worry that, you know, we're not  
22 going to ever be able to hit parity with, you know, the

1 people who live right next door to Mass. General. And so  
2 how do we address that? And how much tolerance do we have  
3 for the fact that it's not perfect but people are willing to  
4 put up with it? And how do we find that out?

5           Then on the other issue around focus groups and,  
6 you know, whether we can interpret them or not, I'm  
7 wondering if it wouldn't be useful to aggregate in different  
8 rural areas the -- I don't know if there even is a way to do  
9 this, but the patient satisfaction and clinical outcome  
10 scores, and then try to pick people from different quadrants  
11 of the responses and say, well, we're going to find out  
12 what's going on in this very highly satisfied rural area and  
13 then we're going to try to find how it's going in this  
14 really unhappy world, even if it's the hospital-based care  
15 you're pulling it out of, and just try to get a sense of,  
16 you know, within rural areas what's the range of  
17 satisfaction and clinical outcome, and then how do we see  
18 what the differences are in practice between the high  
19 satisfaction -- I'm trying to find a standard here for, you  
20 know, what do we want to target? Where do we want to get?  
21 So as a way to use these -- you know, this methodology. You  
22 can't go, you know, talk to everybody, so where should you

1 talk?

2 DR. STUART: This will be really brief, and it  
3 follows up on that notion of what do we mean by access. And  
4 I think there's a tendency -- and you made it explicit -- to  
5 think the more services that are around you, the better.  
6 And I'd just remind us that that's not necessarily true.  
7 And so when you're looking at this, it might be useful to  
8 have a measure of unnecessary services or things that are  
9 happening in urban areas that are not happening in rural  
10 areas, perhaps something like the AHRQ potentially avoidable  
11 hospitalizations or something like that that would capture  
12 some of the other side of having too much access, if you  
13 will.

14 DR. BAICKER: Just briefly to follow up on this  
15 theme that I think came up over the summer, too, there's no  
16 way rural areas are going to look like urban areas, and that  
17 shouldn't be the goal. So then the question is: What  
18 should be the goal? And you can ask people, but their  
19 expectations could be wrong in either direction. They could  
20 expect it to be just like a city, or they could say, well, I  
21 guess what you're supposed to get is what I'm getting and  
22 maybe we think that it should be better. So the challenge

1 is how do we come up with that threshold.

2           One thing we could do is look around at the rural  
3 areas and say, What's the best care achieved in comparable  
4 areas and should we try to get everybody up to that? Now,  
5 the challenge of that is there are going to be positive  
6 outliers that are very hard to replicate elsewhere, and also  
7 we might think overall we're not doing as well as we'd like  
8 to, so looking at what we're doing isn't the right  
9 benchmark. But it seems like the place to start is to try  
10 to figure out what are the models of what's achievable and  
11 do we think we should try to report that over as standards  
12 for other places.

13           DR. CHERNEW: I agree very strongly with the  
14 previous statements that we have to decide what sort of  
15 configuration or access we want in rural areas.

16           Sort of a minor point related to that is when we  
17 think about our cost adjustments, we often think about cost  
18 adjustments based on wages or things in a particular area.  
19 That's not the right way for an economist to think about  
20 costs. They would think in some sort of opportunity cost  
21 way. So it would be how much you need to pay to get people  
22 to go there, and you wouldn't tie it to some other external



1 price measure.

2           So if once we do this other exercise to see what  
3 it is we think should or shouldn't be in a rural area, tying  
4 the geographic adjustment to some measure of what it costs  
5 to be there is actually wrong. It should be tied to what it  
6 takes to induce whatever we think the right practice is. So  
7 if we can't get the right specialists -- and I don't know  
8 what that is -- in a rural area, you don't say, well,  
9 they're getting paid right because this is what a lawyer  
10 makes in those communities. You say, no, we're not paying  
11 enough to get people to go there for whatever reason and we  
12 need to adjust.

13           Now, of course, you might pay urban people less,  
14 and that's a whole separate discussion. But in any case,  
15 the right concept has to be an opportunity cost one, not a  
16 "what do we pay for some other comparable wage" type labor.

17           DR. CASTELLANOS: I would like to give a different  
18 perspective. I'm a physician that works in an urban area  
19 that sometimes go out to a rural area. And one of the  
20 reasons -- we just gave up a rural area, and the reason is  
21 it's a workforce problem. We just don't have the horses to  
22 be able to do that. And it's not worth going out to a rural

1 area to see one or two patients and spend two hours driving  
2 each direction. So, you know, it becomes an economical  
3 problem, but it's also a workforce problem.

4 I'd like to spend a little bit on telemed. That's  
5 concerning to me because in the urban areas and in every  
6 hospital almost in the United States today or tonight, we  
7 have telemed. We have the radiologist sending those films  
8 to an area where they can be read automatically by their ER.  
9 So telemed works. We have EKGs from an ICU unit being  
10 telemedded to a center for an interpretation and perhaps --  
11 so even though it's not in my hospital at night, it's being  
12 done in radiology, and it's being done with EKGs. We've got  
13 to understand why is it not being done as much in the rural  
14 area. Is it because of expense? Is it because -- whatever  
15 it is, we need to drill down and look at that.

16 And my third point -- and I would really like you  
17 just to reassess the past MedPAC access findings in the  
18 paper that you said, because we found, the past Commissions  
19 found that rural and urban beneficiaries reported similar  
20 access. We found that the beneficiary surveys, the rural  
21 Medicare beneficiary reported similar access to physician  
22 services as urban beneficiaries. We found that

1 beneficiaries in the rural counties received similar levels  
2 of care. And we found in the paper that you set out that  
3 there's no pharmacy problem access.

4 I'm not questioning. I just think we just need to  
5 drill out and, perhaps, as Tom says, go out and reach into  
6 other communities to really make sure these points are real.

7 Thank you. Good job, by the way.

8 DR. STENSLAND: This is all going to be very data  
9 driven, and I think obviously even from going around the  
10 table, there's a lot of perceptions and a lot of historical  
11 perceptions which have been pretty consistent over the last  
12 15 years that I've been listening to it. So I think given  
13 these conflicting perceptions, we'll try to really be very  
14 hard on the data driven and here is the data and the data is  
15 what the data is. And I think one nice thing about having  
16 the report from 2001 is we can look at the data from 2001  
17 and look at the data from ten years later and see if  
18 anything has changed, which I think is a great idea for us  
19 to make sure we double-check all that.

20 DR. CASTELLANOS: Thank you.

21 MR. HACKBARTH: Of course, one of the issues  
22 lurking here is that when we report these satisfaction data,

1 my recollection was it was all rural areas aggregated with  
2 the broad definition of rural. But you might get very  
3 different results if you used, you know, what's satisfaction  
4 in the really rural areas versus the ones that are more  
5 heavily populated, because the reality is different in those  
6 places. So, you know, there are aggregation issues in the  
7 satisfaction data and all the data that we'll be dealing  
8 with.

9           Just one last thought on that. In some of these  
10 data files, we can easily, you know, subdivide them and  
11 analyze them, different types of rural areas. When you're  
12 talking about patient surveys, you have a different  
13 logistical problem. You're not just manipulating a computer  
14 file. You've got to go out and collect raw data, and it may  
15 be prohibitively expensive to get enough responses in areas  
16 like Tom's to really have reliable information.

17           DR. STENSLAND: One thing we can look at is the  
18 hospital quality data that CMS reports, and not all critical  
19 access hospitals have to report that data, but those that  
20 do, we could compare the really small hospitals or the  
21 frontier hospitals. And, in general, on the consumer  
22 satisfaction, they do -- everybody does pretty well, but the

1 rurals definitely generally do pretty well on that. And we  
2 can certainly report all that data.

3 MR. HACKBARTH: Okay.

4 MR. ARMSTRONG: First, just briefly I would want  
5 to acknowledge that I would have made the point, but really  
6 appreciate knowing that the anecdotal information that we're  
7 hearing both in our comments and that we read here will be  
8 complemented with this analysis. I just think that's  
9 important.

10 To build on some of the comments people have been  
11 making about access and how you advance access, the  
12 perspective I was going to offer is that we deal with access  
13 issues in urban areas all the time. And we're investing in  
14 electronic records, access by e-mail, more scheduled time  
15 for telephone consultations, and on and on and on. Access  
16 is constrained because of capital and because of man hours  
17 in urban areas, but in rural areas it's geographic and maybe  
18 other things.

19 So my hope is that after we've done the analysis  
20 and we look at opportunities to improve access, we can apply  
21 some of the things that we've learned in those urban areas.

22 I also just worry a little bit. Our conversation

1 about access tends to focus on MIs and specialists rather  
2 than access to those kinds of services we know reduce the  
3 need for emergency rooms and hospital days. We really want  
4 to make sure we're balanced in some of our proposals  
5 investing in access for those services that lower the  
6 expense trends over time.

7           The last point I would make is, being from  
8 Seattle, which is the home for the Gates Foundation and PATH  
9 and other organizations that are coming up with incredibly  
10 innovative ideas for giving access to people who live in  
11 really rural, rural parts of our world, there are  
12 innovations that I think we need to figure out how to apply  
13 to some of our own communities here in this country, and  
14 that just might be an interesting discovery process in and  
15 of itself, too.

16           DR. BORMAN: In preface, I guess I should  
17 disclose, a la Jennie earlier, some of my early experiences  
18 relate to being on the receiving end of individual patient  
19 care from very dispersed populations in a couple of states,  
20 and so that's probably the bias or background that I might  
21 bring to making comments.

22           I would absolutely support the notion of trying to

1 identify what is our goal, what is our target in terms of  
2 equity, parity, access to basic care. I think as we've said  
3 repeatedly on multiple occasions -- and Scott just brought  
4 it out eloquently -- access to services that prevent those  
5 more expensive things is an important goal, whether it's  
6 rural, exurban, suburban, or, you know, downtown Manhattan  
7 or next door to the Mass. General. And so I think that  
8 those are important.

9 I think as we think about this, it's one of those  
10 places, as we've discussed in shared decisionmaking, where  
11 maybe changes in absolute risk are something we should pay  
12 attention to as opposed to changes in relative risk. Just  
13 for an example, if I told one of my geriatric relatives that  
14 by going 30 miles into the city they could reduce their  
15 chance ten-fold of a common bile duct injury during  
16 cholecystectomy, that might sound very convincing. If I  
17 said if you drove 30 miles into the city, it's 1 percent --  
18 or it's 0.1 percent, if you stay home it's 1 percent, they  
19 might look at that very differently. And so I think this is  
20 a place where we can sort of overlap some work in another  
21 topic and be a little bit careful about how we ask the  
22 questions and evaluate what the outcomes are and the goals

1 that we want to achieve.

2 I would ask that if you do more sampling of  
3 opinion, you talk to other folks who have, in fact, been on  
4 the receiving end of the transfers, because I think that  
5 they will have insights. Just as, you know, if you talk  
6 about the primary care consultant relationship, you learn  
7 from talking to both ends of that equation; I think if you  
8 talked to both the origin and the destination of these, it's  
9 very helpful to see what the perspectives are.

10 I think a philosophic issue in here that I have no  
11 clue how you'll do -- but you're very smart so I know you'll  
12 figure out how to do it -- is how to sort out a little bit  
13 the value here that people are placing because the  
14 hospital's an economic engine in their community, and that's  
15 a very different thing than is necessarily how it advances  
16 their own personal health care or the care of their  
17 community. And I think that the data about CT scanners and  
18 MRIs in your findings are just, you know, hugely supportive  
19 of that. And I haven't the first clue how to separate that,  
20 but I think we need to at least acknowledge that that's a  
21 piece that maybe we can't measure, but that certainly  
22 figures into this.



1           The transportation issues have been touched on. I  
2 would only throw out that we may need to really think  
3 outside our box here about is this an area in which there  
4 are some things for which we should have a transportation  
5 benefit. You know, is that appropriate? Are we advancing  
6 access and quality by a transportation benefit for certain  
7 things? And I would pick up on Jennie's piece that some of  
8 the things that are intensive, that are multidisciplinary,  
9 and that perhaps are expensive equipment-intensive, so  
10 things like multidisciplinary oncologic care, particularly  
11 the cost of radiation oncology and the relative scarcity of  
12 those practitioners, things like end-stage renal disease,  
13 things like more complex operations. We know for sure that  
14 general surgeons who practice in smaller communities have a  
15 very different span of operations that they do regularly,  
16 and that raises some issues about what is best done. And  
17 it's not because they didn't go through the same training  
18 everybody else did. It's sometimes in part because the  
19 system can't support and shouldn't support some of those  
20 more complex activities, so we need to think about how to  
21 incent that behavior appropriately. Just like in everywhere  
22 else where we think about primary care, I think we need to

1 think about primary care services, which is a collaborative  
2 team sort of thing, versus what is the unique role of the  
3 primary care physician. And we need to make sure that we're  
4 leveraging scarce resource primary care physicians by having  
5 them practice at the top of their license, if you will, as  
6 opposed to doing things that they may enjoy doing and can be  
7 satisfying, but that can be done by other providers that  
8 perhaps we have more of a supply of, and we need to focus on  
9 those team leader skills perhaps in that somewhat.

10           If you'd go to Slide 12, I would just like to  
11 touch on your slide about reducing isolation with  
12 telemedicine, using teleconference to keep in touch. One of  
13 the things that I think the American Board of Internal  
14 Medicine and the American Board of Surgery will tell you is  
15 that the highest challenge rates, if you will, or failure  
16 rates in maintenance of certification relate to solo, truly  
17 rural providers. And, again, these were bright people that  
18 went through good schools and good residencies. It's not  
19 that all of a sudden they're stupid. It's that they don't  
20 have the opportunity readily to interact with colleagues, to  
21 talk over cases, to be able to participate in activities  
22 that are provocative about new trends and things. And so I

1 think this one is a hugely important piece as a part of the  
2 quality thing, how do we make quality better, and doing that  
3 kind of stuff.

4           One last thing is I would say in quality we have  
5 to be very careful. So, for example, in practice in  
6 Jackson, Mississippi, the time for transfer of many major  
7 trauma victims is pretty substantial, even though the  
8 university has two helicopters and it seems like there's a  
9 bunch of helicopters at places that don't have doctors. So  
10 we get people that are much further down the course of their  
11 illness, and they then have a different morbidity/mortality  
12 profile, and the quality things that we need to judge need  
13 to be a little bit different. And I'm sure there's  
14 analogies in other than surgery, and we need to make sure  
15 we're selecting the right quality metrics to apply. And I  
16 would suggest that just like in transplantation, where time  
17 to referral for evaluation for transplant ought to be a  
18 metric, maybe sometimes the time to referral or transport in  
19 some of these very well defined things could make some good  
20 metrics that are appropriate to this set of hospitals and  
21 providers.

22           MR. HACKBARTH: All right. So this is a good

1 initial discussion. I think this question of what is good  
2 enough, to put it crudely -- that's not very artful  
3 phrasing, but that's sort of at the heart of it -- is  
4 clearly a really important question.

5           You know, for most products or services, you don't  
6 have to answer that in the aggregate. We have functioning  
7 markets, and people decide with their own money how much  
8 they're willing to pay for different things, and the market  
9 sort of sorts it out on a decentralized basis. That's not  
10 going to happen here for a variety of reasons, including the  
11 prevalence of insurance, and we don't want people only  
12 getting access based on what they can individually pay.  
13 That's not consistent with our societal values. So we've  
14 got to figure out other ways.

15           Now, the default mechanism is -- I think Tom made  
16 this point. It's what people know. You know, I want to  
17 keep what I've had or maybe enhance it somewhat, and that's  
18 sort of a natural reference point for folks to take,  
19 although, you know, that may not be the right answer. It  
20 may not even be in their interest to keep what they've  
21 always had. But it's the natural thing for people to do.  
22 And it's certainly the natural thing for the political

1 process to do, is to think in terms of, well, I've got to  
2 protect my community hospital or maybe get it a little bit  
3 more money so it can be a little bit stronger than it has  
4 been in the past.

5           We could, as Kate suggests, say, you know, let's  
6 have explicit discussion about what the goals are and  
7 establish a framework, what is truly needed, and then try to  
8 match our payment policies and other policies to achieve  
9 that explicit goal. That's the logical thing to do. But I  
10 can imagine that it would be a very difficult, awkward at  
11 times, conversation, a very politically charge conversation  
12 that would be difficult for the Congress and others to deal  
13 with. So as logical as it may be, I'm not sure that it's  
14 necessarily going to be an easy one.

15           You know, I'm left wondering whether there's some  
16 part of this ought to be talking about are the ways that we  
17 can shift the paradigm, and I'm not sure how to do this, but  
18 sort of a half-baked idea is, you know, what if we were able  
19 to say to a community you don't have to use the resources in  
20 the way that they've traditionally been used. We're willing  
21 to give you an amount of money, and you can redeploy it in  
22 ways that better meet your needs. So, you know, sort of

1 breaking out of the fee-for-service, siloed mechanism and  
2 maybe paying for some services that haven't been  
3 traditionally paid for, but actually would be much more  
4 highly valued in getting the community the services it  
5 really wants and needs.

6           You know, I wonder whether there's some way that  
7 we could suggest at least on a pilot basis that people be  
8 given more freedom on how to deploy the resources, you know,  
9 sort of a capitation payment, as it were, as opposed to  
10 paying through fee-for-service avenues. So that's just a  
11 half-baked idea. Obviously that's not going to be a  
12 solution for the whole system, but it may generate some new  
13 thinking in communities about how to reconfigure to really  
14 produce high-value services that we could then learn from.

15           DR. DEAN: Just to respond to a couple of things.  
16 The challenge that Nancy raises is really terribly  
17 important, and it's terrible difficult because it's so  
18 location-specific. I mean, the standards for that county  
19 that's adjacent to Rochester, Minnesota, is totally  
20 different than the standards in northwestern South Dakota  
21 where the nearest physician is 50 miles away, and then it  
22 would be an isolated primary care doc. Or even, you know,

1 the two corners of South Dakota, in one corner we've got  
2 Sioux Falls that's got a fairly sophisticated system and  
3 lots of access. The northwest corner, it's basically wide  
4 open prairie and very few people. So it's a huge challenge.

5 I guess what I would plead on the part of rural  
6 providers relates to some of the things that Karen said.  
7 The longer you are in these small communities and the  
8 broader your range of responsibilities, you become less and  
9 less comfortable dealing with some of the technical stuff  
10 that you felt really comfortable about dealing with when I  
11 first got out of residency. And we know that in terms of,  
12 say, setting outcome standards for MIs, for instance -- and  
13 I agree totally with Scott. We probably put way too much  
14 emphasis on that, and yet that's what we can measure and so  
15 that's what we pay attention to.

16 I think one of the things that really interferes  
17 with our recruiting and with interesting young providers is  
18 they don't want to go to a place where there's bad outcomes,  
19 and they don't want to be branded as coming from this place  
20 where things are not done well. And yet we know at the same  
21 time that we can have superbly skilled people doing heroic  
22 things, and still, because of the logistics and the time

1 issues and so forth, you're going to get some less than  
2 ideal outcomes. And I think that that in turn drives away  
3 conscientious people.

4 I don't know what the answer to that is except  
5 that I guess we somehow need to get some, hopefully,  
6 recognition within the broader system that these are not  
7 incompetent people. They're people that have taken on big  
8 challenges and are doing well, but, you know, not as good as  
9 if they were in a different setting.

10 So, like I said, I don't know what the answer is  
11 except I think the test, to answer Nancy's question, is we  
12 need to be sure we're doing the best we can -- and not  
13 everybody is. I mean, I'd be the first to admit that, too.  
14 I've said that in trying to figure out in a small rural  
15 hospital what services should we try to provide, and I've  
16 said we've got two kinds. I said we've got the things that  
17 are more the chronic kinds of problems that we are perfectly  
18 capable of dealing with and we ought to be as good as  
19 anybody else on dealing with those. And then we've got the  
20 group of things that we're going to have to deal with even  
21 though we're not as good. I mean, the major trauma, we're  
22 never going to be as good as a major trauma center. And we



1 would just ask for recognition. That doesn't mean we  
2 shouldn't -- we're going to have to tackle it because  
3 they're going to come in our door. But we -- and we need as  
4 much support as we can have, and the telemedicine issues --  
5 I mean, just now we're really moving forward in doing that.  
6 We have a setting in our emergency room right now where,  
7 when we get somebody in our ER that's really sick, all we  
8 have to do is push a button and we have immediate teled  
9 hook-up with the emergency room at one of the referral  
10 centers in Sioux Falls, and we have a critical care nurse  
11 and an ER physician looking over our shoulder and helping us  
12 with that patient. That's a superb service. It's one of  
13 the first telemedicine services that I think is completely  
14 relevant and terribly helpful.

15           So there are answers to these questions. We've  
16 just got to keep pushing to try to find the ones that really  
17 fit. I think the biggest barrier, I guess, as I said  
18 before, in the lack of sort of the more routine  
19 consultations has just been a logistical problem. I don't  
20 think it's a cost issue. In some cases, it's a broadband  
21 issue, but amazingly enough, South Dakota has lots of  
22 broadband capacity. I don't know but --

1 [Laughter.]

2 DR. DEAN: But it's more a logistic issue.

3 DR. CHERNEW: I'll pass given the time.

4 DR. STUART: I think this is a follow-up both to  
5 what you've suggested, Tom, and a point that you raised,  
6 Glenn, and that is, how can we change the paradigm. Maybe  
7 the paradigm should change. We're not sure what it should  
8 look like, but we have some ideas that it should be locally  
9 generated. And in that regard, I'm wondering if we know  
10 what CMS is doing in preparation for the ACO pilot that is  
11 supposed to start next year and whether there's anything or  
12 any organizations or whether CMS is trying to find  
13 organizations that serve rural areas. Do we know?

14 DR. STENSLAND: I know there is some interest in  
15 the rural community of trying to make sure ACOs are  
16 applicable in rural areas. We can get back to you on that?

17 DR. MARK MILLER: And also wasn't there some  
18 discussions -- I'm probably going to get it wrong, but  
19 Vermont where they were trying to reach --

20 DR. STENSLAND: Right.

21 DR. MARK MILLER: So I think we can bring it into  
22 sharp relief. I think there's some action out there we can

1 find it out.

2 MS. HANSEN: I just wanted to underscore this  
3 shift of looking at it, and I think, you know, whether it's  
4 the ACOs or it's what comes out of the Innovation Center,  
5 it's just a way of reframing this in the paradigm that you  
6 suggested. I think that -- and coupled with Scott's  
7 comment, there -- you know, people are very enterprising,  
8 and I think about when a community is focused on something -  
9 - I think I've raised this before. There's a community  
10 called Albert Lee in Minnesota that focused on really  
11 bringing the health of the entire community in. And so it  
12 brought together not only the traditional health players but  
13 the non-health players so that it was a community standard,  
14 and they lost weight, like tons, literally tons of weight,  
15 together, created a community of walkable spaces. So it's a  
16 real paradigm shift that occurs, but their health care costs  
17 and their, you know, diabetes, and I think things really got  
18 managed. So it really is a very -- it's a true mind shift,  
19 but if there are opportunities in PPACA to think about this  
20 in the innovations and the ACO concept, to actually rejigger  
21 the whole way to think about this so that the local  
22 relevance there of how you use staff, how you use resources,

1 this could be pretty exciting.

2 MR. HACKBARTH: Okay. Thank you.

3 We'll now have our public comment period. So  
4 please begin by identifying yourself and your organization  
5 and limit your comments to no more than two minutes. And  
6 when the red light comes back on, that will signify the end  
7 of two minutes.

8 MS. LUNNER: Great. Good morning. My name is  
9 Kristina Lunner. I'm with the American Pharmacists  
10 Association, and I just wanted to provide a couple reactions  
11 to this morning's discussion.

12 Just recently, the discussion of ACOs and  
13 providing -- maybe this idea of providing a pot of money and  
14 allowing sort of the front-liners decide how best to use  
15 that, we're excited about the opportunities in the  
16 Affordable Care Act for pharmacists to provide more patient  
17 care services. Sometimes they're referred to as medication  
18 therapy management services. But keep in mind that  
19 sometimes they're at a disadvantage in that they don't get a  
20 fee-for-service payment. So if ACOs and medical homes, as  
21 they're currently designed in the Affordable Care Act, still  
22 rely on a fee-for-service payment, the good local doctor

1 from South Dakota will -- it's going to be a much greater  
2 challenge for him to utilize those services. And so we need  
3 to keep that in mind, that there may be some payment  
4 barriers to improved care.

5           Secondarily, I wanted to go back to this morning's  
6 coordinating care of duals. One of the things that we've  
7 learned recently is that in the State of Iowa, they've had a  
8 pharmaceutical care management program, PCM program, for a  
9 while. It's been very successful, the reduced costs and  
10 improved quality. But because they serve duals, we've heard  
11 that those duals now will no longer be eligible for that  
12 program, which is a much more robust program than what many  
13 Part D programs now provide for MTM. And so the challenge  
14 is, if you've got services in Medicaid and Medicare that are  
15 different but considered the same under one bucket, MTM,  
16 those duals may be at a disadvantage if they're forced to  
17 get it from the program that's lesser. And I'm making  
18 generalizations, but it is possible that either some  
19 beneficiaries wouldn't be eligible for their Part D benefit,  
20 MTM benefit, or what they would receive is very different  
21 and less than what they would get if they could continue  
22 with Iowa's program.

1           So I just wanted to raise, as you're working with  
2   MACPAC and, you know, looking further on these different  
3   programs, keep in mind the pharmacists and the role that was  
4   envisioned for them in health reform, and we'd like to move  
5   in that direction, but there are some ongoing challenges.

6           MR. HACKBARTH: Okay, we'll adjourn for lunch and  
7   reconvene at 12:45 p.m.

8           [Whereupon, at 11:51 a.m., the meeting was  
9   recessed, to reconvene at 12:45 p.m., this same day.]

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1                               AFTERNOON SESSION                               [12:51 p.m.]

2                       MR. HACKBARTH:   Okay.   Welcome back from lunch.  
3   The good news is that we have two stimulating, exciting  
4   presenters to carry us over.   So the topic is variation in  
5   private sector payment rates.   And, Julie, are you going to  
6   lead the way?

7                       MS. LEE:   Good afternoon.   In this session, we  
8   will present our work to date looking at variation in  
9   private payment rates for physician services.   The  
10   Commission has previously examined payment rates by private  
11   payers in different contexts.   The Commission's analysis  
12   focused on how Medicare payment rates compare to private  
13   payer rates for hospitals and physicians, especially in the  
14   context of evaluating the adequacy of Medicare payment  
15   rates.   In this project, we will examine how and explore why  
16   private payer rates vary across and within geographic areas.  
17                       By way of background, we should explain why we are  
18   looking at private sector payment rates and what the  
19   implications might be for Medicare payment policy.  
20   Sometimes the argument is made that Medicare prices should  
21   be set through a market-based approach, as in the private  
22   sector, in negotiations between providers and payers.

1    However, the fact that we see wide variation in prices  
2    within a given area suggests that there might not be a  
3    single right price for a given service.

4            Additionally, we know from the literature that  
5    exercising one's market power, either by an insurer or  
6    provider, can be an important factor affecting payment  
7    rates.

8            Since the Medicare program sets the prices through  
9    an administered pricing system, how are market dynamics and  
10   the resulting prices in the private sector relevant to  
11   Medicare?  If the question of whether Medicare payment rates  
12   are sufficient is framed as how do they compare to private  
13   rates, then it is important to understand what those private  
14   rates represent and how they are determined.

15           Furthermore, Medicare's policies related to the  
16   integration and coordination of care across providers may  
17   affect market consolidation and concentration in the private  
18   sector.  We hope the next slide will illustrate some of  
19   these points.

20           Before we describe the analysis and methodology,  
21   we want to show you what we observe in private sector  
22   payment data.  The slide shows the payment data for a single



1 service—a mid-level office visit for an established patient  
2 -- in nine areas. Data are from 2008 and geographically  
3 adjusted for input prices, and these nine areas represent  
4 actual MSAs.

5           In each area, we see a white bar, which displays  
6 the 10th percentile at the bottom and the 90th percentile at  
7 the top of payment rates for office visits in that area. In  
8 other words, the middle 80 percent of payments fall along  
9 the length of the bar. In some areas, the bar is long, and  
10 in other areas it's shorter.

11           You also see somewhere along the bar a green  
12 rectangular marker, which represents the median payment rate  
13 of that area. Where the median payment rate is located  
14 along that bar also tells something about the distribution,  
15 or variation, of payment rates in that area. As a reference  
16 point, the yellow dotted line on the screen represents the  
17 national average payment rate.

18           It's not surprising at all that we see higher  
19 payment rates in some areas than others. But if we follow  
20 only the median payment rate across areas, as we do going  
21 from left to right in the slide, then our understanding of  
22 what's happening in the data seems incomplete.

1           Just in this slide, the nine areas shown  
2 illustrate the range in different kinds of variation we see  
3 in the data. The areas in the left side of the slide have  
4 payment rates below the national average rate; some of them  
5 have variation within the area and some don't. The areas to  
6 the right side have payment rates above the national  
7 average; some of them have lots of variation and some less  
8 than others. And Area D, whose payments are right around  
9 the national average, shows no variation at all.

10           The motivation for our analysis is to more fully  
11 explore the degree and nature of these inter- and intra-area  
12 variations in private sector rates. We will come back to  
13 this slide later in the presentation when we consider our  
14 results in more detail.

15           Our analysis follows a body of research looking at  
16 private payer prices. In 2005, GAO found that PPO plans in  
17 the Federal Employees Health Benefits Program had  
18 substantially different payment rates for hospital inpatient  
19 and physician services across MSAs. In particular, GAO  
20 found a two-fold difference in physician payment rates  
21 across some 320 MSAs and almost a four-fold difference in  
22 hospital payment rates across some 230 MSAs.

1           Earlier in the year, an investigation of payments  
2 by insurers to hospitals and physician groups by the  
3 Attorney General of Massachusetts documented how much those  
4 payments can vary within a single geographic area. Data  
5 from two major insurers showed a difference of up to 300  
6 percent in payments between the lowest to highest paid  
7 network hospitals and a difference of up to 130 percent in  
8 payments made to physician groups.

9           In addition, a recent study of six California  
10 markets reported various strategies used by providers to  
11 negotiate higher payments from private insurers.

12           Now we turn to our analysis and methodology.  
13 First, some definitions. We define payment rate as the  
14 allowed payment for a particular service by an insurer, and  
15 it includes any cost sharing required of a plan member, but  
16 excludes balance billing. We define the market area as the  
17 MSA or each single-state portion of an MSA. For example,  
18 the Washington metropolitan area is divided into four  
19 components: the District of Columbia, Virginia, Maryland,  
20 and West Virginia. This distinction is to allow for the  
21 state-based nature of the insurance market and regulations.  
22 For now we end up with 432 discrete metropolitan areas in

1 our preliminary analysis.

2           The set of physicians services are items and  
3 services billed through the Health Care Common Procedure  
4 Coding System, or HCPCS. About 30 percent of the commercial  
5 sector payments for physician services is for office visits,  
6 followed by imaging services at about 15 percent.

7           Our preliminary analysis is based on commercial  
8 sector claims for 2008 from MarketScan, which include  
9 primarily self-insured employer plans from across the  
10 country. After removing extreme values, the data set  
11 contains over 200 million claims with about \$18 billion in  
12 payments.

13           In this slide, we describe the methodology used in  
14 our preliminary analysis. Because there are thousands of  
15 services and their payment rates can vary in many different  
16 ways, it is useful to define a summary measure or price  
17 index that captures the overall payment rate for a given  
18 area. We constructed our payment rate index in the  
19 following four steps.

20           First, we define a "market basket" of physician  
21 services, consisting of about 160 HCPCS codes that represent  
22 a little over 60 percent of total dollars for physician-

1 billed services.

2           Second, we adjust the payments in our data set for  
3 differences in practice costs across areas. In particular,  
4 we use a set of MSA-level adjustment factors.

5           Third, in each area, we weight each service in the  
6 market basket by the share of national spending associated  
7 with each code.

8           And, finally, we impute payment rates for services  
9 in the market basket for which we don't have at least 30  
10 claims.

11           Now Carlos will present the findings from our  
12 preliminary analysis.

13           MR. ZARABOZO: As for the results so far, in  
14 general, what we have found with respect to private sector  
15 payment rates is consistent with the findings of others, as  
16 Julie noted. We see wide variation across areas in payment  
17 rates, differences across types of services in how much  
18 variation in payment there is, and notable within-area  
19 variation in payment rates. With regard to types of  
20 services, we see less variation across areas in office visit  
21 payments and payments for obstetrical care and greater  
22 variation in imaging, for example.

1           One aspect of variation that has been less well  
2 studied in terms of quantitative analysis of the data is the  
3 extent of intra-area or within-area variation in payment  
4 rates; that is, the extent to which we see payment for a  
5 single service or set of services that vary widely from one  
6 provider to another in a single market. This is something  
7 that Julie touched on with the graphic that she explained  
8 and which we will return to in greater depth after looking  
9 at the variation in payment rates across areas.

10           As Julie explained, we have examined variation in  
11 physician payment rates across 432 metropolitan areas that  
12 are the metropolitan statistical areas or the individual  
13 state components of multi-state MSAs. Our index is  
14 essentially an area's relative payment rates to the national  
15 average, using a fixed basket of services with a fixed mix  
16 of those services. All dollars are geographically adjusted  
17 to recognize variation in practice costs across areas; that  
18 is, what we are showing here removes the effect of differing  
19 input prices in an area. So, for example, if an office  
20 visit in New York city is paid at \$115 but the cost of doing  
21 business in New York City is paid at \$115 but the cost of  
22 doing business in New York City is 15 percent higher than

1 the national average, we set the New York city payment rate  
2 at \$100 for comparability with other areas. We make such  
3 adjustments across all these metropolitan areas. Even after  
4 this kind adjustment, we see very wide variation in  
5 physician payment rates across the country, as illustrated  
6 in this slide.

7           The slide shows the range of area index levels  
8 which go from an index value of 0.73 at the low end to 2.2  
9 at the high end, or a three-fold difference across areas.  
10 You see that the majority of areas -- over 75 percent of the  
11 areas -- have index values that are either less than 0.95 or  
12 higher than 1.05. As for where the high and low areas are,  
13 our findings are similar to the GAO findings in that  
14 metropolitan areas in Wisconsin and Oregon, for example,  
15 have the highest index values while the Washington, D.C.,  
16 area and some parts of New Jersey, California, and Florida,  
17 for example, have among the lowest input-price-adjusted  
18 payment rates compared to the national average.

19           And just as a reminder, especially for the public,  
20 these results are preliminary results subject to change, and  
21 they're very dependent on the methodology that we're using.

22           In the next few slides we will illustrate on a

1 service-by-service basis both the inter-area and intra-area  
2 variation. For our goal of understanding the market  
3 dynamics in a given geographic area, it is important that we  
4 look at intra-area variation. As Julie mentioned, looking  
5 at a market basket average for an area can mask, to some  
6 extent, differences across types of services, as well as  
7 differences across providers within the same market. If  
8 there is a high level of within-area variation, it may be  
9 because one provider or set of providers is a must-have  
10 provider. That is, the provider may be the only provider  
11 offering a particular service, or it is a prestige provider  
12 that is desirable to have in a plan's network of providers.  
13 So the intra-area variation can tell us many things about a  
14 market. Intra-area variation can be an indicator of  
15 provider consolidation in an area, or it could signal the  
16 presence of other market factors that would be important to  
17 understand as we look at different market dynamics across  
18 areas.

19 In the next couple of slides, we will be looking  
20 at specific services -- that is, specific HCPCS codes -- but  
21 we intend to look at groupings of services as we continue  
22 our analysis of the data.



1           In this slide that Julie previously displayed, we  
2   examine inter- and intra-market variation for a mid-level  
3   office visit for an established patient, which is the second  
4   most commonly billed service in the private payer data. We  
5   use actual results from nine different metropolitan areas.  
6   For each of the nine areas labeled A through I, we show the  
7   median payment in the rectangle, the green rectangle, and  
8   the 90th and 10th percentiles, which are the top and bottom  
9   of the bar. These are payments made by PPO plans in each  
10   these areas, and the dotted yellow line is the national  
11   average PPO payment for this service—that is, the  
12   geographically adjusted average across all areas.

13           We show results arrayed from the lowest to the  
14   highest median payment levels. In the middle of the graph,  
15   for areas B, C, D, and E, you can see that there is little  
16   or no variation within the area in the amount that PPOs pay  
17   for this service. All four areas are at about the national  
18   average. Area A has a lower median payment level, but there  
19   is more variation within area A. Looking at the two highest  
20   payment areas, areas H and I on the right side, you see that  
21   H has a lot of variation in the amount paid, while area I  
22   has less variation than H.

1           Although these nine areas are not necessarily a  
2 nationally representative sample, you can see the various  
3 groupings that are possible in looking at variation. On the  
4 one hand, you can have relatively low payment rates with  
5 wide variation in payments to individual physicians, as in  
6 market area A on the right; or at the other end of the scale  
7 you can have high payment rates with a limited degree of  
8 variation, as in area I. We also see some areas with very  
9 little variation, but payments at about the national average  
10 in the middle areas, B, C, D and E.

11           We mentioned that we intend to examine variation  
12 by groupings of types of services. Although we have not  
13 completed that work yet, here we show another dimension of  
14 variation, which is the variation by service type using two  
15 individual services. We use two of the same geographic  
16 areas that we used in the previous slide, areas H and I.  
17 For physician office visits, these two areas were at the  
18 high end of the scale, with median payments at 1.8 times the  
19 national average. Looking at a different service that is  
20 very common in the private payer data, heart echography,  
21 what we see is a very different picture.

22           Looking at area H, the median payment for heart

1 echography is at the national average of payments, while the  
2 median payment for office visits was well above the national  
3 average. Looking at area I, there is very little variation  
4 in payments for heart echography, and the payments that PPO  
5 plans make for heart echography are closer to the national  
6 average. In the same area, though, looking at office  
7 visits, you see that area I has some degree of variation and  
8 very high payment levels in relation to the national  
9 average.

10           So as you can see from these preliminary data and  
11 from other preliminary data that we have presented, in the  
12 private sector there is variation in payment rates on many  
13 dimensions: across areas, within areas, and by service  
14 category, with the variation by service category occurring  
15 both across and within areas.

16           As for next steps, we will continue looking at the  
17 physician payment data and incorporate data from additional  
18 sources. As we mentioned, although we have presented some  
19 service-specific data today, we will be looking at variation  
20 in payment by groups of service categories. We will also  
21 examine payment levels and variation in non-metropolitan  
22 areas.

1           We are still working with the hospital data with  
2 the intention of being able to report on variation in  
3 hospital payments across and within areas. Our larger  
4 objectives in undertaking this project include the task of  
5 determining the factors that explain variation in private  
6 sector payment rates, understanding what constitutes a  
7 market for such an analysis, and also exploring ways of  
8 evaluating market concentration that take into account  
9 factors beyond the usual measures of market concentration of  
10 insurers or providers.

11           We look forward to your discussion and any  
12 comments you may have on the methodology we have used, as  
13 well any suggestions you have for different ways of looking  
14 at the data and at market areas. And contrary to what Joan  
15 said, both Julie and I are happy to take questions. Julie  
16 will take the complicated questions; I'll take the soft  
17 balls.

18           [Laughter.]

19           MR. HACKBARTH: Okay. Thank you. Could you put  
20 up number 3 for a second? I have a clarifying question  
21 about that.

22           You could have variation in payment rates because

1 you have multiple different insurers, each paying a  
2 different rate. And you could have variation because you  
3 have any given insurer paying different rates to different  
4 providers.

5 MR. ZARABOZO: Yes.

6 MR. HACKBARTH: Does this reflect both types of  
7 variation or just the first?

8 MR. ZARABOZO: Well, with this data source, we  
9 cannot tell who the insurer is and who the provider is. We  
10 can only say this is what the PPOs pay. But in other data -  
11 -

12 MR. HACKBARTH: But each PPO has one rate for the  
13 area. It's somehow assigned one rate or is -- in a given  
14 market. And Market F, could part of that variation be  
15 attributable to a given PPO --

16 MR. ZARABOZO: They're two PPOs that we're talking  
17 about, and we're talking about 100 providers, and that one  
18 PPO could pay 50 providers one rate and 50 other providers  
19 another rate.

20 MR. HACKBARTH: Okay. So each PPO is not assigned  
21 one rate.

22 MR. ZARABOZO: Right.

1 MR. HACKBARTH: It could have multiple rates.

2 MR. ZARABOZO: Correct. And we have other data --  
3 the other data that we mentioned enable us to look at this  
4 kind of variation that is specifically differences among  
5 providers for one insurer.

6 MR. HACKBARTH: Okay. That's the clarification I  
7 needed.

8 So I think we're starting on this side, clarifying  
9 questions.

10 DR. BORMAN: Julie and Carlos, I think I  
11 understood it, so it's wonderful. Can you help me to  
12 understand, just to be sure -- I understand for the office  
13 visit code that that's likely a pretty clean stand-alone  
14 HCPCS CPT code. For things outside of that, since you did  
15 160, did you have a way or were things scrubbed so that you  
16 had something that probably represented a unique service.  
17 So, for example, if it's something that typically reported  
18 with more than one code to it, whether it's a test or a  
19 procedure, did you eliminate those and only use the ones  
20 that are reported by a single code?

21 MR. ZARABOZO: I'm not sure I can specifically say  
22 that. We attempted to, you know, make distinctions by

1 modifier or no modifier, facility/no facility. On the  
2 question of whether -- like the heart echography is 93307.  
3 I don't know if that is a specific -- is that typically a  
4 single code. I mean, we can look more carefully to make  
5 sure that we are talking about something that is definitely  
6 a single code.

7 DR. BORMAN: You can try to consider the effect of  
8 modifiers and component coding.

9 MR. ZARABOZO: Right, yeah.

10 MR. HACKBARTH: Other clarifying questions?

11 DR. STUART: I have a couple of kind of mass  
12 questions here. When I look at this and I also see the same  
13 pattern on Slides 10 and 11, and look at the area B, and the  
14 median looks like it's the same as the 90th percentile. And  
15 you also had on Slides 10 and 11, you had a couple where it  
16 looks like the median is the same as the 10th percentile.  
17 Now, I understand how that could happen. I guess I have two  
18 questions.

19 One is, if the median is very close to one  
20 extreme, then the width or the height of the yellow bar is  
21 somewhat misleading, because almost by definition it can't  
22 have very many cases -- which raises another question. I

1 think I know what you're going to find with this database.  
2 I'm assuming that these bars represent many, many  
3 physicians. Is that correct?

4 MR. ZARABOZO: Well, that was Glenn's question.  
5 This could be -- like, for example, one medical group in an  
6 area could be the only group that is getting payment.

7 DR. STUART: Well, if that's the case -- well, for  
8 office --

9 MR. ZARABOZO: This is many claims, it's  
10 essentially claims.

11 DR. STUART: Yeah, okay. Well, I guess that it  
12 might be useful just for presentation purposes to give some  
13 idea of the n's so that you'd know how many are in the tails  
14 here, because if it's just -- if the n is relative small,  
15 then the tails aren't terrible interesting.

16 MR. ZARABOZO: For this particular one, the n's  
17 are -- thousands of n's in these.

18 DR. STUART: Okay. Then another math question.  
19 This is on Slide 8. When I first looked at this, I was kind  
20 of confused because I would have expected some kind of a  
21 normal distribution around this. And then I realized that  
22 the width of the index values varies from 0.05 in the middle



1 section up to 0.2 in the extremes. And I'm wondering why  
2 you did that.

3 In other words, if you look at the two middle  
4 ones, it goes from 1.0 to 1.05, so that's a 0.05 difference.  
5 But then up at the top, you've got 1.3 to 1.5.

6 MR. ZARABOZO: Yeah, that was more to sort of  
7 isolate the center.

8 DR. STUART: I assumed that. I'd suggest you not  
9 do that, just because it's real easy to get a  
10 misunderstanding of this if you look at it quickly.

11 MS. KANE: I think I may be stuck on the same  
12 question or a variation on Slide 3 or Slide 10. Is the unit  
13 the number of -- the median -- is it the median units of  
14 service or providers?

15 MR. ZARABOZO: Service. Claims. This is claims.

16 MS. KANE: Claims that are paid.

17 MR. ZARABOZO: Right.

18 MS. KANE: So the median claim for that service,  
19 so --

20 MR. ZARABOZO: Median payment for a claim.

21 MS. KANE: For a claim, okay. So it is weighted  
22 basically by the number of -- I see. Okay. That helps.

1           And then for the part about where you had to  
2 impute some amount for codes for no claims, how big a deal  
3 is that? How much imputing were you doing? And how did you  
4 impute? What's your sensitivity analysis if you threw out  
5 all those imputations?

6           MR. ZARABOZO: As we mentioned, it's a little bit  
7 over 60 percent of the dollars in total using 159 codes.  
8 And the imputation works out to be about 4 percent of the  
9 dollars in total. But we're looking at that to make sure  
10 that doesn't -- that sounds a little low, but our initial  
11 calculation was 4 percent of the dollars in that set of 159  
12 codes over 432 areas.

13           MS. KANE: Okay.

14           DR. CHERNEW: I just want to hopefully ask and  
15 clarify something. What I think hasn't been said but what I  
16 think is true is in the data set you have, you haven't  
17 chosen to ignore the same -- knowing which PPO it is or  
18 chosen to ignore which provider it's going to. You don't  
19 observe that.

20           MR. ZARABOZO: Well, on the --

21           DR. CHERNEW: Do you observe this is all from the  
22 same plan or this is all from the same employer or this is

1 all --

2 MR. ZARABOZO: We were given to understand that  
3 with respect to the -- they have identifiers, for example,  
4 for insurer and provider, but we were told that it is not  
5 consistent across payers. It is intended to be such that  
6 you cannot identify the provider, essentially, for this  
7 particular data set.

8 DR. CHERNEW: So you can't identify which  
9 hospital, for example?

10 MR. ZARABOZO: Right.

11 DR. CHERNEW: But can you identify which plan,  
12 like this is Blue Cross/Blue Shield or this is Aetna or this  
13 is Cigna? Not with the names, but, you know, they get a  
14 number.

15 MR. ZARABOZO: I don't remember whether the payer  
16 identifier is a unique identifier. You know what I mean?  
17 Whether like PPO-A and PPO-B, I could say -- we're talking  
18 about three PPOs in this market. I'll have to look to see.  
19 But, again, we have other data that answers some of these  
20 questions.

21 DR. STUART: Can I add something to that? I don't  
22 know whether you have it, but MarketScan has a benefit

1 design database that goes along with the claims database for  
2 a selection of the individuals that are included -- not  
3 everybody and not every plan. But in that database, you can  
4 link it to the claims, and that will tell you whether it is  
5 a PPO or an HMO, and it will also give you the unique  
6 combination of activities that are part of that benefit  
7 design. So you can actually get it down to -- it may be  
8 even below the insurer if the insurer offers multiple plans.  
9 But that's a separate database, and so that's a question  
10 about whether you have it.

11 MR. ZARABOZO: And we don't have that.

12 DR. STUART: Or not. But you might want to check  
13 on that. I'm not suggesting that you buy it, but it's at  
14 least something that you'd want to -- that you should know  
15 about in terms of making a decision here.

16 MR. ZARABOZO: Thank you.

17 DR. BERENSON: Yeah, I have a database question,  
18 too. On the last slide, the next steps, you say one of the  
19 things you want to do, which I think will be real important,  
20 is to examine the relationship between market concentration.  
21 You've made a point of both the insurance market and the  
22 provider market. Where will that data come from where

1 you're characterizing the degree of concentration or  
2 competition on the insurance side and on the provider side?

3 MR. ZARABOZO: Well, the AMA has a data set of  
4 insurer concentration, which is what we were initially  
5 using. We're also looking at the NAIC data as a measure of  
6 insurer concentration.

7 DR. BERENSON: So you will be able to match up  
8 those data sources with your --

9 MR. ZARABOZO: With the areas.

10 DR. BERENSON: Okay, great.

11 MR. ZARABOZO: And then it becomes an issue --

12 DR. BERENSON: I mean, the reason I -- I think  
13 this is pretty interesting because there are competing  
14 theories as to what kind of insurance market would produce  
15 higher or lower prices. The straightforward one which the  
16 AMA actually talks about is the single, or the concentrated  
17 insurer will use more market power to drive down prices, but  
18 there's also a competing theory that says they can be more  
19 complacent and not have to drive down prices; whereas,  
20 competing insurers actually may be more aggressive. And  
21 this would be a very good study to try to get at some of  
22 that, so I very much hope you do that.

1 DR. MARK MILLER: And because this is the kind of  
2 guy I am, I don't want to set expectations too high here. I  
3 mean, I think our ability -- we're stepping into an area  
4 that we don't have a lot of experience in. We're going to  
5 drill down. We're going to try and get information. But I  
6 think some of this measurement of concentration, we'll be  
7 back here talking to you how to do it and working obviously  
8 on our own. So that is the objective and that is what we're  
9 going to do. Exactly how clean it turns out to be, I just  
10 want to make sure everybody has the right expectations.

11 DR. KANE: About physician concentration, how  
12 you're going to come up with that, Mark?

13 MR. ZARABOZO: We're looking at that as an issue,  
14 possibly using Medicare data to attempt to determine the  
15 level of concentration.

16 DR. KANE: I couldn't hear --

17 MR. ZARABOZO: Possibly using Medicare data to  
18 determine the level of concentration. I mean, we are  
19 looking --

20 DR. KANE: Except they often bargain through  
21 different units.

22 MR. ZARABOZO: Yes. Yes.

1 DR. KANE: Is there a way to find out about who  
2 they're bargaining through, because some of them bargain  
3 through the hospital system and some of them bargain through  
4 an IPA and some of them --

5 MR. ZARABOZO: Yes. This is something that we are  
6 aware of is an issue, which is who's presenting themselves  
7 as a negotiator and who are they representing and it's very  
8 difficult to find that out.

9 DR. MARK MILLER: It kind of gets to the point I'm  
10 trying to make here. This is going to be fairly difficult.  
11 You know, you can try and think of this two ways over the  
12 long haul. Can you develop measures where you can  
13 systematically look across, say, for example, 400 different  
14 markets, or do you then take a different strategy where you  
15 start to select markets and look at what has gone on inside  
16 those markets because you can get your hands around better  
17 what's happening in those markets. And those are big trade-  
18 offs we're not up to yet, but just sort of keep that in  
19 mind. I'm sorry.

20 MR. ARMSTRONG: So just on this point, is the  
21 focus of the studies specifically on the relationship  
22 between payment variation and market concentration, or could

1 there be other variables that drive payment variation? For  
2 example, we pay our providers much higher prices per unit of  
3 service than anyone else, but we have the lowest overall  
4 costs. And so perhaps there is a variable degree of  
5 concentration of managed care plans or something like that.  
6 Or is this study really just limited to the concentration of  
7 -- market concentration, whether it's health plans and  
8 providers?

9 MR. ZARABOZO: Well, the GAO, the findings of the  
10 GAO specifically mentioned HMO -- the degree to which  
11 physicians take capitation for primary care was a factor.  
12 So we probably would like to look at those kinds of things  
13 to the extent that we can.

14 MR. ARMSTRONG: So it would be a little bit  
15 broader?

16 MR. ZARABOZO: Yes.

17 MR. HACKBARTH: [Off microphone.] Okay. More  
18 round one clarifying questions? Cori and George.

19 MS. UCCELLO: I think you answered this already,  
20 but I just want to confirm. There are not unique  
21 identifiers for providers.

22 MR. ZARABOZO: Correct.



1 MS. UCCELLO: Okay.

2 MR. ZARABOZO: We are supposed to not be  
3 identifying.

4 MR. GEORGE MILLER: If you can go to Slide 9,  
5 please, and the last bullet point, and it may be part of the  
6 conversation Nancy was having and maybe Mark already  
7 answered, but I just want to highlight this at least in my  
8 own mind. In my mind, there would be a difference in entry  
9 area variation because of provider concentration, or in  
10 other words, physician concentration, versus a must-have  
11 provider, someone like a Mayo Clinic or someone like M.D.  
12 Anderson, and in my mind, those are two different things  
13 that are driven there. Are we going to try to drill down  
14 and look at those two different things? I think they're  
15 completely different.

16 MR. ZARABOZO: I mean, I think the answer would be  
17 yes. We would -- if we know that about a market and that  
18 explains what is happening in the market, yes, that's the  
19 kind of thing that we're looking for. Is it because of a  
20 must have? Is it because these are, you know, provider  
21 market leverage versus, well, variation within the market,  
22 you have certain must have. And part of the way we're

1 looking at that is out-of-area use, that people coming from  
2 out of an area to use a particular provider.

3 MR. GEORGE MILLER: Right. Yes. Well, just to  
4 highlight, I'm thinking in Houston, you've got M.D.  
5 Anderson.

6 MR. ZARABOZO: Yes.

7 MR. GEORGE MILLER: That would be a must-have, I  
8 would think. But then there's a pretty large IPA in the  
9 Houston market that could possibly negotiate higher rates  
10 because they're a large player.

11 MR. ZARABOZO: Right.

12 MR. GEORGE MILLER: But that would be a difference  
13 between a must-have and the IPA in Houston.

14 MR. ZARABOZO: Yes.

15 MR. HACKBARTH: That's a really good point,  
16 George. Think of Boston. That's the market I know best.  
17 Tons of providers, but there are still certain providers  
18 that, because of their brand name capital and reputation,  
19 have extraordinary market power and leverage. So there are  
20 different dynamics here.

21 You know, I don't understand the data issues,  
22 being a lawyer, but it seems like -- there are so many

1 nuances here, it's going to be really difficult to capture  
2 them with sort of off-the-shelf databases. A case study  
3 sort of approach sort of seems like a useful complement to  
4 really understand what these dynamics are.

5 DR. KANE: Working with someone like Paul  
6 Ginsberg's group could --

7 MR. HACKBARTH: Yes. What they're doing, yes.  
8 Other clarifying questions?

9 Okay, round two comments, questions. Scott, Ron,  
10 and Mike.

11 MR. ARMSTRONG: I think I would just, first of  
12 all, just a general question that is on my mind that's  
13 rhetorical, but I was impressed to see --

14 MR. ZARABOZO: I can answer rhetorical questions.

15 [Laughter.]

16 MR. ARMSTRONG: Yes. I don't know if it's a  
17 softball or not, but I was impressed to see that Medicare  
18 rates, on average, are 28 percent less than private rates,  
19 and I'm not sure if that means private plans are paying too  
20 much or Medicare is paying too little, but I just thought  
21 that was interesting. I didn't know that.

22 I know the point, though, of this is to really

1 look at payment variation and what are factors driving that,  
2 and I think concentration of providers, concentration of  
3 plans are definitely variables that could be driving that.  
4 But I do think for looking at prices, the degree to which  
5 there is coordinated care or managed care in a marketplace  
6 will have a big impact on prices. I also think we need to  
7 look at the relative Medicare and Medicaid payment rates and  
8 the impact of those rates on private prices.

9 But all of which begs another question, and I  
10 think it's beyond the scope of this, but it should at least  
11 be in the back of our minds somewhere, and that is that  
12 prices is just one component in the formula leading to  
13 overall cost. I just -- I don't know -- I know the goal of  
14 this is to look at prices, but ultimately, our  
15 responsibility is the overall cost and expense trends. So I  
16 say that not knowing what to do with that, perhaps simply to  
17 put out there as a reminder to us as we go forward with this  
18 work.

19 MR. HACKBARTH: And Scott, of course, there's also  
20 a variation around that national average ratio of private to  
21 Medicare payment. In some markets, Medicare pays more than  
22 private insurers. In other cases, there's a huge disparity

1 the other way. It also varies, primary care services versus  
2 specialty services. There's variation everywhere you look.

3 DR. CASTELLANOS: I think we all recognize that  
4 consolidation by the provider, be it a hospital or a  
5 physician or whatever, impacts greatly on the price. I was  
6 just wondering how far you're going to drill down. Are you  
7 going to look at the payer mix, site of service, where it's  
8 being done, and the patient mix? I just don't know how far  
9 you're going to drill down. I think that may be important,  
10 too.

11 MR. ZARABOZO: Well, we do do the site of service,  
12 and the payer mix, we have the various categories. We have  
13 HMO, PPO, getting somewhat to Scott's point, but --

14 DR. CASTELLANOS: How about the patient mix?

15 MR. ZARABOZO: Well, we're looking at prices, so,  
16 I mean, a price for an individual service. I don't know --  
17 I mean, that would be related to the overall costs issue  
18 more than the price issue for an individual service.

19 DR. CASTELLANOS: I think it would make a big  
20 difference on the variation in the patient, too, the  
21 comorbidities, et cetera, et cetera, the cost.

22 DR. CHERNEW: Yes. I want to make a -- first, a

1 question, which I'm pretty sure is right. When you say the  
2 allowed, you mean that's actually what was paid?

3 MR. ZARABOZO: Yes. The insurer paid plus cost  
4 sharing required of the member.

5 DR. CHERNEW: Yes, right. The amount that the  
6 provider received, including all discounts and stuff.

7 MR. ZARABOZO: Yes.

8 DR. CHERNEW: My comments are twofold. The first  
9 one is, there are several data problems and one of them is  
10 this is a sample from a not random, not done for research,  
11 it's based on firms that gave their data in, and I'm  
12 assuming you're using the one that is the -- there's  
13 actually three ways they get data into MedStat, from the  
14 insurer, from the large employers, and then something they  
15 call the channel data, which comes from, like, Hewitts and  
16 Mercers and stuff. You're using all three of them combined,  
17 or just --

18 MR. ZARABOZO: Well, we're using what they call  
19 the employer -- I forget the exact name of it --

20 DR. CHERNEW: Yes, that's the Employer Plus  
21 Channel.

22 MR. ZARABOZO: Yes.

1           DR. CHERNEW: So what happens is when you look at  
2 variation in some of these markets based on the set of  
3 employers they have, there might just be one employer or one  
4 plan there and in others there might be a whole bunch. So  
5 the variation is not simply you've taken a random sample and  
6 then something happened. And it's very hard to observe what  
7 that is. So inter-market variation can be driven by the  
8 idiosyncracies of the MedStat sample as much as by actual  
9 variation in that market one way or another, and I think  
10 that's just an important thing to note.

11           The other thing I would say, and I think it's  
12 crucially important, is -- because we tried to do some of  
13 this -- we are in the process of trying to do some of this.  
14 Before you start doing it, it seems like you could just look  
15 at this, this, and this and this and it would all be  
16 interesting. The data is horribly messy, and that's not a  
17 knock on inter-study. We've looked at a lot of -- a knock  
18 on MedStat. We've looked at a lot of the data. I actually  
19 think theirs is the best for this purpose for a whole number  
20 of reasons. But claims data was generated for reasons other  
21 than having us figure out price variation and there's just  
22 huge amounts of noise.

1           So while it would be nice to know all of the many  
2 things it would be nice to know, my general sense is we want  
3 to start with a basic interesting point that people can  
4 understand and then build once we get there. But to pile on  
5 more and more ways to look at the data, does this differ by  
6 this or does it differ by that, or could you infer this,  
7 there's a whole series of stunningly interesting questions  
8 which I think that if the data were in better shape would be  
9 easier for you to do. But when you look in the data and see  
10 that there's huge numbers of negative claims -- I understand  
11 you've trimmed them, there's all kinds of issues with that.  
12 There's just an enormous number of issues with just working  
13 with the data. It makes it very difficult to answer some of  
14 the questions that we'd like to answer.

15           So I just want to go on record as saying that if  
16 you come close to answering the questions you're asking  
17 despite the imperfections, I think it's a very useful  
18 exercise. And later, we could have a discussion about how  
19 you could figure out how to figure -- how does it differ by  
20 the type of payer, the case mix, a whole slew of other  
21 things which are often not observable and not observable  
22 well in the data. But just getting the modifiers right and



1 figuring out how come they have claims here that just can't  
2 possibly be the price for those claims is an enormous amount  
3 of work.

4 So that's my general sort of comment. So I have a  
5 whole series of methodological ones that I'll spare  
6 everybody.

7 DR. MARK MILLER: Can I just -- because in some  
8 ways, you can interpret what you said as sort of setting  
9 expectations here, and so --

10 DR. CHERNEW: [Off microphone.]

11 DR. MARK MILLER: I like simple, and you sort of  
12 started your comments by saying, you know, it might be  
13 important to make a simple point before you build beyond  
14 that point. Did you have a sense in your mind like what --  
15 and I'm really not trying to put you on the spot. The  
16 comments came out sort of like you had a sense of what you  
17 thought you --

18 DR. CHERNEW: [Off microphone.] I think looking  
19 at the medians and the variation across and not worrying a  
20 lot about the variation within is useful, because I think  
21 the variation within is going to have a huge amount of noise  
22 that's hard to deal with.

1 DR. MARK MILLER: See, that's interesting --

2 DR. CHERNEW: I mean, I like that --

3 DR. MARK MILLER: -- because we were sort of  
4 thinking that --

5 DR. CHERNEW: I like the variation within a lot.  
6 I just think the data is -- if you were going to send  
7 something -- with a different hat. If I was a reviewer for  
8 your paper, I might be more accepting of aspects of the  
9 variation across. The variation within is going to be  
10 subject to some idiosyncracies within the markets that are  
11 going to be hard, and I think the medians are going to be  
12 more stable. I could be wrong, and there's a separate  
13 question about how much you observe about the sample from  
14 MedStat in the markets, not just which PPO, but do you know  
15 the number of PPOs in the market, for example.

16 MR. HACKBARTH: If this is stupid, just pretend I  
17 didn't say it and just go on. Kate, you're next in line,  
18 just in case, all right?

19 [Laughter.]

20 MR. HACKBARTH: To me, if you want to look at the  
21 effect of market concentration on the provider side within a  
22 market, actually, what you may want to do is just look at

1 one payer and the varying rates that they're paying for the  
2 same service. By combining that variation with variation  
3 because of different insurers, you're sort of adding  
4 confounding variables. Different rates for the same service  
5 for different providers by one insurer might be a clear  
6 indicator of the effective market concentration.

7 DR. CHERNEW: I'm moderately skeptical that they  
8 can identify the one insurer. I might be wrong in the data.  
9 But you would need to know that this was the one insurer,  
10 and a lot of these are self-insured employers, and so if you  
11 even had one insurer, it's not completely clear you mean --  
12 it could be that that works out right, but I guess before I  
13 would address that, I would really need to talk or hear from  
14 Carlos about exactly what they think the data can do.

15 DR. MARK MILLER: I think, first of all, it's not  
16 a stupid question and it's certainly something that we've --  
17 and you know I'm going to say that.

18 MR. HACKBARTH: That's okay --

19 DR. MARK MILLER: That's right.

20 MR. ZARABOZO: Julie doesn't agree, but she could  
21 never say so.

22 [Laughter.]

1 DR. MARK MILLER: Actually, we kind of went back  
2 and forth on this, too, because, I mean, there's what you  
3 can do with this data, but then there's also the question of  
4 whether there's another data source where you could sort of  
5 say, okay, I have one payer and I'm going to look at it.  
6 And then you have your own kind of data confidentiality  
7 issues you have to work through there. But that's also  
8 another way to think about his question, where you just go  
9 to an alternative.

10 DR. STUART: I'll be really quick on this. We've  
11 used these data for --

12 DR. BAICKER: Is your name Kate?

13 DR. STUART: Oh, I'm sorry.

14 [Laughter.]

15 DR. BAICKER: Was it really important, because you  
16 can go first.

17 One of the challenges with the strategy you're  
18 proposing, which is getting at one of the questions we'd  
19 like to know, is if you don't know how many providers there  
20 are, I mean, how many insurers there are, and you're looking  
21 at variation within an insurer, you don't know how much of  
22 that is driven by insurer competition versus provider

1 competition, so that the concentration measure is going to  
2 be confounded with competition across payers as well as  
3 competition across providers if you don't know the  
4 competition across payers.

5           So I think of the variation that's due to funny  
6 sampling as fundamentally different from the variation  
7 that's due to all these other things, and if you don't know  
8 the criteria by which people got into your sample, that  
9 could be really problematic for then making inferences about  
10 how the provider variation is being driven.

11           And in taking Mike's point about prioritizing  
12 which things to try to slice by with the understanding that  
13 each of them is incredibly data intensive and you don't want  
14 to just try everything because that's too time consuming, I  
15 might prioritize the things where we think there's the  
16 closest tie to Medicare payment issues. This was all  
17 motivated by thinking about the relationship between  
18 provider, private payer payments and Medicare payments, and  
19 there are some cases it would be great to know the extent to  
20 which there's a causal connection between those or the  
21 extent to which there are common factors that might be  
22 driving each. Is there a sole source provider? How does

1 that affect private payments and how does that affect  
2 Medicare payments, or are private providers adjusting --  
3 private payers adjusting their payments based on Medicare  
4 policy or not? There's controversy about that cost  
5 shifting. So the fields that I would try to dig down depend  
6 upon -- I would choose those based on which ones are most  
7 likely to have implications for the decisions we have to  
8 make about Medicare payments.

9 DR. STUART: There are two things I think you can  
10 help answer the question about what the data is really  
11 telling you about whether you're in one of these MSAs and  
12 then whether it's an insurance company or not. One I  
13 mentioned already is this benefit design database, and you  
14 should talk to the people at Thompson Reuters about that.

15 The other thing is, just talk to the people at  
16 Thompson Reuters about the areas because they know how many  
17 employers, how many insurers are covered within each of  
18 these areas, and that might just be the real easy way to do  
19 it and you just stay away from areas -- well, if you follow  
20 Glenn, you might take those areas where there's just one so  
21 that you can -- you have limited the variation there, or  
22 that you take -- and/or that you take areas in which you

1 have a number of different insurers so that you have some  
2 sense that you've got this.

3 But I think the point that Kate is raising is that  
4 you probably need other information at the aggregate level  
5 about these markets that you wouldn't get from a database  
6 like Market Scan so that you could put that into context, so  
7 that you know what you're measuring relative to what the  
8 whole market looks like.

9 MR. HACKBARTH: Would you make a note, I don't  
10 think we should have three economists in a row anymore.

11 [Laughter.]

12 MR. HACKBARTH: It gets a little intense after a  
13 while.

14 DR. KANE: I can stay here. I'm not an economist.  
15 But one of the things is the number of -- a lot of  
16 employers, you don't know how many insurers they're using.  
17 So like even if they're self-insured, they usually use the  
18 rates of some plan, so I'm just -- so I guess I'm listening  
19 to this discussion of using the claims data instead of  
20 saying, maybe you should go back to what the AG did in  
21 Massachusetts, which was ask the plans for their rate  
22 agreements under -- of course, they had to subpoena them,

1 but maybe --

2 [Laughter.]

3 DR. KANE: But maybe you could get some kind of,  
4 you know, some States to agree to collaborate with you,  
5 particularly States that represent --

6 But to step back, I guess -- and Kate was bring  
7 up, you know, why are we doing this? It was my impression  
8 from every other pages that I got from this paper, because I  
9 couldn't download the full paper, it was my impression we  
10 were looking at this to say, well, how big a deal is market  
11 consolidation and how is power exercised when it does  
12 consolidate? How is market power exercised?

13 Well, since I'm in Massachusetts and saw the AG  
14 study and have known for years that this was going on, I can  
15 tell you, I don't need a national study to kind of know that  
16 when providers get market power, they use it to improve  
17 their prices, and I see it in many other markets when I do  
18 case studies. I guess I'm kind of saying, let's talk more  
19 about so what if you find it, because I think you will find  
20 providers who are consolidated. In fact, that's why they  
21 consolidate, is to gain access to better rates, and they say  
22 it. I mean, you don't even have to go do a data -- I mean,



1 I think it's a great exercise to be able to identify which  
2 markets, but I'm pretty sure they do it.

3           So what are the implications for ACOs and other  
4 forms of integrating payment models and where are we trying  
5 to go with this? I guess I already know, because I've been  
6 out there talking with the world about ACOs, that there's a  
7 big movement afoot now to say, well, ACOs shouldn't be done  
8 because they're going to allow consolidation, you know,  
9 market power. And they're going, well, is that the answer  
10 or what is the alternative, and should there be some -- if  
11 we're going to encourage ACOs, do we also have to encourage  
12 all-payer systems that have some band of rates around the  
13 Medicare or fixed price estimate in order to have the ACO?  
14 Do we have to get that to be part of the ACO agreement?

15           I don't want -- I'm not -- I don't need the  
16 knowledge you're seeking, I don't think, because I think I  
17 already know. But I do think we don't know, so what, and we  
18 should be thinking about that even more than whether or not  
19 providers exercise market leverage. So I guess that's where  
20 I'm at. I started reading this and saying, well, I don't  
21 know that there's a real uncertain answer here to this  
22 question.

1 MR. HACKBARTH: And I like Nancy's recommendation  
2 that we consider a recommendation we get subpoena power --

3 [Laughter.]

4 DR. BERENSON: Yes, let me try to respond a little  
5 bit to Nancy, because I think you and I both knew this was  
6 going on, but in fact, as the lead author of that California  
7 study that was referenced to, it has had an amazing impact,  
8 along with the IG -- I mean, the AG's report from  
9 Massachusetts, and I'd also point to the Rhode Island  
10 Insurance Department study at about the same time. And  
11 there were some providers in California who denied that this  
12 was going on.

13 I think it is important to get another sort of  
14 database, but I'm with you that we really need to move  
15 quickly to the "so what" piece of it. But I do think it  
16 helps to have credible information that looks broader than  
17 California and Massachusetts, and so I do think if it's not  
18 extraordinary work, it's worth trying to do this.

19 MR. HACKBARTH: When I go around various places,  
20 sometimes I'll be confronted by somebody decrying Medicare's  
21 administered prices and this doesn't make any sense and this  
22 is a Soviet-style system, as Tom Scully used to say, and

1 that by definition it can't work. We need competitively set  
2 prices. To which my response is, well, if we had  
3 competitively set prices, that might be a nice thing, but I  
4 don't think that they are.

5           And what struck me about these graphs was maybe  
6 you can in a visual way show people, oh, we don't have  
7 competitively set prices. So I think almost by definition,  
8 if you have a big range for the same service within a given  
9 market, you don't have a competitive market and it's just a  
10 nice way of driving home that point to people, and there are  
11 a lot of doubters out there, some self-interested, some just  
12 because they're not familiar. If you can say visually,  
13 look, these are not competitive markets, you don't have that  
14 variation in competitive markets, it's a useful tool.

15           DR. KANE: I guess my comment, though, is, I mean,  
16 I'm worried that this claims data set isn't going to get you  
17 where you want to go without an enormous amount of work, and  
18 so we might end up putting a lot of resource into trying to  
19 clean this up so you can actually get to measures of  
20 consolidation. I don't know where you're going to find out  
21 physician consolidation measures, because there is no data  
22 set that I'm aware of where you know exactly which umbrella

1 they're bargaining under. I'm just worried that the data  
2 just isn't good enough for this yet and we should just --  
3 there's plenty of reference in the literature already,  
4 though, about providers saying, the reason I'm doing this is  
5 to gain access to better prices.

6 MS. UCCELLO: I think this is all really  
7 fascinating. As an actuary, you guys already know I'm a  
8 geek, so I can think of this huge laundry list of things  
9 that would be interesting to know. But I think Mike makes a  
10 good point that we need to kind of, you know, take a step  
11 back.

12 Even though I like the idea of some of these case  
13 studies, I think the Massachusetts AG thing was really  
14 interesting, I'm wondering, with the lawsuit in Michigan,  
15 the Blues plans getting sued, I wonder if there's going to  
16 be any information coming from that that could shed some  
17 light on the markets there that might just be worth looking  
18 into, and somebody there might have subpoena power, so --

19 DR. DEAN: Just a brief comment. Maybe this is  
20 just restating the obvious, but we are really sort of  
21 supporting two conflicting sort of directions. We're really  
22 supporting the idea of integration, coordination on one

1 hand. On the other hand, we're fearful of consolidation on  
2 the other hand. And I guess it just speaks to your point,  
3 Glenn, that we're probably going to have to look at some  
4 complete -- if, in fact, we really believe both of those  
5 things, we're going to have to look for some other  
6 mechanism. At the risk of causing some people to go  
7 ballistic, are we talking about a public utilities model or  
8 something like that? I mean, that will send some people  
9 through the roof, but I just wonder. I don't know. I don't  
10 necessarily support that, but it seems to me we've got  
11 conflicting directions.

12 MR. HACKBARTH: You know, there's a lot of  
13 discussion about that, and I think a lot of people are sort  
14 of coming to that same realization, that if they're not  
15 absolutely conflicting, there might be at least some tension  
16 between the objective of more organization in a formal  
17 integration and coordination on the one hand versus  
18 competitive markets on the other.

19 DR. DEAN: I mean, I guess it's been a discussion  
20 within the rural community for years on, because whereas if  
21 competition doesn't really work all that well in the urban  
22 centers, it doesn't work at all in the rural areas where we

1 can barely support one system, and if you have two competing  
2 with each other, you lose all kinds of benefits. So --

3 DR. CHERNEW: [Off microphone.] You don't have  
4 rural here by definition, so if you wanted to say something  
5 about urban-rural things, that would have you go back.

6 There's sample issues, right --

7 DR. MARK MILLER: [Off microphone.]

8 DR. CHERNEW: Right. But it's hard to say that  
9 with what they have done because this is all within MSAs.

10 MR. HACKBARTH: Okay. Do you need any more help,  
11 or are you good?

12 [Laughter.]

13 DR. MARK MILLER: Did we do two rounds?

14 MR. HACKBARTH: Yes, we did two rounds.

15 DR. MARK MILLER: We did?

16 MR. HACKBARTH: Yes. Okay. Thank you, Julie and  
17 Carlos.

18 Next we have Scott's annual update on the status  
19 of the Medicare Advantage program.

20 DR. HARRISON: Good afternoon. As Glenn said, I'm  
21 here to report on the current status of the Medicare  
22 Advantage, or MA, program, in terms of enrollment, the

1 availability of plans for 2011, and projected Medicare  
2 payments for those plans.

3 Two pieces of legislation have brought change to  
4 the Medicare Advantage program for 2011. 2008's MIPPA  
5 requires private fee-for-service plans to maintain provider  
6 networks in most areas, and this year's PPACA freezes MA  
7 benchmarks for 2011. PPACA also makes other changes,  
8 including benchmark reductions in future years which I will  
9 also report.

10 Let me first remind you about the MA payment  
11 system.

12 The Medicare Advantage program allows Medicare  
13 beneficiaries to receive their Medicare Parts A and B  
14 benefits through a private plan rather than through the  
15 traditional fee-for-service Medicare program. A beneficiary  
16 who enrolls in a plan continues to pay the Part B premium  
17 and any additional premium that the MA plan charges. The  
18 Medicare program pays the MA plan a monthly capitated amount  
19 that is adjusted for the health risk of the individual  
20 beneficiary. The plan then provides coverage for the  
21 Medicare A and B benefits and usually provides coverage for  
22 additional benefits. Currently, about 24 percent of

1 Medicare beneficiaries are enrolled in MA plans.

2           Now, in some of the analyses, I will differentiate  
3 by plan types and other plan characteristics, and I just  
4 want to define some of them for you up front. Coordinated  
5 care plans, or CCPs, are either HMOs or PPOs. CCPs have  
6 provider networks and various tools to coordinate or manage  
7 care. Under the MA program, there are local PPOs and  
8 regional PPOs. The difference is that like HMOs, local PPOs  
9 can serve individual counties, while regional PPOs are  
10 required to serve entire regions, which are made up of one  
11 or more complete states.

12           The MA program also includes private fee-for-  
13 service plans which typically have not had provider  
14 networks. They use Medicare fee-for-service payment rates  
15 and have less ability to coordinate care than other plan  
16 types. MIPPA changed the plan requirements, and beginning  
17 in 2011 these plans must have networks, or they cannot be  
18 offered in areas with two or more networked plans.

19           We sometimes make other distinctions. Special  
20 needs plans, or SNPs, limit their enrollment to either  
21 Medicare/Medicaid dual eligibles or to those beneficiaries  
22 who either require institutionalization or have certain



1 chronic or disabling conditions. And there are plans not  
2 available to individual Medicare beneficiaries but only to  
3 employer or union groups. Our availability numbers do not  
4 include employer group plans or SNPs because they are not  
5 available to all beneficiaries. But our enrollment and  
6 payment numbers generally include SNPs and employer plans as  
7 well.

8 Plans submit bids each year for the amount they  
9 think it will cost them to provide Parts A and B benefits;  
10 there is a separate bid for Part D drugs, but the MA plans  
11 just get paid for D as if they were stand-alone Part D  
12 plans.

13 CMS actuaries review the bids to make sure they  
14 are reasonable, and each plan's bid is compared to a  
15 benchmark, which is a dollar amount set for each county.  
16 Benchmarks have been administratively set based on  
17 historical payment rates. Currently all benchmarks are at  
18 least as high as per capita fee-for-service spending in the  
19 county and can range up to almost twice as high as spending  
20 in the county.

21 Now, if a plan bids below the benchmark, Medicare  
22 pays the bid plus a rebate calculated as 75 percent of the

1 difference between the bid and the benchmark. The rebate  
2 must be used by the plan to provide extra benefits to the  
3 beneficiaries. These extra benefits can take the form of  
4 reduced cost sharing for A/B services; additional non-  
5 Medicare benefits such as dental, vision, or gym  
6 memberships; or improved Part D benefits, including lower  
7 Part D premiums.

8 Over the past year, enrollment in MA plans grew by  
9 about 5 percent, or about one half-million enrollees, to the  
10 current level of 11.4 million beneficiaries.

11 Growth has occurred every year since 2003, but has  
12 been slowing since 2006. Now, we won't have actual 2011  
13 enrollment information before we publish our March report.  
14 However, the plans project their 2011 enrollment in bid  
15 submissions, and there they have projected enrollment growth  
16 to about 12 million for 2011.

17 Enrollment patterns differed in urban and rural  
18 areas. About 26 percent of urban Medicare beneficiaries are  
19 enrolled in MA while about 15 percent of beneficiaries  
20 residing in rural counties are enrolled.

21 Among plan types, HMOs continued to enroll the  
22 most beneficiaries; 16 percent of all Medicare beneficiaries

1 are enrolled in HMOs in 2010. You'll notice private fee-  
2 for-service enrollment contracted from about 2.4 million in  
3 2009 to about 1.6 million enrollees in 2010, a decrease of  
4 about 800,000 enrollees. The decrease followed reduced  
5 private fee-for-service plan offerings, as plans made  
6 business decisions to reduce their private fee-for-service  
7 areas in 2010 in advance of the coming MIPPA network  
8 requirements for private fee-for-service plans for 2011.

9           Some private fee-for-service plans publicly stated  
10 that they would begin to transition their enrollment over to  
11 networked products. Indeed, PPOs exhibited rapid enrollment  
12 growth, with local PPO enrollment growing about 40 percent  
13 and enrollment in regional PPOs more than doubling over the  
14 past year. Plans' 2011 enrollment projections indicate they  
15 expect these plan-type trends to continue, and you'll see  
16 some evidence of that in the plan availability numbers for  
17 2011.

18           So plan availability. Medicare beneficiaries have  
19 a large number of plans from which to choose. MA plans are  
20 available to almost all beneficiaries, as they have been  
21 since 2006. Now, I say almost because even though the  
22 number in the any MA plan line does round to 100, 0.4

1 percent of beneficiaries do not have a plan available.

2 Now, looking at the top line, in 2011 92 percent  
3 of Medicare beneficiaries have an HMO or local PPO plan  
4 operating in their county, up from 91 percent in 2010 and 67  
5 percent in 2005. And if you combine the local CCPs and the  
6 regional PPOs, you would find that 99 percent of  
7 beneficiaries have a CCP available in 2011.

8 In contrast, access to private fee-for-service  
9 plans will decrease between 2010 and 2011, from 100 percent  
10 down to 63 percent, most likely as a response to the MIPPA  
11 network requirements. The private fee-for-service plan  
12 contractions are the primary reason why the average number  
13 of choices declined from 21 to 12 over the past year. In  
14 both 2010 and 2011, however, there are an average of eight  
15 CCP choices.

16 Every year we use the plan bid projections to  
17 compare projected MA spending with projected fee-for-service  
18 spending. To do that for 2011, we need to assume a given  
19 growth in fee-for-service spending.

20 Because we are comparing fee-for-service  
21 expenditures with plan bids and the resulting MA payments,  
22 we are using a growth factor similar to what the plans used

1 to develop their bids. Plans generally assume costs will  
2 grow modestly and discount the likelihood that physician  
3 services would be cut by the SGR. We included a similar  
4 assumption last year.

5 So, looking at the top row summary, we estimate  
6 that on average 2011 MA benchmarks will be 113 percent of  
7 fee-for-service, bids will be 100 percent of fee-for-  
8 service, and payments would average 110 percent of fee-for-  
9 service spending.

10 Now, last year, we estimated that for 2010 these  
11 figures would be a very similar 112 percent, 100 percent,  
12 and 109 percent. The benchmark freeze between 2010 and  
13 2011, combined with low fee-for-service growth between 2010  
14 and 2011, resulted in very little change in the ratios, even  
15 at the plan-type level. The one-point increases in the  
16 overall benchmarks and payments should not be read as an  
17 increase in those comparisons, but only as a refinement of  
18 the fee-for-service levels for 2010 which may have been  
19 overestimated.

20 Now let's move past 2011. The reform act changed  
21 the formula that sets the benchmarks and phases in an  
22 overall reduction that is fully phased in for all counties

1 by 2017. As I mentioned, the 2011 benchmarks are frozen at  
2 the 2010 levels, and then beginning in 2012 new benchmarks  
3 are phased in over two to six years depending how far each  
4 county's benchmark has to move. For example, if a benchmark  
5 had to move more than \$50 a month, it would be phased in  
6 over six years.

7           The final benchmarks are based on the fee-for-  
8 service spending in each county. The counties are ranked in  
9 order of fee-for-service spending. The top quartile of  
10 counties will have their benchmarks settle at 95 percent of  
11 fee-for-service spending. The next quartile will be at 100  
12 percent of fee-for-service. The next quartile will be at  
13 107.5 percent, and the lowest spending quartile will be at  
14 115 percent of fee-for-service.

15           If the current county enrollment patterns  
16 continue, the benchmarks in 2017 will average 101 percent of  
17 fee-for-service, down from the 2010 average of 112 percent  
18 of fee-for-service.

19           Two further benchmark complications. First, the  
20 counties are reranked each year in terms of spending, so  
21 there will be more movement in a county's benchmark from  
22 year to year. And the benchmarks here and throughout all my

1 presentation today are the benchmarks for plans that do not  
2 qualify for a quality bonus. High-quality plans will have  
3 higher benchmarks, but I am not considering that in today's  
4 analysis.

5           So this graph illustrates the benchmarks that  
6 would result from the current distribution of fee-for-  
7 service costs in each county. Each quartile has about 785  
8 counties. The benchmarks for the low fee-for-service  
9 quartile on the left would be set at 115 percent of their  
10 fee-for-service spending, illustrated with the solid green  
11 line above the red dotted line representing fee-for-service  
12 spending. The picture, unfortunately, the lines have moved.  
13 The vertical lines are supposed to be at the same place as  
14 the vertical lines on the green -- sorry about that.

15           MR. HACKBARTH: Scott, when you say long run, so  
16 this is 2017.

17           DR. HARRISON: 2017, yeah. All right. So we've  
18 got 115 on the left, and we move through the two middle  
19 quartiles at 107.5 and 100, and the highest quartile on the  
20 right is at 95 percent of fee-for-service spending.

21           Now, note how narrow the fee-for-service spending  
22 range is in the middle two quartiles. The benchmarks end up

1 showing a saw-tooth pattern, with the benchmarks falling  
2 from the top of one quartile to the bottom of the next. The  
3 concentration of fee-for-service spending values is such  
4 that many counties will be near the boundaries between these  
5 quartiles. There are many examples where a county on the  
6 low end of a higher-spending quartile will end up with a  
7 substantially lower benchmark than a county on the high end  
8 of a lower-spending quartile.

9           Consider the two counties here marked with stars  
10 as a specific example. The county marked with a yellow star  
11 has the highest level of fee-for-service spending in the  
12 lowest-spending quartile, which would be \$657 a month. The  
13 PPACA formula would multiply the spending by 115 percent and  
14 would result in the county having a benchmark of \$756 per  
15 month.

16           Meanwhile, the pink-starred lowest-spending county  
17 -- there's a county with a pink star there, and it's the  
18 lowest-spending county in the highest quartile, and that has  
19 spending of \$767 multiplied by 95 percent and yields a  
20 benchmark of \$728. And so if you put this in tabular form,  
21 it might be easier to follow. We've got the bolded numbers  
22 there. They're not that bold, but the bolded numbers are



1 what we were just talking about.

2 So the pink-starred county has spending of \$110  
3 per month higher than the yellow-starred county, but would  
4 have a benchmark \$26 per month lower.

5 Now, of course, the exact numbers in here are  
6 going to change, but the general situation is not going to  
7 change. It's still going to be this pattern, and you're  
8 going to have examples like this.

9 When the actual rates are revealed, the  
10 disadvantaged counties, and plans in those counties, are  
11 certain to complain and demand adjustments. Therefore, we  
12 should make some sort of technical adjustments made to the  
13 benchmark-setting formula.

14 The problem can be addressed in a number of ways.  
15 One way is by adding minimum or maximum conditions on  
16 benchmarks between quartiles. So right here what we've got  
17 is an example where counties in quartile 1 could not have a  
18 benchmark above any county in quartile 2; quartile 2  
19 counties could not have benchmarks above any quartile 3  
20 county; quartile 3 counties would keep their 100 percent of  
21 fee-for-service benchmarks; and then quartile 4 county  
22 benchmarks could not be cut below the highest quartile 3

1 benchmark. Okay. Now, the levels would then be adjusted so  
2 that the changes are budget neutral, and the result would be  
3 a set of benchmarks where no county would have a higher  
4 benchmark than another county with higher fee-for-service  
5 spending. And the picture then would look something like  
6 this.

7 I am going to stop here for today. We'll be back  
8 to you in January, and we'll have a draft of the March  
9 chapter which will include this material, discussion of plan  
10 quality and quality bonus payments, and could include more  
11 discussion of payments under PPACA.

12 For now I look forward to your discussion and then  
13 will try to answer any questions you have.

14 MR. HACKBARTH: Okay. Thank you, Scott.

15 Could you put up 7 for a second?

16 DR. HARRISON: Is that 7?

17 MR. HACKBARTH: No. It's the table -- keep going  
18 back.

19 DR. HARRISON: There we go. Okay.

20 MR. HACKBARTH: Yeah, there we go. So there's a  
21 lot of interest in figuring out what this information will  
22 look like as we move through this transition. So what's

1 going to happen to plan availability? What's going to  
2 happen to rebates and additional benefits for beneficiaries  
3 as we go through the transition and payment rates that you  
4 described? Is that something that you're looking at?

5 DR. HARRISON: Yeah, it's definitely something  
6 we're looking at. I'm sure you remember our payment report  
7 from a couple of years ago.

8 MR. HACKBARTH: Vaguely, yes, I do.

9 DR. HARRISON: We did simulations of different  
10 patterns there. Well, I started to try to do that for the  
11 final PPACA formulas. And right now what I'm getting --  
12 preliminary, of course -- is that almost all beneficiaries  
13 would have at least one plan available. The overall number  
14 of plans that are able to bid below the benchmark in 2017 --  
15 let me say how we did this.

16 We took 2011 bids, compared them with 2017  
17 benchmarks. And when we did that, you know, like we do for  
18 availability here, we see that almost all beneficiaries  
19 would have at least one plan that was able to bid below the  
20 benchmark. However, half the plans would not be able to bid  
21 below the benchmark, and almost half of the enrollees are in  
22 plans that are not currently bidding below those benchmarks.

1           The rebates there would probably be cut about in  
2 half from what we have right now, and so that's sort of the  
3 picture you have.

4           Now, of course, you know, this is speculative.  
5 You're out seven years, and we don't know whether plan  
6 bidding behavior would change and whether beneficiaries  
7 would move to go to more attractive plans.

8           MR. HACKBARTH: So you say the rebate would be cut  
9 in half. So currently the average rebate per month is?

10          DR. HARRISON: We're in the \$75 to \$80 range, I  
11 think right now.

12          MR. HACKBARTH: Okay. That work that you are  
13 obviously in process on, will that be available -- do you  
14 envision including that in the March report?

15          DR. HARRISON: I think so, if you're interested in  
16 having it. Yeah, we would put it in.

17          MR. HACKBARTH: Good. Okay. Round one clarifying  
18 questions. I've lost track of which side I'm starting on.  
19 This side, round one clarifying questions.

20          MS. BEHROOZI: I'm sure this is completely  
21 obvious. It seems like the amount of payment above fee-for-  
22 service has come down a little bit over the last couple of

1 years. I think it was \$16.

2 DR. HARRISON: Yeah, right.

3 MS. BEHROOZI: Now it's down to about \$13. In  
4 terms of the extra benefits that beneficiaries are getting,  
5 has the ratio of the extra payment to the extra benefits  
6 changed at all? And I don't know if you know that off the  
7 top of your head, but I guess I'd be interested.

8 DR. HARRISON: From a couple years ago, it looks  
9 like the rebates have come down. It actually looks like --  
10 if I recall right, I think the 2009 rebates were somewhere  
11 around \$90 to \$100. I think last year we dipped to about  
12 \$70, and I think we're now about \$75 or so. So the rebates  
13 had come down from a couple years ago, but it may be a  
14 little higher than last year.

15 MS. BEHROOZI: Yeah, I'm sorry. Just remind me  
16 how that's supposed to be used in terms of extra benefits.

17 DR. HARRISON: Either extra non-Medicare benefits  
18 or lower cost sharing or Part D enhancements.

19 MR. GEORGE MILLER: Yeah, just a quick question.  
20 In the paper you sent out, in the reading material, you talk  
21 about the wide variety of folks who sign up for MA plans, 2  
22 percent in some metropolitan areas, and Pittsburgh

1 particularly had 60 percent and Puerto Rico 70 percent. Do  
2 you know what caused one metropolitan area to have such low  
3 enrollment and what they did right or didn't do right in  
4 Pittsburgh or Puerto Rico?

5 DR. HARRISON: I think it's a variety of factors.  
6 One I think is historical, you know, how much was managed  
7 care in the area. And some of it probably had to do with  
8 payment rates.

9 Puerto Rico is a special case. Their benchmarks  
10 were very high, and, you know, a lot of times that was the  
11 only way they could afford to join -- by joining a plan was  
12 the only way they could even afford Part B. So they're  
13 definitely special. But, you know, other cities it's  
14 really, I think, historical artifacts.

15 MR. GEORGE MILLER: And do you have demographic  
16 information on the MA plans, race, age?

17 MR. HACKBARTH: [Off microphone.] By individual  
18 plan?

19 MR. GEORGE MILLER: By plan, individual plan?

20 DR. HARRISON: No, we don't.

21 MR. GEORGE MILLER: Thank you.

22 MR. HACKBARTH: Medicare Advantage program overall

1 we've got information --

2 DR. HARRISON: We'd need to run a few things to  
3 get even that kind of thing. We have the risk scores, but  
4 we don't have the other demographic factors other than that.  
5 There are databases we could find to match them with,  
6 though.

7 MR. HACKBARTH: Okay.

8 MS. HANSEN: Slide 8 [off microphone] and it's in  
9 regard to the group, the employer groups. I thought that at  
10 one time this was supposed to be phased down relative to  
11 their advantage bidding process. I just wondered if there's  
12 any background you have on that. They still bid higher.

13 DR. HARRISON: They still bid higher.

14 MS. HANSEN: Yeah.

15 DR. HARRISON: The one thing that's happened  
16 recently is that employer groups are not allowed to have  
17 private fee-for-service plans anywhere. So for 2011, there  
18 will be no employer private fee-for-service plans. But I'm  
19 not sure whether there are other -- I think CMS is looking  
20 into how the bids work, but I'm not sure they've actually  
21 said anything.

22 MS. KANE: On the same slide, the SNP bid to fee-

1 for-service, is the fee-for-service standard for an average  
2 population or for a special needs population?

3 DR. HARRISON: It's for the population they're  
4 enrolling. So the average --

5 MS. KANE: So the fee-for-service standard  
6 reflects the dual eligibles, for instance.

7 DR. HARRISON: Right.

8 MS. KANE: If it's a dual-eligible SNP, the --  
9 okay.

10 DR. HARRISON: Right. Their risk scores are much  
11 higher. The SNP scores are much higher --

12 DR. MARK MILLER: The numerator and the  
13 denominator in the 104 are comparable.

14 DR. HARRISON: Yes.

15 MS. KANE: So would that suggest that the SNPs are  
16 less efficient than traditional dual-eligible --

17 DR. HARRISON: Well, I think something's happened  
18 with the SNPs in the way they bid also. I think that the  
19 extra benefits for the duals, I think they now have to go  
20 into the bid, and so the SNPs aren't using the rebate  
21 dollars to do that. I think they're doing that with their  
22 bid.



1 MS. KANE: So the Part A, Part B, plus extra is in  
2 the SNP bid, so it's actually not quite --

3 DR. HARRISON: I believe that is right, but we're  
4 checking into that.

5 MS. KANE: Because, otherwise, that makes it look  
6 like the SNPs -- the coordinated care plans for special  
7 needs populations are more expensive and not coordinated.

8 DR. HARRISON: Right. A couple years ago, they  
9 bid lower, so I think that that change is what has driven  
10 that up. They used to bid below non-SNPs.

11 MS. KANE: Yeah.

12 DR. HARRISON: But I think now that they have to  
13 roll in these other benefits into their bid, the bids are  
14 higher.

15 MS. KANE: Okay, but then --

16 DR. HARRISON: But they don't need as many rebate  
17 dollars perhaps because they're --

18 MS. KANE: But then it's not comparable to fee-  
19 for-service anymore.

20 DR. HARRISON: Right.

21 MS. KANE: So I just don't --

22 DR. MARK MILLER: That's a change since last year

1 [off microphone].

2 DR. HARRISON: Yeah, I believe in the last couple  
3 years.

4 MS. KANE: It would be nice to break that out a  
5 little bit to what of that is Part A, Part B, and what of  
6 that is extra benefit, just so we can see -- I mean,  
7 otherwise, it looks like SNPs don't reduce costs for special  
8 populations. I'd just like to know.

9 MR. HACKBARTH: Well, that I think is an open  
10 question.

11 MS. KANE: But this says for sure that -- well,  
12 it's --

13 MR. HACKBARTH: My guess is some do and some  
14 don't. That's true for various types of other private  
15 plans. They cost more than traditional Medicare would for  
16 the same population, same benefits. And a reason for that  
17 is private plans have higher administrative costs. In  
18 addition, they're usually paying higher unit prices for each  
19 unit of service. And they're not managing the care well  
20 enough to offset those initial disadvantages.

21 MS. KANE: Well, this links back to our earlier  
22 discussion about dual eligibles and whether or not -- you

1 know, what's the evidence that their care management is  
2 worth putting people into these plans or not. And so that's  
3 why I just thought it would be useful if there's something  
4 besides just Part/B in there, it would be nice to pull it  
5 out so we know what's really going on.

6 DR. MARK MILLER: And actually this was kind of  
7 news to me, so it's a comparable risk profile, but the bid  
8 is not strictly A/B. Is that what you're saying?

9 DR. HARRISON: No, they do not have a comparable  
10 risk profile. Their risk scores --

11 DR. MARK MILLER: Between the --

12 MS. KANE: [off microphone] fee-for-service  
13 population.

14 DR. HARRISON: Oh, sure.

15 DR. MARK MILLER: So the 104 is based on  
16 comparable risk populations.

17 DR. HARRISON: Right.

18 DR. MARK MILLER: But you're saying there's been a  
19 change that when they bid, they include something more than  
20 the A and B.

21 DR. HARRISON: Correct. And we'll know by January  
22 for sure.

1 DR. MARK MILLER: Yeah, you also said you were  
2 checking into that.

3 DR. HARRISON: Yeah, I still need to talk with  
4 some people at CMS about it.

5 MR. HACKBARTH: Round one clarifying questions?

6 DR. CASTELLANOS: Mike asked me a clarifying  
7 question. He wanted to know why the cookies haven't been  
8 put out.

9 [Laughter.]

10 DR. MARK MILLER: I'll take this one. I handle  
11 things like this. We made a move and actually maybe we  
12 won't even -- "we." I ask them to put more healthy snacks  
13 out. If there's a large movement back to the cookies, I can  
14 -- you know, I'm always willing to listen to the  
15 Commissioners on this.

16 DR. BAICKER: [Off microphone] because you care.

17 DR. MARK MILLER: I wouldn't press that point.

18 [Laughter.]

19 DR. MARK MILLER: But for purposes of today, yes,  
20 fine.

21 MR. HACKBARTH: Okay, round two, comments and  
22 questions. I thought you would have some.

1 DR. BERENSON: Okay. Has anybody ever looked at  
2 the enrollment behavior of age-ins specifically?

3 The reason I ask is we're about to hit, with my  
4 cohort next year, the baby boomers who, one, have been  
5 exposed much more to managed care choices and, two, are  
6 going to be a much larger number and could actually affect  
7 the numerator and the denominator of plan enrollment. So I  
8 think it might be an interesting thing to know about. And  
9 do you know if anybody specifically looked at that?

10 DR. HARRISON: Not recently. I know when Carlos  
11 was at CMS they did some surveys, and they found quite a  
12 large number of age-ins. Particularly plans like Kaiser had  
13 a lot of their members age in. You know.

14 For general purposes, the employer groups, they're  
15 not all age-ins necessarily, but we've got two million of  
16 them in the program right now.

17 DR. BERENSON: I don't think for this year we need  
18 to do it, but starting next year I think it might be an  
19 interesting thing to either periodically or on a routine  
20 basis sort of get this, try to understand the behavior of  
21 sort of the baby boom generation as it comes on.

22 DR. KANE: This is descriptive and interesting,

1 and I'm just wondering is there a policy question here. One  
2 that comes to mind was didn't we at one point talk about  
3 whether or not it would make sense to smooth the contiguous  
4 county or to have larger than county fee-for-service  
5 benchmarks, and would it be helpful to put some of that in  
6 here because I kind of feel like right now this is  
7 descriptive, but there are really no policy pieces that come  
8 up.

9           Their one option maybe is that the benchmark  
10 should not be allowed to seesaw. I mean jigsaw, whatever  
11 that word is. But isn't the other one whether the county is  
12 the best unit for setting the benchmarks, and can we throw  
13 some of that back in here -- because I think that was a very  
14 interesting, and I thought valuable, discussion, and it's  
15 not here. I think if we're going to bring in all these  
16 policy options, that should be on the table. Or, is it off  
17 the table?

18           I guess I'm --

19           MR. HACKBARTH: So PPACA didn't do anything on the  
20 unit? Any background as to why not -- because Nancy is  
21 right. Over the years that's been a bone of contention from  
22 time to time.

1 DR. HARRISON: I think one of the drafts that  
2 floated around at one point had other payment area  
3 possibilities, but I think that basically people were afraid  
4 to change. I think the status quo was more attractive to  
5 people. They knew what they had. I think they were nervous  
6 about changing everything and changing the payment areas.

7 DR. KANE: Wouldn't it help with the jig, you  
8 know, the sawtooth?

9 DR. HARRISON: I don't think --

10 DR. KANE: Ah, it's getting late.

11 DR. HARRISON: Yeah, I don't think that would help  
12 that, but --

13 DR. KANE: Or make it even overall more rationale,  
14 not just the sawtooth, but the fact, the cliff on the  
15 contiguous counties where suddenly you're in a cheaper  
16 county and you attracting people. You know. I'm just not  
17 sure.

18 Where is the big policy lever here on making this  
19 more rationale? Is it getting rid of the sawtooth, or it  
20 changing the units to be a little more smoothly, less jumpy  
21 up and down with the county rates?

22 MR. HACKBARTH: Yeah, well, I wouldn't see them as

1 competitive alternatives. In fact, I think it's inevitable  
2 that we're going to have to fix the sawtooth pattern. It's  
3 just very hard to defend that.

4 And in addition to that, it may be worth re-  
5 raising the issue of the appropriate geographic unit.

6 DR. MARK MILLER: One thing we've done in this  
7 chapter, and you know there's always a question of whether  
8 you want to bring up a policy issue, consider it and make a  
9 set of recommendations. What we've often done in March,  
10 because we have a set of standing recommendations, is Ron, a  
11 couple -- well, a couple pages where we say we just want to  
12 remind the reader what we've said about MA in the past, and  
13 it's certainly fair game to say we've said that in the past.

14 The only reason I'm bringing this up, on the  
15 sawtooth thing, I think we're seeing this as almost just a  
16 technical -- you know. It's not a large policy issue. It's  
17 just sort of you need to police the borders a little bit on  
18 this, is sort of the way we're thinking about this.

19 I mean you may disagree and want to make a bigger  
20 issue out of it, but we're sort of saying there's a lot of  
21 ways to solve this problem, budget-neutral, probably not  
22 exactly what you intended, that that kind of level of



1 advice.

2 But we can rerun old recs in -- what do we call  
3 it?

4 MR. HACKBARTH: Text box.

5 DR. MARK MILLER: Text box. A sawtooth text box,  
6 we can do that.

7 DR. BAICKER: Mike here practically started  
8 drooling when we saw the sawtooth, from a self-interested  
9 research perspective. Boy, do we like those. Those  
10 irrational discontinuities are great for research, but seem  
11 completely --

12 DR. CHERNEW: And there were no cookies.

13 [Laughter.]

14 DR. BAICKER: It's hard to control.

15 So clearly from a technical perspective, that kind  
16 of irrational drop doesn't make any sense.

17 So you could fix it a number of ways. You could  
18 do that at minimum function. You could make it a continuous  
19 function as opposed to one with drops. It also highlighted  
20 for me if the quartiles, as I understand them, are divided  
21 based on counties, not based on number of people, you get  
22 large numbers of people swinging because you have 42 percent

1 of the people in the top 25 percent of the counties.

2           So another fix would be if you're stuck with  
3 vertical lines that you'd rather not, if you can fix it by  
4 just making it all smooth, great. If you can't, don't make  
5 the vertical lines such that you're moving enormous numbers  
6 of people by tiny movements of the lines.

7           DR. CHERNEW: I'm just going to continue on as if  
8 Kate was finishing her comment. So I agree with everything  
9 she said, and I would add that I think it's very useful to  
10 have different alternatives. I think we could all agree  
11 that something is going to have to be done. So having a  
12 bunch of different alternatives is useful.

13           One of the things in general that also matters  
14 here is, over time, you could be in different quartiles  
15 based on how you're moving and may have, if I understand  
16 correctly, a bunch of transition things. So if you're in  
17 one quartile and you move to the other quartile, you don't  
18 immediately go down the sawtooth. You sort of smoothly roll  
19 down the sawtooth.

20           But of course by the time you get down to there,  
21 then you could have jumped back to the original saw because  
22 some [inaudible] and then you're smoothly going back up

1 somewhere, and just trying to administer where you're  
2 transitioning to could be hellacious.

3 DR. BAICKER: That's a technical term.

4 DR. CHERNEW: Right. I think it's actually  
5 reasonably high priority in the relatively near set of  
6 reports to give some options that recognize the realities of  
7 this as opposed to the way this was written, which is sort  
8 of like you just happened to be in that quartile and you're  
9 always going to be in that quartile. You know.

10 So I think that's actually an obvious way where we  
11 could add a lot of value if we could agree on what three  
12 types of fixes would be useful, and I think it's really  
13 worth doing.

14 MR. HACKBARTH: Scott, did I hear you correctly?  
15 You said, I think, that the placement in the quartiles is  
16 redone annually.

17 DR. BAICKER: If you had a smooth function instead  
18 of quartiles, that would solve that problem too.

19 MR. HACKBARTH: Right.

20 DR. CHERNEW: Right.

21 MR. HACKBARTH: Yeah.

22 DR. CHERNEW: Where you are tends to be a function

1 of where other people are. So you could be, say, exactly  
2 the same.

3 MR. HACKBARTH: Right.

4 DR. CHERNEW: If another county moved, you could  
5 be in a different quartile, and all of a sudden your payment  
6 rate is changing in different ways.

7 MR. HACKBARTH: Yeah, yeah. Right.

8 DR. MARK MILLER: I'm thinking we want cookies for  
9 the economists. I think that will slow them down.

10 [Laughter.]

11 DR. MARK MILLER: Yeah, but then they crash.

12 MR. HACKBARTH: Right.

13 Any comments? Scott?

14 MR. ARMSTRONG: Not a big point. I really don't  
15 understand completely but agree that, you know, the jigsaw  
16 thing. But I think there are probably a lot of other  
17 implications of this policy going forward that we should be  
18 measuring. I mean I just look at that jigsaw chart, and  
19 another question is well, how do we bring the right-hand end  
20 of it further to the left?

21 So I don't know. I assume that as we build out  
22 this report -- I have not had the opportunity to participate

1 in this -- that there will be a number of implications of  
2 PPACA and these policy changes and payment changes that we  
3 will want to be monitoring as we go forward. And at some  
4 point it just would be great for me just to understand a  
5 little bit better what the spectrum of those different  
6 issues -- criteria, if you will, for judging how all this is  
7 working might end up being, not just how do we deal with the  
8 edges around those quartiles but a number of other issues as  
9 well.

10 DR. CHERNEW: This is a real luxury, so I want to  
11 make one other comment. I have not seen how they plan to  
12 pay ACOs, but there is a similarity loosely in ACOs and MA  
13 plans and what they're trying to do, although the rules are  
14 very different in certain ways.

15 I think probably not as part of this chapter  
16 because one has to address this problem first, but I think  
17 any work that's thinking about how you're going to pay on a  
18 quasi-person level, targeted way should have some level of  
19 similarity as opposed to what -- first of all, the ACOs  
20 affect the fee-for-service component, and the ACOS could  
21 conceivably be a different way to get people into a system  
22 that you think is somehow akin to MA, though it's not quite

1 akin to MA. So I think that's another area where this type  
2 of analysis is going to be end up being very important, and  
3 this type of payment you might want to try and transition  
4 across or span across the things.

5 MR. HACKBARTH: I think that's a good point, Mike,  
6 and I was starting to think about that as well. So the  
7 underlying scheme is quite different even though there is  
8 some vague, broad similarity between the goals of the ACO  
9 program and Medicare Advantage.

10 So in the ACOs, what we're saying is that if you  
11 have low historical costs you're going to have a low payment  
12 rate, whereas here we're saying we're going to have a bonus  
13 payment -- a significant, large bonus payment -- in areas  
14 with low historical costs. There's no analog in the ACO  
15 program.

16 So you can imagine in the real world providers  
17 thinking about how I plan my future and work with the  
18 Medicare program. There's a discontinuity here in the  
19 payment schemes that could have unintended consequences.  
20 I've not thought through it, but I think that's a very  
21 interesting point and one worth flagging.

22 The other thing that is sort of a broad policy

1 point that I think is potentially worth including in the  
2 chapter is a lot depends on what your goals are for the  
3 Medicare Advantage program. And one of the challenges that  
4 we've had in the MA program over the last 25-plus years, in  
5 its various iterations, is that the goals have shifted over  
6 time.

7           Initially, the program, the initial TEFRA program  
8 enacted in 1982 paid HMOs 95 percent of the Medicare fee-  
9 for-service costs, and the goal was quite clearly to move  
10 people into more efficient systems. Over time, other goals  
11 have been mixed in, including some geographic redistribution  
12 of payments, finding out ways to add more benefits to the  
13 benefit package for beneficiaries and then try to equalize  
14 those benefits, additional benefits, across geography. As  
15 the goals have migrated, I think it's contributed some to  
16 the policy confusion.

17           The way that's really relevant now is that some  
18 people will judge the success or failure of PPACA based on  
19 what happens, the number of plans offered, the enrollment  
20 and the average rebate. And that's going to be the measure  
21 of success or failure. That's going to be the political  
22 battleground.

1           It's not obvious, to me at least, that that's the  
2 best way to assess whether this performance, this program is  
3 achieving the goals we have for it. And in particular, that  
4 measure does not determine whether we are identifying or  
5 rewarding more efficient delivery systems. It's totally  
6 disconnected from whether we are promoting more efficient  
7 alternatives to traditional fee-for-service Medicare.

8           So I think maybe without getting too immersed in  
9 the details, if we could just have some discussion about the  
10 goals, and we've included this in past reports. So it's not  
11 something that we have to reinvent. We can just lift it.

12           DR. KANE: Along those lines, what does the -- we  
13 like to look at all these different programs by what current  
14 law is expecting about them, and I guess one thing I've  
15 never really fully understood is what does current law  
16 expect out of the MA plans and does it expect ultimately  
17 that it will be more efficient than the traditional  
18 Medicare. I mean what does it say?

19           DR. CHERNEW: I think the current law price  
20 forecasting thing, if you didn't have fee-for-service, you  
21 couldn't have what the MA payment is. If I understand this  
22 correctly, I don't think current law has to take a position



1 on that because it's all tied to the fee-for-service. So  
2 once they project fee-for-service, they just know what  
3 they're going to spend on the MA plans per enrollee.

4 They do have to make an assumption about how  
5 people are going to move into the enrollees. But if the MA  
6 plans are very efficient, the savings are relatively small.  
7 I don't know if they assume there's, yeah, that much big of  
8 a -- in other words, I think they probably assume it just  
9 stays in the same pattern.

10 That's my sense of how it works. I could be  
11 wrong.

12 MR. HACKBARTH: The other thing about including  
13 the projections of the impact of PPACA that we talked about  
14 earlier -- what's the effect on the number of plans offered,  
15 the enrollment and average rebate and the like -- is that,  
16 as I understand the analysis that you're contemplating, it's  
17 a static analysis. That's if the plans don't change how  
18 they operate.

19 And I would think, believing in the market as I  
20 do, that if you change the price signal that you put out,  
21 you're going to evoke a different sort of market response.

22 So if you pay high rates, the path of least

1 resistance for plans is to offer big, open network, free  
2 choice systems if they can do that and still offer  
3 additional benefits that are attractive to get enrollment.  
4 That's the easy thing to do.

5           And the way the law has worked, they've been able  
6 to do that. They've been able to not be very aggressive in  
7 managing costs and offer attractive benefits and get rapidly  
8 growing enrollment.

9           If you change the price signal and say no, we're  
10 not going to just pay everybody a lot more than traditional  
11 Medicare, and send a signal that we're looking for plans  
12 that can do something different and reduce costs, I believe  
13 in the market. I believe plans will start to reconfigure to  
14 get access to this large and rapidly growing market, and  
15 offer tighter networks, more aggressive management. They  
16 can provide additional benefits at lower prices.

17           So a static analysis; it says if plans don't do  
18 anything different, this is what 2017 will look like. I  
19 fear there's a risk of that being inherently misleading and  
20 inaccurate because it dismisses the whole market response  
21 which to me is the principal reason for having a Medicare  
22 Advantage program.

1           So somehow I'd like to get that into the  
2 presentation as well.

3           Any other thoughts, comments?

4           Okay, thank you, Scott.

5           And last -- is it true, last? Talk about  
6 efficient.

7           [Off microphone comments.]

8           MR. HACKBARTH: So last up for today is "Improving  
9 Incentives and Safeguards in the Home Health Benefit."  
10 Evan?

11           MR. CHRISTMAN: Good afternoon. In past meetings,  
12 the Commission has noted several issues which suggest that  
13 the home health benefit could be improved. Many  
14 Commissioners have expressed concern about the variation in  
15 margins. There have been concerns that providers may be  
16 favoring patients, particularly those that need therapy. We  
17 have also noted that certain aspects of the payment system  
18 reward volume or specific services. Providers can increase  
19 payment by delivering more episodes and by delivering more  
20 therapy visits in an episode.

21           In addition, the variations in spending for home  
22 health are larger than other Medicare services. Spending

1 varies by twofold between the 75th and 25th MSA and by  
2 threefold between the tenth and 90th MSA. In the highest  
3 spending area, it is seven times the national average.

4           These concerns are further compounded by the low  
5 capital requirements for entry, limited physician  
6 involvement in the benefit, and the lack of beneficiary  
7 incentives to encourage appropriate use. Understanding  
8 these concerns, we have taken a closer look at the home  
9 health payment system, and before I proceed, I want to take  
10 a moment and remind you how the PPS works.

11           Medicare implemented PPS in October of 2000. The  
12 program pays for care in case mix-adjusted 60-day episodes.  
13 The case mix assigns beneficiaries to one of 153 payment  
14 groups based on clinical conditions, functional status, and  
15 the number of therapy visits provided in the episode. The  
16 role of therapy in assignment to a group is important, as  
17 the number of visits is a factor in 137 of the groups, or  
18 about 90 percent. Generally, payment groups where therapy  
19 visits are a factor pay more than those that do not factor  
20 in therapy.

21           We retained the Urban Institute to take a closer  
22 look at the payment system. Urban's analysis found that the

1 case mix could predict 55 percent of total costs, but this  
2 high value was attributable to the use of the number of the  
3 therapy visits, which are part of the cost being predicted,  
4 as an explanatory factor. When therapy visits are excluded  
5 from the case mix, the explanatory value of the case mix  
6 adjustor dropped to less than eight percent.

7           We also looked at the system's ability to  
8 accurately predict therapy and non-therapy costs separately.  
9 The case mix system could predict about 77 percent of the  
10 therapy costs. This should not be surprising, because  
11 again, therapy is being included as both an explanatory  
12 variable and an outcome in the case mix. For non-therapy  
13 services, the explanatory value of the case mix was one-  
14 tenth of one percent. The low value for non-therapy  
15 services is concerning because these services account for  
16 the majority of episode costs and about half of episodes are  
17 only non-therapy cases. The low value indicates that for a  
18 significant number of episodes, the case mix has limited  
19 predictive value. Episodes which include the most non-  
20 therapy services were significantly affected by the low  
21 explanatory power for these services. The case mix could  
22 correctly identify only 15 percent of the episodes in the

1 highest decile of non-therapy service use. This last  
2 finding is particularly concerning because it suggests that  
3 agencies have an incentive to avoid or reduce service to the  
4 patients with high non-therapy needs.

5           This next slide gives you an indication of the  
6 impact of using therapy visits as a payment factor. It  
7 shows the share of episodes with different numbers of  
8 therapy visits. If you look at the middle bar of the middle  
9 graph, you will see that a significant number of episodes  
10 were clustered in the ten to 15 therapy visit range in 2007.  
11 In 2008, Medicare changed how it factored therapy visits  
12 into payment. The effect of these changes were to lower  
13 payments for episodes in the ten to 13 visit range and  
14 increase them for the episodes just above and below this  
15 range. And the light blue bar in each part of this graph  
16 shows how agencies reacted to this change. Visits increased  
17 for the two groups with higher payment and decreased for the  
18 group with lower payment. The Commission reviewed this  
19 result last year and became concerned that the use of  
20 therapy as a payment factor made the system vulnerable to  
21 manipulation.

22           Urban also found that the case mix system

1 increases payment at a rate that is faster than the increase  
2 in providers' average costs. They found that a one percent  
3 increase in case mix was correlated with a 0.88 percent  
4 increase in provider costs. This implies that higher case  
5 mix agencies, including those which provide more therapy,  
6 will be more profitable than lower case mix agencies. This  
7 finding is confirmed in our review of the characteristics of  
8 high and low margin Medicare agencies, as the table at the  
9 bottom shows. Agencies with high margins had average  
10 profits of 35 percent, delivered more therapy, and had a  
11 higher case mix average. Agencies with low margins had an  
12 average loss of nine percent, delivered less therapy, and  
13 had a lower case mix.

14 All of these findings suggest that the home health  
15 case mix adjuster needs to change. The current system  
16 provides more generous payment for therapy and other high  
17 case mix services. It is highly dependent on therapy and  
18 not patient characteristics for its accuracy. The low  
19 explanatory power for non-therapy means that the case mix is  
20 weakest in explaining the services that are most commonly  
21 provided. And finally, the inclusion of the therapy visits  
22 as a predictor allows agencies to follow financial

1 incentives when determining the number of therapy visits to  
2 provide in an episode.

3           With these considerations in mind, we continued  
4 our work with Urban to develop an alternate case mix that  
5 better predicted non-therapy services and did not use the  
6 number of therapy visits as a factor. Similar to the  
7 current system, Urban examined patient characteristics from  
8 the OASIS to identify factors that could be used in a  
9 revised case mix system. They identified about 70  
10 variables, which included a range of ADLs, other functional  
11 indicators, clinical conditions, and other items.

12           The revised system they developed explained about  
13 14 percent of costs, or about double the explanatory power  
14 of the current system when its therapy thresholds are  
15 removed. The improvement was better at the service level.  
16 For non-therapy services, the explanatory value of the  
17 revised model was 14 percent compared to eight percent for  
18 the current case mix. And for therapy services, the revised  
19 model had an explanatory power that was about double the  
20 current system. The revised system was also more accurate  
21 in correctly identifying high-cost non-therapy cases,  
22 identifying 28 percent or nearly double the current model.



1           Next, we asked Urban to look at the payment  
2 impacts. Payment for non-therapy episodes would increase by  
3 an average of 35 percent, while it would drop for therapy  
4 episodes by 14 percent. High non-therapy episodes, those  
5 for severely ill patients who need lots of nursing or aid,  
6 would see a payment increase of 42 percent, and episodes  
7 provided to dual-eligible beneficiaries would see a three  
8 percent increase.

9           What I just shared with you were episode-level  
10 averages, and this table shows the impact by provider type.  
11 The increases would be for agencies that are nonprofit,  
12 hospital-based, and rural. Across all types of agencies,  
13 those that serve the most non-therapy patients and provide  
14 more non-therapy services in an episode would see larger  
15 increases. Again, the changes you see here are driven by a  
16 redistribution of payments from providers mostly focused on  
17 therapy more towards those focused on non-therapy services.

18           That completes our look at case mix. Next, we  
19 will look at changes in volume.

20           The growth in services under PPS has been healthy.  
21 You can see the 50 percent rise in total home health  
22 episodes in this graph. Much of this growth has been

1 propelled by a rise in home health episodes that are not  
2 preceded by a hospitalization or PAC stay. Put another way,  
3 in 2001, 48 percent of episodes were preceded by a hospital  
4 or PAC stay. By 2008, that share had fallen to 36 percent.  
5 In 2008, almost two-thirds of home health episodes are not  
6 post-hospital or PAC stays.

7           To better understand this trend, we looked at  
8 first episodes of home health, those not preceded by a home  
9 health discharge in the last 60 days. These are important  
10 because they give us an indication of where home health  
11 patients are being referred from. We found that first  
12 episodes admitted from the community with no prior  
13 hospitalization or PAC use increased by 48 percent, or more  
14 than three times the rate of growth for episodes that were  
15 preceded by a hospitalization or PAC stay.

16           We also looked at the increase in subsequent  
17 episodes, which are second and later episodes in a spell of  
18 consecutive 60-day episodes, and found that these doubled  
19 during the period. Subsequent episodes, which constitute  
20 repeat users of home health, accounted for 50 percent of all  
21 episodes in 2008.

22           So in terms of the shift we saw in the last slide,

1 the increase in episodes not preceded by a hospitalization  
2 or PAC stay, it is primarily driven by the increase in  
3 subsequent episodes, and to a lesser extent first episodes  
4 where the beneficiary has been admitted from the community.  
5 The growth in these episodes has been occurring at the same  
6 time that the number of hospital discharges has been flat or  
7 falling and the number of agencies has been increasing.  
8 This decline in demand for post-hospital home health  
9 services and rising agency supply raises concerns that some  
10 providers may be expanding to serve less severe populations,  
11 some of which may qualify, but not necessarily benefit.

12           Physicians and home health agencies are required  
13 to follow Medicare's eligibility and coverage standards,  
14 though studies by the IG and CMS have raised questions about  
15 how effectively they do this. For example, many reports  
16 suggest that physicians frequently defer to home health  
17 agencies, leaving control with agencies that have a  
18 financial interest in eligibility and plan of care  
19 decisions.

20           CMS reviews less than one percent of home health  
21 claims, so administrative review plays a limited role.  
22 Concerns about potential over-utilization are further

1 exacerbated by the lack of cost sharing in home health.  
2 Studies of health care services have generally found that  
3 beneficiaries consume more services when they have limited  
4 or no cost sharing and that these additional services do not  
5 always contribute to better health. The rapid rise in  
6 episodes not preceded by a hospitalization suggest at least  
7 some of this additional volume may be increasing Medicare's  
8 costs without improving beneficiary health.

9           Given the lack of oversight by CMS and the limited  
10 oversight that physicians sometimes provide a cost sharing  
11 requirement would permit patient choice to serve as an  
12 offset to the incentives in the home health PPS which reward  
13 additional volume. The lack of cost sharing for home health  
14 is unusual in fee-for-service Medicare, as most services  
15 have some form of cost sharing. Many private insurers,  
16 including some MA plans, do charge cost sharing for home  
17 health. Adding a cost sharing requirement would recognize  
18 that beneficiary choice influences the demand for home  
19 health, just like other Medicare services. The addition of  
20 cost sharing would lower utilization because beneficiaries  
21 would decline episodes of marginal value. However, a down  
22 side is that it could also reduce the utilization of

1 effective care and create perverse incentives. A carefully  
2 targeted cost sharing requirement would include policies to  
3 minimize these potential harms.

4           The next slide gives you an idea of what an  
5 illustrative cost sharing requirement could look like. A  
6 fixed per episode copay would serve as a demand side  
7 counterbalance to the incentives providers have to deliver  
8 more 60-day episodes. A flat per episode amount would also  
9 protect beneficiaries who need more visits in an episode as  
10 those additional visits would not increase their liability.

11           The amount of the copay could take several forms.  
12 For example, a copay amount equal to ten percent of the  
13 average episode payment would come out to \$300 per episode,  
14 and this would average out to about \$17 per home health  
15 visit for a typical episode. Seventeen dollars is roughly  
16 in the middle range of the cost sharing a beneficiary would  
17 pay for an evaluation and management office visit covered  
18 under Part B.

19           Because most Medicare PAC benefits have limited or  
20 no cost sharing in practice, it would be most appropriate to  
21 charge cost sharing only for first and subsequent episodes  
22 that are not preceded by a hospitalization or other PAC

1 stay. Charging cost sharing for post-hospital episodes of  
2 home health could encourage beneficiaries to use higher-cost  
3 PAC settings, such as SNFs or IRFs, which generally do not  
4 have a cost sharing requirement. A cost sharing requirement  
5 for episodes not preceded by a hospitalization or other PAC  
6 stay would not raise this issue. Beneficiaries admitted  
7 directly to home health from the community or those entering  
8 a second or later home health episode would be ineligible or  
9 unlikely to use the other post-acute care providers. In  
10 addition, the cost sharing could include some exceptions to  
11 mitigate the negative effects for vulnerable populations.  
12 For example, we could exclude low-use episodes with few  
13 visits or Medicare and Medicaid dual eligible enrollees.

14           With these exclusions and with a focus on episodes  
15 that are not preceded by a hospitalization or PAC stay,  
16 about 32 percent of home health episodes would have been  
17 subject to cost sharing under this design in 2008.

18           This completes the look at volume. Next, we will  
19 look at program integrity. Though CMS has launched home  
20 health program integrity initiatives, it seems as though  
21 more effort is required, and a review of trends in Miami  
22 provides an example as to why.

1 CMS launched enforcement efforts in this area in  
2 2007 after it found widespread fraud among providers in  
3 Miami-Dade County. Despite these efforts, the number of  
4 agencies in that county has doubled, from 314 in 2007 to  
5 over 700 in 2010. The higher number of agencies in a county  
6 considered high-risk for fraud suggests that Medicare needs  
7 to do more to fight fraud in the home health benefit.

8 It is also worth noting that aberrant patterns of  
9 utilization reach beyond Miami. For example, in 2008, five  
10 counties had more home health episodes than fee-for-service  
11 beneficiaries. In 29 counties, the rate of fee-for-service  
12 beneficiaries using home health exceeded 20 percent in 2008,  
13 more than double the national average.

14 The PPACA gave CMS broad new powers to combat  
15 fraud and home health may serve as a good test for them. A  
16 first step is that CMS and the IG need to identify areas of  
17 high fraud risk based on utilization and other reviews.  
18 Counties with aberrant patterns of home health utilization  
19 might be an appropriate place to begin these reviews. If  
20 these probes of unusual counties were to reveal widespread  
21 fraud, the Secretary could implement the new authorities.

22 There are several possible approaches to the

1 issues we have just reviewed and we are interested in your  
2 thoughts as to the most appropriate areas to pursue. The  
3 policies we have discussed would encourage more effective  
4 and efficient use of the benefit, create incentives for  
5 patient choice to play a role in a benefit that is otherwise  
6 difficult to manage, and strengthen program integrity.  
7 Addressing these challenges is central to ensuring that  
8 Medicare beneficiaries and taxpayers receive the greatest  
9 value for their home health dollar.

10 This completes my presentation and I look forward  
11 to your discussion.

12 MR. HACKBARTH: Thanks, Evan.

13 Before we start round one, could you just tell us  
14 a bit about the recent litigation involving the home health  
15 benefit?

16 MR. CHRISTMAN: Sure. There was just a court  
17 finding that overruled an ALJ decision that ruled that -- it  
18 denied home health care on the basis that a patient was  
19 stable. The presumption has normally been that the patient  
20 needs to have some ability to improve and that patients who  
21 are stable don't require skilled services, and the finding  
22 of the court was that this presumption that the patient



1 needed to improve was not a valid one.

2 Now, we haven't heard back from CMS about what the  
3 implications are for this, and it was remanded to the ALJ  
4 for redetermination. So that means it could get denied for  
5 some other reason. So understanding exactly how it impacts  
6 coverage is something we're still trying to chew through  
7 ourselves.

8 MR. HACKBARTH: Has the government said whether  
9 it's going to appeal or not?

10 MR. CHRISTMAN: No. I haven't heard.

11 MR. HACKBARTH: Okay. I think we're over on this  
12 side now. Round one clarifying, Karen and Scott and Ron.

13 DR. BORMAN: Could you refresh me as we think  
14 about qualifying hospitalization encounters, because we have  
15 looked in other work about the increasing number of  
16 observation encounters and so forth. Where would someone  
17 who got home health after an observation be counted and/or  
18 someone -- and someone who had an outpatient procedure, so  
19 either hospital outpatient department, like an image-guided  
20 procedure or an ambulatory surgical center and then got to  
21 home health. Do they get counted in the hospitalization  
22 group or no --

1 MR. CHRISTMAN: No. It's --

2 DR. BORMAN: -- because that would drive this a  
3 little bit --

4 MR. CHRISTMAN: I'm sorry. Yes. No, your point  
5 is a good one. The people who are counted as  
6 hospitalizations in these calculations were people who had  
7 an inpatient discharge. So they wouldn't have picked up the  
8 observation days people, as I understand it. That's an  
9 outpatient thing. And then, of course, the people served in  
10 an outpatient setting, they wouldn't be in there, either.  
11 They would be sort of what we think as the community-  
12 admitted crowd.

13 DR. BORMAN: Because I think that we are looking  
14 at a time frame where there was a continuing shift of things  
15 to an ambulatory setting, and while I don't mean to say  
16 there's not concerns here, I'm not sure how much of that is  
17 accounted for by simply that shift in practice. I know, for  
18 example, and Tom can help me here and Bob, I'm aware of  
19 places where patients with deep venous thrombosis, there's  
20 some sets of protocols where they can be treated on an  
21 outpatient basis and they're sometimes held in an emergency  
22 department for observation long enough to know that the home

1 health resources are being put in place and started on  
2 medications and taken care of, whereas before they might  
3 have had a qualifying hospitalization. So just as an  
4 example of how that could impact this, and I don't know how  
5 to get at that, but just a thought.

6 MR. ARMSTRONG: When we see changes in utilization  
7 rates like we're seeing presented here, obviously, you have  
8 a lot of questions about that. To be frank, for home health  
9 services, we're pushing increased utilization because  
10 overall, it lowers our per member expense trends. And so  
11 some of this could actually be really good. I'm just -- I  
12 just don't know this. Does the CMS or does anyone do any  
13 kind of appropriateness review of these home health  
14 referrals like they review the appropriateness of a lot of  
15 other services?

16 MR. CHRISTMAN: The way the process works now is  
17 that a physician has to basically order the service and  
18 attest that the beneficiary is eligible and needs the  
19 service. And to be eligible, there are sort of two main  
20 prongs. There's one, they have to have a skilled need,  
21 which more or less means nursing or therapy. And two, they  
22 have to be homebound, which means they can't leave the home

1 without severe and taxing effort. And so a beneficiary who  
2 meets those two prongs and a physician would authorize the  
3 care and then the home health agency would execute the plan.

4 MR. ARMSTRONG: And then payments dependent on  
5 those criteria being met?

6 MR. CHRISTMAN: Coverage, yes.

7 MR. ARMSTRONG: Yes.

8 DR. MARK MILLER: I thought your question was a  
9 little bit different, which is how much look behind any of  
10 that is, and I would say it's very nominal. And then you  
11 also -- and again, I'm not trying to pick it apart too much.  
12 It was sort of in contrast to where it goes on in other  
13 parts of Medicare. I think, by and large, the resources  
14 that are devoted, and I could be caught out here for a  
15 second, but the resources devoted to looking at the  
16 appropriateness of use have been declining, although more  
17 recently there have been sort of the RAC approach to things.  
18 But I think one of the concerns there is there's not a lot  
19 of oversight here, and I suspect in your system, and  
20 actually it might even be interesting to note, do you have  
21 some kind of prior authorization or some review that goes  
22 on, or is it pretty open ended?

1           MR. ARMSTRONG: It's not open ended, but what the  
2 prior authorization is, I'm not sure. I just know that home  
3 health services are such a highly integrated part of our  
4 overall care process that a patient wouldn't be getting home  
5 health services if it wasn't connected to their primary care  
6 provider's care plan for that patient. And if -- so it just  
7 wouldn't happen. But it doesn't involve actually formal  
8 preauthorization.

9           MR. HACKBARTH: So almost by definition, in a  
10 system like Scott's, it's a clinician that's asking for the  
11 home health. At Harvard Vanguard, the issue for us was not  
12 the front end authorization, but for a period of time, we  
13 were not careful about continuing to monitor and determine  
14 when the need was no longer there, and when you didn't do  
15 that, not surprisingly, the agencies would continue to visit  
16 and continue to bill. And so we had to focus more at the  
17 back end to make sure we were constantly monitoring the  
18 patient and making sure that there wasn't too much.

19           DR. CASTELLANOS: Just a clarification question.  
20 The recent physician payment rule just came out and there  
21 was a big section on therapy in that and it was very similar  
22 to what the issue was on x-rays. If it's concurrent, they

1 pay 100 percent for the first therapy and 50 percent for the  
2 second. So I can envision a person with a stroke having  
3 speech therapy and physical therapy. Again, I have not read  
4 it in detail, but I was wondering if that's going to have  
5 any implication on therapy and home health.

6 MR. CHRISTMAN: I'm not -- I guess I'm not exactly  
7 following the question, because the terms for payment of  
8 therapy of home health are set in the home health rule and  
9 I'm not aware of a relationship of how the physician fee  
10 schedule rule would change what's going on in home health.

11 DR. CASTELLANOS: I don't know, either, but I just  
12 remembered reading about that and it just concerned me  
13 because therapy seems to be a real big issue with home  
14 health. And I'm just putting that out as a clarification  
15 question, whether you have any information concerning that.

16 DR. MARK MILLER: [Off microphone.] We can get  
17 it.

18 DR. CASTELLANOS: [Off microphone.] Thank you.

19 MR. HACKBARTH: Other clarifying questions? Bruce  
20 and then Nancy.

21 DR. STUART: We're talking about home health, but  
22 in counties that have very high home health costs,

1 presumably, that's going to affect the AAPCC and raise the  
2 reimbursement levels for MA plans. Do we have any sense if  
3 that's a -- I mean, does it go up high enough so that it  
4 would really --

5 MR. CHRISTMAN: Oh, I think if you -- you might  
6 remember back at the September meeting, Dave showed you that  
7 when -- after you -- on the geographically-adjusted numbers,  
8 I believe, when you pulled out home health, DME, and  
9 hospice, there were a significant number of counties who  
10 were on sort of the right-hand side of the distribution who  
11 were pulled back towards the mean just for pulling out those  
12 services, and those services do contribute to all of the  
13 things you just listed.

14 DR. KANE: I was wondering, on your Slide 9, how  
15 is cost -- is it cost or number of units of service that you  
16 were trying to predict with your case mix thing? I was just  
17 trying to get a sense of what data are you using to come up  
18 with that, because I thought you were paying on an episode  
19 basis, or how do you --

20 MR. CHRISTMAN: Right.

21 DR. KANE: I just don't know. How do you know  
22 what the input is?

1           MR. CHRISTMAN: Sure. Now, what we're trying to  
2 predict is sort of the cost of each episode and sort of  
3 resource cost-weighted minutes. We know the minutes of  
4 nursing, therapy, and all the services that they received  
5 during the 60-day episode, and we have some standardized  
6 labor factors, you know, BLS wage data. So we can come up  
7 with sort of a standardized cost of a 60-day episode.

8           DR. KANE: Okay. So they're reporting the minutes  
9 to you along with --

10          MR. CHRISTMAN: They report the minutes, yes.

11          DR. KANE: I see. I didn't know that. And then -  
12 - so I can see how you just allocate cost to the minutes,  
13 then.

14                 And then the other question was, you say you  
15 adjusted for demographic factors. Do any of them include  
16 the socio-economic factors of the patient?

17          MR. CHRISTMAN: No, just age, I think, is the big  
18 one.

19          DR. KANE: But nothing about income status or  
20 living alone or --

21          MR. CHRISTMAN: No. Income status is not  
22 something that's -- we were using the assessment tool that



1 they administer at admission sort of to try and predict  
2 from, and income status isn't collected on that.

3 DR. KANE: For language or --

4 MR. CHRISTMAN: That, again, that stuff directly  
5 isn't picked up. You know, the things like cognitive  
6 difficulties and communication will get picked up, but as  
7 you can appreciate, that's a much broader range of things.

8 DR. KANE: Okay.

9 DR. BERENSON: This is very interesting stuff. I  
10 want to just pursue, in the paper, you wrote the following  
11 in the box on fraud. Likely fraud limits the utility of  
12 using payment outliers in the case mix analysis. And you  
13 say that in 2008, the year of data available for this  
14 analysis, a significant number of agencies manipulated the  
15 outlier payment system by claiming payment for fraudulent  
16 outlier episodes with very high visit counts. How do we  
17 know that? I mean, there are actual investigations of a  
18 significant number of home health agencies?

19 MR. CHRISTMAN: Yes. Yes. There are believed to  
20 be -- at one point, I think CMS was throwing around numbers  
21 of a couple hundred.

22 DR. BERENSON: Is that right?

1           MR. CHRISTMAN: And I think probably the one  
2 sentence explanation is there were more blind diabetics  
3 receiving 120, 150 visit episodes in Miami-Dade County than  
4 there were supposed to be blind diabetics in the whole  
5 country, is what I was told at one point.

6           DR. BERENSON: Yes, and what I'm trying to get at  
7 is whether we're sort of extrapolating from places where we  
8 really know this has happened to -- so a significant number  
9 -- if it's in the hundreds, that's significant, and so  
10 you're also thinking that more of this might be going on --

11          MR. CHRISTMAN: Yes.

12          DR. BERENSON: -- making this a problem with this  
13 analysis.

14          MR. CHRISTMAN: Absolutely.

15          DR. BERENSON: Okay.

16          MS. UCCELLO: Kind of following up on Karen's  
17 question about how hospitalization is defined, of those  
18 people who therapy is not post-inpatient hospitalization, do  
19 you have any sense of what share is post-outpatient?

20                 And then even more specifically, what share of  
21 this 32 percent that would be subject to cost-sharing with  
22 the exceptions that you laid out, is a big share of that

1 outpatient?

2 MR. CHRISTMAN: I think that's a fair question,  
3 and I can't give you a good answer. That's certainly  
4 something that we can look into. I guess I would -- you  
5 know.

6 An anecdotal answer I can give you is just that we  
7 haven't heard that outpatient is becoming a major on-ramp.  
8 Now that certainly deserves a more rigorous look at it than  
9 what I just told you, but that hasn't been mentioned when  
10 people talk about drivers.

11 MR. GEORGE MILLER: Yeah, a couple of things. One  
12 is while I think I understand why you would recommend a co-  
13 pay, but it seems to me, based on what you've written here,  
14 the reason for that is because of so much fraud. It seems  
15 like, and I may be extrapolating that, but it seems like  
16 you're penalizing folks because of fraud, to make them have  
17 co-pay to try to decrease fraud.

18 While I don't disagree you may not need a co-pay  
19 for this population, but if that's the reason it seems like  
20 you're penalizing the folks who are least likely, or they're  
21 the victims. It seems like you're penalizing the victims,  
22 at least in my opinion, particularly because in the reading,

1 the chapter that you sent, on Page 4 it says the lack of  
2 cost-sharing requirement to deter beneficiaries from seeking  
3 care of limited or no value. I don't think beneficiaries go  
4 and seek a home health agency and then get lack of care. I  
5 don't perceive that to be the case.

6 And if that statement is the driver for cost-  
7 sharing, that doesn't make sense to me. You know. I  
8 understand the other reasons why you say cost-sharing should  
9 be there, but this statement just doesn't wash with me. I  
10 don't know if you have a response.

11 MR. CHRISTMAN: Right.

12 MR. GEORGE MILLER: I may be all wrong.

13 MR. CHRISTMAN: Let me -- you know. Maybe that  
14 sentence was a little misconstrued, but what I think we mean  
15 is that right now if a beneficiary has health care needs in  
16 the community, they can go to the physician and they're  
17 going to pay somewhere between 10 and 20 bucks.

18 MR. GEORGE MILLER: Okay.

19 MR. CHRISTMAN: For many of the same services,  
20 they could also have a home health agency come to their  
21 house, and right now that's free. So in a sense the lack of  
22 cost-sharing discourages them from considering alternatives

1 when they might be able to go to a physician's office, which  
2 would cost Medicare less.

3 MR. GEORGE MILLER: Gotcha. But however, that  
4 patient doesn't seek a home care agency to come visit them.  
5 They go to the physician because they have a problem, but  
6 they don't say let me call up my nearest home care agency to  
7 get services. No, they don't.

8 MR. HACKBARTH: Well, patients don't self-refer to  
9 home health just as a matter of the design of the benefit.

10 MR. GEORGE MILLER: Correct.

11 MR. HACKBARTH: So it involves a physician  
12 referral in the first instance.

13 MR. GEORGE MILLER: Okay, in the first instance.  
14 Then all of the therapy they're talking about, the reason it  
15 drives the costs up is not the beneficiary who's asking for  
16 this additional therapy. The way I read this is that it is  
17 home health agencies figured out they can get more  
18 reimbursement if they have more therapy.

19 MR. HACKBARTH: Yeah.

20 DR. CHERNEW: [Off microphone.] [Inaudible.]

21 MR. HACKBARTH: So here's the challenge that we  
22 face; when we talked about this back in the spring, a lot of

1 the focus was on well, we've got to get physicians to be --

2 MR. GEORGE MILLER: Engaged.

3 MR. HACKBARTH: -- engaged in determining whether  
4 the beneficiary really needs this.

5 And Tom, for a variety reasons that made sense to  
6 me, said well, that's easier to say than to do when you're a  
7 practicing physician. We're often not in a position to make  
8 a really rigorous assessment of that.

9 Mike, at that time, said well, you know another  
10 potential avenue, and these aren't mutually exclusive, is to  
11 say if there's a modest co-payment then the beneficiary  
12 might be --

13 MR. GEORGE MILLER: Discouraged.

14 MR. HACKBARTH: -- think twice about whether they  
15 really need the additional home health services.

16 MR. GEORGE MILLER: Okay.

17 MR. HACKBARTH: So what we're trying to do is find  
18 some combination of steps that might help us make sure that  
19 the benefits are going to the patients who most need them in  
20 an area that the growth is explosive.

21 Now that's not to say that either of those  
22 responses, physicians or co-pays, is perfect without

1 problems.

2 MR. GEORGE MILLER: Okay.

3 MR. HACKBARTH: Just one other point, then on the  
4 fraud issue, I think Bob and maybe Tom as well. Some people  
5 said well, if we want to engage the patients in helping us  
6 identify potentially fraudulent behavior, which is really  
7 damaging the program, if there's some co-pay involved, that  
8 gets their attention. So that was the fraud angle.

9 MR. GEORGE MILLER: Okay. All right. But you  
10 also said in the paper that some agencies manipulate the  
11 outliers to get better payments also. So I don't know how  
12 co-payment would deal with that issue, but I don't disagree  
13 with the premise then behind that. I'm just really  
14 concerned about that statement, and maybe it's just worded,  
15 or I read it, wrong.

16 Just finally, and Scott mentioned that increased  
17 utilization may save the systems. I wouldn't disagree  
18 except for where those same, maybe different agencies may be  
19 again manipulating the therapy to get higher payment, not  
20 dealing with the fact that increased utilization is giving a  
21 better service and keeping them out of the hospital. Those  
22 are two separate issues here.

1 DR. DEAN: When you were talking about the cost-  
2 sharing, you said one possibility to try to make it fair  
3 would be to exempt episodes that had a low number of visits.  
4 Does that mean it would be determined after the fact, or? I  
5 didn't quite understand how that would work.

6 MR. CHRISTMAN: Well, I think for example, right  
7 now Medicare, if it's less than five, an episode has less  
8 than five visits, it pays on a per visit basis instead of a  
9 case-mix adjusted standardized payment.

10 DR. DEAN: I mean I'm asking so what happens if  
11 the patient then would get the bill after the episode?

12 MR. CHRISTMAN: Well, I think you could inform the  
13 patient that if you go beyond a certain number of visits in  
14 your episode that the cost-sharing is incurred. That  
15 doesn't mean you necessarily do at that point.

16 DR. DEAN: I see.

17 MR. CHRISTMAN: You could prospectively tell them  
18 that if you go beyond this threshold you incur this cost-  
19 sharing.

20 DR. DEAN: Okay.

21 MR. HACKBARTH: Okay, round two comments and  
22 questions; Karen, Ron and Mike.



1                   Karen?

2                   DR. BORMAN: Just one other thought, and then I  
3 don't know whether it's practical, but in terms of trying to  
4 think to your options here. It's conceivable that if we  
5 could identify that episodes preceded by a hospitalized, as  
6 now defined, were somehow more valid or more valuable or  
7 whatever that ones that didn't, is there an opportunity or  
8 would it require less legislation or what would we have to  
9 do to say potentially make the post-hospitalization benefit  
10 be 60 days and the non-hospitalization one be shorter, say  
11 30 days?

12                   I mean presumably if it got treated in a less  
13 intense site of service, then maybe the need for therapy or  
14 intervention would not be as long, and that might be a way  
15 to think about it -- just something else we could manipulate  
16 about the benefit.

17                   MR. HACKBARTH: Any reaction to that, Evan?

18                   MR. CHRISTMAN: I mean the 60 days, it's kind of  
19 vestigial to how Medicare was paying for care before PPS was  
20 implemented. So that's definitely something that changing  
21 the length of the episode is definitely something that's, I  
22 think, down the road on our list, and we can think about

1 that.

2 MR. ARMSTRONG: Just briefly, I want to affirm  
3 that the next steps looking at improved payments for non-  
4 therapy services, dealing with the incentives associated  
5 with that cost-sharing, I support going further with the  
6 analysis that you propose doing around those ideas.

7 I also just wanted to add that I do think that the  
8 role home health plays in some of our other programs too,  
9 too easily gets overlooked. For example, our discussion  
10 around payment structures for ACOs, maybe we ought to be  
11 thinking about how home health services also plays a role  
12 there. This whole paradigm on home health just seems to me  
13 so focused on how we control what seems to be either  
14 fraudulent or overused service. Actually, it's a hugely  
15 valuable service, and we want to promote its use more  
16 appropriately in some places where it's being underused.

17 MR. HACKBARTH: I agree, and it's important to  
18 keep that in mind. And there's also reason to believe that  
19 not everywhere is it being used in that way.

20 Evan, I don't think that there's much correlation  
21 between the high home health use and lower other costs in  
22 the Medicare program.

1           MR. CHRISTMAN: I believe what we talked about in  
2 September is in many cases they were positively correlated.

3           MR. HACKBARTH: Right.

4           MR. CHRISTMAN: When I talk about McAllen, Texas,  
5 Miami, L.A., those are some of the hot spots.

6           MR. HACKBARTH: So properly used and integrated  
7 with a care program, it's a hugely valuable tool. On the  
8 other hand, the way it runs in Medicare it can often sort of  
9 get off on its own track.

10          DR. CHERNEW: You're talking MA, though, Scott,  
11 right? You're talking MA system.

12          MR. ARMSTRONG: I am, yeah. But I was thinking  
13 about some of the structures we're looking at around ACOs,  
14 that this is I think something to consider there.

15                 By the way I don't want to sound like I'm  
16 understating the importance of dealing with the issues here,  
17 and I really do believe we need to go forward with it. I  
18 just wanted to offer a little bit of a balance to that in  
19 that this is a service that fits in some other discussions  
20 as well.

21          DR. MARK MILLER: If I could say here, I didn't  
22 take it as anything other than trying to balance.

1           And I would just sort of remind everybody again  
2 this part of the conversation is about restraining  
3 utilization and that potential, but the first part of the  
4 conversation was this concern that the payment system was  
5 rewarding a certain kind of care and telling you to avoid  
6 strokes in Medicaid patients and that type of thing. So  
7 that part is also trying to get at changing the underlying  
8 use of the benefit and trying to orient it more evenly, if  
9 you will, the incentives more evenly.

10           DR. CASTELLANOS: I really want to add two points.  
11 I want to strengthen what Karen started and what Cori really  
12 pressed on, and that's the outpatient surgeries. In urology  
13 specifically, I've seen such a move out of the hospital into  
14 the outpatient. Today, we do 60, 70 percent of our surgery  
15 as outpatients, and it's the home health care that allows us  
16 to do that in a certain percentage of those patients, and  
17 these people do not have a preexisting hospital admission.  
18 I would strongly want you to look at outpatient.

19           And I would also think observation status. I see  
20 a lot of people in observation status that, you know, a  
21 person with a broken bone with blood in the urine. She  
22 doesn't qualify for SNF. She hasn't been in the hospital.

1 Yet, she requires home health. So I think you need to look  
2 at observation and outpatient surgery.

3 The other thing that I guess we talked a little  
4 bit this morning about, these inconsistencies in the number  
5 of dates and times that we have in the Medicare system. We  
6 talked about a 60-day, a 30-day rehospitalization. Here,  
7 it's 15 days. A SNF is 3 days. I understand that you  
8 really have to have some judgment, but it's quite, to me, a  
9 somewhat confusion this is, the inconsistency sometimes that  
10 appears to be in the Medicare system.

11 DR. CHERNEW: So I thought this was terrific, and  
12 I might be at the extreme of people in support of the  
13 general notion of cost-sharing here. So I realize that.

14 So let me first start by saying that I think  
15 patients love home care. My grandmother loved home care.  
16 My parents loved home care for my grandmother. When the  
17 home care ended for my grandmother, my parents were really  
18 upset.

19 In part, they liked it because the home care was  
20 great. The home care providers were remarkable people that  
21 I really think that we would all be better if we had half of  
22 the traits of the home care providers. So I thought it was

1 a wonderful service.

2           The challenge I think, and I'll say this  
3 personally. I think it's generally true. A lot of the care  
4 that's desired isn't really necessarily necessary, and  
5 that's really where the challenge is. It's very hard in  
6 home care to figure out the distinction between I'm really  
7 glad you're coming which my grandmother loved, and I'm  
8 really glad you're helping with this as my grandmother  
9 needed a lot of help from this is really necessary in  
10 society, you should subsidize it because frankly my mom  
11 didn't want to go there. And I'm not saying that's all what  
12 happens all the time, but that happens I think in some  
13 cases, and I think there's evidence that that's a problem.

14           What I'm worried about, you would think that by  
15 supporting cost-sharing for home care that I don't like the  
16 home care program. In fact, I support the cost-sharing  
17 because I think without the cost-sharing the whole home care  
18 thing will collapse because we're going to end up getting to  
19 the situation where we're going to lower the rates and lower  
20 the payment rates, and I'm worried that the bad home care  
21 providers will drive out the good home care providers as we  
22 try and get the margin right when there's all this

1 heterogeneity. And I think that's a really big problem.

2           So I think that beneficiaries in this area, they  
3 know their needs reasonably well, not all them. So it's  
4 hard to get these things perfect. Their families know. And  
5 some modest cost-sharing can do a lot to make sure that  
6 people are willing to pay when they really need the home  
7 care and maybe not when they don't. I wouldn't want to have  
8 necessarily very high or onerous cost-sharing, but I think  
9 some cost-sharing could be incredibly useful in preserving  
10 the program, making it more efficient and making sure that  
11 we can do a better job of differentiating different types of  
12 care.

13           That said, I think in here a little more thinking  
14 needs to go into the exact form of the co-pay, and I've  
15 given a little thinking to it based on what was written  
16 here, and I'm just not sure.

17           So, for example, there's this issue of per episode  
18 or per visit. It's a very complicated one because if you do  
19 it per episode you end up charging a lot, say, for the  
20 person that might need a little bit of home care following  
21 an outpatient procedure, right, which maybe you wouldn't  
22 want to charge them very much for, but they have to pay the

1 average amount for the episode.

2 I could see a system where you give them maybe  
3 some for free after some procedure, and then it depends how  
4 you want to administer it. Then you charge them more at the  
5 end because you want to cut out those home visits at the  
6 end, but if there's someone really severe you might not. So  
7 I'm not sure how to deal.

8 We dealt with this in hospice, in this inverted U  
9 kind of thing. I don't think this deserves an inverted U,  
10 but some thinking about how to do the per episode versus per  
11 visits I think matters.

12 It might vary based on type. It might vary based  
13 on how we end up bundling because I actually think the way  
14 to deal with some of Ron's issues might be to bundle some  
15 home care and then not. So I think that matters.

16 There are issues of risk. So I might want to have  
17 a maximum amount you could pay, a co-pay per visit up to a  
18 max. That sounds reasonable to deal with the risk.

19 This issue of co-pays post post-acute, that wasn't  
20 a stutter. It was really post post-acute. I guess my  
21 general view is a solution to that is not to lower co-pays  
22 in that setting but to raise co-pays for the post-acute



1 because the issue is to get the efficient setting. A lot of  
2 the figuring out how to do it -- just because you had a  
3 hospitalization doesn't mean, to me, you should have some  
4 waiver of co-pays because we don't want to encourage you to  
5 go to some other setting. We might want to deal with that  
6 in a separate way because those people have the same issue  
7 as they get towards the end of their spells, and a whole  
8 bunch of other things.

9           So my general view is we need to think about how  
10 to change the form of the co-pays, which I haven't gotten  
11 yet. I'm not convinced that this is right to solve all of  
12 the problems, but I think cost-sharing is very important.

13           And the last thing I'll say, somewhat channeling  
14 John Bertko, once we do this, we have to think about the  
15 role that supplemental coverage plays in all of this. So I  
16 could envision that we make some change, and then people are  
17 buying supplemental coverage that are filling in where the  
18 post-acute, where the home co-pays would have been, and  
19 we're not getting the right incentives that we want.

20           So I think there's a lot of issues about how to do  
21 it, but I really think the problem we have with home health  
22 in general is it's an extraordinarily valuable service, and

1 if you put it in an MA plan like Scott's I think you can see  
2 how strongly valuable it is. But left to run around in the  
3 wild, it's just rife with both blatant abuse, the type of  
4 abuse that just makes TV commercials and just you  
5 infuriated.

6 And then there are things which I think aren't  
7 really abuse, but it's like well, I'll say my wonderful  
8 relatives. I'll just use them as an example, but there are  
9 so many examples of this. They're not really abusing the  
10 system. They probably should qualify, and they really liked  
11 it. But if you were going to have a genuine discussion  
12 honestly about do you really think that this is what we  
13 meant when we said home health, that's probably, probably  
14 not.

15 So we have to deal with the distributional issues  
16 and the co-pay waivers for low income. We have to think  
17 about the right form. But I really think the whole system  
18 would be better if we did a smarter job of making  
19 beneficiaries have at least a little incentive in some self-  
20 policing for a service that at least has some discretionary  
21 demand.

22 MR. HACKBARTH: So can I just pick up on one of

1 Mike's points there somewhere in the middle, the John Bertko  
2 point? I'm not going to talk about your relatives, but the  
3 John Bertko point, that to change the co-pay or add a co-pay  
4 and leave everything else the way it is probably would  
5 generate a lot of political flack for very little benefit in  
6 terms of changing utilization patterns because it will end  
7 up being covered by supplemental coverage and the system  
8 will just move on. It will be paid once a month through  
9 premiums as opposed to at the point of service.

10           You will remember that one of the items on our  
11 longer-term agenda for the spring is to pick up again our  
12 discussion about the benefits structure, and so we may want  
13 to think about discussing home health co-pay some more in  
14 the context of home health. But it could be that any  
15 recommendations that we make maybe would be best packaged in  
16 a chapter on the benefits structure and where we may  
17 concurrently deal with the supplemental coverage issue as  
18 opposed to doing it one-off.

19           Kate?

20           DR. BAICKER: Unsurprisingly, I agree with what he  
21 says, at least the parts I can remember.

22           The part that I would add on about co-payments is

1 that normally when we think about what the right co-payment  
2 is we're balancing insurance against incentives -- that  
3 you're trying to protect people against uncapped risk on the  
4 insurance side, but you're trying to maintain some incentive  
5 to monitor use, and you pick the co-pay to balance those.

6 Here, the thumb on the scale of the co-pay is the  
7 fraud component, that there's an extra value to the co-pay  
8 because it directs people's attention to having actually  
9 received the service, to having the service be consistent  
10 with their needs, and that pushes us towards an even greater  
11 value of co-pays. At the same time, you don't want people  
12 exposed to uncapped, or potentially very large, risk. So  
13 what do you do about that fraud incentive when you get to some  
14 maximum out-of-pocket?

15 I don't know if we have the tools at our disposal  
16 to say something like you get a co-pay waiver, but you still  
17 have to fill out the same paperwork to validate that the  
18 person was there and that the co-pay would have been this,  
19 but because you're over the cap you don't have to pay the  
20 co-pay. Maybe you could build in some of the same  
21 monitoring without the actual dollar attachment once you get  
22 over that threshold, which doesn't solve the problem of his

1 relatives but solves the problem of the imaginary blind  
2 diabetic.

3 DR. STUART: I'm not sure it solves the problem of  
4 the blind diabetic. I'm really concerned about having fraud  
5 control being handled through co-payments. I just don't  
6 think that it's going to work, given the fact that if you  
7 look at the distribution of people that get these services  
8 there is a large proportion are not in a position to be able  
9 to judge whether they need them or not.

10 And a large proportion, this is something that has  
11 always bothered me about co-pay policy is we say okay, well,  
12 let's have co-payments, but we'll exclude the bottom 15  
13 percent, 20 percent, 30 percent, whatever it happens to be,  
14 and they get a free ride. So what do you do with those  
15 people?

16 That leads to a question that would be has there  
17 been any analysis of the extent of home health use in the  
18 dual eligible population versus the non-duals? Maybe even  
19 go a little above that and look at the people who are in  
20 Part D plans and LIS. They have a little bit higher income,  
21 so that you'd be able to see whether in fact there is some  
22 correlation between income and receipt of home health

1 because it's really important if you're going to address  
2 this.

3 And you may well be right, Glenn, that this is not  
4 the chapter in which you want to do it. But if you really,  
5 really believe that co-pays are the way to go, then you've  
6 got to come up with some other alternative for handling the  
7 problems of those people who aren't going to pay the co-  
8 pays.

9 MR. HACKBARTH: I'm going to ask a clarifying  
10 question, Bruce, about your reference to looking at duals or  
11 the LIS population. I'm not sure I understand what you're  
12 after there. You have two populations that don't face any  
13 out-of-pocket costs?

14 DR. STUART: That would be the point. It would be  
15 what proportion of home health benefits are going to those  
16 who might presumably be exempt from co-pays.

17 MR. HACKBARTH: Okay, I see.

18 DR. STUART: Because those are obviously not going  
19 to be the ones for which the co-pay is going to have an  
20 effect on the utilization.

21 MR. CHRISTMAN: If I'm following you, you're  
22 asking kind of simply, for example, what share of home

1 health episodes are delivered to dual eligibles and things  
2 like that. I'm learning identifying duals in administrative  
3 data is sometimes a bit of an art, but from what we can tell  
4 they are over-represented in home health, and it's somewhere  
5 between 30 and 40 percent.

6 DR. STUART: Thirty to forty percent is huge. And  
7 if that is the case, then I think it argues for a slightly  
8 different mix of policies to address the issue.

9 If it turns out, and this would be something else  
10 to look at, is it 30 or 40 percent in Dade and Los Angeles  
11 County and these others, or is it even higher in those  
12 counties? The reason that I would ask that question is that  
13 these are very vulnerable people, and you might expect that  
14 they would be more vulnerable to fraudulent practices as  
15 well, not going along with fraudulent practices but being  
16 victims of fraudulent practices.

17 DR. MARK MILLER: I wanted to ask this, and it's  
18 been long enough now since I read the paper before it went  
19 out to Evan -- how hard of a linkage in the paper we were  
20 making between the co-payment and fraud because my view.  
21 Just to kind of reset the table for a second, my view of  
22 what we've talked about here were three things, and this is

1 kind of how it worked, and this is obviously a  
2 simplification and all the rest of it.

3           So we feel like we see this distortion in the  
4 system that says you should chase therapy, you should avoid  
5 stroke and Medicaid. Okay. And we're trying to get the  
6 payment system to deal with that.

7           The second layer is there's no one in the system,  
8 and I'm not talking about fraud yet, there's no one involved  
9 in the system who has any reason to say no. Physician Tom  
10 was very articulate on this point several meetings back.  
11 And just to pull George's point into it, rather than the  
12 beneficiary seeking it -- and I think this is what was  
13 concerning you -- it's sort of I'm coming to your house and  
14 why not, and so there's nothing to slow that down. I don't  
15 mean to be facetious at all. There's just no reason to slow  
16 that down.

17           Then the third thing that we brought into this  
18 discussion was fraud. What we were saying here is there are  
19 some new authorities in PPACA -- such as suspending billing  
20 privileges, stopping the number of providers who can come  
21 into a market -- that we may also want to talk about to  
22 address the fraud thing.



1           I think there was probably some sense that if the  
2 beneficiary -- I mean the co-payment might put some drag on  
3 that, but I don't think we brought it into this discussion  
4 particularly as a fraud tactic. It's sort of -- anyway,  
5 I'll stop.

6           MR. HACKBARTH: Yeah, and I think that's right.  
7 In today's conversation, I was the one who brought it in.  
8 It wasn't highlighted in the paper, and I was sort of  
9 channeling something that Bob has said.

10          DR. BERENSON: I'm waiting to talk.

11          MR. HACKBARTH: Whoops. Go.

12          [Laughter.]

13          DR. BERENSON: So I was the one. I was one of the  
14 people who brought this up before, and I'll disagree a  
15 little bit with Bruce. This is not one where we -- we're  
16 looking for a couple whistle-blowers. We don't need to have  
17 everybody who receives the benefit to have a co-payment.  
18 You'd have to hypothesize that some of the fraud people  
19 would only be targeting the duals, and I don't think, I  
20 don't see it as a prominent part of the fraud program.

21           I do think it is a useful thing for patients to,  
22 or for beneficiaries to, have even nominal cost-sharing in a

1 service like this for the just gross fraudulent activities  
2 when somebody never even came to their house. We don't need  
3 everybody to have that incentive. We need a couple whistle-  
4 blowers to be out there.

5           And so that goes to Glenn's point which I agree  
6 with completely, and John Bertko raised it. We would have  
7 to change the basic structure of the program, so that we  
8 didn't have supplemental providing first dollar coverage  
9 except for low income. But on this one, I don't think it  
10 needs to be a substantial co-payment. I just think it needs  
11 to be a co-payment.

12           DR. STUART: How about having a substantial  
13 payment for a whistle-blowing?

14           DR. BERENSON: Well, we get in --

15           DR. STUART: I mean if you're really interested in  
16 getting fraud out of the system, then give people a positive  
17 incentive to get at fraud.

18           DR. MARK MILLER: [Off microphone.] But they  
19 might not even know.

20           DR. BERENSON: No, under the False Claims Act,  
21 that's how it works, I mean.

22           But I'm just saying that from my personal

1 experience -- I won't bring in all my relatives -- I have  
2 still not looked into a certain claim that came in  
3 relationship to a relative because it was first dollar  
4 covered. I keep saying I'm going to call and ask somebody  
5 to explain what that service was, and I just never get  
6 around it. It was a substantial amount of money that  
7 Medicare and the supplemental insurer paid, and I have no  
8 skin in that. I don't like to use that term. I have no  
9 interest in doing that.

10 I do think there is some value in people seeing  
11 claims. It wouldn't detect sophisticated fraud where  
12 they're just using outlier payments. It would detect the  
13 situation where nobody ever showed up at somebody's house  
14 and a claim comes in for \$100 for their share of that  
15 episode. So I don't think we give it prominent attention,  
16 but I think it probably does belong in the chapter.

17 With regard to Mike's point, I think it's -- I do  
18 think we want to think through whether the co-payment should  
19 be on the visits or the episode. By going-in bias is on the  
20 episode. There's already an exception for episodes that  
21 have only a couple of visits where you don't get the whole  
22 episode. It's LUPA, I guess is what it's called.

1           We need to think it through, but I think there's  
2 lower transaction costs if we just have a co-pay for the  
3 episode. The payment is by the episode. But I'm all for  
4 sort of thinking through that sort of logically to make sure  
5 where we would want to come up and how to deal with those  
6 exceptions.

7           And we also have to address the issue of  
8 equivalence to hospitalization. You know the issue that  
9 Karen raised.

10           DR. KANE: Yes. I'm going to change the subject.  
11 I hope people don't mind. I know you want to talk more  
12 about copays, but I want to talk about the case mix  
13 adjustment. In this 26 percent predictive -- predicting 26  
14 percent of a cost variation, is that -- relative to other  
15 case mix indices that we have out there, is that a good  
16 number or is that kind of an inadequate number? I don't get  
17 a sense.

18           MR. CHRISTMAN: Well, I guess -- you know, it does  
19 vary and there are systems with higher and systems with  
20 lower. I mean, the headline number is 14 percent. That is  
21 all the costs. You were pointing to the 26 --

22           DR. KANE: Yes. So is 14 --

1           MR. CHRISTMAN: -- and, you know, I think that  
2 there's sort of a few responses I would make to that. One  
3 is that that is the amount of variation that we can explain  
4 using patient characteristics, and it is not out of line  
5 with what people have found in the past. To get anything  
6 higher than that, what people have done is they throw in  
7 things --

8           DR. KANE: Put the services in.

9           MR. CHRISTMAN: -- like the therapy visits --

10          DR. KANE: Yes.

11          MR. CHRISTMAN: -- or the treatments and the  
12 things like that.

13                 Now, why does that number look the way it does?  
14 One thing that is discussed is that even people in the home  
15 health industry say that there's a lot of variation in how  
16 care is practiced, and this is stepping outside of even just  
17 geographic variation. But when the clinical folks talk,  
18 they talk about the lack of best practices and things like  
19 that, and there have been studies that have pointed out that  
20 practice just does vary and that a patient with the same  
21 characteristics, where they are will determine how they get  
22 treated. So this model is trying to distill that variation

1 and just find the piece that's related to the  
2 characteristics, and we're finding that it is what it is. I  
3 mean, probably the -- the HCMS-HCC system, it's R-squared is  
4 somewhere around 11 percent, for example. So I guess that  
5 the message -- I think it's consistent with the other things  
6 we've noted about home health, about the broad variation in  
7 the use of its benefit. If you want to get up beyond that,  
8 you start to add things to the payment pile that can create  
9 problematic incentives.

10 DR. KANE: Well, I'm kind of -- Mike said  
11 something about home health just wandering around all by  
12 itself out there in the wilderness, and I think that's part  
13 of the problem with trying to get your hands around this, is  
14 it isn't linked up to a diagnosis or an episode across the  
15 side. That's just a home health visit. So I was just  
16 wondering if there's any way we could get a handle on are  
17 there particular episodes for which the home health benefit  
18 can be more contained into, like the post-stroke amount or -  
19 - I just sort of feel like there's so many possible things  
20 going on on this one, it is really hard to get down to -- I  
21 mean, maybe we'd be better off going back to a per visit  
22 payment, because we don't really know what's in an episode

1 or why and why it might vary. It's just very fuzzy.

2 And then the notion that maybe 30 or 40 percent of  
3 these patients are dual eligibles makes me wonder if there  
4 shouldn't be some sort of socio-economic adjuster for what  
5 we're -- so the whole thing just makes me feel like we don't  
6 really know what we're paying for and it's very, you know,  
7 just -- I don't like it.

8 [Laughter.]

9 MR. HACKBARTH: Well, and I think your discomfort  
10 is appropriate. To me, the prerequisite for a robust system  
11 of prospective payment is that you have a clearly defined  
12 product that you're buying and you can say, this is the  
13 product and this is how it varies for different case mix,  
14 you know, a case mix adjustment system. Then you can have a  
15 robust system.

16 Home health has never met that test. It's an  
17 amorphous product, one, frankly, that can be subject to  
18 manipulation, and yet we decided to do prospective payment  
19 in sort of a festival of prospective payment systems for  
20 post-acute care. It was like, hey, it worked for inpatient  
21 hospitals so let's do it for everything, and that was a  
22 fundamental error that occurred back in the 1990s.

1           You know, I think if we were starting with a clean  
2 piece of paper, you could make a strong case that much of  
3 home health care should never be paid for as an independent  
4 service, but as an adjunct to other services so it is well  
5 integrated with the other care and there's a clear clinical  
6 responsibility for overseeing the home health. That's how  
7 you achieve the sort of high-value home health that Scott's  
8 referring to. This having it, as Mike put it, running in  
9 the wild is really problematic.

10           DR. STUART: [Off microphone.] Can I respond to  
11 this, just very briefly? I've got another take-away on  
12 that, because remember, this revised case mix system uses  
13 ADLs, among other things. And so the fact that that can  
14 predict therapy better than the current case mix system  
15 predicts therapy without therapy in it, which obviously you  
16 can predict therapy by therapy, tells me that maybe this is  
17 the heart of the matter, you know. You've got at least 27  
18 percent of the variation that can be explained by, my guess  
19 is that it's mainly ADLs. I don't know, Evan, whether  
20 that's true. And then you'd be in much stronger position of  
21 saying, okay. Well, people that have whatever the  
22 difficulty is, and it could be a stroke, it could be the hip



1 fracture, it could be the other kinds of things that are  
2 going to lead to ADLs and, by the way, need to -- adjunctive  
3 therapy. So I thought the take-away was moving us in the  
4 right direction here with this new system.

5 DR. KANE: Well, I'm not against the case mix  
6 index being better than it was. I'm just wondering, is  
7 there something even better than --

8 DR. STUART: But that's good. Twenty-six percent  
9 is huge. I mean, if you look at --

10 DR. KANE: For therapy, yes.

11 DR. STUART: If you look at the HCC or you look at  
12 the DRGs, they're not anywhere near that high. Now, the 14  
13 percent is not great, but it's still not terrible compared  
14 to the predictive power of the hospital service, prospective  
15 payment system, for example.

16 MR. HACKBARTH: So my take on the case mix was,  
17 hey, this looks like a significant improvement relative to  
18 where we are. And I would add to that, improving the case  
19 mix system is particularly important as we transition to a  
20 different payment structure. So as long as there's lots of  
21 money flowing into the system and payments are way over  
22 average costs, a sloppy case mix system is less likely to do

1 real harm. If, as you tighten the payment rates and you've  
2 got a poor case mix system, the risk that you're going to do  
3 active harm to some good providers increases. So now that  
4 Congress has put us on a path where there's going to be  
5 tightening of the rates, I think it's really important to  
6 improve the case mix compared to what it is right now.

7 MS. HANSEN: Sure. A lot of the points have been  
8 well made, and I think Mike covered a lot of it in areas, so  
9 I'm just going to highlight one. If we could talk about  
10 this case mix and go to Slide Number 10, and one of the  
11 things, I must say, that this new method is something that  
12 I'm really delighted that the redistribution of a population  
13 of concern for me has always been about the other kinds of  
14 things that go on with people who have more complex  
15 frailties that get adjusted. So it seems like this whole  
16 approach, at least, addresses that so that it's not just the  
17 therapy as it was before as individual discrete areas.

18 But I'd like to tie in to have an adjunct comment  
19 to the dual eligible, if this is the 30 to 40 percent that's  
20 involved. One of the things I just wanted to help  
21 distinguish is this whole thing of home health care as  
22 compared to home care. Home health care has a more

1 technical, clinical perspective to it that you oftentimes  
2 need a registered nurse or a licensed vocational nurse or a  
3 certified home health aide. So those are skilled care kinds  
4 of things.

5           What I do know is that especially with the dual  
6 eligibles, oftentimes they're qualified for home care, which  
7 are help with the general activities of daily living that go  
8 on regardless of these episodes, of whether it's after  
9 surgery or whether it's coming home from the hospital. So  
10 it's one of the areas to just understand, because this is  
11 where it starts to fold into the Medicaid said for the dual  
12 eligibles. So I just wanted to point that out, that people  
13 like home care, not just home health care. But people --  
14 for us, it's really a technical definition. For the public,  
15 it's one in the same oftentimes and it's an area that is  
16 further kind of blurry to all of this.

17           The other aspect was this whole thing of how Scott  
18 uses home health care is kind of like the ideal aspect of  
19 bundling it together. So I just wonder whether or not we've  
20 really thought about this as to whether this episode  
21 bundling or episodes of care that's come in the new  
22 legislation has been thought of as to what impact that may

1 have in having any impact on home health care itself, with  
2 the post-acute folks starting to roll into this, and then in  
3 which case it doesn't become this stand-alone system of home  
4 health but it's about the outcome that is there. So I  
5 wonder whether we've done anything.

6           And then my final comment is picking up on the  
7 fraud aspect that had some blended conversation here. Or,  
8 actually, I have one on copay. On fraud, I think the last  
9 time we discussed this, the role of the beneficiary was also  
10 discussed as whether or not they could be the whistleblower,  
11 and CMS has this program called the Senior Medicare Patrol,  
12 but I heard that it was not very successful in the course of  
13 its implementation. But I think that was just another  
14 effort to have a watchdog approach to it as compared to --  
15 or in addition to the copay side.

16           The copay side that I would bring up, I think I  
17 veer personally on the side of what Bob said, some kind of  
18 tiny aspect of being at least aware that perhaps a billing  
19 has occurred that you don't even know about, because this is  
20 not unusual, that people don't show up and a billing occurs,  
21 so how to catch that, that's one. And maybe if the Medicare  
22 Senior Patrol was more effective, that would be great. But

1 I do know, having talked to my AARP colleagues recently,  
2 they are still very strong about the idea of no copay. So  
3 that's one thing I just wanted, to represent them.

4 And the last thing about the -- sorry -- the last  
5 thing is about the supplemental programs right now, because  
6 I saw that it's trying to prevent the supplemental programs  
7 from covering this, and I just wonder how hard that would be  
8 to kind of change the supplemental programs in terms of the  
9 way they're designed. So that was more of a reality  
10 implementation question.

11 MR. HACKBARTH: On that last point, Jennie, the  
12 approach that Congress elected to take in the Affordable  
13 Care Act was to down the road -- I think it's 2015, if I  
14 remember correctly -- that the standard benefit packages  
15 would be changed so that the most popular ones, whichever  
16 letters they are -- I can never remember -- would no longer  
17 have complete coverage. There would be some copays. So  
18 that would be the mechanism.

19 MS. BEHROOZI: Can you turn it to the next slide,  
20 to Slide 11? Yes. Just so much of the conversation about  
21 what is the benefit and what are we paying for and all of  
22 that feels familiar from the time that I've been hearing

1 this, Bill Scanlon and this conversation. But it certainly  
2 does look like one of the things that drives us crazy every  
3 time we're doing the updates and looking at the margin  
4 spread, it looks like this case mix adjustor would bring  
5 those very low and very high margins closer to a middle that  
6 hopefully would also not be so skewed toward the high ends.  
7 That's a good thing.

8           And then just on the subject of what's a good  
9 provider, it does -- I like that last bar on the bottom.  
10 The providers that deliver more services in non-therapy  
11 episodes would get paid more and providers that don't  
12 deliver more services in non-therapy episodes, as George  
13 said, it makes very clear that they're going after the  
14 therapy for the payment, not to serve the patient. So this  
15 just seems like moving toward a more patient-centric way of  
16 paying. So I think that's all great.

17           On the copayments, I think I've made clear over  
18 the years how I feel about copayments applied broadly and  
19 generally. But, on the other hand, I do think that having  
20 people bear costs when they are accessing low-value services  
21 is not a bad thing, and that's a way to use copayments,  
22 right. And it seems like what I was reading in the mailing

1 materials, exactly not targeting copayments toward averting  
2 fraud, but there's sort of like this underlying sense of  
3 targeting copayments toward driving better value purchasing  
4 in home care services so that it's almost like there's a --  
5 you're kind of making a connection that some people have  
6 question.

7           Karen and Cori, I think, have raised the question  
8 about whether all episodes that don't follow a  
9 hospitalization are, in fact, low value. Maybe there are  
10 some that are high value, and Ron also talked about that.  
11 And so maybe we need to get a little beneath the absolute  
12 line of whether it's just post-hospitalization or not. But  
13 it does seem like that's what you're kind of trying to get  
14 at when you're looking at the episodes that don't follow  
15 hospitalizations. Those might be the lower-value ones  
16 because, guess what, it turns out that they're higher  
17 profit, right. So maybe less services are needed or  
18 whatever.

19           So I think it's a good idea to keep pursuing this  
20 idea of what's high value and low value and use copayments  
21 to drive people to higher value services, and that might be  
22 also provider-specific. It might be that there are

1 providers who get to fall into a Centers of Excellence kind  
2 of category or whatever where people wouldn't have to make  
3 copayments or would have to make dramatically lower  
4 copayments rather than for providers who don't seem to be  
5 providing high-value services consistently, and that's  
6 obviously -- and I'm not just talking about the fraud  
7 outliers, but some way of measuring that. I don't know what  
8 that is, because this is a very provider-driven thing. As  
9 much as there is some beneficiary choice to it, it's much  
10 more provider-driven than a lot of other things are. So I  
11 think that we need to look a little bit more at what  
12 distinguishes low-value services.

13           And then one thing about how to calculate the  
14 copayment in the paper you talked about, a percentage of  
15 what Medicare pays for the service, but that's looking at it  
16 from a program-centric point of view. From the beneficiary-  
17 centric point of view, and this is also channeling John  
18 Bertko, he will tell you that small copays drive -- or small  
19 changes in copays drive behavior. So you really don't need  
20 to do ten percent of a \$3,000 episode payment or five  
21 percent of it. You could probably do \$25 and that would  
22 make people -- or I don't know what the number is, but that



1 would make people think about, I don't need that low-value  
2 service. I'm going to go for the high-value service that  
3 would have the lower copay associated with it. So I think  
4 that's it.

5 DR. DEAN: I think most of what I have to say has  
6 already been said. I guess I'm generally sympathetic to the  
7 idea of copay, but at the same time have all the concerns  
8 that have been raised about what behavior it actually  
9 precipitates. I mean, it will be a greater burden on some  
10 people than on others and there are some people that could  
11 perfectly well afford it that will say -- and who also need  
12 it who will reject it because they don't want to pay  
13 anything. I'm thinking of my parents, who did that. We did  
14 our best to talk them into it, and no, it wasn't worth that.

15 Anyway, it seems to me, though, that the more  
16 important thing is what Scott said, that to the extent that  
17 this is a very poorly defined service, like Glenn said, and  
18 if it's going to be used appropriately and efficiently and  
19 carefully, it's got to be part of a broader plan of care,  
20 and that plan of care needs to be initiated by the  
21 caregivers overall and not by some independent service that,  
22 to use a phrase, is running around in the wild, because

1 otherwise you will get clearly inappropriate utilization.

2           Just to finish, I've been concerned about access  
3 to this service in isolated areas and it would seem to me  
4 that the prospective payment really militates or  
5 incentivizes against the use of the service in isolated  
6 areas because it really does add substantial costs. If  
7 people have 30, 40 minutes' driving time each direction to a  
8 beneficiary, programs will not do that, and we have seen  
9 that in our area. They have drawn in. They have cut their  
10 distance that they're willing to travel. So that's a  
11 concern. And hopefully, as we look more and more at that,  
12 we could kind of hope to moderate the effect of those  
13 incentives.

14           Finally, you know, to respond to Jennie's comment,  
15 I was really interested in this Senior Medicare Patrol and I  
16 believe that we're seeing -- I've seen some -- just  
17 recently, there's a new initiative on the part of CMS, which  
18 I think comes out of the Reform Act, that there is a "Stop  
19 Medicare Fraud" website that has a bunch of really useful  
20 information on it, and I've even seen some TV commercials on  
21 that thing. So I think even though it hasn't been  
22 particularly, or apparently hasn't been very effective in

1 the past, I think it's trying to be reenergized and I really  
2 support that idea.

3 MR. HACKBARTH: Two thoughts, one about copays and  
4 one about revised case mix system. One of the benefits of  
5 continuing our discussion about copays in the context of a  
6 broader restructuring of the benefit package is that that  
7 also brings some other issues into play. For example, you  
8 can say, well, we're going to introduce a copay on home  
9 health and restructure some other services in order to help  
10 finance catastrophic coverage or something that's missing  
11 from the system now. These issues are complicated. There  
12 are pros and cons on copays, whether it's for a home health  
13 or physician services or anything else. But we don't live  
14 in a perfect world with unlimited resources and I think we  
15 need to think -- the Medicare program, for sure, needs to  
16 think about how we get the most benefit for our  
17 beneficiaries with a finite and probably ever more  
18 constrained set of resources, and I think that needs to be  
19 part of the copay conversation, as well, and that's best  
20 handled not looking at home health as an isolated service,  
21 but looking at the overall benefit package. So that's one  
22 thought on that.

1           And then on the case mix system, like Mitra, I was  
2 struck by these numbers and how many of the issues this  
3 seems to, if not fully address, at least partially address  
4 that we have touched on year after year after year when we  
5 look at the tables in doing the update analysis. And so I  
6 was struck that, hey, this -- and, of course, it deals with  
7 the therapy issue, which has been a chronic problem. So I  
8 was really struck by Evan's work and thought maybe we're  
9 onto something quite important here.

10           I guess my question for you, Evan, would be what's  
11 the downside of this? Is there a downside that we need to  
12 start talking about? There's always the obvious one, that  
13 it will redistribute resources. There will be winners and  
14 losers. The losers won't like it, and so on. But are there  
15 other more technical issues that we ought to be worrying  
16 about in the next couple months?

17           MR. CHRISTMAN: I guess the key one is just that,  
18 right now, the system pays better for high therapy episodes  
19 than it will under this revised system. Those high therapy  
20 episodes, there's a payment group for episodes that have 20  
21 or more therapy visits. So you can imagine that it's going  
22 to pay better for the higher groups than this system and

1 that's kind of the compromise. But I think that that's  
2 always been a relatively small number of patients and I  
3 think the, overall, the non-therapy services are the more  
4 commonly provided ones. So to me, focusing on that -- if  
5 you have to make a choice, focusing on that basket of  
6 services is trying to sharpen your accuracy is kind of what  
7 you do.

8 MR. HACKBARTH: Is CMS aware of this work? Do we  
9 have any initial reaction from CMS about this?

10 DR. MARK MILLER: CMS is aware of it, but they  
11 haven't been aware of it for a real long time. We've only  
12 recently brought them up to speed on it.

13 We did something very similar to this in the  
14 skilled nursing facility situation where we had the same  
15 kind of thing, where we saw this very disparate performance  
16 and then we sort of dug in and it was the same researchers  
17 at Urban who helped us do that, and figured out a way,  
18 again, to set things on more of a prospective basis.

19 CMS has shown some interest in that. I wouldn't  
20 say wild enthusiasm. And I think a lot of it is kind of  
21 workload and a lot of things going on. But they haven't  
22 been resistant to it. They're aware of this and their point

1 was, yes, we want to understand better what you're saying,  
2 is sort of where they are in their -- I think that's a fair  
3 statement of where they are. So they haven't said no or  
4 yes. They want to understand deeper.

5 I was hoping that, or thinking that maybe your  
6 line of questioning was if we didn't see major problems, and  
7 in some ways, I hope for those of you who have been around  
8 the block a couple of times with us, what you see, and  
9 actually some of this is complaints from the industry, as  
10 well, and the Hill, as well, where something is not right,  
11 and we spent a year and a half kind of messing around with  
12 trying to find what isn't right and we feel like we've found  
13 something here. Nothing comes perfect and nothing comes  
14 without screaming. There's a lot of redistribution here.  
15 But if we're going to take the copayment thought and put  
16 that on a longer-term track, I was wondering where you were  
17 going is could we put this one on a shorter track and begin  
18 to even consider it in the context of our update  
19 recommendations. Let's bring people on a little more parity  
20 as we think about the updates. I hope that was -- I hope I  
21 wasn't too out of line. I hope that was where you're going.

22 MR. HACKBARTH: In fact, that's what I meant to

1 imply earlier when I said, now that we're embarking on a  
2 path towards putting pressure, well-needed pressure, on the  
3 payment rate, that means that there's an added premium on  
4 trying to get the distribution of a shrinking pool of  
5 dollars more accurately distributed. So I think of this as  
6 high priority, fast track sort of stuff, and if we could  
7 fold it into our March recommendation, a redistributive  
8 recommendation along with the update, that would be good.  
9 Do people agree with that?

10 [Agreement by Commission members.]

11 MR. HACKBARTH: Mike?

12 DR. CHERNEW: I just wanted to make one last copay  
13 comment in agreement with what you said earlier about  
14 thinking about this more comprehensively. Copays are never  
15 going to be easy, and there's always going to be drawbacks,  
16 but we have copays for -- if you have a heart attack, you  
17 pay a huge copay for going to the hospital and it's unclear  
18 that you would ever want the person not to go to the  
19 hospital. If you need to take a statin to prevent you from  
20 having a subsequent heart attack, you have a deductible,  
21 then a coinsurance rate, then a copay, you know, and all  
22 kinds of things. So there's things that we already do just

1 as a matter of looking comprehensively at the benefit  
2 package.

3 I think it's hard to argue, if you were starting  
4 from scratch and figuring out, how are we going to set  
5 copays, you would say, oh, you should pay for the  
6 deductible. If you have cancer, your out-of-pocket is going  
7 to be some huge amount of money. But if you need an extra  
8 home care visit, that's free. Not that I don't think that  
9 home care visits aren't important; I think, in general, they  
10 are. But I think in a comprehensive way, it's hard to argue  
11 that you have the system we have.

12 MR. HACKBARTH: Any other comments, concluding  
13 comments?

14 [No response.]

15 MR. HACKBARTH: Okay. Thank you, Evan. Good job.  
16 And now we'll have a public comment period.

17 [Pause.]

18 MR. HACKBARTH: Seeing none, we are adjourned  
19 until 8:00 a.m. again tomorrow.

20 [Whereupon, at 4:05 p.m., the meeting was  
21 recessed, to reconvene at 8:00 a.m. on Friday, November 5,  
22 2010.]



## 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 5, 2010  
8:01 a.m.

## COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, JD, Chair  
ROBERT BERENSON, MD, FACP, Vice Chair  
SCOTT ARMSTRONG, MBA  
KATHERINE BAICKER, PhD  
MITRA BEHROOZI, JD  
KAREN R. BORMAN, MD  
RONALD D. CASTELLANOS, MD  
MICHAEL CHERNEW, PhD  
THOMAS M. DEAN, MD  
JENNIE CHIN HANSEN, RN, MSN, FAAN  
NANCY M. KANE, DBA  
GEORGE N. MILLER, JR., MHSA  
BRUCE STUART, PhD  
CORI UCCELLO, FSA, MAAA, MPP

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2 MR. HACKBARTH: Good morning. So first this  
3 morning is a status report on Part D which Shinobu is going  
4 to present. And then we have our panel discussion on  
5 Medicare's role in motivating and supporting quality  
6 improvement.

7 Shinobu?

8 MS. SUZUKI: Good morning. Before I start, I  
9 wanted to quickly thank my colleagues Kelly Miller, Rachel  
10 Schmidt, and Joan Sokolovsky for their contribution.

11 In this presentation, I'll be providing you with  
12 information on Part D enrollment, spending, and utilization  
13 trends, and plan offerings for 2011, as well as some of the  
14 changes made to Part D by the health reform.

15 This chart shows the different sources of drug  
16 coverage for Medicare beneficiaries. According to CMS, in  
17 2010 about 90 percent of Medicare beneficiaries had Part D  
18 or another source of drug coverage that's at least as  
19 generous as Part D, which are called credible coverage,  
20 shown here in orange, that includes employer-sponsored plans  
21 that receive Medicare's retiree drug subsidy.

22 At the start of the year, 59 percent of Medicare

1 beneficiaries were enrolled in Part D. The 59 percent with  
2 Part D coverage consists of 38 percent in stand-alone  
3 prescription drug plans that provide a drug-only benefit --  
4 those are the blue pieces -- and 21 percent in Medicare  
5 Advantage prescription drug plans -- the green pieces --  
6 where enrollees get both medical and drug benefits through a  
7 single private plan.

8           Focusing just on the blue pieces, which are the  
9 PDP enrollees, there are over 17 million beneficiaries  
10 enrolled in PDPs and nearly half receive Part D's low-income  
11 subsidy, which provides extra help with the premiums and  
12 cost sharing for people with low income and low assets. LIS  
13 enrollees tend to be sicker and tend to use more drugs,  
14 which you'll see in just a few minutes.

15           In contrast, the green pieces show that about 10  
16 million beneficiaries are enrolled in MA-PD plans, with  
17 about one in five receiving the low-income subsidy, which is  
18 a much smaller share compared to PDP enrollees.

19           There hasn't been a dramatic shift in  
20 beneficiaries' choice of plans from year to year, but I  
21 wanted to highlight some of the differences between PDPs and  
22 MA-PD enrollees. On the left, you can see that 78 percent

1 of PDP enrollees are in basic benefit plans. These are  
2 plans that have the same benefit value as the defined  
3 standard benefit. MA-PD enrollees, on the other hand, are  
4 predominantly in plans that offer enhanced benefits which  
5 have higher average benefit value than the defined standard  
6 benefit. Typically, plans enhance their benefits by  
7 lowering the deductible. Currently, about half of PDP  
8 enrollees pay reduced or no deductible, or almost MA-PD  
9 enrollees pay reduced or no deductible, and a much larger  
10 share of MA-PD enrollees are in plans that offer coverage in  
11 the gap.

12 All of this is consistent with the patterns we've  
13 seen the last few years. This pattern reflects the fact  
14 that many sponsors of MA-PD plans are using some of the  
15 Medicare Advantage rebate dollars to lower Part D premiums  
16 or enhance the drug benefits, for example, by eliminating  
17 the deductible or by providing coverage in the gap.

18 Here's some information about drug use for  
19 beneficiaries enrolled in Part D. In 2008, 92 percent of  
20 enrollees filled at least one prescription during the year,  
21 and on average, they used 4.1 prescriptions at about \$220  
22 per month. But the utilization varied across plans and by

1 LIS status. For example, average spending for LIS enrollees  
2 was about double that of non-LIS enrollees, and some of it's  
3 due to differences in medication needs since LIS enrollees  
4 tend to be sicker. It also is due to differences in mix of  
5 brand versus generics. The generic drug dispensing rate  
6 tends to be lower for LIS enrollees compared to non-LIS  
7 enrollees, and some of this reflects the fact that they face  
8 weaker financial incentives to switch to generics.

9 In 2008, 31 percent of enrollees had spending high  
10 enough to reach the coverage gaps where most non-LIS  
11 enrollees pay 100 percent of the cost of the drugs. For LIS  
12 enrollees, the cost-sharing subsidy effectively eliminates  
13 the coverage gap. Nine percent reached the catastrophic  
14 coverage phase of the benefit, and most of them received the  
15 low-income subsidy.

16 Now I'm going to talk about plan offerings for  
17 2011. The open enrollment starts on November 15th, and in  
18 the past, a relatively small share of enrollees switched  
19 plans in any given year. But the large reduction in the  
20 number of plan offerings for 2011 will likely result in more  
21 beneficiaries switching plans this year.

22 In 2011, there will be 11,009 PDPs compared to

1 over 1,500 in 2010. There will also be fewer MA-PD plans,  
2 1,566 compared to over 1,800 in 2010. In any given year,  
3 there could be different plan strategies that could result  
4 in the reduction in a number of plans. Some of the  
5 reduction in PDP offerings this year issued to CMS  
6 regulations intended to more clearly differentiate between  
7 basic and enhanced benefit plans. And some are a result of  
8 past CMS regulations that required plan sponsors to reduce  
9 the number of plans within three to four years of plan  
10 mergers and acquisitions.

11 On the MA-PD side is the continuation of the CMS'  
12 effort to reduce plans with low enrollment. Private fee-  
13 for-service plans will be required to establish a network of  
14 providers beginning in 2011, and that has contributed to the  
15 drop in the number of private fee-for-service plans. Even  
16 with the reduction, beneficiaries will still have a choice  
17 of 28 to 38 PDPs in any given region, along with many MA-PD  
18 plans. The share of PDPs offering plans with no deductible  
19 remains stable at around 40 percent, and a large share of  
20 MA-PDs will continue to offer plans with no deductible.

21 One change that I wanted to call your attention to  
22 is the increase in the share of PDPs offering coverage in

1 the gap, 33 percent compared to 20 percent for 2010, which  
2 reverses the trend we've seen in the last few years. About  
3 half of MA-PD plans will offer some coverage in the gap,  
4 which is about the same as in 2010, and over 40 percent of  
5 MA-PDs that provide gap coverage will cover both brands and  
6 generics during the gap phase compared to about 30 percent  
7 for PDPs.

8           You may recall this chart from -- or actually the  
9 slide from Rachel's presentation in September that Part D's  
10 coverage gap will be phased out gradually between 2011 and  
11 2020 as a result of changes made by PPACA. And I'm not  
12 going to go over everything in this slide, but I'll focus on  
13 two changes that are going to be in effect in 2011.

14           First, there will be a coverage gap discount  
15 program beginning in 2011 that's going to be provided by  
16 pharmaceutical manufacturers. It will cover 50 percent of  
17 the cost of the drugs in the coverage gap for non-LIS  
18 enrollees. The discount amount will count towards the out-  
19 of-pocket threshold, which will likely have the effect of  
20 increasing the number of enrollees who reach the  
21 catastrophic phase.

22           Second, cost sharing for generic drugs will be



1 lowered to 93 percent in 2011.

2           We've been focused on LIS churning for the past  
3 few years, so I'm going to update you on plan turnovers for  
4 2011 and what that means for LIS enrollees. To give you a  
5 quick background, each year Medicare sets regional  
6 benchmarks for maximum premium subsidy amounts for each  
7 region based on plan bids. So there's some turnover from  
8 year to year in the plans that are premium-free to LIS  
9 enrollees. If an LIS enrollee is in a plan with a premium  
10 higher than the threshold and they haven't picked a plan  
11 themselves, then CMS reassigns them to a lower-premium plan.

12           I mentioned earlier that there will be fewer plans  
13 overall in 2011, but the number of PDPs that are premium-  
14 free to LIS enrollees will be 332 compared to 307 this year.

15           About 2.1 million LIS enrollees are in plans that  
16 will not be premium-free in 2011. That's actually fewer  
17 than over 3 million that was affected last year. So a  
18 couple of things could happen to these 2.1 million  
19 enrollees. If you're one of them and are in a plan assigned  
20 by CMS, you'll be reassigned to a different plan. CMS is  
21 expecting that will be about 600,000 beneficiaries.

22           Some LIS enrollees will be reassigned to plans

1 offered by the same sponsors. This is generally less  
2 disruptive because they often use the same formulary. If  
3 you're one of the 2.1 million and you're a chooser, which  
4 means that you picked your own plan at some point, CMS will  
5 not reassign you and you will have to either choose another  
6 plan to avoid paying a premium out of pocket or remain in  
7 the plan and pay the premium.

8 Now, this chart shows the year-to-year changes in  
9 average bids from plan sponsors. It reflects the expected  
10 cost of providing the basic benefit for a beneficiary with  
11 an average health. I want to call your attention to two red  
12 boxes on the right. The one at the top shows that the  
13 overall increase in average bids was 1 percent for 2011.  
14 That's the lowest growth we've seen since 2007.

15 But if you look at the lower box, you'll see that  
16 the individual reinsurance component is increasing at a much  
17 higher rate of 8 percent. So the lower growth overall was  
18 driven by the other components of the bid. The base  
19 beneficiary premium remained about the same at \$32, and  
20 Medicare's direct subsidy or monthly payments to plans  
21 actually saw a slight decrease.

22 In 2009, there was a big jump in the reinsurance

1 component of the bid. The reinsurance component reflects  
2 what plans were expecting in the catastrophic phase for  
3 their higher-cost enrollees. Drugs that treat certain  
4 conditions like rheumatoid arthritis and multiple sclerosis  
5 can be very high cost, and beneficiaries who use those  
6 therapies tend to move quickly through the coverage gap and  
7 into the catastrophic phase of the benefit, where Medicare  
8 pays most of the cost through the reinsurance.

9           We need to keep our eye on this reinsurance  
10 component of the bid because for many of those high-cost  
11 drugs, plans are unable to negotiate rebates with  
12 manufacturers, and that has significant cost implications  
13 for Part D.

14           So you just saw that, based on bids, the base  
15 beneficiary premium will be \$32 in 2011. That's not going  
16 to be the average of the premiums beneficiaries will pay in  
17 2011. Because of the reductions in plan offerings we just  
18 talked about, there is a greater uncertainty surrounding  
19 beneficiaries' choice of plans, and we won't know what the  
20 average premium will be until we have the actual enrollment.

21           Beginning in 2011, higher-income beneficiaries  
22 will pay a surcharge calculated based on their income. This

1 income-related premium for Part D is set up just like the  
2 income-related premium for Part B, using the same income  
3 threshold and same subsidy schedule.

4           So most LIS enrollees don't pay a premium because  
5 the subsidy pays for the entire amount of the plan premium  
6 up to the regional threshold. But when an LIS enrollee  
7 chooses a plan that's different from the one they're  
8 assigned to and that plan's premium is above the regional  
9 benchmark, enrollees are responsible for paying the  
10 difference between the plan premium and the regional  
11 benchmark.

12           In 2010, about 1.7 million LIS choosers are in  
13 PDPs that require them to pay plan premiums out of pocket.  
14 Of the 1.7 million, about 600,000 pay premiums of more than  
15 \$10 per month, and some are paying premiums as high as \$80  
16 per month. This raises some questions and concerns. Are  
17 these conscious decisions by the enrollees? For example, do  
18 they know that they could choose a plan that is premium-  
19 free? And given their limited income, can they afford the  
20 monthly premiums, especially those who are paying more than  
21 \$10 per month?

22           So we looked at the average plan bid in an earlier

1 slide which reflects plans' expectations about what it would  
2 cost to provide basic coverage for a beneficiary with  
3 average health. The actual payment of plans, however, is  
4 risk-adjusted to reflect the actual health status of  
5 enrollees in each plan. Here the chart shows what Medicare  
6 paid to plans in aggregate, in reinsurance and direct  
7 subsidy, which are the red and green pieces; in addition to  
8 cost-sharing and premium subsidy for LIS enrollees, which  
9 are in yellow; and at the bottom in blue are the subsidy  
10 payments to employers who offer retiree drug coverage.

11 Incurred benefits have grown from about 43 billion  
12 in 2006 to 53 billion in 2009, and CMS expects spending to  
13 total 56 billion in 2010. That's an overall average annual  
14 growth rate of about 7 percent.

15 There are a couple things about this law that I'd  
16 like to call your attention to.

17 First, the LIS has grown to become the single  
18 largest piece of Part D spending in 2008, and it continues  
19 to be so.

20 Second, reinsurance has been the fastest-growing  
21 component of Part D spending with an annual average growth  
22 rate of 17 percent. Reinsurance covers most of the

1 catastrophic costs for beneficiaries who have very high drug  
2 spending, and this reinforces what we're seeing in plan  
3 bids. That spending for high-cost drugs and biologics are  
4 driving the growth in Part D spending.

5 LIS enrollees take a disproportionate share of the  
6 more expensive drugs and accounts for a larger spending  
7 above the catastrophic limit, most of which is picked up by  
8 Medicare's individual reinsurance.

9 We can talk about Part D's performance measures.  
10 Every year, CMS collects data from a variety of sources to  
11 measure the performance of Part D plans. CMS uses this  
12 information to rank plans, and beneficiaries can use this  
13 information to compare plan options.

14 There are currently 19 measures that are included  
15 in plan ratings. Most relate to customer service and member  
16 satisfaction. Two measures relate to patient safety. One  
17 measures members' use of medication with high risk of side  
18 effects when there may be safer alternatives. The second  
19 assesses whether members with diabetes with high blood  
20 pressure are getting appropriate blood pressure medications.

21 In 2008, the Commission convened an expert panel  
22 on Part D performance ratings that highlighted the

1 importance of developing performance metrics that measure  
2 cost, access, quality, and customer service. Although the  
3 measures now include some quality measures, additional  
4 measures of patient safety and appropriate medication use  
5 could help beneficiaries choose higher-quality plans.

6           So, to summarize some of the main points, there  
7 will be fewer plan offerings in 2011. More PDPs qualify as  
8 premium-free to LIS enrollees. Spending for LIS and  
9 reinsurance continues to be a concern. And we also find  
10 that some LIS enrollees are in plans that require them to  
11 pay premiums out of pocket. And, finally, current plan  
12 performance measures focus more on customer service and  
13 member satisfaction and less on measures more oriented  
14 towards clinical competence, such as patient safety and  
15 appropriate use.

16           That concludes my presentation.

17           MR. HACKBARTH: Thank you, Shinobu.

18           Let's begin with round one questions, clarifying  
19 questions. Tom, we'll begin on your side. Any over here?

20           MR. GEORGE MILLER: Thank you, and this was very  
21 informative. On slide 4, please, you mentioned while you  
22 were talking about this slide the incentives to switch to

1 generics. What are the current incentives and what are the  
2 issues, if you know, why some folks may not switch to  
3 generics?

4 MS. SUZUKI: LIS enrollees, I mentioned that they  
5 get extra help with cost sharing, and for some of them it  
6 means that they don't pay anything in cost sharing. Some  
7 pay nominal cost sharing. They would pay, I would say,  
8 about \$2 for generics and preferred brands and maybe \$5 to  
9 \$6 for non-preferred brands; whereas non-LIS enrollees would  
10 pay something like \$5 to \$7 for generics, higher amounts  
11 probably on the order of \$20, \$25 for brands, and for non-  
12 preferred brands usually even higher.

13 MR. GEORGE MILLER: But you mentioned the  
14 incentives. Are those the only incentives? Or are there  
15 incentives to try to get them to use generics other than the  
16 price? Or is that the only incentive?

17 MS. SUZUKI: That's the primary incentive.

18 MR. GEORGE MILLER: It's not education or --

19 MS. SUZUKI: Not specifically, you know, the Part  
20 D plans would do -- I mean the incentives they try to build  
21 into the benefit package.

22 MR. GEORGE MILLER: Okay. Thank you.



1 MS. UCCELLO: I know I should know this, but I  
2 can't remember. The thresholds for the catastrophic, they  
3 increase by what?

4 MS. SUZUKI: They increase by the growth in  
5 aggregate annual spending --

6 MS. UCCELLO: In drugs?

7 MS. SUZUKI: Right, for all Part D spending.

8 MS. UCCELLO: Okay. So the reinsurance is not  
9 then -- the growth in that is not an artifact, even in  
10 part, of a leveraging effect?

11 DR. MARK MILLER: It's indexed to something  
12 different than the growth. The fact that the reinsurance is  
13 growing as a larger proportion when the reinsurance is tied  
14 to the total growth, she's trying to explore why that  
15 proportion might be shifting. Is that your question?

16 MS. UCCELLO: Yeah, and I think that's not the  
17 case. It is from these other things.

18 [Comment off microphone.]

19 MS. SUZUKI: Right. I think that's right.

20 MS. UCCELLO: And your data don't --

21 DR. MARK MILLER: Just maybe to -- we don't see --  
22 and you need to watch this here, okay? We don't necessarily

1 see a mechanical or design reason this is going, and that's  
2 why I think we're sort of focusing on this.

3 MS. UCCELLO: Right, and I'm just confirming that  
4 that's the case.

5 You don't include the risk corridor payments in  
6 this?

7 MS. SUZUKI: The plan level reinsurance you're  
8 talking about.

9 MS. UCCELLO: Yes. No, plan -- yes, yes.

10 DR. MARK MILLER: [Off microphone.]

11 MR. HACKBARTH: [Off microphone.]

12 MS. UCCELLO: I don't think it is because I think  
13 you even said here that it's not. And I guess I was just  
14 wondering if not now, at some point --

15 MS. SUZUKI: I'll get back to you. I believe it  
16 does not -- I mean, I don't think we're showing the risk  
17 corridor amounts. I'm trying to remember if this would be  
18 reconciled post-reconciliation or pre-reconciliation. I can  
19 double-check on that.

20 MS. UCCELLO: Yes, I think this was post-  
21 reconciliation on the individual reinsurance stuff.

22 DR. MARK MILLER: And, again, we'll double-check

1 that, but that's what I take from our discussions and the  
2 read of the paper, Shinobu.

3 MS. UCCELLO: And I guess I'm just curious on the  
4 level of the risk corridor payments and how they may have  
5 changed over time. It's just something I'm interested in.

6 MS. SUZUKI: We had some information for 2006-  
7 2007. In 2006, I believe there was a net payment back to  
8 CMS of about \$4 billion, so plans were getting paid a lot  
9 more than they actually expected to spend. In 2007, the  
10 amounts were much smaller. I'm thinking it was a few  
11 millions of dollars. In 2008, I don't think the data has  
12 been released.

13 MS. UCCELLO: Thanks.

14 MS. HANSEN: Slide 12, please. Relative to the  
15 measures on patient safety that are different from the  
16 customer service and satisfaction, is that something new  
17 that all the plans are going to have to collect relative to  
18 every enrollee's or every beneficiary's use of their plan?

19 MS. SUZUKI: These two measures are already in the  
20 Plan Finder, and plans report these measures already. CMS  
21 is currently reviewing other measures and actually collects  
22 some additional information that hasn't been released to the

1 public.

2 MS. HANSEN: And do know how these measures of  
3 safety are currently being used?

4 MS. SUZUKI: Currently it contributes to the  
5 overall rating, so they create these five-star ratings for  
6 each plan, and beneficiaries can see this on Plan Finder.  
7 These are components of the five-star rating that aggregates  
8 across the 19 measures, and I was saying that most of them  
9 relate to customer service, satisfaction. But two do  
10 measure the clinical side of things. But that all gets  
11 aggregated into the five-star system, so --

12 MS. HANSEN: This might be related, but do the  
13 beneficiaries use the plan -- the rating system, do we know?

14 MS. SUZUKI: I don't know.

15 DR. SCHMIDT: [Off microphone.]

16 MR. HACKBARTH: Either come to the microphone, or  
17 somebody needs to repeat what Rachel said.

18 DR. SCHMIDT: It's not entirely clear. We don't  
19 have our data on it. But the fact that there hasn't been a  
20 lot of switching of plans from year to year suggests that,  
21 you know, in the aggregate maybe not. But this coming year,  
22 as Shinobu said, there's a reduction in the number of plans.

1 We're expecting more people to switch plans, so this year  
2 could be a little bit different.

3           Could I also say on the patient safety issue,  
4 those measures are available to plans by CMS on a separate  
5 website. It's actually calculated from the claims data. So  
6 the plans are getting feedback on their patient safety, in  
7 not quite real time but pretty close.

8           DR. BERENSON: Just a brief follow-up on the  
9 question of the 10 percent who don't have any coverage,  
10 either Part D or credible coverage. In the paper you say  
11 they tend to be healthier. At least research suggests  
12 they're healthier and don't have a lot of drug use. That 10  
13 percent, has that been a stable number over the years? Is  
14 it growing? Decreasing?

15           MS. SUZUKI: It has been about the same since  
16 2006.

17           DR. BERENSON: So we don't think there's a major  
18 problem for those who are not signing up, they basically  
19 don't need the benefit? Is that overstated? If that is  
20 overstated, I won't ask you -- but, I mean, are there any  
21 issues that you're aware of with that 10 percent where there  
22 are problems?

1 MS. SUZUKI: I think I've heard that, you know,  
2 some of them could be eligible for low-income subsidy, but I  
3 don't think there is a real accurate estimate on how many of  
4 them are not getting drug coverage because they are lower  
5 income versus, you know, they could purchase a coverage but  
6 are choosing not to. I don't think we know too much about  
7 this 10 percent in general.

8 MR. HACKBARTH: Shinobu, remind us what the  
9 penalty is for late enrollment.

10 MS. SUZUKI: For people who do not get low-income  
11 subsidy, I believe it's 1 percent for each month that they  
12 delay enrolling in Part D, and that gets added to their  
13 premium when they do enroll in Part D.

14 MR. HACKBARTH: In perpetuity.

15 MS. SUZUKI: Yes.

16 DR. STUART: I can just add a little tiny bit to  
17 that. It has remained constant around 10 percent, but there  
18 actually is a dynamic involved in there because there are  
19 people that drop out of the program. And it's small, but  
20 every year there are people that stop paying their premiums  
21 and so, therefore, drop coverage. So the 10 percent is  
22 stable, but it probably involves slightly different groups

1 of people.

2 MR. HACKBARTH: Does that suggest, Bruce, that  
3 some people are opting to pay the penalty and leaving the  
4 10-percent group to go into the covered group?

5 DR. STUART: We haven't followed people who  
6 disenrolled and see whether they re-enrolled, so we don't  
7 know whether they were -- you know, whether this was  
8 voluntary on their part, whether there was a mistake. But  
9 you could follow them, you know, in the claims data -- I  
10 mean, in the enrollment data.

11 MR. HACKBARTH: Okay. Round one clarifying  
12 questions?

13 DR. KANE: Yes. I'm just wondering, how long does  
14 it take to get that drug use data? I see we're looking at  
15 2008, and I'm wondering, what's the timing of when data  
16 comes and why does it take so long? It's now the end of  
17 2010.

18 MS. SUZUKI: I think part of it is CMS has to  
19 reconcile data, actual spending with what they are paying on  
20 a monthly basis in prospective payments. That takes some  
21 time. We are expecting to receive 2009 PD data in the next  
22 month or two. We actually got 2008 last December.

1 DR. KANE: So it's sort of a two-year lag before  
2 we --

3 MS. SUZUKI: Mm-hmm.

4 DR. KANE: And is there any effort to try to speed  
5 that up, or is there always --

6 DR. MARK MILLER: That is about a one-year lag.

7 MS. SUZUKI: Well, one-year lag.

8 DR. STUART: That is good.

9 DR. KANE: Well, 2008 --

10 MS. SUZUKI: Was last December --

11 DR. KANE: Yes, so 2009 now, but we'll be in 2011.

12 DR. BAICKER: No, December of 2010 --

13 DR. KANE: Ten, yes --

14 DR. BAICKER: -- so one year --

15 DR. KANE: Yes, so it's one year lag.

16 DR. STUART: That's pretty good.

17 DR. KANE: But you'll get it. Okay. Got it. So  
18 will we see updated -- but you probably can't process it for  
19 a while.

20 MS. SUZUKI: It usually takes some time.

21 DR. KANE: Yes.

22 DR. STUART: I just have a couple of clarifying



1 questions, one on this slide in terms of the quality  
2 metrics, performance metrics. In the chapter, you had a  
3 couple of bar graphs that showed the number of people who  
4 were in plans according to the star rankings, and it turns  
5 out that whether you're in a PDP or an MA-PD, there's a  
6 minority of beneficiaries are in plans that are scored four  
7 to four-and-a-half, and practically nobody is in five.

8 But one of the important things here, and I don't  
9 know whether you've had a chance to look at it, is not just  
10 the absolute number who are in those plans, but the number  
11 who are in regions that could have been in those plans. In  
12 other words, what is the proportion of people who are in the  
13 high starred plans who could have been in the high starred  
14 plans? So do we have some sense of whether it is individual  
15 behavior or whether it is plan characteristics?

16 MS. SUZUKI: Umm -

17 DR. STUART: The second point I'd like to --

18 MR. HACKBARTH: Do you have a response on that,  
19 Shinobu? Is it possible?

20 MS. SUZUKI: Well, one of the things is those star  
21 rankings are at the plan sponsor level, so it --

22 DR. STUART: At the contract level?

1 MR. HACKBARTH: Yes.

2 DR. STUART: No, that's true, and that's an issue.  
3 But even at that point, it would be interesting to see what  
4 the ratios are.

5 The second point is on Slide 10, and this is  
6 looking at people that have made a decision at some point or  
7 another to pick their own PDP, irrespective of whether it  
8 was premium-free or not. The LIS beneficiaries who come in  
9 on their own that are not dual eligibles and auto enrolled,  
10 the question -- I'm not sure about this, whether they have  
11 to choose and therefore are not protected from this auto  
12 enrollment.

13 And then kind of a follow-up on that is whether  
14 you've looked at distinctions in terms of numbers and  
15 utilization behavior and what not between the LIS duals, who  
16 in a sense are kind of the continuing Medicaid population,  
17 as opposed to those that were brought in at that -- the  
18 distinction between the dual eligible cutoff, which varies  
19 by State, and then the 150 percent.

20 MS. SUZUKI: We haven't looked at it at the  
21 individual level. Part of it is that we were using plan  
22 level enrollment that doesn't distinguish between partial

1 and full subsidy enrollees. I guess if you were going to  
2 SSA to apply for LIS and you have not chosen a plan, you get  
3 facilitated into a plan by CMS. That --

4 DR. STUART: But you're telling me the plan level  
5 data do not distinguish the type of LIS enrollee?

6 MS. SUZUKI: I don't think they do. The one that  
7 I worked with just had total LIS enrollment.

8 DR. STUART: That information is available, as you  
9 know, on the individual level, so if that became an issue,  
10 then it could. And we've done a little bit of work on the  
11 difference between LIS duals and LIS non-duals and it turns  
12 out they're actually quite different, not only in terms of  
13 their underlying characteristics but also in terms of their  
14 utilization behavior.

15 DR. BAICKER: My question is also on this slide,  
16 which raises some very interesting points. The premium that  
17 people are paying isn't a sufficient statistic to tell you  
18 if they've chosen a plan that is the best value for them  
19 because we don't know their out-of-pocket costs. So I  
20 wonder what share of these people -- and this, I think,  
21 would be very hard to answer with plan level data, you'd  
22 have to look at individual level -- but I wonder what share

1 of these people are in plans where they're then paying less  
2 out-of-pocket per prescription, so it's not such a bad  
3 decision to be paying the premium? I know at the individual  
4 level, you can run people's prescriptions through different  
5 plan features and see maybe people have chosen these plans  
6 because they cover their particular drug that another plan  
7 doesn't, and so it's a good call.

8 I also wonder what share of those people who are  
9 paying premiums are in more highly-rated plans. Is there  
10 any correlate of the choice that makes us think they are  
11 choosing for some reasons that we can observe. They are  
12 choosing for some reason, but if it is something that make  
13 sense from a perspective of either total out-of-pocket  
14 spending or quality of the plan or something that makes us  
15 less concerned that they have accidentally found themselves  
16 in a higher premium plan.

17 MS. SUZUKI: And we have not looked into that, but  
18 we could certainly start thinking about how we can do the  
19 analysis.

20 One thing I'd like to point out is that most LIS  
21 enrollees don't pay a lot in cost sharing because they get  
22 the subsidy. So -- I mean, we'll have to look into this.

1 DR. CHERNEW: I want to follow up on George's  
2 question, to some extent, about the generic use, which is  
3 for the low-income subsidy folks that aren't using as many  
4 generics, I wanted to trace through who sort of eats that  
5 extra cost. The plans, because they got randomized to them,  
6 they had bid a low bid amount, and that to some extent caps  
7 the government's payment to the plan. So I first thought  
8 that, well, that just means if the plan isn't controlling  
9 generic use in some way, it's the plan that has to eat that  
10 difference because they bid low, by the definition of the  
11 fact that they were low income.

12 Now, it's possible that that comes out in the risk  
13 adjustment for low-income subsidy people, that somehow we're  
14 paying plans more when they get low-income subsidy in their  
15 risk adjustment. So while you would think that what's going  
16 on is the plans bid low and so they have to eat it if they  
17 don't do a very good job of managing efficient use, because  
18 there's this extra risk adjustment component for low-income  
19 subsidy people, maybe it's flowing through there and the  
20 government is paying that way. And I wasn't sure which it  
21 was.

22 MS. SUZUKI: I don't think that we know the answer

1 to that question, but the payments do get risk adjusted and  
2 they do get higher payments for low-income subsidy enrollees  
3 given the same conditions, which presumably require use of  
4 drugs in the same therapeutic class. If low-income subsidy  
5 people use more brands or more expensive drugs and they get  
6 through the coverage gap and into the reinsurance component,  
7 then government also then picks up the spending.

8 DR. CHERNEW: No, but that's really -- a lot of  
9 this is going to be for chronic care meds that -- if they're  
10 through the coverage gap, then I understand. But a lot of  
11 it, I -- my stereotypical, and I might be wrong, is you're  
12 taking a branded statin, not a generic statin, and I guess  
13 how I care about that depends on whether or not it's the  
14 plan that's paying for the brand or whether it's the -- it's  
15 not the person, because they're low-income subsidy, and I  
16 don't think it's the government because of the way the bid  
17 worked.

18 MS. SUZUKI: The government -- oh, go ahead.

19 MR. HACKBARTH: In the long run --

20 DR. CHERNEW: They would have to change their bid  
21 and no longer be low-income subsidy, right? But as long as  
22 they bid the lowest amount -

1 DR. MARK MILLER: But just first think of it on a  
2 static basis. I mean, one thing I think it would try and  
3 shift the frame, and I feel like this is conversations I've  
4 had with you, is the low-income beneficiary isn't  
5 necessarily taking a statin. I mean, they're often taking  
6 very expensive brand name drugs that are related to much  
7 more complicated chronic conditions. And so I think there's  
8 a few things here. You get the base payment from the  
9 government. You get the cost sharing. If you blow through  
10 the uncovered period, you're into the uninsured. And I  
11 think one of the concerns, and why we're looking at that  
12 growth in the reinsurance portion, is why aren't the plans  
13 seemingly being more vigilant on this front, and I think  
14 some of it, that's what we're --

15 MR. HACKBARTH: So the premise is that generic use  
16 among LIS beneficiaries is lower. Do we know that?

17 MS. SUZUKI: We have looked into this. We --

18 MR. HACKBARTH: Okay. I missed that.

19 DR. MARK MILLER: [Off microphone.]

20 MR. HACKBARTH: All right.

21 MS. SUZUKI: On the generic use side, if LIS  
22 enrollees are taking more brands, and, for example, not in

1 the catastrophic, but maybe in the gap, the coverage gap,  
2 then LIS subsidy picks up 100 percent of the cost sharing.

3 DR. MARK MILLER: Right.

4 MS. SUZUKI: So in that sense, the government pays  
5 for the additional cost.

6 MR. GEORGE MILLER: So Mike is right. I mean --

7 DR. MARK MILLER: [Off microphone.] It is a risk-  
8 adjusted -- they are covering their cost sharing. If it is  
9 an expensive drug and they blow through either the gap or  
10 into the catastrophic, then they're into reinsurance --

11 DR. CHERNEW: [Off microphone.] I didn't -- it  
12 sounded -- when George asked his question, it sounded as if,  
13 well, we have this inefficiency going on in the low-income  
14 subsidy population because they're not taking generics and  
15 they should. But if they're taking an expensive drug for  
16 arthritis that they need to take the arthritis drug, that's  
17 very different than if there's a generic drug that they  
18 could switch to and they're just not and it's an  
19 inefficiency. And I was confused about who is paying for  
20 that inefficiency one way or another, and I think the point  
21 that the government is paying by the subsidizing of the  
22 copay part might be the main reason why it's flowing



1 through.

2 MR. GEORGE MILLER: Well, if we can go back to the  
3 original question, it seems to me a plan should have  
4 incentive to have someone on a generic drug versus a name  
5 brand drug, and what are those incentives? I think Mike  
6 asked the question better than I did, but it is still the  
7 point. I am not sure I got the answering or understanding,  
8 and so maybe that's a better statement. It would seem to me  
9 the plan should be incentivized to have the low-income  
10 subsidy beneficiaries use a generic drug over a name brand  
11 drug, and if they don't, who does pay for it?

12 DR. STUART: It gets a little more complicated  
13 than that because the copay structure is set up such that  
14 the only LIS beneficiaries that do not pay any cost sharing  
15 are those that are in long-term care facilities. Everybody  
16 else faces some differential between the generic and the  
17 preferred brand. My understanding is that LIS does not  
18 cover non-preferred brand, and you may want to comment on  
19 that --

20 MS. SUZUKI: My understanding is that generics and  
21 preferred brands have the same cost sharing because subsidy  
22 picks up whatever amounts that plan requires above two or

1 three-dollar cost sharing requirements for generics and  
2 preferred brands. There is a separate cost sharing for non-  
3 preferred brands. I can double-check and get back to you on  
4 this.

5 DR. STUART: Yes.

6 MR. HACKBARTH: George, do you feel like your  
7 question was -- so let me provide my answer, and correct me  
8 if I'm wrong. So all plans have an incentive to encourage  
9 generic substitution just because of the basic competitive  
10 structure. They're trying to hold down their premiums. And  
11 I think that's true for LIS plans as well as all others  
12 because they're trying to stay below the level where they  
13 can qualify to receive LIS enrollees. So I think there is a  
14 plan level incentive to do that, but the cost sharing  
15 structure differs for the LIS patients, which may make it  
16 more difficult for them to engage the patients. Does that  
17 make sense?

18 MR. GEORGE MILLER: [Off microphone.] Yes.

19 MR. HACKBARTH: Round one clarifying questions?  
20 Okay.

21 MS. UCCELLO: The reinsurance is 80/20, right? It  
22 is not 100 percent.

1 MS. SUZUKI: Yes.

2 MS. UCCELLO: So the plan is still on the hook for  
3 some post the catastrophic threshold.

4 MR. GEORGE MILLER: Is that right?

5 DR. MARK MILLER: But I think what we -- part of  
6 the reason that we're raising this, and back to Mike and  
7 George's question, is you could have a couple of things, and  
8 I think we really want to understand this. I mean, implicit  
9 in all these questions is we're seeing something we're not  
10 quite sure we're understanding. It can be that because of  
11 the cost sharing structure and the fact that the government  
12 stands behind it and all of that, maybe you're not getting  
13 the shift to the generics, in addition to the fact that this  
14 population is using a set of drugs which often isn't as easy  
15 to substitute, and so you may see a couple of those  
16 patterns. And I think that's what we want to unpack a  
17 little bit, and I think one of the points of the slide  
18 presentation is this is an area that we want to unpack a  
19 bit.

20 There's also one other thing I want to bring back  
21 into this conversation from some stuff that Joan put in  
22 front of you. We were looking at what people do in the gap.

1 You may remember some of this, and it's kind of good and bad  
2 news. The bad news is sometimes people cut their  
3 prescriptions, split pills, do that type of thing. But the  
4 other thing was there was a big impact on generic use or  
5 some sensation that there was a big impact on generic use  
6 where the beneficiaries would start trying to figure out how  
7 to lower their out-of-pocket, and that doesn't really occur  
8 for the LIS population. I think implicit in all of this is  
9 that the beneficiary is not participating in a big way --  
10 although, Bruce, I understand your question -- not in a big  
11 way in slowing down the utilization, and depending on how  
12 the plan is being reimbursed, it kind of goes to your  
13 question. Why aren't they monitoring this more carefully?

14 Shinobu, that was all --

15 MR. HACKBARTH: Shinobu, to the best of my  
16 recollection, the only place the draft chapter talks about  
17 beneficiary satisfaction is in talking about the star system  
18 and how it's one of the factors there. What data are  
19 available from other sources about beneficiary satisfaction  
20 with Part D, and should we include some of that data in the  
21 status report?

22 MS. SUZUKI: I believe MCBS had some survey

1 questions in there about Part D use, access, that sort of  
2 thing, and we plan to look into it in the future. We just  
3 have not done so yet.

4 MR. HACKBARTH: Okay. Round two questions and  
5 comments. Tom?

6 DR. DEAN: Actually, as I stop to think about  
7 this, it may be more round one, but whatever. On Slide 12,  
8 you talked about the measures that relate to patient safety.  
9 Do you have more specifics about -- it says, members' use of  
10 high-risk drugs. What actually is the measure? Is it just  
11 the number of people using high-risk drugs? And then more  
12 so, optimal treatment for diabetic patients. How is that  
13 judged?

14 MS. SUZUKI: So the members' use of high-risk  
15 drugs, I believe, has a list of drugs that CMS looks for,  
16 and I believe it's the percent of -- can you help?

17 DR. SCHMIDT: It's similar to but not exactly the  
18 same as Biers List drugs. It's, I believe, an NQF validated  
19 measure.

20 DR. DEAN: So is it just a listing? I mean, is  
21 there any action or interventions on those, or how -- what's  
22 the response?

1 DR. SCHMIDT: Let's see if I can -- I'm not going  
2 to get this precisely right, but it is a listing of drugs  
3 that are perceived to be high risk and it's derived from the  
4 claims information, so it's going to be like the percent of  
5 the beneficiaries who filled scripts who have those drugs.

6 DR. DEAN: I guess what I'm getting at is, okay,  
7 we know they're using these drugs. Is there any action to  
8 determine whether it's appropriate use, I mean, because I  
9 think as we've talked about before --

10 DR. SCHMIDT: Right.

11 DR. DEAN: -- this list continues to be  
12 controversial, that most of the drugs on that list have some  
13 limited justified uses, even though they also get listed as  
14 "should never be used in the elderly" and so forth. And so  
15 it's a controversial area.

16 DR. SCHMIDT: Right.

17 DR. DEAN: But I'm just wondering, what is the  
18 response? I mean, we can list them easy enough, but is  
19 there any sort of intervention that takes place or --

20 DR. SCHMIDT: Well, there's, as I mentioned, a  
21 website where plans can at least refer to what their ongoing  
22 rate of dispensing those drugs and providing those drugs to

1 their enrollees looks like, and I think that they can go  
2 back and actually track it to providers to look at whether  
3 those rates are higher for individual providers or not.

4 DR. DEAN: Okay. So it's kind of at the option of  
5 the plan to determine how they use the data?

6 DR. SCHMIDT: Right, and presumably CMS, if  
7 they're seeing some crazy high rates, can kind of put some  
8 pressure on.

9 DR. DEAN: And with the diabetes drugs, it says  
10 optimal treatment. I mean, who determines that?

11 DR. SCHMIDT: Well, I think it's following a  
12 guideline that has to do with use of ACE or ARBs, ACE  
13 inhibitors or ARBs -

14 DR. DEAN: Okay.

15 DR. SCHMIDT: -- if they're already a diabetic,  
16 dispensing of those.

17 DR. DEAN: Okay. And the second question, what is  
18 the overall cost of the program? I mean, we heard some  
19 claims tossed around during the campaign about this is much  
20 more expensive than everything. All of Obama's programs  
21 aren't as expensive as Part D, or something. And I was just  
22 curious. What is the overall cost and what's happening with

1 that?

2 MS. SUZUKI: So total spending, this chart shows  
3 you that in 2009 --

4 DR. DEAN: Oh, there it is.

5 MS. SUZUKI: -- we spent \$53 billion. In 2010, we  
6 think we'll spend \$56 billion in total.

7 DR. DEAN: Fifty-six billion. Okay. Thank you.

8 MR. HACKBARTH: So, Tom, I think at least the  
9 pieces of that discussion that I heard was people focused on  
10 the projected ten-year cost, which initially was, what, \$600  
11 billion or something, and it was lowered to 400. Anyhow, it  
12 was hundreds of billions of dollars over ten years, and the  
13 fact that there was no effort to pay for that by making  
14 offsetting reductions elsewhere.

15 So let's just do a time check here. We've got  
16 about ten minutes left. Our next session involves two  
17 guests, so we really need to stay on time. Could I see the  
18 hands of people who have second round comments so I can just  
19 get a sense of how many? Only Cori?

20 DR. KANE: [Off microphone.]

21 MR. HACKBARTH: I actually do have some things  
22 about the shape of the chapter that I'd like to raise for



1 discussion, but let me see the hands of the people who have  
2 round two questions or comments. One, two -- okay. Scott?

3 MR. ARMSTRONG: [Off microphone.]

4 MR. HACKBARTH: Boy, we are shy this morning.  
5 Okay. Cori?

6 MS. UCCELLO: I'm just going to reiterate the need  
7 to look at and try to figure out what's going on in this  
8 reinsurance piece and try to understand kind of what --  
9 given that the plan -- I mean, I think it's still on the  
10 hook for this 20 percent. What else is going on? Is that  
11 not enough, or is the risk adjustment kind of overlooking  
12 that? You know, lots of people have incentives that are  
13 either there or not there with the low-income people, and  
14 this is going to be more important as more people are now  
15 going to be hitting that catastrophic threshold with the gap  
16 issue.

17 MR. HACKBARTH: Are you focused on the rate of  
18 growth in the reinsurance and why is it growing --

19 MS. UCCELLO: Yes. Yes.

20 DR. STUART: [Off microphone.] Or as a portion --

21 MR. HACKBARTH: Yes, but one --

22 MS. UCCELLO: Both.

1           MR. HACKBARTH: One hypothesis that John Bertko  
2 used to talk about is that because these are sole source  
3 drugs, the plans have very little leverage in negotiation.

4           MS. UCCELLO: And I think that's the question when  
5 looking into that. Is that the answer, or is there  
6 something else going on with the incentives that aren't  
7 quite aligned correctly.

8           MR. HACKBARTH: Yes. Bruce?

9           DR. STUART: It may actually be more serious than  
10 it looks, because remember that when the program first  
11 began, the plans had very narrow risk corridors for that  
12 reinsurance amount and those risk corridors have become  
13 wider, which means that the plan is responsible for a larger  
14 proportion of the catastrophic cost than at the beginning of  
15 the program. At least, that's my understanding.

16          MS. UCCELLO: I think maybe you're confusing the  
17 risk corridor, which is trying to get the right price  
18 target, versus the higher spending due to an individual  
19 having a catastrophic claim, and the thought was that, over  
20 time, as plans get more experience with the pricing, those  
21 risk corridors could be widened. And so I think those are  
22 two different risks that are trying to be addressed. But in

1 any --

2 MS. SUZUKI: Right. So risk corridors, now that  
3 it's wider than when it began, presumably, it puts more  
4 pressure on plans because they're taking on more risk.  
5 Reinsurance is a separate part of the risk adjustment.

6 MR. HACKBARTH: So we get plan level versus the  
7 individual.

8 MS. SUZUKI: Yes.

9 MR. HACKBARTH: Jennie?

10 MS. HANSEN: This is probably a comment,  
11 observation, pulling together a few things here. One is  
12 looking at the gradual rate of growth on Slide 11 for the  
13 total spending for Part D, just looking at that rate of  
14 growth tied with some other things we've brought up in the  
15 past day or so about the growth of the dual eligible numbers  
16 that are coming down the pike and then Bob's comment about  
17 just the boomers hitting, and then the sole source drug  
18 expenditures that are there, it just seems like the rate --  
19 these are factors that are going to really compound this  
20 program, just from an estimation standpoint.

21 MR. HACKBARTH: Right.

22 MS. HANSEN: But I'm also then intrigued by a

1 chapter that we'll discuss later on hospitalizations and  
2 that there has been seemingly a slight reduction in  
3 admissions. So again, we take a look at the whole program  
4 in composite. What are the effects of growth? What are the  
5 effects of other parts of the program intended by Part D?  
6 And I don't know we're in a position to comment yet, but  
7 these are related trends and factors to consider.

8 MR. HACKBARTH: Yes. Scott?

9 MR. ARMSTRONG: Glenn, I just -- as we think about  
10 the work going ahead around this topic, I just wanted to  
11 make sure we didn't lose our recommendation around two  
12 topics. First, this whole issue around the incentives, the  
13 impact of the 50 percent discount on brand drugs and our  
14 desire for generics to be used. So I wanted to confirm, we  
15 are going to spend some more time trying to explore that and  
16 understand what's going on there a little bit more clearly.

17 And then, second, with respect to the quality  
18 measures and the star rating and so forth, that's not an  
19 area I have a deep understanding of, but it sounds to me  
20 we're reporting on a lot of information, particularly some  
21 of the high-risk areas. There may be some new measures to  
22 consider looking at or diving into. But as far as I could

1 tell, there's actually really no consequence to being a two  
2 star-rated plan versus a five star-rated plan. And I just  
3 would like us, as we go forward, to think a little bit about  
4 how the quality rating may have more relevance to either the  
5 patients making choices or perhaps even have some kind of  
6 financial incentive or consequence to help encourage the use  
7 of the more highly-rated plans.

8 MR. HACKBARTH: The star system is new and  
9 developing. I fear that you're going to turn out to be  
10 correct, that it will be incidental. I'm not sure that we  
11 know yet that it won't be effective in moving beneficiaries,  
12 but that's certainly an area for us to watch and explore as  
13 the system develops.

14 Does anybody else want to get in before I make a  
15 couple concluding comments, or actually, I want to frame  
16 those questions to get your reaction to. This is very well  
17 done, Shinobu, and very thorough, and thank you for that.

18 The questions I have are a little bit about the  
19 framing of this. My personal sort of overall impression of  
20 Part D is that it's achieved some important goals. We have  
21 dramatic expansion in the number of Medicare beneficiaries  
22 that have prescription drugs, which is, of course, the

1 primary goal. That's a good thing.

2 I believe that Medicare beneficiaries are largely  
3 satisfied with it, but that's why I asked, Shinobu, for you  
4 to see if we can bring some more data to bear on that.

5 As we discussed a minute ago, the program has come  
6 in at a lower cost than was initially projected, which, of  
7 course, is a good thing.

8 In the data that we have been presented, I think  
9 there are a couple, I wouldn't say warning flags, but  
10 certainly things to watch more carefully, and I would say  
11 the rapid growth of reinsurance costs are high on that list.  
12 And the reason it's high on that list from my perspective is  
13 not just because of the budget implications, but because it  
14 poses a challenge potentially that the model is not well  
15 suited to address. A competitive model has proven  
16 successful, for example, in getting people to switch to  
17 generics, which is a very good thing. But a competitive  
18 model may not be very successful at dealing with the rapid  
19 increasing cost going to sole source drugs.

20 Let me just have one more minute, Mike, and then I  
21 will let you react. So that's one thing that I think may be  
22 worth flagging and making a little bit more prominent than

1 it is in the current chapter, and I want reactions to that.

2 A second thing is the plan switching rate. This  
3 model is premised on Medicare beneficiaries disciplining the  
4 market by choosing different plans when some under-perform.  
5 And this also gets to the star issue, as well. I think we  
6 need to, on an ongoing basis, look at that premise and is it  
7 playing out. Are, in fact, the beneficiaries able to  
8 provide the market discipline that this competitive system  
9 depends on?

10 Now, I don't know the answer to that. I think the  
11 switching rate was six percent, is what is in the paper. Is  
12 that right, Shinobu?

13 MS. SUZUKI: That was the switching rate for the  
14 first couple of years. We don't have the latest  
15 information.

16 MR. HACKBARTH: And that, as I understand it, is  
17 comparable to FEHBP -

18 MS. SUZUKI: Yes.

19 MR. HACKBARTH: -- and so I'm not implying that  
20 that number, oh, this is bad and we ought to be concerned,  
21 but I think it bears watching. I think in particular it  
22 bears watching here because of the potential stickiness

1 around formularies and the like. If particularly high-cost  
2 patients have a lot of drugs and they're in a plan and  
3 they've got what they need on the existing formulary, the  
4 prospect of shifting for a relatively modest per month  
5 savings in premium expense just may be too daunting, and if  
6 that stickiness is significant, it could affect the market  
7 discipline.

8           So those are some thoughts that I have. Again, I  
9 don't mean to characterize either the reinsurance issue or  
10 the switching issue as a problem, we know this is a problem,  
11 but rather as things that we need to watch because they're  
12 so fundamental to the success of this competitive model.  
13 Reactions?

14           DR. CHERNEW: So now I will say in response to  
15 this, I think it's extremely difficult to think about how to  
16 deal with the sole source high-cost drugs, because if you  
17 assume, oh, they exist, now let us get the cheaper price in  
18 a competitive market, that gives you one set of things to  
19 do. But there's all kinds of innovation incentives and  
20 other broad issues related to that. So it's a very  
21 different thing, and my own personal opinion is, of course,  
22 in cases where they're really providing value, we want to



1 encourage innovation and so we don't want to have a system  
2 that says, this is a new, good drug but we're simply not  
3 going to pay for it. On the other hand, we do want to avoid  
4 situations where there's a drug that's not giving us very  
5 much and for a whole series of reasons we're just paying a  
6 ton more than competition is working. And separating that  
7 out matters.

8 But the key point is, recognizing the value of the  
9 innovation is important in figuring out how one wants to set  
10 the price for these types of drugs. That's the way the  
11 system is supposed to work. That's very different than the,  
12 you should be taking a generic instead of a branded when  
13 there are perfectly good substitutes.

14 MR. HACKBARTH: And I don't disagree with any of  
15 that, and I would think if we were to flag this as an area  
16 to watch, that would be one of the messages, is that there  
17 are important issues at stake here, including innovation,  
18 incentives for innovation.

19 DR. KANE: Maybe tie it to comparative  
20 effectiveness types of priorities? Maybe the priorities in  
21 that program should start with those types of drugs.

22 MR. HACKBARTH: I don't want to wade so -- let me

1 just be clear here. I don't want to wade into this and  
2 start laying out policy options and the like. This is a  
3 status report on Part D. And so what I'm trying to do is  
4 just highlight some areas that bear watching and give a  
5 little bit of a sense of what the issues are at stake and  
6 not talk about solutions, not talk about policy options.  
7 Bruce?

8 DR. STUART: Part of this is bringing threads  
9 together. We have had that paper on bio-similars. I mean,  
10 that addresses a point that Mike raised. So maybe it's just  
11 looking across our portfolio of activities in the Part D  
12 arena, pulling those together that are focused on sole  
13 source drugs, and then pulling those together that are  
14 really focused on the reinsurance, and those two are  
15 obviously not independent of one another.

16 MS. BEHROOZI: I also noted in the paper that next  
17 time, we'll be getting information on drug pricing in the  
18 program, or the impact on prices, and while there are -- you  
19 know, there was a lot of discussion about what the  
20 incentives are for plans to drive people to generics or get  
21 best pricing from pharmaceutical companies, they are still  
22 somewhat insulated. I mean, it is really not a perfectly

1 competitive market because of the imperfect information that  
2 beneficiaries have, like is the higher premium going to get  
3 me better copays, and do I have the time to figure this all  
4 out, and maybe I'll just stay with what I have because it's  
5 easier than switching. So maybe plans aren't being driven  
6 quite as hard as they could to get the best prices because  
7 they can somewhat pass along more than they ought to be,  
8 even though they're exposed to 20 percent of the reinsurance  
9 costs, you know, they're making it up at the front end or  
10 something like that. So I think that's going to be really  
11 interesting to look at, too, not just with the biotech  
12 drugs.

13 MR. ARMSTRONG: Just in response to your question,  
14 the way you characterized the work going ahead, I totally  
15 support that. I like the way you did that.

16 MR. HACKBARTH: Thank you, Shinobu.

17 And now we have our panel on Medicare's role in  
18 motivating quality and supporting quality improvement.

19 Are we all set, Anne?

20 MS. MUTTI: [Off microphone.] Yes, we are.

21 MR. HACKBARTH: Okay, Anne, would you do the  
22 introductions?

1 MS. MUTTI: Sure. This presentation picks up on a  
2 conversation we started last year, one that asks whether  
3 Medicare can better leverage its policies for technical  
4 assistance and for Conditions of Participation in order to  
5 accelerate quality improvement.

6 We take this question on because the evidence on  
7 the effectiveness of both programs, that is the QIO program  
8 and the COPs, is not strong. Also, there is wide variation,  
9 and that persists over time, and low performers tend to  
10 serve a higher proportion of minorities, contributing to our  
11 disparities problem. And third, we recognize that while  
12 payment policy may be Medicare's most effective mechanism to  
13 motivate and support quality improvement, it may be that by  
14 leveraging multiple at once we have the best chance of  
15 succeeding in improving quality.

16 I'll take a moment to summarize some of the ideas  
17 we presented in the June 2010 report, and then our  
18 panelists, Bob Wachter and Chris Queram, will speak to the  
19 problems we have identified and discuss ideas on how these  
20 parts of the Medicare program could be improved. And  
21 depending on your conversation, we could be coming back to  
22 you early next year with draft recommendations for some of

1 these ideas.

2 Medicare spends more than \$300 million annually on  
3 the Quality Improvement Organization program, yet the  
4 evidence from the literature on the effectiveness is mixed,  
5 and our recent interviews with providers and health quality  
6 experts suggest room for improvement. The following six  
7 ideas for change are intended to spur your discussion. They  
8 do fit together as a package, but they could also be  
9 considered individually.

10 So first, we could target assistance to low  
11 performers, and CMS has begun to do this but not across all  
12 its priorities in the 9th Scope of Work. Targeting  
13 assistance to low performers does a couple of things. It  
14 constructively offsets some of the penalty for poor  
15 performance that can occur under value-based purchasing  
16 policies as well as the readmissions policy, increasing the  
17 chance for these low performers to improve. And by  
18 directing quality improvement assistance to providers who  
19 tend to serve large minority populations, we are in a better  
20 position to address our disparities issues.

21 Second, we could measure performance largely on  
22 outcomes measures, and specifically these should include

1 measures of systemness because improving performance on  
2 these types of measures will require that providers working  
3 with their technical assistance agents explore strategies  
4 for overcoming fragmentation in the delivery system and  
5 engage multiple providers in the community, to focus on  
6 things like care transitions and access to primary care, and  
7 this will help us avoid reinforcing the silos and instead  
8 promote systemness through our technical assistance program.

9           Third, Medicare could change the contract  
10 structure to encourage low performers, to better engage low  
11 performers. One way to do this is to have the financial  
12 support for quality improvement go directly to the poor  
13 performer instead of the QIOs or technical assistance  
14 agents. In turn, the poor performer would select its own  
15 technical assistance agent perhaps from a list of  
16 organizations that meet basic requirements. This approach  
17 empowers the provider, engages the provider in improvement  
18 and makes the provider, rather than CMS, the client.

19           Fourth, we could broaden the criteria for  
20 technical assistance agents that deliver assistance to  
21 providers, so a much wider group of organizations would be  
22 eligible to function as Medicare technical assistance

1 agents. Currently, there are legislative restrictions on  
2 what type of entities can participate as QIOs, including  
3 that they must be able to serve an entire state and be  
4 physician sponsored, which limits the types of organizations  
5 that can compete to be QIOs. By removing these  
6 restrictions, we would expect to see entities currently  
7 functioning as QIOs still completing but also other  
8 organizations competing for business from low performers,  
9 and we might get types of organizations that specialize in  
10 helping rural populations or types of organizations that are  
11 especially experienced in offering provider collaboratives.

12 Fifth, we could allow flexibility in the way the  
13 technical assistance is provided and the focus of that  
14 assistance. For example, the technical assistance may  
15 include one, or a combination of, in-person mentoring,  
16 participation in a collaboration, or maybe the focus really  
17 should be about learning how to use and read your data, that  
18 that is a first step that needs to happen and one-on-one  
19 assistance would be helpful. The focus could be on anything  
20 from best practices for pressure ulcers, if you felt that  
21 was the reason for your poor performance, your overall poor  
22 performance, or maybe it would be strategies to implement

1 culture change. Addressing management issues like staff  
2 turnover can be one of the types of things you might need to  
3 focus on, and also improving coordination with other  
4 providers in the community. So it would allow for a broader  
5 sense of what kinds of problems need to be addressed.

6           And lastly, we could pair flexibility with  
7 accountability. The provider receiving a technical  
8 assistance grant should be accountable for using it to  
9 improve performance, and this accountability can be achieved  
10 through payment policy that financially penalizes or rewards  
11 providers that fail to improve performance, like we have  
12 under the current P4P policy and readmissions. But there  
13 could be an additional accountability through Medicare's  
14 Conditions of Participation. For example, providers that do  
15 not improve after having received assistance could be  
16 subject to intermediate sanctions, and one example of that  
17 could be a corrective action plan that requires management  
18 changes. And we see precedence for this approach in nursing  
19 home policy and recent education reforms.

20           Another way Medicare can stimulate quality  
21 improvement is by reforming its Conditions of Participation.  
22 The COPs are the minimum standards that certain providers



1 are required to meet in order to participate in Medicare.  
2 Millions of dollars are spent annually preparing for and  
3 conducting these surveys to ensure compliance with  
4 standards. Yet, it's unclear how much these efforts have  
5 accelerated the pace of change.

6 The types of options that we have talked about to  
7 reenergize this process are:

8 To create a voluntary higher standard. Under this  
9 option, CMS could create a more rigorous set of standards  
10 for which compliance was voluntary, to allow providers  
11 meeting these standards to publically distinguish themselves  
12 as high performers, and perhaps these would be more  
13 outcomes-oriented standards that would be the optional set.

14 Another option is create mandatory outcomes-  
15 oriented standards for select services, and this would be to  
16 better direct patients to quality providers for high cost  
17 and complicated procedures. The COPs could be amended to  
18 incorporate outcomes, volume or other types of criteria for  
19 select services, much like it does for transplant centers.  
20 So in the end, we wouldn't pay for services unless the  
21 facility or organization has passed those Conditions of  
22 Participation for those services. A similar approach was

1 recently taken by the VA to prevent scheduled surgeries from  
2 exceeding infrastructure capabilities of the VA facilities.

3           A third option is to create intermediate sanctions  
4 because one problem with enforcement under the current  
5 survey and accreditation process is that the consequence for  
6 failing to pass the survey or accreditation is so extreme.  
7 It's exclusion from the Medicare program, and that action is  
8 rarely taken. So intermediate sanctions that had a real  
9 possibility of being imposed may be a greater motivator, and  
10 examples of these sanctions could be public disclosure of  
11 poor performance, requirement to receive the technical  
12 assistance that we were just talking about, the corrective  
13 action plans with management changes or perhaps even  
14 suspension of payment to facilities from performing elective  
15 procedures for which there were quality problems.

16           And lastly, we could update COPs to align them  
17 with current quality improvement efforts. Here, some of the  
18 ideas that we've thought about focusing on was discharge  
19 planning, better engagement of physicians and boards in  
20 quality improvement efforts, and focusing on efficiency  
21 improvement.

22           So let me just switch gears here, and we'll turn

1 to the panel in a moment, but first I want to convey some of  
2 the kinds of things that the QIO trade association says to  
3 us when we are talking to them about some of these ideas, so  
4 that you can take them into consideration in your  
5 discussion.

6 First, I think they might say don't be so sure  
7 that we haven't made a big and very positive difference. It  
8 is very difficult to measure quality improvement in general,  
9 and this is not only for QIOs but other organizations that  
10 try and improve quality. They would point to one survey of  
11 11 percent of hospitals which ranked QIOs higher than any  
12 other source for technical assistance.

13 They would also note the fact that not to be  
14 concerned that there's been so little change in the  
15 organizations that are functioning as QIOs because there has  
16 been a lot of stability over time in these. They say that  
17 this can be a real positive, that they develop experience  
18 and know their communities.

19 Third, they would point that QIOs are constrained  
20 by declining funding. CMS directs a significant amount of  
21 the QIO budget to other quality-related activities, leaving  
22 QIOs with less.

1           Fourth, they would say one of the key advantages  
2 to QIOs is their local presence and their ability to bring  
3 different providers in a community together to tackle  
4 systems issues, and this strength might get lost if we were  
5 to now have the assistance go directly to providers instead  
6 of QIOs.

7           And I imagine that there are other points.  
8 They'll have an opportunity, obviously, to add to this.

9           So with that, we now turn to our panel. We are  
10 very fortunate to have Chris Queram and Bob Wachter with us.

11           Chris is the President and Chief Executive Officer  
12 at the Wisconsin Collaborative for Health Care Quality. He  
13 also served on the IOM panel that considered QIOs in 2006,  
14 so he's a great resource to ask him about what went on  
15 there. And he serves on the board of the Joint Commission.

16           Bob Wachter is a professor and Associate Chairman  
17 of the Department of Medicine at the University of  
18 California in San Francisco, is an expert on quality issues,  
19 widely published and also generally regarded as the academic  
20 leader of the Hospitalist Movement.

21           So with that, I will turn it over to them.

22           MR. QUERAM: Thank you, Anne, and thank you for

1 this opportunity to come before you and share some  
2 perspectives on the quality improvement program but also the  
3 work of regional quality organizations such as ours.

4           We have a short amount of time to prepare or  
5 present opening comments, so I'll move right into a  
6 description of the Wisconsin Collaborative for Health Care  
7 Quality.

8           We're a nonprofit voluntary consortium of  
9 organizations -- hospitals, medical groups, provider-  
10 sponsored health plans, consumer organizations, business  
11 coalitions and employers -- that was formed in 2003 for the  
12 specific purpose of using public reporting of comparative  
13 performance of health care information, to catalyze  
14 improvements in care and to begin to change behavior on the  
15 part of not only provider organizations but other  
16 stakeholders, in terms of how they use that information to  
17 support transformational change in health care delivery.

18           We've reshaped our vision, and we focus now on  
19 trying to bring coherence to the use of performance  
20 measures. We live in a time of an embarrassment of riches  
21 from the standpoint of performance measurement. Some might  
22 call it cacophony. And one of the roles that we seek to

1 play is to try to bring coherence to the balance between  
2 national priorities and local interests, and guide the use  
3 of performance measurement not only for public reporting but  
4 quality improvement, consumer engagement and payment reform.  
5 And our focus explicitly is on not only improving how health  
6 care is delivered but also seeking to drive improvements in  
7 community health status and individual health status.

8           Our member organizations -- we are structured as a  
9 membership organization -- are many of the major health  
10 systems in our state. Wisconsin is unusual in the fact that  
11 a large percentage of physicians practice in multispecialty  
12 groups. The statistic, I think, is around 40 or 50 percent  
13 of the physicians are in these multispecialty groups. So we  
14 have a significant market penetration by virtue of a  
15 relatively small membership of provider organizations.

16           And some of these, I think, are probably familiar  
17 to you -- groups like Marshfield Clinic, the two academic  
18 medical centers, Gundersen Lutheran Health System and others  
19 that are listed on this slide.

20           A couple of comments and perspectives on the  
21 Quality Improvement Organization program, and some of this  
22 is informed not only by my participation on the IOM

1 committee, as Anne mentioned, but also our experience  
2 working as a CMS subcontractor a few years ago in the Better  
3 Quality Information for Medicare Beneficiaries program which  
4 was conducted by CMS as part of the High-Value Health Care  
5 Project under the previous administration.

6           And I can resonate with some of the themes that  
7 were articulated in the chapter in terms of the lack of  
8 flexibility and adaptability because of contractual  
9 constraints. I appreciate that CMS takes its obligations as  
10 a steward of Medicare trust funds very seriously, but the  
11 contractual requirements do have a tendency to stifle  
12 innovation and experimentation in this rapidly changing, and  
13 very dynamic, environment.

14           It's been my observation, observing the Quality  
15 Improvement Organizations for many years that there is a  
16 lack of constancy of purpose, not only between one scope of  
17 work to the next but also within scope of works -- rapidly  
18 shifting priorities that tend to make it difficult to foment  
19 and pursue systemic change.

20           I already commented a little bit on the disconnect  
21 between local priorities and the national agenda.  
22 Hopefully, the soon to be issued National Quality Strategy

1 will bring some organizing frame and principle to that  
2 concept, but there are often local priorities that tend to  
3 take precedence over national ones.

4           And I think a critically important point is the  
5 inherent limitations of externally mandated interventions,  
6 and by that I mean one of the strengths of multistakeholder  
7 collaborations is bringing people together, bringing  
8 organizations together to establish common purpose, identify  
9 priorities, share data with one another and, more  
10 importantly, share best practices from within the health  
11 care system, the local ecosystem, rather than having that  
12 expectation or that change imposed from outside of the  
13 consortium model.

14           In terms of Conditions of Participation, one of  
15 the clear opportunities I think we have is to begin to link  
16 accountability for performance much more robustly to the  
17 Conditions of Participation. Our data systems have matured.  
18 The acceptance of performance measures has advanced  
19 significantly over the last decade. And I do think that  
20 there is a disconnect between the Conditions of  
21 Participation and the availability of good data on  
22 accountability.



1           I also think that the Conditions of Participation  
2 don't do adequate justice the importance of culture in  
3 driving transformational change, both at the board level and  
4 at the senior leadership level.

5           And increasingly, we're seeing again the  
6 integration of physician and organizational roles,  
7 popularized perhaps by accountable care organization models,  
8 but I think the conditions need to recognize the blended  
9 interests of physician and hospital organization.

10           I do think this is a time of opportunity for  
11 experimentation and innovation. A number of the themes  
12 identified in your briefing materials stand out to me in  
13 terms of broadening the criteria of who might serve as  
14 what's referred to as a technical agent -- linking  
15 flexibility and trying different models to try to accomplish  
16 goals of quality improvement, with accountability for  
17 improvement and outcomes in health status, and intermediate  
18 sanctions for persistently low performing organizations.

19           I'd like to suggest with all due humility that one  
20 alternative model for consideration in this category of  
21 technical agents are multistakeholder, regional Quality  
22 Improvement Organizations such as the Collaborative.

1           I say that with humility in part because to a  
2   certain extent we represent yet another hypothesis in terms  
3   of what will drive systemic change, for the reasons that  
4   have been cited by the QIOs themselves in terms of  
5   evaluating cause and effect relationship. But the core  
6   functions of Quality Improvement Organizations such as WCHQ  
7   revolve around use of comparative performance measurement,  
8   public reporting, collaborative learning, consumer  
9   engagement and payment reform, which I think are the  
10   confluence of the levers of change that I think represent  
11   some real promise and real potential.

12           I've compiled some observational data. We've been  
13   continuously reporting outcome measures, as well as process  
14   measures, in Wisconsin for over years now. These are graphs  
15   that simply show the sum of numerators and denominators from  
16   the first year or baseline at which we introduced these  
17   measures. This one happened to be related to diabetes. You  
18   can see a fairly significant increase over time in both  
19   process and control measures. The same is true for cancer  
20   screening measures, again continuously reported for about  
21   five years.

22           One of the distinguishing characteristics of

1 regional health care collaboratives as compared to Quality  
2 Improvement Organizations is the diversity and the breadth  
3 of representation that, by definition, they represent as  
4 multistakeholder.

5 Another differentiating characteristic is the  
6 strong reliance upon consensus and collaborative decision-  
7 making to identify priorities and commit to shared goals,  
8 and this relentless focus on both improving cost and  
9 quality, or value, in health care delivery.

10 And I think these models have shown that there is  
11 enormous flexibility in terms of addressing the myriad of  
12 issues related to transforming health care at the local  
13 level.

14 There are multiple examples of these types of  
15 organizations. Federal policy, as well as private sector  
16 policy, has encouraged their development through the  
17 Aligning Forces for Quality Initiative sponsored by the  
18 Robert Wood Johnson Foundation, the Chartered Value  
19 Exchanges launched under the previous administration and  
20 continuing on through the Agency for Health Care Research  
21 and Quality, and a new organization that brings all of these  
22 entities together, the Network for Regional Health Care

1 Improvement.

2           And the last slide that I have shows that this is  
3 a broad network of organizations that are extant in many  
4 states around the country, and it is another infrastructure  
5 that I think lends itself to the type of innovation and  
6 experimentation that I think these critical important times  
7 suggest we give consideration to.

8           So with that, I'll stop and turn the podium over  
9 to Bob and look forward to the discussion.

10           DR. WACHTER: Thank you. Good morning. It's a  
11 pleasure and an honor to be here. I see some old friends  
12 around the table, so it's really terrific to be here.

13           Let me start with a few biases. So I am a  
14 hospitalist. I am the Chief of Hospital Medicine at my  
15 institution. So my world view is a little bit hospital-  
16 centric as you'll hear my comments. I think I know more  
17 about what's happening in the hospital world than the rest  
18 of the universe.

19           I am the Chair-Elect of the American Board of  
20 Internal Medicine. So you may hear comments that relate to  
21 the role of boards in all of this.

22           And finally, I think Anne partly asked me to come

1 because I like being provocative, and I will be deliberately  
2 provocative in some of my comments.

3 Because the last time the Giants won the World  
4 Series Medicare had not yet been invented, I figured I'd  
5 start with this. I bring you greetings from the World  
6 Champion San Francisco Giants. I brought my son out to San  
7 Francisco for Games 1 and 2, and so I know what it's like to  
8 worry about having your trust fund exhausted.

9 [Laughter.]

10 DR. WACHTER: I want to start with some  
11 observations about things that have worked better than I  
12 would have expected 10 years ago as I date the beginnings of  
13 the quality and the safety movements to the IOM reports on  
14 quality and safety. So both fields, to my mind, are really  
15 10 years old.

16 Here are things that work better than I would have  
17 predicted 10 years ago, and I think many of you are at least  
18 as aware, if not more than I am.

19 Transparency has been remarkably effective, I  
20 think, particularly as I see it in the hospital world.  
21 That's particularly interesting because if you had asked me  
22 10 years ago whether it would work I would say only if it

1 engenders consumerism, and there's no great evidence that it  
2 has. There are not many real people that go on to Hospital  
3 Compare to decide whether to go to your place or the place  
4 across town. So the mechanism appears to be some  
5 combination of shame and pride rather than consumerism, but  
6 I think it's worked better than any of us would have  
7 guessed, certainly than I would have guessed.

8           A dynamic, evidence-based, trusted set of quality  
9 and safety metrics can drive change, and I think we've seen  
10 that with the core measures, with some exceptions, but by  
11 and large I think they have driven important change. The  
12 role of the NQF never events I think has been a very  
13 important set of focal points for the patient safety  
14 movement, which I think without them was too diffuse. The  
15 National Patient Safety Goals, there have been a couple of  
16 missteps, but I think by and large they've helped drive the  
17 safety movement forward.

18           And I think the development of bundles of  
19 evidence-based practice sets, to try to decrease the  
20 probability of some adverse outcomes, central line  
21 infections being the most prominent, I think have been  
22 extraordinarily salutary. And I think we have now a lot of

1 evidence there are certain techniques that seem to drive  
2 these fields forward.

3 Integrated delivery organizations, without  
4 question, have a staggering advantage over what I call 99-1  
5 organizations. Ninety-nine to one is a reference that you  
6 may have heard before. That's what do you call a 99-1 vote  
7 of the medical staff, and the answer is a tie.

8 It is a reflection of the ability of any  
9 individual doctor to veto anything the institution wants to  
10 do under the old order. I think we've seen that  
11 organizations that manage to create integration and shared  
12 purpose between the physicians and the organization have a  
13 major advantage, and that's evident when you look at  
14 Geisinger or Kaiser Permanente, or the VA for that matter.

15 And finally, once there's a business case to  
16 improve quality and safety, organizations actually seek  
17 help, and I think that's a very important change from the  
18 environment as recently as seven or eight years ago.

19 Just a quick story, just to make real this issue  
20 of the role of transparency, this is U.S. News and World  
21 Report. It comes out every year, and here is my hospital,  
22 the University of California, No. 7. We all know the

1 methodology for this is imperfect. It does not prevent us  
2 from putting it on every billboard in San Francisco,  
3 assuming we're on the Top 10 List.

4           This is our world view of ourselves. We're a big,  
5 fancy academic medical center, with people with very  
6 impressive pedigrees, and a long and storied history, and  
7 great research and great trainees.

8           In 2003, Medicare began reporting data on our  
9 performance on a group of core measures, and here we were on  
10 one of them -- percent of pneumonia patients given  
11 pneumococcal vaccination, a measure that I think the  
12 evidence for it is limited but positive enough that it  
13 wasn't unreasonable that it was on the list. And here we  
14 are just doing quite terribly.

15           I think these sorts of measures created, I think,  
16 very important cognitive dissonance. And the dissonance was  
17 between our world view of ourselves, as being a really  
18 impressive organization that does great work and helps a lot  
19 of patients, and publically reported measures that show that  
20 we're not so good.

21           To me, every organization -- this makes us sad.  
22 Every organization needs its what I call Golda Meir moment.



1 This is the late Israeli prime minister who once said:  
2 Don't be humble; you're not that great.

3 [Laughter.]

4 DR. WACHTER: And I think that in many ways is  
5 what transparency does. It really gives you -- it makes it  
6 quite visible to you that although your world view is that  
7 you're pretty slick, you are not performing at the level  
8 that you should be.

9 Again, what I believe has been really very  
10 impressive to me is that dissonance is an incredibly  
11 powerful platform for change. I think a lot of  
12 organizations really want to do the right thing, and doctors  
13 and other caregivers want to do the right thing. And seeing  
14 that they're not and having it be exposed to the public I  
15 think has been very important.

16 Here are things that have worked less well than I  
17 would have hoped, and they relate to the issues that Anne  
18 asked us to address: Bureaucratic, static and non-  
19 harmonized quality measures are unhelpful, and I believe  
20 counterproductive, and I believe that's a good description  
21 of many of the Medicare Conditions of Participation that are  
22 extraordinarily static and feel very 70s or 80s-ish,

1 particularly when compared with the extraordinarily dynamic  
2 environment that we're seeing in some of the other quality  
3 measures and safety measures that are emerging.

4           In a dynamic, robust quality improvement  
5 ecosystem; nimble, connected and often virtual organizations  
6 add great value, and I think probably the iconic example  
7 here is the Institute for Health Care Improvement. But I  
8 think we've also seen this with organizations like Chris's,  
9 some specialty and regional collaboratives, the surgical  
10 measures. For example, in my own world, the Society of  
11 Hospital Medicine has been a major proponent of something  
12 called Project BOOST which has really been a transformative  
13 effort to improve the discharge process. I think that's one  
14 example of what has happened as the system has become more  
15 diverse and nimble, and I'd that's not a good description of  
16 most Quality Improvement Organizations.

17           So what should Medicare do in this environment?  
18 Well, again with great humility because you have a very hard  
19 job trying to figure out these answers, but it seems to me  
20 that many of the steps you've taken already are very  
21 positive, and I encourage you to do more. The system needs  
22 to be driven to produce value.

1           I think we've learned that pay for performance is  
2 not the only mechanism to do this, and I think it's  
3 important not to underestimate transparency and even  
4 professionalism as important drivers. I really do believe  
5 that most people want to do the right thing and that  
6 transparency sometimes is a mechanism to tell them that  
7 they're not doing the right thing and get them to think  
8 about how to do better.

9           I think at this point, certainly in the hospital  
10 world, the physicians in some ways have been bystanders and  
11 recipients of trickle-down accountability, with most of the  
12 accountability being focused on the hospital, the hospital  
13 then needing to try to engage the physician. Every hospital  
14 in the country has in its strategic plan the physician  
15 engagement strategy, and that's sort of an interesting  
16 animal and says something about the lack of integration.

17           So I think as we go forward it's going to be very  
18 important to figure out what are the strategies to get  
19 physicians as invested in quality and safety improvement as  
20 I think hospitals now are, whether that's public reporting  
21 of physician outcomes, which I think is important although  
22 methodologically tricky. In my world, the role of board

1 certification is a very important piece of that.

2           Obviously, more integration is critical, whether  
3 it's through ACOs or some other mechanism. And I believe  
4 the value pressure that you and others are putting on  
5 institutions is beginning to do some of that, even in the  
6 absence of some formally constructed ACO. But clearly,  
7 Medicare has a role in facilitating the construction of new  
8 organizational frameworks where the docs and the  
9 institutions are part of the same thing and rowing in the  
10 same direction.

11           I think it's very important to abandon static and  
12 non-harmonized measures. It's an extraordinarily tricky  
13 thing to do, but recognizing that the measurement burden  
14 that presently is placed on institutions and physicians is  
15 not neutral. It is a distraction and, as my boss likes to  
16 say, death by a thousand duck bites. We have to be very  
17 careful about that and clean up things that are not adding  
18 value.

19           And finally, I think it's a very important role of  
20 Medicare to promote capacity-building, and really the  
21 observation is that well-meaning poor performers often just  
22 don't know how to succeed, don't have the tools.

1           So I believe Medicare could save many lives by  
2   abandoning COPs that are nitpicky, trivial, vague, and  
3   arbitrary, create an inspector-inspected environment. And I  
4   can tell you we have been visited a few times by our  
5   friendly inspectors looking at our performance on COPs, and  
6   it's an extraordinarily unpleasant and somewhat adversarial  
7   environment where the feeling is the focus is on relatively  
8   small, relatively, to my mind, unimportant issues in the big  
9   picture of quality and safety. And there is, of course, a  
10  huge lack of alignment with all of the other entities that  
11  are measuring quality and safety in different ways, and  
12  adopting requirements that are meaningful. I've just put  
13  two here that are not presently on the list but seem to me  
14  that they would begin saving many lives tomorrow if we did  
15  them. One would be that 90 percent of hospital discharge  
16  summaries are on the desk of the next provider within 48  
17  hours. The literature says two-thirds of the time the  
18  patient sees the follow-up provider and there is not a  
19  discharge summary available to that person. And hospitals  
20  have audited hand hygiene rates of greater than 90 percent.  
21  Most hospitals are in the 50 to 60 percent range and  
22  struggling with how to do better. If that was a condition

1 of participation, they would figure out how to do that.

2           What about the QIOs? I would say as a general  
3 principle a monopoly of regional QIOs might have made sense  
4 when poor performance had absolutely no pressure to improve,  
5 and, therefore, there was a need to push quality improvement  
6 in their direction. And so having a regional entity that  
7 was the repository of deep knowledge about quality  
8 improvement was important. And face-to-face meetings were  
9 the main ways people connected with each other in the pre-  
10 Web/Facebook era.

11           Today I believe, and increasingly so, that the  
12 business case for quality and safety is driving  
13 organizations to seek out improvement because that is what  
14 the landscape will require for them to thrive. And we also  
15 know that the Web and telecommuting and all of the new  
16 technologies are facilitating collaborations that really  
17 don't have to be geographic in an organizational framework.  
18 That doesn't mean there isn't value to face-to-face  
19 meetings. There is. But it opens up the question whether  
20 the regionality of your quality improvement entity is the  
21 most important attribute or there are others, and certainly  
22 in other -- we've seen many examples where regionalness was

1 much less important than relevance and being a trust agent  
2 and having the right expertise and distance learning has  
3 worked very well.

4           So Medicare I believe in this regard should  
5 consider giving poor-performing organizations the resources  
6 to "buy" support and having this QIO, as Anne said, compete  
7 for the business, and I suspect many of them will do quite  
8 well in this environment -- but some may not -- and very,  
9 very importantly, creating accountability among both the  
10 giving and receiving organizations, creating a really well-  
11 functioning, high-functioning quality improvement market  
12 where organizations need to demonstrate that they're doing  
13 the right stuff and that their satisfaction among their  
14 caregivers, among the organizations they're supporting is  
15 very high, and that their outcomes that they achieve are  
16 what we would all hope for for the money that we're  
17 spending.

18           So the bottom line is, I think, that I thought the  
19 chapter was terrific, and I think the work that you're  
20 undertaking and the directions are all positive, that what  
21 we're really talking about here is supporting and nurturing  
22 a value market. And it is dynamic, and extraordinarily

1 dynamic, getting more so every day. Medicare must continue  
2 to drive this market. There are obviously a lot of other  
3 players, but you are the most important one.

4 In this market, '80s style, highly prescriptive,  
5 non-evidence-based laundry lists of conditions of  
6 participation I believe are a painful distraction from the  
7 real work. And in this market, provider organizations will  
8 seek out help, and in some ways that's part of the job here  
9 is to create environment where they want to seek out help  
10 because they have so much skin in the game. And their  
11 choices to get that help should be as modern and as dynamic  
12 as their need.

13 Thank you for the opportunity to speak to you.

14 MR. HACKBARTH: Thank you both. Excellent  
15 presentations, right on point and on time.

16 Our custom is to have at least two rounds of  
17 questions, and the first round focuses just on clarifying  
18 questions. You know, what did you mean, Slide 5, by this  
19 statement, that sort of thing. So the first round we'll  
20 begin on this side. Let me see hands for clarifying  
21 questions.

22 DR. CHERNEW: There were two important phrases



1 that went by that I didn't understand. The first one I  
2 guess is for Dr. Wachter, which is: What's a static non-  
3 harmonized measure?

4 DR. WACHTER: Let's start with static. Static is  
5 a measure that was promulgated in the '80s and hasn't been  
6 updated based on new evidence. And there are some measures  
7 in the COPs that really don't get touched very often in an  
8 environment where the evidence is very dynamic. So there's  
9 a real challenge here to make sure that measures are updated  
10 based on new evidence as it emerges as we begin to  
11 understand what are the processes that lead to improved  
12 quality, and we've learned to measure outcomes and do the  
13 appropriate case mix adjustment.

14 Non-harmonized measures, I guess in some ways it's  
15 contextual, which is I think if the hospital perspective  
16 these days is we understand we're going to be measured, we  
17 understand it will be transparent and be reported, but we're  
18 being measured on the same thing in five or ten different  
19 ways, and that's a distraction and it's resource sink and  
20 it's demoralizing. So the question is: How do we come up  
21 with a single way of measuring the quality of care for heart  
22 failure, for example?

1 DR. CHERNEW: And I had a similar question for Dr.  
2 Queram, which was you mentioned the disconnect between local  
3 and national priorities, and I wonder if you could give an  
4 example of what a local versus national priority might be.

5 MR. QUERAM: Sure. One of the best examples I can  
6 give you is we have put quite a bit of time and energy into  
7 constructing a value metric. We have long been interested  
8 in examining ways that we can take the clinical quality  
9 measures that we've been reporting in some cases going back  
10 to 2004, and pair that with an equally valid measure of  
11 resource utilization, episode-based resource use, and do  
12 that in a way that has sufficient validity and reliability  
13 to begin to look at quality and cost together.

14 While that has been a national area of interest,  
15 there isn't any requirement to report in that context or  
16 mechanism to do so, so we have just chosen to invest a  
17 considerable amount of time and energy.

18 There are probably other examples where we have  
19 fostered local clinical quality collaboratives in areas that  
20 have unique resonance to the provider organizations  
21 themselves that may have nothing to do with what the  
22 statement of work entails for that period of time for the

1 QIOs.

2 MR. HACKBARTH: Other clarifying questions?

3 MS. KANE: This is for Dr. Queram. I was looking  
4 at your list of collaboratives that are around, and I'm from  
5 Massachusetts so I'm probably more familiar with them. But  
6 one of the -- I just wonder what your thought is on what  
7 happens when the providers aren't as collaborative as the  
8 collaborative?

9 [Laughter.]

10 MR. QUERAM: Well, first of all, I should tell all  
11 of you I'm not a physician, so "Dr. Queram" is overstating  
12 my qualifications and my title.

13 MS. KANE: Sorry.

14 MR. QUERAM: One thing that we are fond of saying  
15 is that when you've seen one regional quality collaborative,  
16 you've seen one regional quality collaborative. And so one  
17 of the strengths and perhaps one of the limitations of this  
18 model of bringing stakeholders together is that there's  
19 incredible variability. And we happen to have in our state,  
20 as I mentioned, a medical marketplace that is concentrated  
21 with multi-specialty physician groups and integrated  
22 delivery systems. We also tend to be in a part of the

1 country that's sort of naturally collaborative. We get  
2 along. We say hello to strangers on the street, you know,  
3 things of that sort. But that's not to say that there isn't  
4 tension that exists between and among our member  
5 organizations. But we work very hard at building social  
6 capital among all of the stakeholders, being very explicit  
7 in the goals that we seek to accomplish together, and we  
8 have certain behavioral norms that we expect of our member  
9 organizations and their participants that so far has enabled  
10 us to overcome those tensions. But I appreciate in other  
11 marketplaces that those tensions are much more extreme and  
12 difficult. That's probably why you don't see in many parts  
13 of the country these types of multi-stakeholder groups.

14 MS. KANE: What kind of sanctions do you actually  
15 have? Do you actually eject members who are not -- I'm just  
16 curious to know if you've come up with that kind of --

17 MR. QUERAM: No, we haven't had to resort to that,  
18 but one of the things on our website -- and we do abide by  
19 these -- is we established a statement of principles and a  
20 code of ethics that guides how we operate. One of them,  
21 just to cite an example, using Bob's reference to UCSF's  
22 presence in U.S. News and World Report and billboards, we

1 don't allow the use of our comparative performance metrics  
2 for marketing purposes. You won't see a billboard in  
3 Wisconsin that, you know, "ranks number one in WCHQ's  
4 performance measures" because the focus -- while we don't  
5 deny that there are competitive realities within and across  
6 markets in our state, the focus really is on using measures  
7 to benchmark performance and to share with one another in  
8 terms of best practices. And that was established right at  
9 the very inception of WCHQ in 2003.

10 DR. BERENSON: Yeah, I have a question for Bob  
11 Wachter. First, I'd want to say as a New York Giants fan  
12 going back to watching Willie Mays playing in the Polo  
13 Grounds, I want to share your jubilation around this -- but  
14 I have a serious question here.

15 If you could go to the slide, what about QIOs, I  
16 want to push a little bit on the bullet that says the  
17 business case for safety, quality drives organizations to  
18 seek improvement. I'm not so sure I understand the business  
19 case. You said at the beginning that you're not impressed  
20 by consumerism, that individuals are using the information  
21 to sort of make their selections, and that pride is pushing  
22 more of this. Health plans seem to be responding to demands

1 for very broad networks, have pretty much abandoned  
2 selective contracting, haven't been successful with tiered  
3 networks; payment by Medicare and plans tends to be still  
4 you get the fee-for-service payment whatever the outcome is,  
5 whatever the justification for the service. What's the  
6 business case?

7 DR. WACHTER: Again, Bob, I guess my view comes  
8 more from the hospital world than the rest of the world, and  
9 in the hospital world, I have been extremely impressed --  
10 and this is not just being at UCSF where I see a narrow  
11 sliver of the universe, but I've spent a fair amount of time  
12 at other meetings and at other institutions -- that the  
13 hospital that previously gave lip service to quality and  
14 safety now is focusing quite a bit and increasing resources  
15 -- in the beginning, of course, it's talk but after a while  
16 it's a recognition that we need people to do this work on  
17 how do we smooth the discharge process, on how do we perform  
18 well on all the publicly reported measures on preventing  
19 health care-associated infections, on preventing falls --  
20 all of these sort of things which I think were not the focus  
21 of hospitals as recently as ten years ago. There was an  
22 ethical case, but I believe they perceive a growing business

1 case, and some of it is, I think to a surprising degree,  
2 based simply on the transparency, and some of it is kind of  
3 prospective feeling that you are going to come out and are  
4 coming out with policies where there actually is money on  
5 the table that they either make or lose based on their  
6 performance in these areas, and it's going to take several  
7 years to perform well on those.

8           So I think that what that means to the practicing  
9 physician in a three-person office, at this point I think  
10 the business case is weak. What that means to your health  
11 plan trying to put together a provider network, I think the  
12 business case is not particularly strong there. But I think  
13 in some ways hospitals have --in the safety and quality  
14 field, hospitals have emerged in some ways as the test case  
15 of what does it look like to have an environment where  
16 there's more transparency, more accreditation pressure than  
17 there was, and at least the beginnings of payment  
18 differentials. And I believe they are responding.

19           MR. HACKBARTH: Actually, I was going to ask a  
20 similar question. I was struck by what you said, Bob, about  
21 the power of shame and pride, and to me that's almost an  
22 independent force. It's like the hospital paths or

1 consumerism, you know, individual patient choice, maybe  
2 payment incentives and the activities of insurers, either  
3 pay for performance or steering patients away from low-  
4 performing providers. And then the third is shame, pride,  
5 professionalism. And I thought what I was hearing you say  
6 was maybe of all of those the most powerful is the third.  
7 And the key to driving that is effective public reporting.

8 DR. WACHTER: I think my observation in the  
9 hospital world, at least so far -- and I think the Premiere  
10 Demonstration Project bears this out to some degree -- is  
11 that simple public reporting, the absence of consumerism has  
12 led to significant changes in behavior. If you look at the  
13 curves on all of the core measures, very impressive changes.  
14 You could argue are those the right measures, but at least  
15 those are the measures and people are improving without a  
16 lot of evidence of consumerism and without -- and so the  
17 question of pay for performance to my mind is not does it  
18 create more change than simple transparency, but does it  
19 create enough more change to be worth all of the hassles,  
20 all of the political challenges, your choices, you're paying  
21 best performers or best improvers, all those sort of things  
22 I think may it far more fraught than simple transparency.



1 And I think the lesson that I have gleaned from the last ten  
2 years of this in the hospital world has been that the  
3 transparency is quite transformative and that it's  
4 individual shame, pride and it's institutional shame, pride.  
5 It is the board which previously wasn't engaged in quality  
6 and safety, seeing these data and saying, "What's going on  
7 here?" and tapping the CEO on the shoulder and saying,  
8 "What's going on with our quality scores?" That creates a  
9 huge amount of trickle-down change. It actually creates a  
10 fair amount of internal pay for performance within  
11 organizations. So even if you're not doing it, the  
12 organization may say we have to move money around in  
13 different ways to get the physicians, for example, to  
14 perform in different ways than they were previously.

15 MR. QUERAM: I'd like to comment. Most of the  
16 measures that we -- we report some hospital measures, but  
17 we've increasingly put our emphasis in reporting measures of  
18 physician group performance and have been doing that, as I  
19 mentioned, since 2004. And the physician leaders, CEOs and  
20 chief medical officers from our member organizations, have  
21 said repeatedly in various forums that the publication of  
22 the performance data has changed the conversation inside

1 their organizations in a positive way, partly because our  
2 data is accurate and it's actionable, because we have built  
3 the measures and have a robust validation process that  
4 ensures that they're accurate. But it has changed how they  
5 approach their quality improvement initiatives internally.  
6 As Bob is suggesting, a number of the organizations use our  
7 measures as a component of their internal payment scheme for  
8 their physicians. And we have actually had pressure for us  
9 to move forward both with the value metric but also to begin  
10 to move beyond primary care and chronic disease into  
11 specialty measures. The impetus for that is coming from the  
12 physician groups themselves who want to get more of their  
13 physician colleagues engaged in this important work.

14           So I think I can attest to what Bob is saying.  
15 Our experience has been very similar.

16           DR. BERENSON: I just wanted to follow up because  
17 you're both emphasizing the transparency and the  
18 responsiveness to the published measures. What is happening  
19 to performance on unpublished -- on other activities related  
20 to quality? Because our measures are only able to capture a  
21 small sliver of care. Is this testing to the test or  
22 training to the test or whatever the term would be? Or is

1 there a real cultural change that is extending across the  
2 institution?

3 DR. WACHTER: I think we're at the tipping point  
4 between those two poles. I think in the beginning it was  
5 playing for the test. It was: Can we perform well on  
6 discharge instructions? We'll hire somebody to run around  
7 the building to do discharge instructions and check a box  
8 that we're doing that. Those measures that are game-able I  
9 think probably should go away, and I collaborated with Mark  
10 Chassin and a few other authors from the Joint Commission on  
11 an article making that point a few months ago in the New  
12 England Journal.

13 But I think what has happened, which I'm guessing  
14 is your intent all along, is that the measures now have  
15 become sufficiently broad that -- and by broad, I mean a  
16 mixture of outcomes and process and structure covering a  
17 bunch of different domains that the institution that was  
18 trying to get away with doing this as one-offs five years  
19 ago is now recognizing that doesn't work. And as they  
20 recognize it doesn't work, really very powerful things  
21 happen. They reorganize the way they do quality work. They  
22 recognize that they need to build capacity within their

1 caregivers, that people need to understand the science of  
2 quality and the science of safety, and they did not learn  
3 any of those things in medical or nursing school. They  
4 understand they need robust IT. Obviously, there are other  
5 pressures that are pushing that, but they are beginning to  
6 recognize that if we don't have a terrific IT system, we  
7 can't perform there.

8           So I think that is the critical point. You've  
9 gotten to the point, and I think increasingly we are all  
10 getting to the point, where you will not be able to do this  
11 as singular one-off kinds of activities. You have to  
12 systemically change the way information flows, the  
13 expertise.

14           There, of course, will always be a risk that if  
15 you are measuring MI and pneumonia and heart failure and  
16 stroke that those will garner more attention than, you know,  
17 another problem. And I think the cure for that is as the  
18 science gets better we can add in other domains, and we do  
19 that. But I think the pressure to create a different kind  
20 of organization to meet these demands I think has grown to  
21 the point that people are no longer approaching this as a  
22 single entity-by-entity endeavor.

1           MR. QUERAM:  If I could just add a comment from  
2   our experience, if you look at the longitudinal data of the  
3   measures that we've been reporting for some length of time,  
4   you'll see that there is separation in terms of both the  
5   level of performance but also the rate of performance year  
6   over year across the physician groups that are currently  
7   members in the collaborative.  And I think that speaks to  
8   the fact that there are a handful who have really driven  
9   quality improvement and data deeply into their cultures and  
10  have designed decision support tools and other elements that  
11  really emphasize continuous improvement across a broad  
12  spectrum.

13           I think the fact that we're reporting 24 and soon  
14  to be 27 ambulatory measures has made it a little bit more  
15  difficult to teach to the test, as you were suggesting, but  
16  we've also taken some steps to introduce composite measures  
17  so that we look at the ability of an organization to drive a  
18  complete system and process redesign around an entire  
19  disease process -- diabetes is the classic example -- so  
20  that we don't find ourselves looking at organizations that  
21  have one rate of performance on hemoglobin A1c testing and a  
22  different rate of performance on cholesterol testing, but

1 instead bring those together and reflect system-ness  
2 thinking in terms of performance. And I think you'll see  
3 some real separation in those organizations that have made  
4 this a cultural imperative, not just a project.

5 MR. HACKBARTH: Okay. Bob and I have to go to the  
6 penalty box for five minutes for round two questions in  
7 round one. Jennie, you're next. We're still on round one.

8 MS. HANSEN: We are? Could we go back to the  
9 slide right before this one on Medicare can save many lives?  
10 And this is for Dr. Wachter. Bob, as another San  
11 Franciscan, up until recently I too cheered the orange.

12 Moving on again to this aspect, you know, I'm  
13 struck by this particular slide in terms of, again, the  
14 utility of the conditions of participation and then your  
15 suggestions on the specific possible recommendations. And  
16 these are notable in that these are evidence-produced  
17 recommendations of what difference it can really make, so  
18 it's like driving actual change.

19 Where do you see these criteria -- like if these  
20 two specific elements were to be adopted, you know, where  
21 does that decision point come from in order to affect  
22 inpatient care safety, you know, for Medicare lives? So

1 where might that come from?

2 DR. WACHTER: Well, I don't understand the  
3 intricacies of the relationship between the COPs and the  
4 Joint Commission, for example, well enough to know exactly,  
5 I think, Jennie, to answer your question, because all I know  
6 is that when you're sitting in the hospital world and you  
7 know that the Joint Commission may come this morning at  
8 7:30, if one of the things that they will look at are, for  
9 example, that you can prove that 90 percent of the  
10 encounters your clinicians clean their hands, you'll do that  
11 and you'll have it done all the time. We're pretty good at  
12 playing for those tests. We do play for the tests. We want  
13 the test to be better. And whereas if you look at the  
14 conditions of participation around infection prevention, for  
15 example -- I was just reading them last night, you know, the  
16 infection prevention officer will keep a list of all the  
17 infections in the building. It's very static, it's very  
18 dated.

19 MS. HANSEN: Right.

20 DR. WACHTER: None of it reflects Peter  
21 Pronovost's work, you know, what we now know about central  
22 line infections, that you will be measuring the rates of

1 these things and you will be adopting evidence-based  
2 practices and bundles and all that.

3           Now, that's a hard thing to do. You've got to  
4 have a very dynamic process that's constantly synthesizing  
5 the evidence to come out with appropriate recommendations  
6 that can evolve with the times, not only as we learn new  
7 science, but -- I've written about the door-to-antibiotic  
8 measure. Sometimes we learn that a measure, a well-intended  
9 measure, actually didn't have the effects that we hoped for  
10 and needs to be discarded.

11           And so you just need a very, very nimble system  
12 that's mining the evidence and mining the experience of the  
13 organizations that are the subjects of these measures to see  
14 whether they're working and having the intended effects.  
15 And my impression of the COPs is they don't have that --  
16 that's not what's going on in them. They feel like they  
17 were promulgated many, many years ago. The enforcement is  
18 very -- you know, are you doing this or not? They don't  
19 seem to evolve with the times in a very, very dynamic  
20 environment. Ten, 15 years ago, that might have been fine.  
21 The environment and quality was not very dynamic. The  
22 research wasn't -- there wasn't funding for research and



1 safety and quality. That's just not the world today.

2 So I'm not sure exactly what the interface is, and  
3 this may be part of the problem. I know a fair amount about  
4 this field. But if you ask me could I tell you to the ninth  
5 decimal place where -- whose measure this is, the Joint  
6 Commission's or the COPs' or how do those interrelate to  
7 each other, I think it's a very tricky thing to do, and I  
8 think most people in this business would have no idea where  
9 these live exactly.

10 MS. HANSEN: Thank you.

11 MR. GEORGE MILLER: Two quick questions, one for  
12 both of you, on disparities in health care. I wonder if  
13 you've addressed that in either one of your organizations,  
14 how you've addressed them. Are there any quality measures  
15 that you measure to make sure that all of your patients  
16 receive the same quality of care and how you deal with  
17 cultural competencies in dealing with minority populations?  
18 And then probably the second question is more of a -- if you  
19 could describe the difference in quality with your urban  
20 health care counterparts versus rural health care, if  
21 there's any difference in quality, and if you could  
22 highlight positive and negative for either one of them.

1 Thank you.

2 DR. WACHTER: Thank you. I think it's a very,  
3 very important question. I think in terms of the  
4 disparities, we're a member of the University Health System  
5 Consortium, which does look at a wide array of quality and  
6 safety measures. I think in some ways it makes the point  
7 that not only does transparency and your feeling about your  
8 performance exist in the Medicare world, there are other  
9 lenses that we're looked at, and in that lens, one of the  
10 things that is looked at is a disparity measure which  
11 basically is the differences in your performance on quality  
12 and safety and patient experience standards based on  
13 different patient groups. And in that we pride ourselves on  
14 doing very well.

15 As I think about the activity, the specific  
16 activities, if you said what are you doing to address this  
17 as a specific activity, I'm actually not sure that I could  
18 come up with a lot of answers, which I think that's  
19 important. I always struggle with disparities, whether the  
20 right approach is you figure out a way to provide the best  
21 care to everyone sort of systemically or it requires a  
22 specific approach to specific populations. So I think we

1 probably do this better, but I think it is part of the  
2 measurement challenge that I'm reasonably certain that  
3 organizations and individuals that have disparities often  
4 don't know that. And that, again, what we've learned is  
5 transparency works, and I think this would be an area where,  
6 when we learn that there are differences, I think that's  
7 provocative and often gets organizations and people to  
8 approach their work differently.

9 MR. HACKBARTH: Could I just, Chris, ask a follow-  
10 up question of Bob? You referred to the consortium that  
11 you're part of, and this is one of the focal points at UCSF;  
12 there's not a big disparity within your institution --

13 DR. WACHTER: At least the data would say that we  
14 do well on that measure?

15 MR. HACKBARTH: What about other institutions? Or  
16 do you not see that data?

17 DR. WACHTER: I don't see that data and I'm  
18 guessing that this is an issue in terms of, to get to Bob's  
19 question, will we shine the light on certain things and  
20 forget about others? So it's going to be important, as we  
21 report your performance, if disparities are an important  
22 concern, which I believe they are, then that should be one

1 of the things that gets reported out. I believe that  
2 shining that light on the issue would create a change.

3 MR. HACKBARTH: The reason I'm focused on this is  
4 that in the earlier work that Anne did for us, one of the  
5 issues that we focused on is disparities. As I recall,  
6 Anne, and correct me if I'm wrong, there's some recent  
7 literature suggesting that a big portion of the difference  
8 in outcomes at the population level for the whole country is  
9 attributable not to differences within institutions, but  
10 rather, where different population groups go.

11 So it's a difference at the institutional level,  
12 not within institutions. I wanted to get your reaction to  
13 that, Bob or Chris.

14 DR. WACHTER: Well, I guess in the system I work  
15 in, we have a county hospital, we have a university  
16 hospital. I'm based at the university hospital now, but was  
17 based at the county hospital for five years. You have the  
18 same doctors, essentially the same nurses, a very, very  
19 different patient populations, and you need a different set  
20 of competencies for those populations, everything from  
21 interpreters to focusing more on health literacy in  
22 different groups.

1           I think, at least in my organization, I have seen  
2 that. At San Francisco General Hospital, we have built  
3 those in probably to a greater extent than we have in the  
4 university hospital because I think it's a bigger issue.  
5 But I think in none of these areas are we doing as well as  
6 we should and I imagine -- my sense is that part of that is  
7 because there is a general lack of skills and understanding  
8 in this area, and part of that is there is a general lack of  
9 -- transparency here is not the right word -- I think just  
10 data.

11           I think in many cases when people are exposed to  
12 data that demonstrates that there are disparities, they are  
13 surprised by it. They say, you know, I treat everybody the  
14 same. But the data are clear. So I think it's a very  
15 important part, as we move to this more robust and diverse  
16 quality measurement landscape, that building in measures of  
17 disparities, that people look and say, you know, it's the  
18 Golda Meir question, you're not doing so well, I think, are  
19 very important drivers of change.

20           What we've begun to learn is there are tools,  
21 whether it's some of the health literacy tools or others, or  
22 cultural kinds of training, there are tools that can help

1 providers and organizations reach a better place with regard  
2 to disparities. I think in many cases, these aren't used  
3 because the need to do them -- people don't perceive the  
4 need to do them.

5 I think in many cases, people think that, I'm sure  
6 there are disparities out there, those other people aren't  
7 as sensitive as I am, but it's only when you see the data  
8 about your own practice that you're motivated to change.

9 MR. QUERAM: A couple comments and I appreciate  
10 very much your question. When we started our public  
11 reporting, we organized our Web site along the six domains  
12 of the quality chasm report, and to this day, if you go to  
13 our Web site, you will see nothing under equity.

14 Part of the reason for that is, we have discovered  
15 that we lack a systematic method of collecting race,  
16 ethnicity, and primary language data from our physician  
17 groups. And so, we are in the early stages of developing a  
18 common methodology and a common or systematic approach to  
19 gather that information.

20 Similar to what Bob was just saying, we're a  
21 participant in the Aligning Forces for Quality Project of  
22 the Robert Wood Johnson Foundation, and RWJ is making a

1 major emphasis on disparities as part of their grantee  
2 requirements.

3           We were provided with data on the rate of leg  
4 amputations for African-American diabetic patients on a  
5 statewide basis, but a significant percentage of African-  
6 Americans in our state live in the Milwaukee area, and the  
7 rate, as you might guess, was quite a bit higher than for  
8 non-African-American populations. There was that similar  
9 phenomenon in terms of both shock and disbelief and  
10 questioning the data.

11           So that is what catalyzed us to begin to try to be  
12 more systematic in how we collect this information. We've  
13 contracted with the Population Health Institute at the  
14 University of Wisconsin, that other U-Dub that is sometimes  
15 referenced in the Seattle area, and we have begun to try to  
16 understand that data a little bit better, not so much to  
17 question its accuracy or its validity, but to help us  
18 identify where the opportunities, geographically, might be  
19 most robust for interventions. So I think we're on a  
20 journey. We're on a learning process.

21           And I'll say, in a state like Wisconsin, which is  
22 maybe a segue to your second question, sometimes disparities

1 have been seen in economic terms between what large  
2 organizations have available to them and what small  
3 organizations have available in terms of resources. So this  
4 has been a real cultural or sociological process for us, to  
5 begin to think differently about what we mean in terms of  
6 disparities.

7           In terms of differences between urban and rural  
8 facilities, we don't have good data on that, in part because  
9 we are voluntary and so our best data are for those  
10 organizations that are participating with us. There are  
11 some large organizations in what might be considered rural  
12 parts of our state. Marshfield Clinic, being a good  
13 example, is in the northern third of our state, which is  
14 pretty rural.

15           But we are participating in an empirical  
16 evaluation of the relationship between our public reporting  
17 and interventions that might be explaining the observed  
18 trend in quality improvement. As part of the study design  
19 for this, one of the control groups is non-WCHQ members, and  
20 we're doing a comparison using Medicare data, similar  
21 measures for WCHQ members using Medicaid data to non-WCHQ  
22 members.



1           My understanding is that some of the preliminary  
2 results that are coming out of this study show that the rate  
3 of performance in WCHQ members is consistently higher than  
4 non-WCHQ members. So it may not have the granularity to get  
5 down to the individual hospital or small physician group  
6 level, but on a broad basis, it does appear that  
7 participating in this type of public reporting initiative  
8 and learning collaborative is associated with higher rates  
9 of performance.

10           DR. BORMAN: As a practicing surgeon perspective,  
11 and thinking about this just from not necessarily a large  
12 entity perspective, some of what I see is, in thinking about  
13 our work primarily, related to a federal regulatory program,  
14 if you will, in these areas.

15           It seems to me what we have is sort of a process  
16 by which currently, regulators are throwing out measures  
17 that we all accept may or may not be great ones, and the  
18 subtitle is inviting you come back with relevant ones. All  
19 right?

20           Part of what I see as the problem here is that  
21 time and energy are diverted to meeting these throw-out-  
22 there measures, let's start somewhere, as opposed to the

1 come back with relevant and, as you say, nimble and dynamic.  
2 How do we sort of break that cycle? Because, for example,  
3 when things come out about not going to pay for UTIs or  
4 Meson resistance, staph infections, or whatever, what I see  
5 is an enormous defensive response of we screen everybody  
6 that walks in the door to prove they had it before we got  
7 them, as opposed to -- is there something better we could  
8 come back with that tries to get in the same areas?

9 I think with that is the question, I think, that  
10 you brought up, Bob, in your term of harmonizing, the notion  
11 of trying to make one measure do as opposed to ten that are  
12 circling on different facets of the same thing. Because  
13 there's just not enough time in the day for people to  
14 deliver care and do some of this stuff, and a spin-off of  
15 that is now sort of a quality safety bureaucracy enormously  
16 well-intentioned, but now is starting to rival some of the  
17 bureaucracies that we criticized as getting us to where we  
18 are to start with.

19 So how have you seen success in intervening in  
20 those kinds of cultures? Are there some take-homes from  
21 that? If there are, how can Medicare use its leverage to  
22 push those things down?

1 DR. WACHTER: Well, that's an enormously and  
2 important and tough question. I'll tell you my own view on  
3 this is that there are two views of this world and one is  
4 that none of this quality measurement stuff should have  
5 started until we had better measures that were really ready  
6 for prime time. I just don't believe that because I think  
7 we would never have started.

8 I think this is extraordinarily difficult work. I  
9 think it's technically difficult. I don't think we've put  
10 the resources into understanding how you measure quality and  
11 safety. Up until recently, I don't think the IT  
12 infrastructure is sufficient, none of it. I don't think the  
13 capability in provider groups is sufficient. We didn't  
14 learn how to do this in our training.

15 So I think I can't see a way of getting to where  
16 we want to get without going through this admittedly clunky  
17 stage where some of the measures are not great measures and  
18 feel a little bit trivial or clinically irrelevant, because  
19 I believe that providers had to go through their Kubler-  
20 Rossian stages and get to the point where they say, I get  
21 it. You're going to measure me, it's going to be available  
22 on the Web, I get that. At least make them clinically real

1 and accurate and timely and don't kill me with a thousand  
2 different measures.

3 I guess when I say harmonized and try to argue for  
4 fewer measures, I'm not -- because it gets at Bob's  
5 question. I'm not necessarily saying there should be one  
6 measure for heart failure because I don't think there is. I  
7 actually do think a diverse set of measures around how do we  
8 take care of patients with -- I mean, when I need my hip  
9 done, I actually want some measures of infection rates and  
10 technical skills, if there are such things, but most  
11 importantly, I want to know will I be able to walk 18 holes  
12 in three months. And I want a mixture of all of those  
13 things.

14 When I say non-harmonized, right now the specific  
15 measure of something, some process that relates to the care  
16 of patients with heart failure, you may have to measure that  
17 one measure five different ways for different stakeholders  
18 who are looking in on you. So I think that's the piece that  
19 has to get harmonized, not that there is going to be -- I  
20 don't believe we're going to have a single roll-up measure  
21 to figure out, am I a good internist or even am I a good  
22 internist or even am I good internist for a patient with

1 pneumonia.

2 But unfortunately, I think we have to go through  
3 this difficult stage because I think it is this difficult  
4 stage that leads to the industry, providers, organizations,  
5 and payers all coming together and saying, this is not  
6 exactly what we want, but the direction is the right  
7 direction, we just have to do it better.

8 MR. QUERAM: If I could just add a comment? I  
9 don't see this tension ending anytime soon. In some  
10 respects, that's what catalyzed the formation of our  
11 organization, the collaborative, back in 2001. A business  
12 coalition in south-central Wisconsin used administrative  
13 data to publish a comparative hospital performance report  
14 card that was, as you might guess, enormously controversial.

15 It immediately catalyzed, however, a very  
16 proactive response, both on the part of the State Hospital  
17 Association, to try to manage the evolution of quality  
18 measurement, but also, it led to the formation of WCHQ  
19 because I think physician leaders running many of these  
20 multi-specialty groups and integrated systems saw that the  
21 transparency imperative was coming their way and it's better  
22 to work in a collaborative way to try to balance the urgency

1 that purchasers feel with the equally strong sense on  
2 provider organizations. If we're going to do this, let's at  
3 least make sure that we get something that we can use to  
4 drive change in our organizations.

5           We found a way to keep that in balance, but it's  
6 dynamic because we don't have enough specialty measures.  
7 The specialty societies and other organizations have not  
8 stepped up to the plate to bring forward robust outcome  
9 measures quite apart from the data issues associated with  
10 how we populate those measures.

11           The other significant tension now is around the  
12 efficiency or value of care measures and using  
13 administrative data with episode groupers to come up with  
14 some portrayal of relative efficiency in terms of delivering  
15 good diabetes care.

16           So I don't see that ending. I don't know that is'  
17 necessarily a bad thing. I think how you harness that  
18 tension toward creative purposes is really the challenge and  
19 the opportunity.

20           DR. WACHTER: And I think for physician groups,  
21 it's our groups now that are saying these measures have to  
22 be more relevant and more authentic to our practice. But I

1 think by and large, we've not been central players to the  
2 development of those measures. We've been on the sidelines  
3 and we are reaping that to some extent. Other entities are  
4 developing these measures, but I think the only way we would  
5 have jumped into that pool is to feel that, feel that okay,  
6 we're being measured, but we're not -- we need to be more  
7 central to the process.

8 MR. HACKBARTH: Let me do a time check. Can I see  
9 hands of people who have questions or comments? Okay.  
10 We've got 40 minutes left so please keep that in mind in  
11 both your questions and, if possible, on the answers.

12 MR. ARMSTRONG: So let me briefly say that we are  
13 a participant in a program much like the one that, Chris,  
14 you've been describing and it's been very valuable. I  
15 appreciate many of the comments both of you have made about  
16 the transparent reporting of this kind of information and  
17 have seen evidence that it makes an enormous difference.

18 I am interested, though, in thinking about,  
19 particularly as we apply this to value we can create for the  
20 Medicare program, going further and, frankly, have come to  
21 believe that the reporting we've been talking about is just  
22 the ante. Now, this is baseline. The question is, what are

1 the consequences and how can we push this even further?

2 I guess the question I would ask would be, in  
3 particular, we're talking here about quality measures. We  
4 tend to think about quality of care. We tend actually to  
5 think about either process measures or technical quality  
6 measures. We're trying to think about how quality blends  
7 with utilization and cost measures for populations as well.

8 I think inevitably, we need to start more  
9 transparently reporting on some of those. I'm wondering  
10 what your comment about that might be.

11 DR. WACHTER: One of the privileges I have is I  
12 run a hospitalist group and I think because the field is  
13 still relatively new and because we often get money from our  
14 hospitals, it's been a field that's been, I think, ahead of  
15 the curve in terms of thinking about value and quality. I  
16 asked my group several months ago, how many of you -- out of  
17 50 docs -- how many of you were involved in a quality  
18 improvement project? About 30 people raised their hand. I  
19 asked, how many of you were involved in efficiency  
20 improvement projects? Two or three people raised their  
21 hands.

22 So I think what we've done in the last seven or



1 eight years is created a -- begun to create competencies in  
2 quality improvement, but we've sort of neglected the cost  
3 reduction efficiency part, and I think part of the challenge  
4 here is to create a balanced environment where we care about  
5 both equally.

6           One of the challenges I can tell you in hospitals,  
7 they have developed reasonably robust quality  
8 infrastructures and the efficiency infrastructure kind of  
9 lives in a different part of the building. That's not going  
10 to work because often the project is everything. It's how  
11 do we improve value, how do we improve quality, how do we  
12 improve efficiency. You need the same people around the  
13 table.

14           So I think we have to do a better job of  
15 harmonizing these and having the measures be sort of equally  
16 important. So I completely agree with you.

17           MR. QUERAM: I would make a couple of comments.  
18 We introduced a value metric for hospitals in 2005. It's on  
19 our Web site. It shows the intersection of a bundled set of  
20 process measures in all payer-adjusted DRG. It's been  
21 interesting to watch the migration of hospitals from various  
22 quadrants toward that ideal combination of high quality and

1 relatively low cost. So we've shown that it can be done.

2           To do it on the ambulatory side, we need Medicare  
3 data, one of the most critical things, and I know it's part  
4 of the Affordable Care Act, but the sooner we can get our  
5 hands on actual Medicare data for physician services and  
6 combine that with commercial data and ASO data and Medicaid  
7 data, we have a robust enough data set that we can begin to  
8 do much more accurate episode-based resource use profiling  
9 of physician groups. Then I think we can get to the point  
10 where we can come closer to matching denominators for  
11 various conditions and various procedures.

12           The other thing that I think would be really  
13 important to think about is looking to build on the  
14 integrated suite of tools that AHRQ and others have built  
15 over the years for patient experience with care and begin to  
16 look at patient-reported outcomes. I do think if we are  
17 moving toward the Triple Aim inexorably and focus on  
18 improved community health and individual health status, we  
19 need to hear the voice of the patient much more actively and  
20 telling what the net effect of their intersection with the  
21 health care system has been in terms of their quality of  
22 life. I think we need to experiment with tools by which to

1 make that happen.

2 DR. CASTELLANOS: Two questions. Chris, the first  
3 one is, could you turn on Slide 12? I would expect to see  
4 stars all over the country and I just see it in the north-  
5 central, northeast, and the west. It's the map with the  
6 stars. I'm just curious. I live in the southeast and I'm  
7 curious -- and there's a whole central area of the United  
8 States that doesn't have anything.

9 Is there a reason for that? I would hope we'd  
10 have it all over the place.

11 MR. QUERAM: Well, all of these organizations -- I  
12 know a reasonable amount about most of them and quite a bit  
13 more about some of them. But I think there's one common,  
14 maybe two common characteristics. They're all voluntary so  
15 there is no mandate that is requiring the formation of these  
16 organizations. I think it reflects that unique set of  
17 market characteristics, local leadership, other impetuses  
18 like rogue organizations publishing report cards or  
19 whatever.

20 But the other common denominator is there's  
21 incredible variability in terms of the infrastructure and  
22 the capacity to drive change, either in a metropolitan area

1 or across the state. But all of us suffer from having rich  
2 missions and challenging resource requirements. We are  
3 thinly resourced. Our organization for a statewide focus  
4 has eight full-time equivalents and an operating budget of  
5 about \$1.5 million a year to do this work. That's true of  
6 most of these organizations.

7 DR. CASTELLANOS: Bob, the question really is to  
8 you. I'm a practicing physician, too. I'm a urologist. I  
9 think you guys did a great job talking about quality and  
10 safety. One of the things that Glenn and myself have talked  
11 about in the past is appropriateness. I have not heard that  
12 one time, both on the national level and as it trickles down  
13 to the hospital, and at our local hospital we're having a  
14 real problem with the hospitals with appropriateness of what  
15 they do.

16 I think there's a need, even on the specialty  
17 level, because I've had a lot of discussions with my  
18 speciality organization, of trying to get some kind of help  
19 or resources to be able to look at some of the technical  
20 things you have to do when you starting thinking of  
21 appropriateness criteria.

22 Now, we're a Medicare committee and we talk about

1 SGR. That's a real big thing with appropriateness. I'm  
2 just wondering what kind of comments you may have concerning  
3 this.

4 DR. WACHTER: I couldn't agree with you more. I  
5 think appropriateness, in some ways, is the intersection of  
6 the two, the numerator and the denominator, the value  
7 equation. I believe up until recently, we have left  
8 appropriateness off the table, in part because it's, I  
9 think, more politically fraught than some of the other  
10 quality measures. But when you look at the waste in the  
11 system, that is, in some ways, a dominant issue, that people  
12 are doing things that are not appropriate and not evidence-  
13 based, how it has to be built into the next generation of  
14 quality measures. It's poor quality care, it's harmful  
15 care, and it's costly care.

16 So you're absolutely right. It should be a key  
17 part of any presentation talking about where measurement  
18 needs to go. Thank you.

19 DR. CASTELLANOS: What do you think we can do  
20 about it at this point in time, rather than just talk about  
21 it?

22 DR. WACHTER: Stop paying for it.

1 DR. CASTELLANOS: Thank you.

2 DR. WACHTER: Glenn asked for pithiness.

3 DR. CHERNOW: It's hard not to pay for it, of  
4 course, if we can't tell what it is, but that's a separate  
5 issue. The question I had is, Anne presented a whole litany  
6 of possible things we could do that weren't necessarily  
7 mutually exclusive and spanned a whole wide range of  
8 possible strategies. So I've been trying to synthesize this  
9 since we got this list and I've had a little bit of a hard  
10 time doing it.

11 I guess I have a few questions about where you  
12 think, in general, we might focus our attention. So one  
13 type of thing that comes out of all of this is that the  
14 measures aren't as soon as they could be, and there's two  
15 aspects of that. One is a very microsense which we go in  
16 and say, I don't like this measure, it was developed in  
17 1953, and it doesn't work very well.

18 Or we could say, well, the process by which these  
19 measures are developed and revised and renewed isn't very  
20 good and we could focus instead on the process as opposed to  
21 the measures, and within the process, we would worry that  
22 CMS is going through some process and there's six other

1 organizations that are going through processes and that's  
2 how we end up with measures that are static and not  
3 harmonized.

4           So, I guess, we can't control what other  
5 organizations do, per se, so question one is, how much  
6 should we focus on the process of the whole measurement  
7 setting, renewing it right. The second thing that comes up  
8 in sort of Anne's list of things, basically, has to do with  
9 money and how the money goes to these Technical Assistance  
10 Grants. So there's a notion which doesn't seem to work in  
11 most other areas of the economy, which is, you aren't doing  
12 well so I'm going to save you money so you can do well, but  
13 let's accept that that's okay here.

14           So the question is, is the problem that we just  
15 don't give enough money? Should we give more money to make  
16 low performers better? Or is the problem who gets the money  
17 and maybe you have some thoughts as to whether or not we  
18 should maybe make the business case stronger and step back  
19 and let the world work. Or do you think a much more  
20 aggressive, targeted, managerial intervention from CMS is  
21 worthwhile and how this sort of money goes?

22           And the third stream that seems to flow out of

1 this litany of things that Anne laid out and I may have  
2 missed something in my little typology is this sort of  
3 regulations and conditions of participation stuff. And  
4 again, it has the same flavor in my mind as before which is  
5 some of this is micro stuff. This would be a lot better if  
6 the conditions of participation didn't include this, because  
7 this is really not relevant anymore.

8           So just take this one off and then we're actually  
9 fine. Or the whole process by which the conditions of  
10 participation are set need revisiting and we need to go back  
11 and think about the process and how that works. And so,  
12 sort of in these three areas, I realize you're tempted to  
13 say well, you need to do all three, but it would be useful  
14 if we knew which ones you thought were most salient in  
15 places where there's sort of trade-offs between sort of what  
16 I would call micro-managing or changing the process, what  
17 you think we might want to focus on. I think that was a  
18 lot.

19           DR. WACHTER: Wow. Okay. No, these are all  
20 absolutely terrific questions. In general, if the outcome  
21 is not what you want, the chances are the process wasn't  
22 perfect and it's worth looking at the process to sort of get



1 to the issue of do you want systemic change or one-off  
2 changes. So the sort of the metaphor for what's happening  
3 within the provider organizations.

4           It does strike me that the process for measure  
5 development needs to be different than the one that we have,  
6 and it is interesting for you to say that we can't control  
7 all of these other organizations. They say the same thing  
8 about you, and they all say -- everybody agrees in principal  
9 on harmonization, but everybody kind of thinks their  
10 measures are the best ones. So we end up with this  
11 cacophony that I think has to be cleaned up.

12           So I don't know how to do that. I mean, I think  
13 that somehow everybody has to come around the table and  
14 agree to a set of principles and agree that we will all  
15 together only measure quality of heart failure care in one  
16 way.

17           DR. CHERNOW: So let me ask you about that. There  
18 has been some effort to improve harmonization through the  
19 National Quality Forum and Congress has begun providing some  
20 government funding for that as a vehicle for harmonization.  
21 Is that working?

22           DR. WACHTER: I think it's been helpful, yeah. I

1 think is it helpful. I think integration is becoming  
2 increasing important because as we all eventually have  
3 electronic health records. Right now, none of them really  
4 support quality measurement and quality improvement very  
5 well, but ultimately they'll have to. It will be much, much  
6 easier if there's a single way that we've chosen to measure  
7 the quality of care.

8           So I think this is getting better, but it is a  
9 fundamental tension with a lot of well-meaning organizations  
10 in the same pool trying to do the right thing, and the  
11 metaphor, of course, is in our world where you have a bunch  
12 of physicians come together and say, I agree on the need for  
13 standardization, let's see if I can everybody to agree to do  
14 it the way I do it without recognizing that we actually may  
15 have to compromise to come out with a single way of doing  
16 things. So it's tricky to do, but I do think this is an  
17 important thing to work on.

18           The issue of is there enough money being spent on  
19 quality improvement, of course not, but you don't have  
20 enough money to spend on everything that you want to spend  
21 on. I believe that in organizations that can afford it,  
22 that creating a return on investment for investing in

1 quality will get the kinds of things you want without  
2 necessarily having to provide supplemental Medicare money  
3 for technical assistance.

4 I think the challenge is for organizations that  
5 can't afford it, where we don't have the luxury of allowing  
6 them to go bankrupt if they can't do this well. I think  
7 that's a difficult balancing act. But I do believe that  
8 it's worth looking at the budget. I think the QIO structure  
9 is fundamentally not sound, but I think as you look at the  
10 budget for, are we getting bang for the buck for technical  
11 improvement, some of that money probably is going to  
12 organizations that could do this on their own and previously  
13 didn't because they didn't have to. And now they're going  
14 to have to and I think they will take money out of their  
15 operating budget to say we have to educate, we have to do  
16 team work training, we have to do simulation, things that we  
17 never would have thought of and we have to train the docs on  
18 the science of quality improvement.

19 Things they never would have done in the past, I  
20 believe they will do with sufficient pressure, and that may  
21 let you partly off the hook in terms of having to pay for it  
22 yourself. You're then going to have to target your

1 resources on poor performers that simply can't do it.

2 MR. HACKBARTH: And, Chris, do you agree with it?

3 MR. QUERAM: Yes. Just a couple of comments. I  
4 love Bob's pithiness. It's easy to be pithy when you have  
5 tenure.

6 [Laughter.]

7 DR. WACHTER: And provocative, too.

8 MR. QUERAM: And provocative maybe. But another  
9 driver to pithiness is the time constraints that we have, so  
10 I'll try to be very brief in response to your excellent  
11 questions.

12 I would say that the harmonization issue, yes, the  
13 NQF has made some progress, but I think two of the more  
14 robust multi-stakeholder groups doing performance reporting  
15 in the country is ourselves and, across the river, Minnesota  
16 Community Measurement. We're both reporting similar  
17 measures in different ways. We use different  
18 specifications, we have different denominator algorithms  
19 that we use to construct.

20 So one of the real challenges is to get this  
21 thousand flowers that have bloomed over the last few years  
22 to adopt exactly identical specifications and methods for

1 constructing measures so that we can compare mail facilities  
2 in Minnesota with mail facilities in Wisconsin and know that  
3 it's apples to apples.

4 But back to your point, I'd say three things. Tie  
5 payment to performance. That will make this real for  
6 provider organizations. I do think that there are still  
7 many, many health care organizations, hospitals and  
8 physicians who think this will just pass and therefore we  
9 don't have to pay attention to it. We'll just wait it out.

10 I think when we start to tie payment to  
11 performance, that will create a market for interventions. I  
12 do think that there should be flexibility to organizations  
13 to seek the technical assistance from entities such as  
14 ourselves and hold us accountable to drive results over a  
15 period of time using data that's accurate, valid, and has a  
16 baseline so you can see if we're delivering a result or not.

17 DR. KANE: This may or may not be a quick  
18 question, but how do you feel about -- so one of the areas,  
19 a lot of what you're talking about is really hospital-  
20 centric or system-centric, where there's some pretty large  
21 institution with some kind of resources trying to help  
22 upgrade the quality in the community.

1           But something like, I forget exactly, about 60  
2 percent of practices are small doctors out there in the  
3 community who are not yet affiliated, although it's  
4 shrinking, but that's still the majority. And one area  
5 where -- you know physicians have to renew their license  
6 every few years, but so far I don't think there's been any  
7 connection to any of these quality activities, and I'm just  
8 wondering what's your hope for that if there is any. Is  
9 that feasible or is that just ridiculously impossible, to  
10 create expectations around maintenance renewals that improve  
11 physicians' education or show proof of achieving certain  
12 levels of quality, competency?

13           DR. WACHTER: My bias is the board certification  
14 process is the right way to go and that those organizations  
15 are more connected to the providers, more nimble, more  
16 likely to keep up with the evidence, less politicized than  
17 using licensure as the mechanism to drive a level of quality  
18 improvement, I think it seems. I think certainly the  
19 licensure standards could be raised somewhat, and that would  
20 raise the boats, but it seems to me an unlikely mechanism to  
21 ensure that providers are keeping up with the literature or  
22 evolving their practice the way they should.

1           And I think you have this other problem with  
2 licensure which is a shortage of physicians in certain  
3 areas, that if you raise the bar too, too high you may  
4 exacerbate some of those challenges.

5           I can tell you at the board certification level,  
6 when I finished my residency in 1986, I passed by boards in  
7 internal medicine, and I was good to go for the rest of my  
8 life. That assumed that I would be a really good internist  
9 at age 67 based on that activity at age 28. That's  
10 ridiculous. So the boards now are moving to a much more  
11 continuous cycle of having to do something every year or  
12 two, pass the test more frequently, engage in quality  
13 improvement, and I think that is the leverage point to try  
14 to get physicians to be engaged when they are not parts of  
15 large organizations.

16           My final hope I think is that the ACOs, or  
17 whatever this turns out to be, will be a mechanism that the  
18 two or three doctors office is part of some larger entity  
19 that is accountable for their performance and helps enable  
20 their performance at a level they couldn't possibly achieve  
21 by themselves.

22           DR. BERENSON: A very quick question for Chris, in

1 your role as being on the IOM panel, looking at QIOs, to  
2 what extent do you think that the 9th Scope of Work was  
3 restructured in response to the IOM such that our work in  
4 looking at the QIO program should wait until we get some  
5 sort of assessment of how the 9th Scope worked out, or to  
6 what extent really are we in the same position as the IOM  
7 was in 2006 in which we could come to some judgments at this  
8 moment?

9 MR. QUERAM: Well, I do think that the IOM report  
10 had an impact on CMS's words. I'm not so sure it had an  
11 impact on their actions. I do believe that there was a  
12 sincere effort to feed back many of the recommendations and  
13 the conclusions.

14 I apologize if I sound skeptical, if downright  
15 conclusive, in my thinking that CMS has its own  
16 organization, has its own culture, its own established way  
17 of doing things, and I do not believe that that report had a  
18 magnitude of impact on how CMS approached that scope of  
19 work. I think the field is open to recommendations that  
20 could lead to more transformational change.

21 MS. HANSEN: In the area of institutions paying  
22 for some of this quality, if not in the future efficiency,



1 one other piece of work that we've done on the Commission is  
2 really raising some visibility to the use of graduate  
3 medical education or indirect medical education funds. I  
4 just wondered whether there's been any kind of discussion on  
5 the part of where from a universe of again not new Medicare  
6 funds, but basically repurposed for these kinds of things in  
7 order to assure that this curriculum be done, in tandem  
8 perhaps with the certification, but again thinking about  
9 existing funds that could elevate the quality and the value  
10 of use of Medicare money.

11 DR. WACHTER: Well, this is a discussion Glenn and  
12 I have had a number of times. I think Medicare has -- it's  
13 a perfectly reasonable, important question to ask: Are we  
14 getting our money's worth in training and are we training?  
15 Are we putting out the right product to achieve what we want  
16 in this world? I think the answer has been probably not.

17 And the question is do you use the lever of your  
18 control of those funds to drive the system in the right  
19 direction? I would say yes, but be careful.

20 I think this is a -- the environment of how we  
21 train medical nursing students, for example, or residents in  
22 medicine is pretty dynamic and reasonably well

1 regulated/accredited at this point. So the ACGMEs and the  
2 RRCs have proven to be at least modestly nimble. I mean  
3 nobody changes as quickly as anyone would like, but I think  
4 the requirements now for training programs to adopt quality  
5 improvement training, safety training projects are  
6 reasonable robust.

7           Now the problem is a lot of training programs  
8 aren't quite doing this at the level we'd like at this point  
9 because a lot of us don't know how to do this or don't have  
10 the faculty who know how to teach this, and I think that's  
11 an evolutionary phase. But I think that using, sort of  
12 taking the IME dollars and saying you must do this I think  
13 at this point would be redundant to the things that the  
14 accrediting bodies are already doing in the training domain.

15           That's not to say that this doesn't need to be  
16 changed, and I do think the strategy of giving that money to  
17 the hospital CEO to spend is not an effective strategy  
18 because it does lead to the programs essentially being  
19 beholden to the hospitals to give them money that is not  
20 fully oriented at the best possible training. So I think  
21 that needs to be rethought.

22           But in terms of using it to specifically change

1 quality and safety training, I think a lot of that is  
2 already happening at the level of the accreditation.

3 MR. GEORGE MILLER: Yeah, just briefly, since we  
4 have so many different vehicles for measuring quality, and I  
5 think you addressed it a little bit, but I want to circle  
6 around on it again. What is the best mechanism to come up  
7 with one set of standards for each of the categories that  
8 we're describing here today?

9 I mean we've got the Joint Commission, got  
10 different states, the QIOs, and on and on and on, NQF, and  
11 on and on and on. How would we do that and what's the best  
12 one?

13 And then how do you get everybody to engage, to  
14 participate since your -- this is under the 99-1 scenario  
15 that you talked about.

16 MR. QUERAM: Well, I think there was reference  
17 made earlier to the National Quality Forum, and I do think  
18 that many stakeholders have come to look to the NQF as the  
19 financial accounting standards board for health care, and to  
20 endorse standards and standard methods that can be widely  
21 adopted.

22 I think the problem that many people see with the

1 NQF, and it's not so much a problem with the NQF as it is  
2 the state of the industry or the state of the science, is  
3 that so many of the measures that have been endorsed aren't  
4 robust and tend to be process measures, not outcomes. So  
5 that's a phenomenon that will take care of itself over time,  
6 I think.

7           The other piece that many of us are hoping for, if  
8 nothing else, to provide a framework around which we can  
9 begin to have some constancy of purpose is the National  
10 Quality Strategy. We have dualing frameworks. We've got  
11 the Six Domains of the Institute of Medicine. We've got the  
12 National Priorities Partnership. Soon we'll have the Triple  
13 Aim. So how we integrate all of these into a coherent  
14 structure I think is going to be critically important, and  
15 many of us want to use that National Quality Strategy as an  
16 organizing principle.

17           But then I think it's incumbent upon organizations  
18 like us to resist this deep cultural norm we have in health  
19 care, to always want to tweak. Bob alluded to it. Now we  
20 want to measure diabetic care this way even though over in  
21 Minnesota they're measuring it that way because we've got  
22 better knowledge or better science behind how we want to do

1 it. So we have to find ways to overcome that, and I think  
2 organizations like ours are a vehicle to accomplish that,  
3 not the only one, but an important vehicle.

4 MS. BEHROOZI: Let me see if I can articulate  
5 this. Dr. Wachter, I wanted to get a little more of your  
6 thinking on P4P which I feel like, contrary to your maybe  
7 desire to be provocative or whatever, in some other areas  
8 you're a little coy about because you say P4P is not the  
9 only mechanism to promote, but you don't put it on either of  
10 the things that have worked less well or the things that  
11 have worked better, whereas you do put the Medicare COPs  
12 straight up on the things that haven't worked well. And I  
13 imagine that P4P systems suffer from some of the same  
14 deficiencies of the COPs with respect to the staticness and  
15 non-harmony of the measures.

16 So the question really is has your organization  
17 participated in, or are any of your payers using, systems  
18 that you feel like have been successful, or should they just  
19 all sit on the shelf until the standards, the quality  
20 standards get worked out?

21 DR. WACHTER: I didn't mean to be coy. I think  
22 I'm ambivalent about P4P. I think we're still in the -- we

1 should be in the humble, we don't quite understand this well  
2 phase.

3 I think we understand some things better than we  
4 used to. We understand that the amount of money at stake in  
5 most P4P programs is relatively small, and we understand  
6 that you can't just pay the best performers or the  
7 improvers; you have to cut that small amount of money in  
8 half. So there are just these structural issues with P4P  
9 that are tricky.

10 I don't see P4P in terms of the goodness of the  
11 measures. I don't see it being separable in many ways from  
12 transparency. I think that's its own issue. Are the  
13 measures good enough, are they authentic enough, are they  
14 real, are they evidence-based, to do something with them  
15 that will motivate change?

16 I think then you have -- once you get -- and I  
17 think the answer is we have to make it that way, and they  
18 are variable there now. It's getting better. As Chris  
19 says, this is a problem that I think solves itself over  
20 time, with all of the pressures.

21 Then I think you have to then be -- you have to be  
22 open then to all right now what do we do them? Do we report

1     them publically? Do we use P4P?

2                   And I think we are at the experimental stage where  
3     we're trying both of those, and the reason it's kind of in  
4     that middle range.

5                   Transparency worked much better than I would have  
6     expected.

7                   I think P4P; I've seen places where it worked very  
8     well, and I've seen places where it worked much less well  
9     than expected and does lead to, I think even more than  
10    transparency, this phenomenon that Bob worried about, which  
11    is completely paying for the test. You know. I'm going to  
12    do everything for my little bonus -- and in some ways its  
13    cultural impact on, and sort of being a threat to  
14    professionalism and the internal motivation.

15                   Transparency doesn't seem to do that.  
16    Transparency in some ways plays on people's motivation.  
17    They can say: I want to be a good doctor. Here's evidence  
18    that I'm not being a good doctor. I'm going to improve my  
19    practice because of that.

20                   Once money is at stake, I mean we're human beings.  
21    We'll react to the money. We'll jump through the hoop. But  
22    in some ways it feels wrong. It feels different than

1 transparency.

2           So I'm kind of ambivalent about it. I encourage,  
3 I think we should have further experiments and just kind of  
4 see how it goes over time, remaining open to the possibility  
5 that unlike many parts of the capitalist economy this may  
6 not turn out to be the most important driver -- differential  
7 payments. There are other drivers that may work well,  
8 equally well, be less politically fraught and less cultural  
9 challenging.

10           DR. DEAN: A couple of questions. First of all,  
11 thank you both. This has been a wonderful session.

12           Chris, first of all, you listed as one of the  
13 concerns about the Conditions of Participation the lack of  
14 appreciation for the primacy of culture. I mean we all know  
15 that that's a fundamental issue, and it's been a barrier  
16 we've all banged up against in various places. I'm  
17 interested in your experience or observation in where that  
18 has proven to be a problem what works as to try to -- what  
19 should I say -- attack, adjust, fix.

20           I mean certainly I assume that transparency is  
21 probably one of the big tools. What are your comments about  
22 that?



1           MR. QUERAM: Well, I know it's going to sound like  
2 a cliché or very trite, but I do think it comes down to  
3 leadership, both at the board level and at the executive  
4 level. The organizations, I alluded to this before, that  
5 have differentiated themselves across time in terms of both  
6 their level and rate of improvement -- level of performance,  
7 rate of improvement -- are those that have taken on deep  
8 cultural change within their organizations. They have  
9 adopted principles and techniques that have been shown to be  
10 effective in other industries, whether it's Six Sigma or  
11 Toyota production principles, and they have completely  
12 oriented their operation, not only their administrative  
13 processes but their clinical processes, to those  
14 philosophies and those tools of improvement.

15           And their performance shows. They're consistently  
16 high across all measures rather than one here and one there,  
17 but not all of them.

18           And the common characteristic in my observation  
19 that I would say is true of all of these organizations, and  
20 there's a handful of them in Wisconsin, is they have  
21 relentlessly passionate leadership at the CEO level that has  
22 driven this change. In a couple of cases, it's physicians

1 who just are unabashed in their belief that there is  
2 unacceptably high rates of variation from evidence-based  
3 practice and there's no longer excuses for that, and they  
4 have tenaciously taken on all doubters and all resistance.  
5 It's not easy, and it's not fun, and it's not quick, but  
6 they have built cultures of improvement. And they're held  
7 accountable to those cultures, to a balanced set of  
8 performance measures, by their board.

9           So I can't think of anything other than that; it's  
10 leadership.

11           DR. DEAN: Thank you.

12           Secondly, Bob, I'm a family doc. I practice in a  
13 very small rural community. So the issue I was really  
14 struck by, one of the requirements you suggested about  
15 hospital discharge summaries, because we deal with a lot of  
16 transfers going both directions. It has been one of the  
17 most frustrating parts of my clinical experience -- the  
18 inadequate level of transfer. And I mean I know the data  
19 show that it's at the handoff phase where a lot of the bad  
20 things happen.

21           Just as an example, just this week, we had a  
22 patient with a complex problem -- a guy that had a bad

1 stroke and a bunch of other complications transferred back  
2 from a tertiary care center. The information that was sent  
3 with him was six packets that full of printouts. They just  
4 took the EMR and hit print, I guess. I don't know. I mean  
5 it was almost worse than nothing at all.

6           And I guess I'm curious because even when we get  
7 discharge summaries, we have sat a -- we accept patients for  
8 our swing-bed program. We have a requirement which has hit  
9 some resistance, but I have said we just have to do it, that  
10 we demand that there be a physician-to-physician contact, a  
11 phone call from the physician.

12           And we get a lot of almost pushback from that,  
13 from specialists and the docs in the hospital, in the bigger  
14 hospitals, like this is a burden that they shouldn't have to  
15 contend with. Yet, in my view, it's an absolutely central  
16 part of the care. I feel at least I've failed at this point  
17 to communicate how important that is.

18           And when we do get discharge summaries, oftentimes  
19 there will be important data that isn't in there,  
20 significant changes in regimens that have taken place  
21 without any explanation as to why that happened. There are  
22 drugs that appear to be probably we don't need to continue,

1 but I don't have the data to justify stopping them, and so a  
2 lot of things get continued that I have real questions about  
3 whether they're necessary.

4 I'm interested in what do we do.

5 DR. WACHTER: I think, I mean that story is  
6 shameful, and we should all be ashamed of having  
7 perpetuating a system that created that.

8 I think the work that you've all done on  
9 readmissions is one of the most powerful things I've seen.  
10 As I look at lessons, things that I've seen in the last few  
11 years that were really impressive and important, I think the  
12 central line infection story has that dynamic. I think the  
13 readmission story is beginning to have that dynamic.

14 I think three or four years ago none of us knew  
15 our readmission rate. I think Jencks's study that came in  
16 the New England Journal was shocking -- 20 percent of  
17 Medicare patients are readmitted in a month. Are you  
18 kidding me? Then we all looked at our data, and it turns  
19 out it's true.

20 And it turns out it's not that hard to fix.  
21 Really, it turns out that there's a group of evidence-based  
22 practices that aren't rocket science, calling a patient

1 after the discharge, getting a good discharge summary,  
2 communicating with the primary care doc, getting the patient  
3 seen quickly, those sorts of things, not that hard.

4           We just didn't do it because the environment  
5 created this unbelievable set of silos. So most hospitals  
6 invested absolutely nothing in the process of making sure  
7 you got good information from me about the patient. We  
8 didn't invest enough psychological energy in recognizing how  
9 important that was, and just putting it on the table,  
10 presenting the data.

11           On this one, I think do having some financial skin  
12 in the game, that a readmission, an undue rate of  
13 readmission means you're not going to get paid. It will  
14 transform things.

15           And I think what's important is not only will it  
16 transform processes, meaning I need to get you a discharge  
17 summary, and actually 48 hours is liberal. You should have  
18 it at the moment the patient leaves the door, and I should  
19 be calling you as well.

20           But it also creates cultural change. It creates a  
21 change in philosophy that we say that our job is not done  
22 when the patient leaves the building; our job is done when

1 the patient is safely back in your care. That takes a  
2 cultural shift, and it happened because of the data. It  
3 happened because of the pressures, and I think it does  
4 happen because of some -- in this one, P4P I think is the  
5 right thing to do.

6 On behalf of the hospitals in the country, I'm  
7 sorry. That's a terrible story.

8 MR. HACKBARTH: Let me get Anne to put up Page 3  
9 from your set, Anne.

10 By way of summary, I just want to -- yeah, there  
11 you go. So I just want to go through these quickly and see  
12 if I'm hearing accurately what you're saying.

13 So Anne has listed here some of the ideas that we  
14 came up with in previous discussions about how we might  
15 reshape what is now the QIO program. One is as opposed to  
16 spreading the money broadly across the system, focus it more  
17 on the low performing providers. I think I hear from the  
18 two of you that probably makes some sense.

19 DR. WACHTER: Assuming that low performing and low  
20 resource are the same. I guess a low performing provider in  
21 an environment where I've got the money, I should be able to  
22 pay for that if you've created an environment where there's

1 skin that game.

2 MR. HACKBARTH: Okay. The second one, I'm not  
3 sure that we discussed all that much in this conversation.  
4 So I'm going to skip over that.

5 On the third bullet, change contract structure to  
6 engage low performers, a grant goes to low performers; they  
7 select a system agent. What I hear is a pretty strong  
8 endorsement of that -- that saying oh, you've got to get  
9 this via QIOs that are statewide or physician-controlled  
10 doesn't make sense to you. A more flexible system would be  
11 better.

12 The second one I think is a corollary of, the  
13 second sub-bullet is a corollary of the first, to help  
14 people identify potential agents.

15 Turning to Page 4, again I heard a clear message  
16 that the existing requirements are true restrictive, and a  
17 broader array of organizations ought to be eligible to  
18 provide assistance.

19 Well, let me ask this: Again, these are federal  
20 dollars. So the natural instinct is to say if we're going to  
21 be spending federal dollars to support technical assistant,  
22 there needs to be some criteria for who is eligible to

1 perform that task, but it needs to be looser. It's going to  
2 be sort of a difficult thing to say who's good enough or  
3 who's eligible, but not make it too restrictive.

4           Next bullet, allow flexibility, I think we covered  
5 that.

6           Next one, pair flexibility with accountability, I  
7 think Chris in particular, you spoke to that, that if an  
8 organization like yours is eligible to serve as providing  
9 technical assistance there ought to be real accountability.  
10 You ought to be measured in how well you're carrying out  
11 that function.

12           DR. WACHTER: I guess, Glenn, there's a broader  
13 point on that which I don't think we've talked much about,  
14 which is that part of the challenge here is that if you  
15 don't do well under the COPs, for example, the threat is you  
16 lose all of your Medicare funding. So creating some  
17 gradation of what happens, what bad thing happens if you  
18 didn't make it, but not the death penalty I think is very  
19 important. Right now, it's so terrible that everyone is  
20 reluctant to fire that bullet.

21           MR. HACKBARTH: Chris, what do you think?

22           MR. QUERAM: Well, yes, I wanted to make just two



1 quick comments. The criteria for technical assistant agents  
2 -- I may reflect a bias here because I know the paper spoke  
3 about other models as well, but one of the characteristics  
4 of the type of organization we represent is 501(c)(3), not-  
5 for-profit, clear mission and clear purpose directed at  
6 these same objectives. I think that clearly needs to be one  
7 of the criterion, if not a very strong one.

8           The other idea I think suffused through all of  
9 this is what's good for organizations like ours is the  
10 flexibility and accountability should equally apply to the  
11 QIOs. I think we have an established infrastructure that we  
12 need to find ways to unleash, and see what their creativity  
13 and what their potential is.

14           So I think it's important in all of the comments  
15 that we've made. It's not an either/or or a zero-sum game.  
16 I think there needs to be increased flexibility within the  
17 current QIO construct as well as making it possible for  
18 other organizations to participate.

19           MR. HACKBARTH: And what do you think, Chris,  
20 about the idea of intermediate sanctions so as opposed to  
21 just having the death penalty exclusion from the program?

22           MR. QUERAM: Oh, no, very strongly in favor of

1 intermediate sanctions.

2 MR. HACKBARTH: Okay. Then the next page is about  
3 the Conditions of Participation. We didn't talk, I don't  
4 think, about the first point, which often comes up in the  
5 certification context for physicians, of having not just a  
6 base level but having sort of meritorious levels. Any quick  
7 thoughts on that?

8 DR. WACHTER: In general, I favor it. In general,  
9 I think it's part of transparency. It's making transparency  
10 a little bit more customer-friendly in that people can look  
11 and see where you are on that, and then the challenge is how  
12 you set the strata. But I think in general it's better than  
13 just yes or no.

14 MR. HACKBARTH: Yeah. Okay. Let's see.

15 I don't think we've talked too much about the  
16 second bullet or -- well, we talked about the last one as a  
17 pressing need, that the COPs are rigid, outdated, blah,  
18 blah, blah.

19 Any other thoughts that you want to offer on this  
20 set of bullets?

21 Okay. Thank you very much. Terrific  
22 presentations and very, very helpful. We appreciate your

1 taking the time. Thanks.

2 We now need to move on to our last session on  
3 "Hospitals' Capacity to Serve Medicare Patients." So this  
4 is like a first installment on our hospital payment adequacy  
5 framework. Zach?

6 MR. GAUMER: Okay. Each year as a part of our  
7 hospital payment adequacy analysis, we assess Medicare  
8 beneficiaries' access to hospital care by evaluating trends  
9 and a set of indicators that measure hospital capacity, the  
10 scope of hospital services offered, utilization, and the  
11 financial stability of the industry as it relates to  
12 capacity and capacity growth. Collectively, these measures  
13 provide context to draw general conclusions about the  
14 availability of hospital services to Medicare beneficiaries.

15 This year, we're presenting hospital access  
16 information to you in November because our work includes a  
17 few new measures, such as hospital consolidation. We'd like  
18 to gather your perspective on whether these new and old  
19 measures adequately inform your decision making.

20 Please keep in mind that this is the first of two  
21 installments, as Glenn said. In December, we will present  
22 data on other hospital issues, such as margins.

1           As a result of our evaluation -- you can see a  
2 summation of the conclusions here -- we believe hospital  
3 capacity has increased and Medicare beneficiaries' access to  
4 hospital services remains good. Contributing to this  
5 conclusion are the facts that hospital facility and bed  
6 capacity increased, the level of hospital consolidation  
7 remains steady, hospitals have expanded their scope of  
8 services, the industry has demonstrated continued investment  
9 in capacity and maintains access to capital to do so, and  
10 the change in utilization appears reasonable.

11           The number of acute care hospitals entering the  
12 Medicare program exceeded the number of hospitals exiting  
13 the program in 2009. Specifically, 31 hospitals opened and  
14 17 hospitals closed, and as a result, this was the eighth  
15 consecutive year in which hospital openings exceeded  
16 closings. Among the 31 hospitals that opened, the average  
17 bed size was 54 beds. Just over half of them were for-  
18 profit hospitals and most opened in urban areas. More than  
19 half of the new hospitals opened in four different States,  
20 Ohio, Texas, Oklahoma, and California.

21           By contrast, the 17 hospitals that exited the  
22 program were larger than those that opened and a larger

1 share of these were nonprofit hospitals. These hospitals  
2 had an average bed size of 190 beds. Over half of them were  
3 nonprofit hospitals, and all were in urban locations. Five  
4 of the closed hospitals were in Pennsylvania, but not in the  
5 same marketplace.

6           In response to reading the chapter, Peter asked a  
7 question this past week about the trend in bed capacity as  
8 opposed to facility capacity, which we showed in the paper.  
9 In our chapter, we noted that hospitals' openings and  
10 closings resulted in a net decline of about 1,600 beds in  
11 2009. However, this figure does not include the volume of  
12 beds being added to existing facilities. What we know from  
13 the AHA survey data is that from 2006 to 2008, the number of  
14 hospital beds increased by approximately 11,000 beds  
15 nationally, from about 740,000 beds to 750,000 beds, and  
16 this recent increase comes after relatively consistent  
17 decline in the number of beds throughout the decade.

18           The analysis of hospital consolidation is new to  
19 our assessment of capacity and access. The trend in  
20 hospital mergers and acquisitions may be an indirect measure  
21 of access to hospital services because they may affect  
22 access to care if consolidation of the marketplace results

1 in price increases or bed capacity decline.

2 In general, we find that the volume of hospital  
3 merger and acquisition data have been steady in recent  
4 years, and smaller deals have been the norm over the past  
5 two years. In 2009, the hospital sector saw 52 mergers and  
6 acquisitions of hospitals in which 80 individual hospitals  
7 were acquired. The green bars on the chart above illustrate  
8 that the number of hospital deals has hovered around 50 or  
9 60 deals for the last five years, and the red bars suggest  
10 that the number of hospitals involved in each deal has  
11 become smaller. Many of the deals completed in 2006 and  
12 2007 -- you can see the spike there -- were multi-hospital  
13 deals, whereas more recent deals have included just one or  
14 two hospitals.

15 Deals made in 2009 differed from earlier years  
16 because the majority of deals involved regional hospital  
17 systems acquiring smaller local hospital systems or just  
18 smaller local independent hospitals. For example, 64  
19 percent of hospital merger and acquisition deals in 2009  
20 involved the regional systems as opposed to large national  
21 systems.

22 In addition, a disproportionate share of the

1 acquirers were for-profit entities. The majority of  
2 acquired hospitals were small, having less than 200 beds.  
3 They tended to be more financially solvent than they had  
4 been in past years, and nearly all of them were nonprofits.  
5 Data through the first eight months of 2008 suggest that the  
6 level of merger and acquisition activity is on par with what  
7 we saw in 2009.

8           A variety of sources have suggested that the rate  
9 at which hospitals are acquiring physician group practices  
10 has increased in recent years. This trend would suggest  
11 that hospital consolidation is broader than just hospitals  
12 acquiring hospitals and it would suggest that hospitals are  
13 diversifying their service lines, also expanding their  
14 referral bases and in turn maybe increasing their leverage  
15 with payers.

16           Data from the AHA survey revealed that the share  
17 of hospitals with an integrated physician employment model  
18 increased from approximately 31 percent in 2004 to 38  
19 percent in 2008. Different data from Irving Levin  
20 Associates reveals that the majority of hospitals' non-  
21 hospital acquisitions in 2009 were physician group  
22 practices. Among the acquisitions made by hospitals and

1 health systems in 2009, 66 percent were, in fact, hospitals,  
2 but 21 percent were physician group practices and eight  
3 percent were ASCs and about three percent were labs or  
4 diagnostic centers.

5           Finally here, PricewaterhouseCoopers concluded in  
6 a June 2010 publication that the number of individual  
7 physicians involved in merger acquisition deals spiked at  
8 the end of 2009. Over one-third of all physicians involved  
9 in merger and acquisitions from 2007 to 2010 occurred in  
10 deals that took place in the last two quarters of that span,  
11 the fourth quarter of 2009 and the first quarter of 2010.

12           Shifting to service offerings here, hospitals and  
13 their affiliated providers expanded the scope of their  
14 service offerings in 2008. Overall, 42 of the 50 clinical  
15 hospital services we tracked were offered by a larger share  
16 of hospitals in 2008 than in 2004.

17           The most pronounced expansion of services during  
18 this time was for translation services and for robotic  
19 surgical services. For example, translation services were  
20 offered by 65 percent of hospitals in 2004, and by 2008, 74  
21 percent of hospitals had translation services. That is an  
22 increase of about nine percentage points. Other services



1 that grew most rapidly were palliative care, cardiac  
2 catheterization, and neurological services. And many of the  
3 services that grew most rapidly were either relatively new  
4 services or very specialized.

5 By contrast, eight of the 50 services we track  
6 were offered by a smaller share of hospitals in 2008 than in  
7 2004, and most of these declined by just a percent or two.  
8 Urgent care centers are one of these, declining by one  
9 percentage point from 2004 to 2008. Other services that  
10 declined included burn care, cardiac ICUs, and a variety of  
11 different in-patient post-acute care services.

12 The majority of hospital services grew more  
13 rapidly at urban hospitals and slower at rural hospitals.  
14 For example, in the first block of services pictured in the  
15 lightest shade on the slide above, you can see three  
16 examples of this. You can see that the share of urban  
17 hospitals offering palliative care services increased by ten  
18 percentage points from 2004 to 2008, but the share of rural  
19 hospitals offering palliative care increased by three  
20 percentage points. More rapid expansion of access to  
21 hospital services at urban hospitals may be a consequence of  
22 the relative complexity of a given service.

1           In the slightly darker block directly below,  
2 translation and MRI services are examples of those that grew  
3 more rapidly at rural hospitals than at urban hospitals.

4           And in the last block, we see that while the  
5 majority of services increased to some degree, to the extent  
6 that there were reductions in service offerings, they tended  
7 to occur at rural hospitals and they tended to be associated  
8 with services that were relatively more complex. For  
9 example, up on the slide you can see that cardiac ICU  
10 services are an example of a service that declined in the  
11 rural setting relative to the urban setting.

12           On to employment. Hospital industry employment  
13 slowed in 2009, but remained positive and the industry  
14 continued to add jobs. Bureau of Labor Statistics data  
15 reveal that the number of individuals employed by hospitals  
16 increased about four percent over the last 36 months. This  
17 industry added approximately 180,000 jobs during this time,  
18 and as of September 2010, about 4.7 million people were  
19 employed by U.S. hospitals.

20           The industry's employment growth was slower than  
21 the rest of the health care sector, which grew by about 7.2  
22 percent. The segments of the health sector that expanded

1 the most rapidly were home health, outpatient care centers,  
2 and physicians' offices.

3 In contrast, hospital employment growth can be  
4 viewed as strong relative to the rest of the economy, which  
5 as you can see declined by about 6.6 percent in the past 36  
6 months. Very few sectors of the U.S. economy experienced  
7 positive employment growth over the last 36 months.

8 Over the last two years, hospitals continued to  
9 hire a broad assortment of staff, but certain occupations  
10 were added more rapidly than others. Among those that were  
11 added more rapidly were computer and math science  
12 occupations, which increased about ten percent from 2007 to  
13 2009, and others that increased rapidly were pharmacists,  
14 management occupations, social workers, and nurses. Very  
15 few occupations experienced an overall decline in hospital  
16 employment.

17 Two somewhat related measures of hospital industry  
18 investment in capacity displayed similar trends over the  
19 last decade. The first, non-federal hospital construction  
20 spending, represented in green on the chart above, declined  
21 slightly from 2009 following numerous consecutive years of  
22 increases. In 2009, hospitals invested about \$32 billion in

1 construction projects, a billion dollars less than they had  
2 in the previous year. In the context of the rest of the  
3 decade, the level of construction spending remains high.  
4 Hospital industry executives suggest that in addition to the  
5 slight decline, for the first time in several years, the  
6 majority of hospital construction projects were devoted to  
7 renovations of facilities as opposed to the building of new  
8 facilities.

9           The second indicator of investment in hospital  
10 capacity is the level of tax-exempt hospital bond issuances.  
11 This is represented in red on the slide above. In 2009, the  
12 level of bond issuances declined from about \$51 billion to  
13 \$44 billion. This decline follows numerous years of  
14 increases, and similar to what was observed with  
15 construction spending, the level of bond issuances in 2009  
16 remains high in the context of the decade. Financial  
17 analysts suggest that in the last year, hospitals have  
18 focused on controlling their capital expenditures by scaling  
19 back their construction projects and avoiding taking on new  
20 debt.

21           Last year when we discussed this one specific  
22 indicator of bond issuances, we described the general freeze

1 in the bond market at the end of 2008. Since that freeze,  
2 the bond market has opened up starting at the beginning of  
3 2009, and as of October 2010, interest rates had declined to  
4 their lowest levels in three years. We have heard that some  
5 hospitals have experienced difficulty accessing capital in  
6 2010, but judging from the low interest rates and the  
7 relatively high level of bond issuances, it appears that  
8 hospitals largely remain able to access capital at this  
9 time.

10           The number of overall inpatient discharges has  
11 declined over the last seven years and the overall number of  
12 outpatient services has increased. Medicare fee-for-service  
13 beneficiaries had approximately 11.2 million inpatient  
14 discharges in 2003 and slightly less than 11 million  
15 inpatient discharges in 2009. Beneficiaries also had  
16 approximately 123 million outpatient services in 2003 and  
17 approximately 160 million outpatient services in 2009.  
18 Various quarterly financial reports concerning hospital  
19 systems suggest that admissions volumes are down for all  
20 payers this year, including Medicare and non-Medicare  
21 patients.

22           The growth rates in inpatient and outpatient

1 services are somewhat clearer when we look at them in the  
2 context of the cumulative percent change in volume on a per  
3 beneficiary basis, and that's what we have pictured on the  
4 slide above. In this context, the red line displays that  
5 from 2003 to 2009, the cumulative percent change in  
6 inpatient discharges per fee-for-service Part A beneficiary  
7 was negative 3.6 percent. Medicare inpatient discharges  
8 declined about 2.3 percent per beneficiary from 2008 to  
9 2009, and this was the fourth consecutive year of decline  
10 and also the largest single year decline during that period.  
11 For 2003 to 2009, the cumulative percent change in  
12 outpatient services per fee-for-service Part B beneficiary  
13 was over 30 percent, as displayed by the yellow line above.  
14 And from 2008 to 2009 specifically, hospital outpatient  
15 services increased about 4.8 percent per beneficiary.

16 In light of this decline in inpatient discharges,  
17 we have also observed a slight decline in the share of  
18 beneficiaries who use inpatient services in a given year.  
19 From 2003 to 2009, the share of Medicare fee-for-service  
20 Part A beneficiaries who had an inpatient claim declined  
21 from 23 percent to about 22 percent. We observed wide  
22 variation in the share of beneficiaries using inpatient

1 services in different geographic locations, across different  
2 age groups, and across different racial populations.  
3 Therefore, we cannot definitively say that this decline in  
4 inpatient services represents a decline in access.

5           Moving to our discussion on the subject, I just  
6 wanted to remind you that Jeff Stensland and others will be  
7 presenting a second installment of the hospital update  
8 measures in December.

9           And also, at our retreat this past July, some of  
10 you raised questions about the access to capital and  
11 capacity measures that we usually present and did today as a  
12 part of the update process. Therefore, we would like to  
13 gather from you your opinions about whether the measures,  
14 such as hospital consolidation or construction spending or  
15 bond issuances, are useful in making your update  
16 recommendations for hospitals.

17           Thanks for your time, and I'd be happy to take  
18 your questions.

19           MR. HACKBARTH: Okay. Thank you, Zach.

20           For the benefit of the new Commissioners, let me  
21 put this in a little bit more context. So as you know, each  
22 year we make recommendations on the updates and we go

1 through what we refer to as a payment adequacy analysis to  
2 help inform that decision. And so we look at information on  
3 a variety of different factors, including access to care,  
4 quality, access to capital, supply of services, and margins,  
5 Medicare margins, where that data is available. So this is  
6 one installment.

7           As Zach indicated and as we discussed at the  
8 retreat, there have been questions about the utility of some  
9 pieces of that framework. So to focus on this material in  
10 particular, information about changes in the supply of  
11 hospital beds is obviously influenced somewhat by Medicare,  
12 but influenced by factors that go well beyond the Medicare  
13 program. So in that sense, it's not a highly powerful tool  
14 in telling you whether Medicare's payments are accurate or  
15 not.

16           So one of the questions that's being raised is, is  
17 it useful to provide such information or are there ways that  
18 it could be reformulated that might make it more powerful in  
19 making a decision about Medicare payment rates. So let me  
20 give an illustration.

21           On the supply of hospital beds, maybe what I would  
22 really want to know is are hospitals closing in areas where



1 there is a shortage of beds or a really tight supply. That  
2 would be an indicator of -- it still wouldn't be Medicare-  
3 specific, but if it's a tight market and we see hospitals  
4 closing, that would be an indicator of some real financial  
5 distress. Conversely, if we see lots of hospitals opening  
6 in markets where there is real low occupancy rate on average  
7 and a lot of excess capacity, that might be an indicator of  
8 quite a generous payment, again, albeit not Medicare-  
9 specific. So there are ways that we can somewhat increase  
10 the power of the information, even if it's not necessarily  
11 Medicare-specific.

12 Did that help at all? Do you sort of understand  
13 what we're trying to get at here? Whether it helped or not,  
14 we're going to go to round one clarifying questions. Karen,  
15 I think it's your turn, Scott, and then Ron.

16 MR. ARMSTRONG: Actually, your comments were very  
17 helpful, thank you, and spoke directly to a question I had,  
18 and that was I would be more familiar with, and I think it  
19 might be helpful to look at beds per thousand. And then you  
20 also have -- you're looking at the admission rates. That's  
21 interesting, but I would always ask as a complement to that  
22 the base rate to go with the admission rate, whether it is a

1 rate per thousand or whatever that might look like.

2 DR. CASTELLANOS: [Off microphone.] Slide 6,  
3 please. With the translation services, I could be mistaken,  
4 but that's -- I thought under limited English proficiency  
5 was a non-funded mandate that all hospitals have to provide  
6 that and all physicians have to provide that. And I'm just  
7 curious, the percentages, I thought it was a Federal law and  
8 a mandate that they had to provide that.

9 MR. GAUMER: I need to look into that, actually.  
10 I'm not sure --

11 DR. CASTELLANOS: Yes. It is a Federal law --

12 MR. GAUMER: Okay.

13 DR. CASTELLANOS: -- and we have to do it in a  
14 physician's office. It's non-funded, also.

15 MR. GAUMER: Okay.

16 DR. CASTELLANOS: Could you put on Slide 8?

17 MR. HACKBARTH: [Off microphone.] Before we go on  
18 --

19 DR. BERENSON: Yes. I was going to ask exactly  
20 the same question. My hypothesis is that there are these  
21 phone-in services that hospitals can use to get translation  
22 and what we're capturing is an in-hospital dedicated

1 activity, but that we still -- I was going to ask exactly  
2 the same question.

3 DR. CASTELLANOS: Okay. Well, you know, you could  
4 be correct on that, but I know it needs to be provided,  
5 however.

6 Could we go to Slide 8 for a second? Of the four  
7 percent of hospital employment, you mentioned computer,  
8 pharmacy. What percentage of physicians are being hired in  
9 that four percent?

10 MR. GAUMER: Well, we didn't include the  
11 physicians in the breakout of occupations because the BLS  
12 data, I think, are not optimal for the physician counts.  
13 There's a little uneasiness on our side about what's in  
14 there and what's being reported in the larger BLS survey  
15 that's collecting this, because it's a sample. So I think,  
16 generally, the feeling is that more and more physicians are  
17 getting hired directly by hospitals and we can see that if  
18 we go to -- let me see if I get the right -- right here on  
19 Slide 5, the first bullet here, where we looked at AHA  
20 survey data and we showed that -- what we found, that  
21 basically 31 percent of hospitals in 2004 had an integrated  
22 physician payment model working, and we interpret that as

1 more physicians being hired directly by hospitals. And so  
2 we're seeing some growth here, I think, generally, in that  
3 measure.

4 DR. CASTELLANOS: And the last question, and it's  
5 part of, I guess, the hospital beds. Since you brought it  
6 up, let me continue on that. I'm a little concerned,  
7 because there's no mention -- we have an aging population  
8 and the people are living longer. We have the baby boomers  
9 coming up. Under PPACA, we have, what, 31 million people  
10 now perhaps going to be insured and will be using hospital  
11 beds. I know in the article you mentioned we had a loss of  
12 1,600 beds, and I look at Chart 2 and you still think  
13 there's a slight increase in the beds.

14 MR. GAUMER: Mm-hmm.

15 DR. CASTELLANOS: I just wondered, did you take  
16 into consideration the aging population, the baby boomers,  
17 PPACA with the need?

18 MR. GAUMER: That was a very similar question that  
19 Peter fed to us earlier in the week, as well. And so that  
20 1,600 bed loss was specific to the hospitals that were  
21 entering or exiting the program. But what's not in that  
22 1,600, net 1,600 bed count, is the beds that are being added

1 by existing facilities -- added or subtracted by existing  
2 facilities. So overall, we are seeing a more recent  
3 increase in bed capacity on a raw level. We haven't looked  
4 at it per beneficiary, and we can do that.

5 DR. CASTELLANOS: The reason I'm bringing this up  
6 is that I recognize there's regional variations. In our  
7 community now because of the winter visitors, we have a bed  
8 shortage now. People are out in the halls. People are here  
9 and there and everywhere. We have a lot of old buildings  
10 that are going under construction now. A lot of the three-  
11 and four-bed wards are now being cut back to one bed and  
12 some of the small rooms, we're losing beds. So I just think  
13 the bed capacity, at least as a practicing physician, is a  
14 concern in my community and I just -- I look at this slight  
15 increase and I'm just concerned.

16 MR. HACKBARTH: And I think you're making a good  
17 point, a logical point. We're not making any statement  
18 about the need for beds. We're simply reporting on what the  
19 trends are, and so you're identifying factors that, at least  
20 in some communities, may justify an acceleration in the rate  
21 of growth in beds, which is part of what I was trying to get  
22 at. On the other hand, if you see beds being added at a

1 significant rate in communities where there's lots of excess  
2 capacity, that also at least raises a question in my mind.

3 Round one clarifying questions?

4 DR. BAICKER: On Slide 10, I was a little  
5 uncertain about how to interpret the units. If I think  
6 about some potential substitutability of outpatient care for  
7 what used to be inpatient care, would one inpatient  
8 discharge translate to one outpatient service, or ten  
9 outpatient services because you go through a series of  
10 things that are billed separately? I just wasn't sure how  
11 to interpret the axis for the two different measures.

12 MR. GAUMER: Yes. There's not a one-for-one  
13 relationship because of the volume of different outpatient  
14 claims that are coming in, and there was an attempt in this  
15 data that Dan very well does every year to pull these  
16 together and consolidate them as much as possible. So it's  
17 not a one-for-one relationship, but it's somewhere between  
18 that and the very raw relationship of all outpatient claims  
19 --

20 DR. BAICKER: So what is --

21 DR. CHERNEW: [Off microphone.] This is on a  
22 different base, though. The base --

1 DR. BAICKER: Sure. Sure. But what -- I'm just  
2 trying to figure out what the unit of observation is. Is it  
3 a claim or is it a --

4 MR. HACKBARTH: It's the unit in the outpatient  
5 payment system, isn't it?

6 MR. GAUMER: That's right. It begins with a  
7 claim.

8 MR. HACKBARTH: Yes. And so they are, generally  
9 speaking, pretty small units as opposed to discharges, which  
10 are bundling a lot of services together.

11 DR. BAICKER: [Off microphone.] So this is all  
12 normalized to zero.

13 MR. HACKBARTH: Yes. Clarifying questions?

14 DR. MARK MILLER: And I think, too, the conceptual  
15 point, I don't think you look at this as strictly  
16 substitution, which I think is what you were asking. There  
17 may be some of that going on, but certainly not one-to-one.

18 DR. BERENSON: My question has to do with  
19 reporting on closures and acquisitions. If a hospital is  
20 acquired but remains as an operating hospital, it doesn't  
21 show up as a closure, I assume. It's still a licensed  
22 hospital.

1           MR. GAUMER: That's right. So we took the efforts  
2 to weed out all of those kind of gray areas and run through  
3 the list each year and figure out which ones are actually  
4 still open but may have a different provider I.D. number.  
5 Where this starts is with provider I.D. numbers, you know.

6           DR. BERENSON: Right.

7           MR. GAUMER: If 400 new provider I.D. numbers pop  
8 up, we try and track down what is actually coming and going  
9 and not just getting a new name and a new lobby.

10          DR. BERENSON: Okay. So you think you've cleaned  
11 that up?

12          MR. GAUMER: Yes.

13          DR. BERENSON: Okay.

14          MR. HACKBARTH: Round one clarifying questions?  
15 George?

16          MR. GEORGE MILLER: Yes. Back to Ron's question  
17 on bed capacity, I don't know if you said this or not, I  
18 apologize, but I've missed it. Are you talking licensed  
19 beds or occupied beds as on the cost reports? What are you  
20 using for beds?

21          MR. GAUMER: We looked at staffed beds --

22          MR. GEORGE MILLER: Staffed beds, okay.



1 MR. GAUMER: -- as reported on the AHA survey.

2 MR. GEORGE MILLER: Okay, staffed beds. And so  
3 you're talking about the increase of about 1,600 beds, did I  
4 hear that correctly?

5 MR. GAUMER: No. When comparing the beds  
6 associated with those hospitals that are opening and  
7 closing, we saw a decline of 1,600 beds coming and going.

8 MR. GEORGE MILLER: Okay.

9 MR. GAUMER: But that doesn't factor in what else  
10 is going on out there.

11 MR. GEORGE MILLER: Okay.

12 MR. GAUMER: But the general trend over the last  
13 two years has been a slow increase, and I say the last two  
14 years, from 2006 to 2008, which is the most recent data.  
15 There's been a slight uptick in the number of beds out  
16 there, about 11,000 beds, which is small relative to the  
17 750,000 that are out there.

18 MR. GEORGE MILLER: And what's the timing of the  
19 data again from the AHA survey?

20 MR. GAUMER: That would be 2006 to 2008.

21 MR. GEORGE MILLER: Okay. Okay. So since that  
22 time, again, I'm just thinking in my community, we closed

1 beds, didn't staff beds because there was a new hospital,  
2 doctors' hospital opening in town, and to save dollars,  
3 we're not going to close a hospital, but we'll certainly  
4 close services. So your survey wouldn't include any changes  
5 in the last two years, just since 2008?

6 MR. GAUMER: Right.

7 MR. GEORGE MILLER: Okay.

8 MR. GAUMER: It wouldn't match with the time  
9 period of the chart above, which is 2009 as the earliest.  
10 But yes. So we wouldn't have 2009 and 2010 data in there.

11 MR. GEORGE MILLER: Okay. And then quickly on the  
12 slide dealing with the inpatient and outpatient, Slide 10,  
13 is there a correlation between the increase in outpatient  
14 and the decrease in inpatient to the bed capacity at all?  
15 It's probably hard to figure that out, because this is only  
16 Medicare data and not the total. But I wonder if there's a  
17 correlation.

18 MR. GAUMER: We haven't looked at the correlation  
19 specifically with bed capacity.

20 MR. GEORGE MILLER: Okay.

21 MR. GAUMER: We can do some thinking about that.

22 MR. GEORGE MILLER: Yes. But the problem would

1 be, this wouldn't be all the data --

2 MR. GAUMER: That's correct.

3 MR. GEORGE MILLER: Yes. Okay. Thanks.

4 MR. HACKBARTH: Round two? Karen?

5 DR. BORMAN: Zach, I wanted to go to your question  
6 to us about is this helpful, and just can answer for myself.  
7 I certainly think that I try to look at this in the sense of  
8 more big picture, and so I think having more information,  
9 albeit biopsies, if you will, and not necessarily the whole  
10 specimen, are helpful to me. I certainly can't pretend to  
11 think that I can look at what you present to us and in some  
12 very numerically driven scientific calculation come out to  
13 say, this is what we should recommend as an update, or  
14 whatever else. That's way past me. But I do find the  
15 notion of multiple snapshots or biopsies or data points,  
16 recognizing that they're not all specific to the Medicare  
17 program, do help me frame a more general concept from which  
18 I can try and develop some principles to look at  
19 consistently from time period to time period. So in my  
20 world, these information are helpful as long as you present  
21 to us their limitations and positives, as you do so well.

22 The one comment I would make is that from my

1 perspective, in addition to the question of how do we  
2 sharpen these up to be helpful, is are there analogous kinds  
3 of things that we can ask about the other parts of the  
4 program that we look at that would give us a more fully  
5 fleshed-out big picture in order to make evaluations in  
6 those, because I think hospital is a place where we have  
7 sort of gone out of the beginning update box that we lived  
8 in and now we have built a bigger box, and I just wonder if  
9 part of our thinking should be, can we build some bigger  
10 boxes for the other parts of the things that we consider.  
11 So I know that's not your job, but I just throw that out  
12 there as a concept.

13 MR. HACKBARTH: About other provider groups?

14 DR. BORMAN: Right.

15 MR. HACKBARTH: So I think in all of them, we  
16 provide data that are roughly comparable to these in terms  
17 of capacity, trends and capacity, capital investment, and  
18 the like. Now, the data aren't always exactly the same. In  
19 some, they may be stronger or weaker. But there's analogs  
20 to this, I think, for the other provider groups.

21 DR. BORMAN: I mean, I know we look at some of the  
22 company data in some of the home health agency DME, some of

1 those kinds of things. I just wonder, for example, albeit  
2 not necessarily a clear mandate for us to make a physician  
3 update, there might be some data about physicians per capita  
4 and some of the other distributions --

5 MR. HACKBARTH: Some ratios or --

6 DR. BORMAN: -- that might help us a little bit in  
7 thinking about that. We talked a lot about what is the  
8 right distribution, but maybe just in terms of saying some  
9 big trends, can we think about that a little bit. Just a  
10 thought.

11 MR. HACKBARTH: Yes. Home health is actually an  
12 interesting example of how, depending on the sector, there  
13 can be special challenges. So thinking about home health  
14 capacity is always difficult because it's not bricks and  
15 mortar dependent, so the data that we have is counts of  
16 agencies which tell you almost nothing about capacity. So  
17 there are particular challenges for some sectors.

18 Scott?

19 MR. ARMSTRONG: The one comment I would make,  
20 which I think is kind of in the same neighborhood as this  
21 last comment, is that this relationship between inpatient  
22 utilization and outpatient utilization that's hospital-based

1 is kind of interesting, but I'm spending a lot of time  
2 worrying about the movement of physician practice-based  
3 outpatient procedures to hospital-based outpatient  
4 procedures, and it may be outside the scope of a hospital  
5 evaluation or profile that we're doing, but for what it's  
6 worth, that may be driving part of that yellow line in the  
7 slope there and it just might be worth looking at if that's  
8 in the scope of this report.

9 DR. CASTELLANOS: I guess I'm fixated on hospital  
10 beds. I forgot to ask, where did the observation beds fit  
11 into this, since they're not hospital admissions?

12 MR. GAUMER: The observation bed unit doesn't  
13 necessarily get captured in the same way that a staffed  
14 hospital bed gets captured because it's kind of an amorphous  
15 thing. But related to this slide, the observation issue is  
16 tied in here and such things. But we don't have a count of  
17 specific observation beds, and I guess to give more detail  
18 on that, that's because they aren't counted by a lot of the  
19 surveys specifically, and also some hospitals don't identify  
20 what's an observation bed versus what's an inpatient bed or  
21 an observation unit, even.

22 DR. CASTELLANOS: But it's still a bed that's

1 occupied by a patient that prevents other patients from  
2 using that bed.

3 MR. GAUMER: Right.

4 DR. CASTELLANOS: So shouldn't it be counted?

5 MR. GAUMER: It gets folded into the staffed beds  
6 count. I think that more directly answers your question.

7 MR. HACKBARTH: I'm confused now. I thought I  
8 heard you say that it was not included in the staffed bed  
9 count because --

10 MR. GAUMER: Sorry. What I meant was that they're  
11 not folded in or counted by a hospital specifically.  
12 They're all lumped into the same staffed bed on the AHA  
13 hospital survey.

14 MR. HACKBARTH: Oh, I see. I see. They're not --

15 MR. GAUMER: Sorry.

16 MR. HACKBARTH: There's not a separate subcategory  
17 for observation beds. It's just staffed beds versus --

18 MR. GAUMER: Yes, exactly.

19 MR. HACKBARTH: Okay. I have got you.

20 MR. GAUMER: But you might get a different answer  
21 from an administrator who may have different counts in their  
22 mind.

1           MR. HACKBARTH: Yes. But to the extent that it is  
2 used, it shows up in the outpatient category. The expense  
3 would show up in the outpatient category.

4           MR. GAUMER: They show up in both places,  
5 depending on upon what happens to the beneficiary. So if  
6 the -- to go back --

7           MR. HACKBARTH: I'm going to be sorry I asked this  
8 question.

9           MR. GAUMER: No, no --

10           [Laughter.]

11           MR. GAUMER: The observation patients that end up  
12 as inpatients get folded into that red line, right, because  
13 they -- okay, but the observations that never go to  
14 inpatient show up in the yellow line.

15           MR. HACKBARTH: The yellow line.

16           MR. GAUMER: Yes.

17           MR. HACKBARTH: Okay.

18           MR. GAUMER: That's the majority of them.

19           MR. HACKBARTH: Yes. Mike?

20           DR. CHERNEW: So you asked if it is useful, and my  
21 general sense is, compared to not seeing it, it's clearly  
22 useful. That doesn't mean, as you alluded to, I might want



1 to see it in some other way. And I guess the challenge that  
2 we always face is we control the general hospital payment  
3 level, but we often worry about what is going on in specific  
4 places. So if you look in the chapter, it says the  
5 hospitals opened in Ohio and they closed in Pennsylvania and  
6 it's very hard to tell what that means because there's a  
7 mix.

8           So if I were, I guess, I was trying to pick what I  
9 would want to see, I'd like to see sort of maybe a  
10 Dartmouth-style map of bed capacity to see if there's places  
11 in the country where the bed capacity is very high. Now,  
12 that doesn't mean we need more beds there. So I guess I'd  
13 also like to see maybe a utilization rate per capita in some  
14 way to see -- because the problem is if you see there's 95  
15 percent bed capacity in Ron's place, I don't know if that's  
16 because they don't have enough hospital beds or they're just  
17 sending too many people to the hospital, right. So you want  
18 to see some comparison of those two to try and figure out if  
19 there's trouble places.

20           And then I think the issue is, even if you found  
21 on that that overall it looked good for the country but  
22 there were some places that didn't look good, you'd want to

1 ask, well, are there hospitals opening there, which is where  
2 you would want, or are they closing there, that might be a  
3 problem. And I guess the solution I would infer wouldn't  
4 be, oh, we need to raise the update factor, but you'd worry  
5 about the geographic factor one way or another.

6           So what I guess -- the reason why this is useful,  
7 just to bring it all full circle, is it tells me that, on  
8 balance, it doesn't seem like we have a big problem with  
9 access. Whether or not there are markets where there are  
10 problems is a separate thing where we need to see more  
11 disaggregated sort of Dartmouth mappy - you know, however  
12 Dartmouth got that adjective, now all maps like Dartmouth  
13 maps. I mean, this is a wonderful trademark, now.

14           DR. BAICKER: Dartmouth Map, TM.

15           DR. CHERNEW: Yes, right, exactly. But some map  
16 like that to give you some idea of how the distribution is,  
17 I think, would help. But I think this is extremely useful  
18 in at least answering the first order question, do we have  
19 to worry, particularly the one part I like most. The fact  
20 that investor-owned hospitals are entering in places  
21 suggests that at least somewhere -- either the geographic  
22 factors are really messed up and those are just really well

1 ordered places, or there is adequate average payment for  
2 hospitals, because investor hospitals aren't going to go  
3 entering if there's not adequate --

4 DR. MARK MILLER: [Off microphone.] To do that --  
5 I will think about it. There's a technical thing, but I  
6 will think about it.

7 MR. HACKBARTH: Okay. Round two? Nancy?

8 DR. KANE: Well, I was thinking along the same  
9 lines as Mike. It does seem like it would be nice to see  
10 the distribution of the hospital resources. But I also  
11 thought it would be useful to kind of see what the national  
12 average -- how Medicare compares to all beds per thousand  
13 for the whole population, for the under-65, and get some  
14 kind of a norm that then you can look at the different areas  
15 and say whether or not it seems like Medicare is getting the  
16 same or less or more on average than it would nationwide.

17 DR. CHERNEW: [Off microphone.]

18 DR. KANE: I agree with that. I'm saying the  
19 standard would be there's a national average Medicare per  
20 thousand --

21 DR. CHERNEW: [Off microphone.]

22 DR. KANE: And then let's just say it's six per

1 thousand for Medicare and two per thousand for non-Medicare,  
2 and then how does that vary across markets, about HRRs or  
3 whatever convenient way to allocate, just to see. You know,  
4 we're trying to get a sense, is the bed supply adequate.  
5 Well, let's assume the standard is the national average  
6 ratio of Medicare per thousand to non-Medicare per thousand  
7 and when where does it vary, because I think it's hard to  
8 tell just on Medicare alone. And the private sector  
9 theoretically has some levels, some types of maybe -- we all  
10 say it's maybe more efficient, but it would be nice to know  
11 whether we vary from the national average. I don't know how  
12 you bring in the -- I don't know how you -- I guess you just  
13 do it by HRR and you count both MA and regular fee-for-  
14 service Medicare beneficiaries in an area as the population.

15           And I guess the other piece that would be useful  
16 to see is the technology services per thousand. So not just  
17 the beds, but the robotic surgery, so the range of services  
18 that are available per thousand Medicare beneficiaries,  
19 access to high-technology services.

20           And then on the list of are any of these measures  
21 helpful, I think they are helpful. Again, I'd like to see  
22 them more -- I don't know why you left off the employment

1 and the volume per capita. Those are actually quite useful,  
2 too. So, yes, I think it's better than not having it, and  
3 all we're asking is maybe some more disaggregate metrics,  
4 because I think Glenn mentioned when we were talking about  
5 updates that we might want to start thinking about how might  
6 we want to redistribute not just single measure, but what  
7 are the distributional issues we might want to be  
8 considering.

9 DR. BERENSON: Yes. My general view is that these  
10 measures are helpful, but I would point out that a couple of  
11 them, I think, are lagging indicators. Hospital  
12 construction, hospitals opening to a lesser extent, bond  
13 issuances are based on decisions made three or four or five  
14 years ago. And the interviews that I'm doing with health  
15 system change suggest there's been a change that will not be  
16 reflected until a year or two from now, probably, that first  
17 the October 2008, that hit, and then the PPACA is changing  
18 behavior. So it's better to have this information than not,  
19 but I do think those, in particular, are lagging indicators  
20 whereas employment isn't, and so we just have to keep that  
21 in mind.

22 MR. GAUMER: Okay. Thanks.

1           MR. GEORGE MILLER: Just to reflect, Bob covered  
2 what I was going to say because they are lagging indicators,  
3 and some other economic indicators from a hospital  
4 perspective dealing with changes in our environment. Again,  
5 the new hospital opening, you don't have the license yet,  
6 you don't have that information, but that's going to affect  
7 one way or the other in the market. Again, these are two-  
8 year lag indicators. We're making a decision now for next  
9 year about the hospital margins. While this is good  
10 information, there may be other more relevant information.  
11 Margins obviously is the one we will look at, but I agree  
12 with Bob.

13           MS. BEHROOZI: I like the information, Zach, about  
14 -- you alluded to it, Glenn -- about how at capacity the  
15 neighboring hospitals were as to the hospitals that closed  
16 and opened. It did strike me that among the hospitals that  
17 closed, there was more density of occupancy around them than  
18 where the hospitals were opening. And more of the ones that  
19 are opening are investor-owned, as Mike said, so what's in  
20 it for them if there aren't a lot of -- if there doesn't  
21 seem to be a lot of demand based on how full the other  
22 hospitals are. And then you also note that 11 of the 31 are

1 likely to be specialty hospitals by their name.

2           So I feel like it would be worth drilling down  
3 into that and maybe over a period of time, not so much to go  
4 to the one national update, but maybe there are inequities  
5 in payment somewhere that we could have an influence on,  
6 because that just --

7           MR. HACKBARTH: Let me pick up on that and the  
8 specialty hospital piece in particular. Was it 2005 that we  
9 did the specialty hospital --

10          DR. MARK MILLER: We did it twice.

11          MR. HACKBARTH: Right. When we did the specialty  
12 hospital report, I think it is fair to say that there were  
13 some Commissioners who favored an outright ban, you know,  
14 this is an unethical arrangement, it is destined to cause  
15 problems. And then there were other Commissioners who said,  
16 well, the first step should be to correct the obvious  
17 payment problems on which specialty hospitals seem to be  
18 particularly focused, for example, around cardiac services.  
19 We made a series of recommendations which were largely  
20 adopted, have now been implemented by CMS and have resulted  
21 in significant changes in the relative payment rates,  
22 reducing some things and increasing others.

1           It would be interesting to me to know whether, in  
2 fact, that slowed the rate of growth in specialty hospitals.  
3 So that is a particular type of information that might be  
4 useful. And I suspect that could be a debate that is  
5 reopened now in the new Congress. It was a facet of the  
6 Affordable Care Act to do basically a prohibition. There  
7 are some people in the new Republican majority who have very  
8 strong feelings on the other side, and whether this is an  
9 issue that might be separated out and negotiated, I don't  
10 know, but I suspect it could become an issue again. So if  
11 we could somehow shed some light on whether the payment  
12 changes were effective in slowing what was very rapid  
13 growth, that would be useful to know.

14           DR. BERENSON: And my only point is the tricky  
15 data issue of separating out physician-owned specialty  
16 hospitals from hospital-owned specialty hospitals. There's  
17 a whole bunch of joint ventures that were going on, and now,  
18 in fact, I know of at least one and maybe more in which the  
19 physician owners are selling their stake to the hospital and  
20 it will show up as a specialty hospital.

21           MR. HACKBARTH: Yes. That is an important issue,  
22 although the argument I made at the time, maybe didn't



1 persuade anybody, is I really don't care whether it's a  
2 physician-owned specialty hospital or a not-for-profit  
3 specialty hospital if what they're trying to do is exploit  
4 problems in the payment system. It's all the same to me.  
5 And so --

6 DR. BERENSON: Well, if the dollars are merged, I  
7 mean, if, in fact, it's a hospital system that starts a  
8 specialty hospital and they're siphoning patients away from  
9 one hospital --

10 MR. HACKBARTH: Right.

11 DR. BERENSON: -- but the dollars are all flowing,  
12 then it's a different situation, I think.

13 MR. HACKBARTH: Okay.

14 MS. BEHROOZI: I think also, Glenn, it goes to the  
15 motivation, right, but it also goes to what is it that we  
16 see when we are looking at a map. You could also look at  
17 what kinds of beds they are. They are not all the same  
18 beds. Do you have a high concentration of certain types of  
19 beds in one place and not in another, you know.

20 MR. HACKBARTH: You know, I am being too glib in  
21 saying it doesn't matter to me, although I would say, Bob,  
22 that even if it is a system and what they're doing is

1 reallocating their resources and saying, oh, we're going to  
2 take resources out of psychiatric care or caring for  
3 medically complex patients and put everything into our new  
4 cardiac center, that's a problem.

5 DR. BERENSON: Well, that's a second order  
6 question which we can't get at just by --

7 MR. HACKBARTH: Right. Any other comments?

8 DR. MARK MILLER: Yes. I will just say a couple  
9 of things, and I want to preface this comment by saying we  
10 can and will drill down. This will be forgotten by the time  
11 I get to the end of the comment, but I'm going to say it  
12 anyway.

13 Keep in mind, I mean, the kinds of things you will  
14 find will be the products of things like supply-driven  
15 competition, admission rates that are peculiar to those  
16 areas. And so when you start to disaggregate and then say,  
17 well, these represent different standards, just like when  
18 you got into the geographic utilization stuff, there were a  
19 lot of other things that you needed to kind of -- and I say  
20 this as a caution, because what that sets off is never a  
21 search for what we think is the right, at least in the  
22 larger debate. It always says, why aren't I at the highest?

1 And so just kind of keep that in mind, that the direction  
2 that this can go is, by definition, why aren't I up here in  
3 the larger policy debate, and I assume there will be some  
4 comments.

5           There's just one other thing I wanted to say.  
6 What I'd also like to hear, and we can't do it today, and I  
7 don't know how to orchestrate it given the limited time that  
8 we have, I think the discussion on beds is really  
9 interesting on a couple of fronts. Ron, you are saying I  
10 actually don't have enough beds, and there is an issue of  
11 admission rates in that part of the country, but how are  
12 hospital people -- Herb, Peter, George, people like that --  
13 thinking about hospital beds? They are looking at inpatient  
14 trends, if they are declining. But then the baby boom. How  
15 are hospitals thinking about it? And there is construction  
16 going on. There is a net increase in the beds, at least up  
17 to the point that we have data. So how are hospital people  
18 thinking about it? And we actually have some people here  
19 who could potentially help us with that. I would like to  
20 hear the continuation of that conversation with some of the  
21 hospital input.

22           But I know I said some things that were going to

1 set you off, so --

2 DR. CHERNEW: I think one of the biggest  
3 challenges is the hospital decisions about entry, exit, and  
4 beds has to do with what they think payment rates are going  
5 to be for a long period of time. And one of the challenges,  
6 of course, PPACA signaled what that might be, and we're  
7 doing an update factor which is like one year. And so we're  
8 almost, and I hate to say this, we're almost now -- I'm  
9 thinking about whether to say this -- we're almost like the  
10 Fed, right, which is not only we want to give an update, but  
11 there is some sort of guidance as to what our principles  
12 would be, because at least in this area, people are looking,  
13 are we -- and that is so politically fraught, because  
14 imagine we wanted to say, we think that the PPACA cuts  
15 aren't sustainable and that we have as a matter of policy a  
16 belief that our trajectory -- so if we wanted to change beds  
17 for whatever reason, and I don't think we do, which is why  
18 this was useful, but if we did, a one-year update factor  
19 kind of strategy isn't what would solve that problem. We  
20 would need to think about the trajectory of what we were  
21 saying, like the Fed has to give its guidance, and that  
22 becomes really hard in this particular area.

1           So I think the best we can say is it doesn't look  
2 like there's an access problem yet, and I'll let you and  
3 your political wisdom decide how much one wants to signal or  
4 not what MedPAC's general thinking is about this new  
5 baseline and trajectory and what it will mean for access,  
6 because what's going to happen is the ramifications of that  
7 won't be felt when those cuts get really draconian. The  
8 ramifications of that will get felt in the investment  
9 decisions that are made now, for better or worse -- I think.

10           MR. HACKBARTH: Yes.

11           MR. GEORGE MILLER: And just to that point, if I  
12 could just piggy-back, from a hospital CEO perspective, a  
13 hospital bed can cost between \$120,000 to \$200,000 per bed,  
14 and you're talking about a one-year update and that's a 30-  
15 year amortization. That's a critical piece in dealing with  
16 it.

17           DR. CHERNEW: Right. I agree.

18           MR. HACKBARTH: So I think it won't be soon that  
19 we are providing that long-term forecast on what our update  
20 recommendation is likely to be. You're right, that would be  
21 politically difficult and hazardous. But beyond that, even  
22 more important than that is that the structure that has been

1 created, at least as I see it, in the Affordable Care Act is  
2 they have set this baseline, and what they want from us is  
3 sort of a year-by-year assessment, you know, how is this  
4 going, not us to add our voice to what the long-term update  
5 should be. They want us as a check. Our role in the system  
6 is as a check as opposed to trying to replace them, or  
7 second-guess them for the long term. Do you see --

8 DR. CHERNEW: That's a very difficult thing to do  
9 if we thought the baseline was problematic and it had  
10 ramifications --

11 DR. BAICKER: I know Mark said not to focus on the  
12 substitutability aspect, but when I go back to why I care  
13 about hospital beds, I care because I care about people's  
14 access to care that they need and because I think our  
15 payment rates drive supply in a way that may be more or less  
16 efficient. So then that makes me want to look at hospital  
17 beds relative to use of other services for the same patient  
18 group to see, are we talking about substitution across modes  
19 of achieving the same health outcome and is that  
20 substitution better or worse? Have we set margins on these  
21 different ways such that people are substituting towards a  
22 more efficient way of getting to the same health outcome or

1 a less efficient way, and what are the measures of access  
2 that might help us know that, and that speaks to the  
3 decomposition across areas in a way where I want to be  
4 capturing the bundle of services consumed by beneficiaries  
5 towards a specific outcome.

6 DR. MARK MILLER: [Off microphone.] And I hope my  
7 comments are narrowly right.

8 DR. BAICKER: [Off microphone.] Right.

9 DR. KANE: One of the reasons I'm interested in  
10 the differentials across the country is sort of the socio-  
11 economic issues that happen. So you often get a lot of  
12 older people sort of stuck in an area and all the young  
13 people leave and the beds will follow the money and it tends  
14 to be the private money, not the Medicare money. And I just  
15 don't know if we need to rethink even the Medicare  
16 disproportionate share or whether we be just keeping an eye  
17 out for markets where -- I think the rural argument was also  
18 along the same lines, is you've got a lot of people who  
19 aren't going to be moving to the areas where there's a great  
20 new population growth and more affluence. So I'm kind of  
21 interested in just seeing how much variation there is and  
22 whether areas that are predominantly elderly and not

1 particularly wealthy are losing access to hospital services.

2 So that's the reason to disaggregate to me.

3 MR. HACKBARTH: Others? I think we're done, Zach.

4 Thank you.

5 MR. GAUMER: Thank you.

6 MR. HACKBARTH: Now we'll have our public comment

7 period.

8 MR. KETCH: If I could keep you here just for a

9 minute --

10 MR. HACKBARTH: Sure.

11 MR. KETCH: My name is Todd Ketch. I'm the

12 Executive Director for the American Health Quality

13 Association.

14 MR. HACKBARTH: Yes.

15 MR. KETCH: We are the organization that

16 represents the National Association of Medicare Quality

17 Improvement Organizations.

18 MR. HACKBARTH: Okay. And if you're familiar with

19 the ground rules, a couple minutes --

20 MR. KETCH: Yes.

21 MR. HACKBARTH: -- and when the light comes back

22 on, that's the end of your time.



1 MR. KETCH: I will keep it brief.

2 MR. HACKBARTH: And we've got people who need to  
3 go catch airplanes.

4 MR. KETCH: I fully understand. I'll just take a  
5 minute here.

6 I just wanted to thank you for taking up the  
7 discussion of quality improvement technical assistance  
8 again. I particularly want to say we agree with much of  
9 what was said by the two panelists as well as in the report  
10 in June about the need for more flexibility for quality  
11 improvement organizations to innovate within the program as  
12 it exists. The contract requirements can often be very  
13 limiting, and so we think that would be a great opportunity  
14 to allow for there to be more innovation within the program  
15 by loosening up some of those restrictions so they can do  
16 more. We know that this is something that CMS is looking at  
17 now and going into the new scope of work and that Dr.  
18 Berwick is really committed to.

19 The idea of diverting funds away from the QIO core  
20 contracts to grants to low performers is problematic from  
21 our point of view, primarily because when you look at the  
22 amount of funds available, that would be available for that

1 kind of thing, that actually would ultimately be pretty  
2 limited.

3 I won't argue that the amount of funding going to  
4 the QIO program in total is not substantial. It's a lot of  
5 money. Forty percent of that, however, goes off to other  
6 activities outside the QIO core contracts for the work they  
7 are doing on the ground, so that's a significant chunk that  
8 goes away, and that was addressed in your report in June and  
9 by the IOM, as well, so we need to look at that.

10 But then when you divide it out over three years  
11 across 53 contracts and all of the providers, if you were to  
12 then divvy up whatever chunk of money that might be there  
13 for these low-performing providers, it potentially looks  
14 pretty small from our point of view and may not be an  
15 adequate amount of money for them to really get the kind of  
16 help that they need.

17 The QIOs in doing this through a single contract  
18 can use efficiencies in those contracts. They're just by  
19 nature, because of the amount of funds available for a  
20 fairly broad contract, they have to be efficient. And so  
21 you would lose that, potentially, by just doing it through a  
22 grant process, not to mention then there is the

1 administrative aspect of this. It's hard enough for CMS to  
2 administer 53 contracts. You can imagine with potentially  
3 what would look like hundreds of grants to administer that  
4 that would be a real burden on the administration.

5           And the QIOs are moving already in the 9th Scope  
6 of Work, as you mentioned, to working with low-performing  
7 providers. But what we found is that they're not  
8 necessarily being driven to pursue quality improvement  
9 assistance. They're often lower resourced. They're often  
10 in far-off areas. They don't necessarily have quality  
11 improvement technical assistance readily available to them.  
12 So it's sometimes a challenge even coming to them with free  
13 assistance technically to get them to engage.

14           And so we don't see any evidence that a grant of  
15 some modest amount is necessarily going to drive some of  
16 these organizations to engage in quality improvement  
17 technical assistance, so we think that would be a problem in  
18 moving away from the efficiencies that the QIOs can offer.

19           And then finally, I would say the QIOs are very,  
20 very involved in many places with the regional  
21 collaboratives and often are providing data analysis in  
22 those situations, quality improvement, technical assistance

1 in those situations, and in even some cases some credibility  
2 to the organizations that may be new, where you've got an  
3 organization, a QIO that's very well established and  
4 respected in the State.

5 And so we think that there's an opportunity there  
6 for the QIOs, collaboratives, and all these other players to  
7 really work together, as Chris Queram had talked about,  
8 where it's not necessarily a zero-sum game, but we need to  
9 put all of these resources together and use them as best we  
10 can.

11 The 9th Scope of Work is almost finished. The  
12 Tenth Scope of Work, we expect is going to look very  
13 different. The 9th Scope was a step in the process from  
14 where IOM was recommending. So I think we'll see a Tenth  
15 Scope here soon, at least the rough draft of it, and I think  
16 it'll open up a lot of new doors and questions about how the  
17 program is going to proceed forward. Thank you.

18 MR. HACKBARTH: Okay. We're adjourned.

19 [Whereupon, at 12:10 p.m., the meeting were  
20 adjourned.]

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