MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
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Thursday, November 4, 2010
9:11 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
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AGENDA PAGE

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

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

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

So first us is care coordination for duals. Carol?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Our analysis this past spring of spending patterns

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

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

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

The intensity of these activities varied by

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

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

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

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

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

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

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

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

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

In sum, the programs vary in their approach,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

MR. HACKBARTH: Thank you, Christine and Carol.

So let me see hands for first round clarifying questions.

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

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

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

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

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

DR. CHERNEW: There are probably many slides on

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

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

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

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

MS. AGUIAR: That's correct, yes.

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

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

DR. CHERNEW: Jennie probably knows.

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

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

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

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

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

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

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

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

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

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

[Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. AGUIAR: Right.

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

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

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

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

MS. AGUIAR: Yes.

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

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

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

MR. HACKBARTH: So it could go either way?

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

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

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

MR. HACKBARTH: Okay.

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

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

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

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

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

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

DR. BORMAN: Right.

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

MS. AGUIAR: I think the --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. AGUIAR: Yes.

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

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

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

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

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

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

I think that in reading this, one thing that

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

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

a general issue.

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

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

opposed to a facilitator.

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

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

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

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

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

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

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

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

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

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

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

[Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CARTER: Right.

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

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

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

Jennie?

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

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

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

voluntary versus retrospective. But how do we discuss this?

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

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

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

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

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

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

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

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

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

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

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

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

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

basis would be the under-65.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you, Christine and Carol.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We visited several communities where beneficiaries

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

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

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

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

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

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

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

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

practice in their home communities.

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

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

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

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

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

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

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

The providers we interviewed generally spoke

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

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

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

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

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

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

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

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

[Laughter.]

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

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

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

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

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

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

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

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

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

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

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

DR. DEAN: [Off microphone.]

DR. STENSLAND: Yeah.

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

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

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

DR. BERENSON: It's adjacent to --

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

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

DR. STENSLAND: Adjacent to the MSA.

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

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

DR. MARK MILLER: Being from Arlington --

[Laughter.]

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

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

[No response.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[Laughter.]

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

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

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

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

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

MR. HACKBARTH: [Off microphone.]

[Laughter.]

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

patients didn't have to travel to them.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. KANE: Just a couple things.

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

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

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

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

talk?

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

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

is how do we come up with that threshold.

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

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

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

price measure.

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

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

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

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

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

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

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

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

Thank you. Good job, by the way.

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

DR. CASTELLANOS: Thank you.

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

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

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

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

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

MR. HACKBARTH: Okay.

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

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

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

I also just worry a little bit. Our conversation

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

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

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

I would absolutely support the notion of trying to

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

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

that we want to achieve.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[Laughter.]

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

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

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

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

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

DR. STENSLAND: Right.

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

find it out.

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

this could be pretty exciting.

MR. HACKBARTH: Okay. Thank you.

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

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

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

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

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

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

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

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

AFTERNOON SESSION [12:51 p.m.]

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

MS. LEE: Good afternoon. In this session, we will present our work to date looking at variation in private payment rates for physician services. The Commission has previously examined payment rates by private payers in different contexts. The Commission's analysis focused on how Medicare payment rates compare to private payer rates for hospitals and physicians, especially in the context of evaluating the adequacy of Medicare payment rates. In this project, we will examine how and explore why private payer rates vary across and within geographic areas.

By way of background, we should explain why we are looking at private sector payment rates and what the implications might be for Medicare payment policy. Sometimes the argument is made that Medicare prices should be set through a market-based approach, as in the private sector, in negotiations between providers and payers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

our preliminary analysis.

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

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

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

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

billed services.

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

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

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

Now Carlos will present the findings from our preliminary analysis.

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

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

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

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

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

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

In the next few slides we will illustrate on a

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

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

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

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

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

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

Looking at area H, the median payment for heart

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

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

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

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

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

[Laughter.]

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

You could have variation in payment rates because

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

MR. ZARABOZO: Yes.

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

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

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

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

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

MR. ZARABOZO: Right.

MR. HACKBARTH: It could have multiple rates.

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

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

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

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

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

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

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

MR. ZARABOZO: Right, yeah.

MR. HACKBARTH: Other clarifying questions?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. KANE: Claims that are paid.

MR. ZARABOZO: Right.

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

MR. ZARABOZO: Median payment for a claim.

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

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

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

MS. KANE: Okay.

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

MR. ZARABOZO: Well, on the --

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

all --

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

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

MR. ZARABOZO: Right.

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

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

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

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

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

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

MR. ZARABOZO: Thank you.

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

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

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

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

MR. ZARABOZO: With the areas.

DR. BERENSON: Okay, great.

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

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

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

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

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

DR. KANE: I couldn't hear --

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

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

MR. ZARABOZO: Yes. Yes.

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

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

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

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

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

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

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

MR. ZARABOZO: Yes.

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

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

MR. ZARABOZO: Correct.

MS. UCCELLO: Okay.

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

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

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

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

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

MR. ZARABOZO: Yes.

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

MR. ZARABOZO: Right.

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

MR. ZARABOZO: Yes.

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

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

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

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

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

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

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

MR. ZARABOZO: I can answer rhetorical questions.

[Laughter.]

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

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

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

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

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

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

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

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

DR. CASTELLANOS: How about the patient mix?

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

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

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

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

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

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

MR. ZARABOZO: Yes.

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

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

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

MR. ZARABOZO: Yes.

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

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

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

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

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

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

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

DR. CHERNEW: [Off microphone.]

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

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

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

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

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

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

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

[Laughter.]

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

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

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

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

MR. HACKBARTH: That's okay --

DR. MARK MILLER: That's right.

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

[Laughter.]

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

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

DR. BAICKER: Is your name Kate?

DR. STUART: Oh, I'm sorry.

[Laughter.]

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

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

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

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

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

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

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

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

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

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

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

[Laughter.]

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

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

but maybe --

[Laughter.]

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

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

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

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

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

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

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

[Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. MARK MILLER: [Off microphone.]

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

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

[Laughter.]

DR. MARK MILLER: Did we do two rounds?

MR. HACKBARTH: Yes, we did two rounds.

DR. MARK MILLER: We did?

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

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

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

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

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

Let me first remind you about the MA payment system.

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

Medicare beneficiaries are enrolled in MA plans.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

percent of beneficiaries do not have a plan available.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

what we were just talking about.

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

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

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

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

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

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

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

MR. HACKBARTH: Okay. Thank you, Scott.

Could you put up 7 for a second?

DR. HARRISON: Is that 7?

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

DR. HARRISON: There we go. Okay.

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

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

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

MR. HACKBARTH: Vaguely, yes, I do.

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

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

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

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

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

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

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

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

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

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

years. I think it was $16.

DR. HARRISON: Yeah, right.

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

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

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

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

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

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

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

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

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

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

MR. GEORGE MILLER: By plan, individual plan?

DR. HARRISON: No, we don't.

MR. GEORGE MILLER: Thank you.

MR. HACKBARTH: Medicare Advantage program overall

we've got information --

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

MR. HACKBARTH: Okay.

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

DR. HARRISON: They still bid higher.

MS. HANSEN: Yeah.

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

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

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

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

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

DR. HARRISON: Right.

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

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

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

DR. HARRISON: Yes.

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

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

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

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

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

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

MS. KANE: Yeah.

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

MS. KANE: Okay, but then --

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

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

DR. HARRISON: Right.

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

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

[off microphone].

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

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

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

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

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

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

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

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

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

DR. MARK MILLER: Between the --

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

DR. HARRISON: Oh, sure.

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

DR. HARRISON: Right.

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

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

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

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

MR. HACKBARTH: Round one clarifying questions?

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

[Laughter.]

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

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

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

[Laughter.]

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

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

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

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

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

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

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

DR. KANE: This is descriptive and interesting,

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

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

I guess I'm --

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

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

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

DR. HARRISON: I don't think --

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

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

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

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

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

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

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

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

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

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

advice.

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

MR. HACKBARTH: Text box.

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

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

DR. CHERNEW: And there were no cookies.

[Laughter.]

DR. BAICKER: It's hard to control.

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

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

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

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

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

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

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

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

DR. BAICKER: That's a technical term.

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

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

MR. HACKBARTH: Scott, did I hear you correctly? You said, I think, that the placement in the quartiles is redone annually.

DR. BAICKER: If you had a smooth function instead of quartiles, that would solve that problem too.

MR. HACKBARTH: Right.

DR. CHERNEW: Right.

MR. HACKBARTH: Yeah.

DR. CHERNEW: Where you are tends to be a function

of where other people are. So you could be, say, exactly the same.

MR. HACKBARTH: Right.

DR. CHERNEW: If another county moved, you could be in a different quartile, and all of a sudden your payment rate is changing in different ways.

MR. HACKBARTH: Yeah, yeah. Right.

DR. MARK MILLER: I'm thinking we want cookies for the economists. I think that will slow them down.

[Laughter.]

DR. MARK MILLER: Yeah, but then they crash.

MR. HACKBARTH: Right.

Any comments? Scott?

MR. ARMSTRONG: Not a big point. I really don't understand completely but agree that, you know, the jigsaw thing. But I think there are probably a lot of other implications of this policy going forward that we should be measuring. I mean I just look at that jigsaw chart, and another question is well, how do we bring the right-hand end of it further to the left?

So I don't know. I assume that as we build out this report -- I have not had the opportunity to participate

in this -- that there will be a number of implications of PPACA and these policy changes and payment changes that we will want to be monitoring as we go forward. And at some point it just would be great for me just to understand a little bit better what the spectrum of those different issues -- criteria, if you will, for judging how all this is working might end up being, not just how do we deal with the edges around those quartiles but a number of other issues as well.

DR. CHERNEW: This is a real luxury, so I want to make one other comment. I have not seen how they plan to pay ACOs, but there is a similarity loosely in ACOs and MA plans and what they're trying to do, although the rules are very different in certain ways.

I think probably not as part of this chapter because one has to address this problem first, but I think any work that's thinking about how you're going to pay on a quasi-person level, targeted way should have some level of similarity as opposed to what -- first of all, the ACOs affect the fee-for-service component, and the ACOS could conceivably be a different way to get people into a system that you think is somehow akin to MA, though it's not quite

akin to MA. So I think that's another area where this type of analysis is going to be end up being very important, and this type of payment you might want to try and transition across or span across the things.

MR. HACKBARTH: I think that's a good point, Mike, and I was starting to think about that as well. So the underlying scheme is quite different even though there is some vague, broad similarity between the goals of the ACO program and Medicare Advantage.

So in the ACOs, what we're saying is that if you have low historical costs you're going to have a low payment rate, whereas here we're saying we're going to have a bonus payment -- a significant, large bonus payment -- in areas with low historical costs. There's no analog in the ACO program.

So you can imagine in the real world providers thinking about how I plan my future and work with the Medicare program. There's a discontinuity here in the payment schemes that could have unintended consequences. I've not thought through it, but I think that's a very interesting point and one worth flagging.

The other thing that is sort of a broad policy

point that I think is potentially worth including in the chapter is a lot depends on what your goals are for the Medicare Advantage program. And one of the challenges that we've had in the MA program over the last 25-plus years, in its various iterations, is that the goals have shifted over time.

Initially, the program, the initial TEFRA program enacted in 1982 paid HMOs 95 percent of the Medicare fee-for-service costs, and the goal was quite clearly to move people into more efficient systems. Over time, other goals have been mixed in, including some geographic redistribution of payments, finding out ways to add more benefits to the benefit package for beneficiaries and then try to equalize those benefits, additional benefits, across geography. As the goals have migrated, I think it's contributed some to the policy confusion.

The way that's really relevant now is that some people will judge the success or failure of PPACA based on what happens, the number of plans offered, the enrollment and the average rebate. And that's going to be the measure of success of failure. That's going to be the political battleground.

It's not obvious, to me at least, that that's the best way to assess whether this performance, this program is achieving the goals we have for it. And in particular, that measure does not determine whether we are identifying or rewarding more efficient delivery systems. It's totally disconnected from whether we are promoting more efficient alternatives to traditional fee-for-service Medicare.

So I think maybe without getting too immersed in the details, if we could just have some discussion about the goals, and we've included this in past reports. So it's not something that we have to reinvent. We can just lift it.

DR. KANE: Along those lines, what does the -- we like to look at all these different programs by what current law is expecting about them, and I guess one thing I've never really fully understood is what does current law expect out of the MA plans and does it expect ultimately that it will be more efficient than the traditional Medicare. I mean what does it say?

DR. CHERNEW: I think the current law price forecasting thing, if you didn't have fee-for-service, you couldn't have what the MA payment is. If I understand this correctly, I don't think current law has to take a position

on that because it's all tied to the fee-for-service. So once they project fee-for-service, they just know what they're going to spend on the MA plans per enrollee.

They do have to make an assumption about how people are going to move into the enrollees. But if the MA plans are very efficient, the savings are relatively small. I don't know if they assume there's, yeah, that much big of a -- in other words, I think they probably assume it just stays in the same pattern.

That's my sense of how it works. I could be wrong.

MR. HACKBARTH: The other thing about including the projections of the impact of PPACA that we talked about earlier -- what's the effect on the number of plans offered, the enrollment and average rebate and the like -- is that, as I understand the analysis that you're contemplating, it's a static analysis. That's if the plans don't change how they operate.

And I would think, believing in the market as I do, that if you change the price signal that you put out, you're going to evoke a different sort of market response.

So if you pay high rates, the path of least

resistance for plans is to offer big, open network, free choice systems if they can do that and still offer additional benefits that are attractive to get enrollment. That's the easy thing to do.

And the way the law has worked, they've been able to do that. They've been able to not be very aggressive in managing costs and offer attractive benefits and get rapidly growing enrollment.

If you change the price signal and say no, we're not going to just pay everybody a lot more than traditional Medicare, and send a signal that we're looking for plans that can do something different and reduce costs, I believe in the market. I believe plans will start to reconfigure to get access to this large and rapidly growing market, and offer tighter networks, more aggressive management. They can provide additional benefits at lower prices.

So a static analysis; it says if plans don't do anything different, this is what 2017 will look like. I fear there's a risk of that being inherently misleading and inaccurate because it dismisses the whole market response which to me is the principal reason for having a Medicare Advantage program.

So somehow I'd like to get that into the presentation as well.

Any other thoughts, comments?

Okay, thank you, Scott.

And last -- is it true, last? Talk about efficient.

[Off microphone comments.]

MR. HACKBARTH: So last up for today is "Improving Incentives and Safeguards in the Home Health Benefit." Evan?

MR. CHRISTMAN: Good afternoon. In past meetings, the Commission has noted several issues which suggest that the home health benefit could be improved. Many Commissioners have expressed concern about the variation in margins. There have been concerns that providers may be favoring patients, particularly those that need therapy. We have also noted that certain aspects of the payment system reward volume or specific services. Providers can increase payment by delivering more episodes and by delivering more therapy visits in an episode.

In addition, the variations in spending for home health are larger than other Medicare services. Spending

varies by twofold between the 75th and 25th MSA and by threefold between the tenth and 90th MSA. In the highest spending area, it is seven times the national average.

These concerns are further compounded by the low capital requirements for entry, limited physician involvement in the benefit, and the lack of beneficiary incentives to encourage appropriate use. Understanding these concerns, we have taken a closer look at the home health payment system, and before I proceed, I want to take a moment and remind you how the PPS works.

Medicare implemented PPS in October of 2000. The program pays for care in case mix-adjusted 60-day episodes. The case mix assigns beneficiaries to one of 153 payment groups based on clinical conditions, functional status, and the number of therapy visits provided in the episode. The role of therapy in assignment to a group is important, as the number of visits is a factor in 137 of the groups, or about 90 percent. Generally, payment groups where therapy visits are a factor pay more than those that do not factor in therapy.

We retained the Urban Institute to take a closer look at the payment system. Urban's analysis found that the

case mix could predict 55 percent of total costs, but this high value was attributable to the use of the number of the therapy visits, which are part of the cost being predicted, as an explanatory factor. When therapy visits are excluded from the case mix, the explanatory value of the case mix adjustor dropped to less than eight percent.

We also looked at the system's ability to accurately predict therapy and non-therapy costs separately. The case mix system could predict about 77 percent of the therapy costs. This should not be surprising, because again, therapy is being included as both an explanatory variable and an outcome in the case mix. For non-therapy services, the explanatory value of the case mix was one-tenth of one percent. The low value for non-therapy services is concerning because these services account for the majority of episode costs and about half of episodes are only non-therapy cases. The low value indicates that for a significant number of episodes, the case mix has limited predictive value. Episodes which include the most non-therapy services were significantly affected by the low explanatory power for these services. The case mix could correctly identify only 15 percent of the episodes in the

highest decile of non-therapy service use. This last finding is particularly concerning because it suggests that agencies have an incentive to avoid or reduce service to the patients with high non-therapy needs.

This next slide gives you an indication of the impact of using therapy visits as a payment factor. It shows the share of episodes with different numbers of therapy visits. If you look at the middle bar of the middle graph, you will see that a significant number of episodes were clustered in the ten to 15 therapy visit range in 2007. In 2008, Medicare changed how it factored therapy visits into payment. The effect of these changes were to lower payments for episodes in the ten to 13 visit range and increase them for the episodes just above and below this range. And the light blue bar in each part of this graph shows how agencies reacted to this change. Visits increased for the two groups with higher payment and decreased for the group with lower payment. The Commission reviewed this result last year and became concerned that the use of therapy as a payment factor made the system vulnerable to manipulation.

Urban also found that the case mix system

increases payment at a rate that is faster than the increase in providers' average costs. They found that a one percent increase in case mix was correlated with a 0.88 percent increase in provider costs. This implies that higher case mix agencies, including those which provide more therapy, will be more profitable than lower case mix agencies. This finding is confirmed in our review of the characteristics of high and low margin Medicare agencies, as the table at the bottom shows. Agencies with high margins had average profits of 35 percent, delivered more therapy, and had a higher case mix average. Agencies with low margins had an average loss of nine percent, delivered less therapy, and had a lower case mix.

All of these findings suggest that the home health case mix adjuster needs to change. The current system provides more generous payment for therapy and other high case mix services. It is highly dependent on therapy and not patient characteristics for its accuracy. The low explanatory power for non-therapy means that the case mix is weakest in explaining the services that are most commonly provided. And finally, the inclusion of the therapy visits as a predictor allows agencies to follow financial

incentives when determining the number of therapy visits to provide in an episode.

With these considerations in mind, we continued our work with Urban to develop an alternate case mix that better predicted non-therapy services and did not use the number of therapy visits as a factor. Similar to the current system, Urban examined patient characteristics from the OASIS to identify factors that could be used in a revised case mix system. They identified about 70 variables, which included a range of ADLs, other functional indicators, clinical conditions, and other items.

The revised system they developed explained about 14 percent of costs, or about double the explanatory power of the current system when its therapy thresholds are removed. The improvement was better at the service level. For non-therapy services, the explanatory value of the revised model was 14 percent compared to eight percent for the current case mix. And for therapy services, the revised model had an explanatory power that was about double the current system. The revised system was also more accurate in correctly identifying high-cost non-therapy cases, identifying 28 percent or nearly double the current model.

Next, we asked Urban to look at the payment impacts. Payment for non-therapy episodes would increase by an average of 35 percent, while it would drop for therapy episodes by 14 percent. High non-therapy episodes, those for severely ill patients who need lots of nursing or aid, would see a payment increase of 42 percent, and episodes provided to dual-eligible beneficiaries would see a three percent increase.

What I just shared with you were episode-level averages, and this table shows the impact by provider type. The increases would be for agencies that are nonprofit, hospital-based, and rural. Across all types of agencies, those that serve the most non-therapy patients and provide more non-therapy services in an episode would see larger increases. Again, the changes you see here are driven by a redistribution of payments from providers mostly focused on therapy more towards those focused on non-therapy services.

That completes our look at case mix. Next, we will look at changes in volume.

The growth in services under PPS has been healthy. You can see the 50 percent rise in total home health episodes in this graph. Much of this growth has been

propelled by a rise in home health episodes that are not preceded by a hospitalization or PAC stay. Put another way, in 2001, 48 percent of episodes were preceded by a hospital or PAC stay. By 2008, that share had fallen to 36 percent. In 2008, almost two-thirds of home health episodes are not post-hospital or PAC stays.

To better understand this trend, we looked at first episodes of home health, those not preceded by a home health discharge in the last 60 days. These are important because they give us an indication of where home health patients are being referred from. We found that first episodes admitted from the community with no prior hospitalization or PAC use increased by 48 percent, or more than three times the rate of growth for episodes that were preceded by a hospitalization or PAC stay.

We also looked at the increase in subsequent episodes, which are second and later episodes in a spell of consecutive 60-day episodes, and found that these doubled during the period. Subsequent episodes, which constitute repeat users of home health, accounted for 50 percent of all episodes in 2008.

So in terms of the shift we saw in the last slide,

the increase in episodes not preceded by a hospitalization or PAC stay, it is primarily driven by the increase in subsequent episodes, and to a lesser extent first episodes where the beneficiary has been admitted from the community. The growth in these episodes has been occurring at the same time that the number of hospital discharges has been flat or falling and the number of agencies has been increasing. This decline in demand for post-hospital home health services and rising agency supply raises concerns that some providers may be expanding to serve less severe populations, some of which may qualify, but not necessarily benefit.

Physicians and home health agencies are required to follow Medicare's eligibility and coverage standards, though studies by the IG and CMS have raised questions about how effectively they do this. For example, many reports suggest that physicians frequently defer to home health agencies, leaving control with agencies that have a financial interest in eligibility and plan of care decisions.

CMS reviews less than one percent of home health claims, so administrative review plays a limited role. Concerns about potential over-utilization are further

exacerbated by the lack of cost sharing in home health. Studies of health care services have generally found that beneficiaries consume more services when they have limited or no cost sharing and that these additional services do not always contribute to better health. The rapid rise in episodes not preceded by a hospitalization suggest at least some of this additional volume may be increasing Medicare's costs without improving beneficiary health.

Given the lack of oversight by CMS and the limited oversight that physicians sometimes provide a cost sharing requirement would permit patient choice to serve as an offset to the incentives in the home health PPS which reward additional volume. The lack of cost sharing for home health is unusual in fee-for-service Medicare, as most services have some form of cost sharing. Many private insurers, including some MA plans, do charge cost sharing for home health. Adding a cost sharing requirement would recognize that beneficiary choice influences the demand for home health, just like other Medicare services. The addition of cost sharing would lower utilization because beneficiaries would decline episodes of marginal value. However, a down side is that it could also reduce the utilization of

effective care and create perverse incentives. A carefully targeted cost sharing requirement would include policies to minimize these potential harms.

The next slide gives you an idea of what an illustrative cost sharing requirement could look like. A fixed per episode copay would serve as a demand side counterbalance to the incentives providers have to deliver more 60-day episodes. A flat per episode amount would also protect beneficiaries who need more visits in an episode as those additional visits would not increase their liability.

The amount of the copay could take several forms. For example, a copay amount equal to ten percent of the average episode payment would come out to $300 per episode, and this would average out to about $17 per home health visit for a typical episode. Seventeen dollars is roughly in the middle range of the cost sharing a beneficiary would pay for an evaluation and management office visit covered under Part B.

Because most Medicare PAC benefits have limited or no cost sharing in practice, it would be most appropriate to charge cost sharing only for first and subsequent episodes that are not preceded by a hospitalization or other PAC

stay. Charging cost sharing for post-hospital episodes of home health could encourage beneficiaries to use higher-cost PAC settings, such as SNFs or IRFs, which generally do not have a cost sharing requirement. A cost sharing requirement for episodes not preceded by a hospitalization or other PAC stay would not raise this issue. Beneficiaries admitted directly to home health from the community or those entering a second or later home health episode would be ineligible or unlikely to use the other post-acute care providers. In addition, the cost sharing could include some exceptions to mitigate the negative effects for vulnerable populations. For example, we could exclude low-use episodes with few visits or Medicare and Medicaid dual eligible enrollees.

With these exclusions and with a focus on episodes that are not preceded by a hospitalization or PAC stay, about 32 percent of home health episodes would have been subject to cost sharing under this design in 2008.

This completes the look at volume. Next, we will look at program integrity. Though CMS has launched home health program integrity initiatives, it seems as though more effort is required, and a review of trends in Miami provides an example as to why.

CMS launched enforcement efforts in this area in 2007 after it found widespread fraud among providers in Miami-Dade County. Despite these efforts, the number of agencies in that county has doubled, from 314 in 2007 to over 700 in 2010. The higher number of agencies in a county considered high-risk for fraud suggests that Medicare needs to do more to fight fraud in the home health benefit.

It is also worth noting that aberrant patterns of utilization reach beyond Miami. For example, in 2008, five counties had more home health episodes than fee-for-service beneficiaries. In 29 counties, the rate of fee-for-service beneficiaries using home health exceeded 20 percent in 2008, more than double the national average.

The PPACA gave CMS broad new powers to combat fraud and home health may serve as a good test for them. A first step is that CMS and the IG need to identify areas of high fraud risk based on utilization and other reviews. Counties with aberrant patterns of home health utilization might be an appropriate place to begin these reviews. If these probes of unusual counties were to reveal widespread fraud, the Secretary could implement the new authorities.

There are several possible approaches to the

issues we have just reviewed and we are interested in your thoughts as to the most appropriate areas to pursue. The policies we have discussed would encourage more effective and efficient use of the benefit, create incentives for patient choice to play a role in a benefit that is otherwise difficult to manage, and strengthen program integrity. Addressing these challenges is central to ensuring that Medicare beneficiaries and taxpayers receive the greatest value for their home health dollar.

This completes my presentation and I look forward to your discussion.

MR. HACKBARTH: Thanks, Evan.

Before we start round one, could you just tell us a bit about the recent litigation involving the home health benefit?

MR. CHRISTMAN: Sure. There was just a court finding that overruled an ALJ decision that ruled that -- it denied home health care on the basis that a patient was stable. The presumption has normally been that the patient needs to have some ability to improve and that patients who are stable don't require skilled services, and the finding of the court was that this presumption that the patient

needed to improve was not a valid one.

Now, we haven't heard back from CMS about what the implications are for this, and it was remanded to the ALJ for redetermination. So that means it could get denied for some other reason. So understanding exactly how it impacts coverage is something we're still trying to chew through ourselves.

MR. HACKBARTH: Has the government said whether it's going to appeal or not?

MR. CHRISTMAN: No. I haven't heard.

MR. HACKBARTH: Okay. I think we're over on this side now. Round one clarifying, Karen and Scott and Ron.

DR. BORMAN: Could you refresh me as we think about qualifying hospitalization encounters, because we have looked in other work about the increasing number of observation encounters and so forth. Where would someone who got home health after an observation be counted and/or someone -- and someone who had an outpatient procedure, so either hospital outpatient department, like an image-guided procedure or an ambulatory surgical center and then got to home health. Do they get counted in the hospitalization group or no --

MR. CHRISTMAN: No. It's --

DR. BORMAN: -- because that would drive this a little bit --

MR. CHRISTMAN: I'm sorry. Yes. No, your point is a good one. The people who are counted as hospitalizations in these calculations were people who had an inpatient discharge. So they wouldn't have picked up the observation days people, as I understand it. That's an outpatient thing. And then, of course, the people served in an outpatient setting, they wouldn't be in there, either. They would be sort of what we think as the community-admitted crowd.

DR. BORMAN: Because I think that we are looking at a time frame where there was a continuing shift of things to an ambulatory setting, and while I don't mean to say there's not concerns here, I'm not sure how much of that is accounted for by simply that shift in practice. I know, for example, and Tom can help me here and Bob, I'm aware of places where patients with deep venous thrombosis, there's some sets of protocols where they can be treated on an outpatient basis and they're sometimes held in an emergency department for observation long enough to know that the home

health resources are being put in place and started on medications and taken care of, whereas before they might have had a qualifying hospitalization. So just as an example of how that could impact this, and I don't know how to get at that, but just a thought.

MR. ARMSTRONG: When we see changes in utilization rates like we're seeing presented here, obviously, you have a lot of questions about that. To be frank, for home health services, we're pushing increased utilization because overall, it lowers our per member expense trends. And so some of this could actually be really good. I'm just -- I just don't know this. Does the CMS or does anyone do any kind of appropriateness review of these home health referrals like they review the appropriateness of a lot of other services?

MR. CHRISTMAN: The way the process works now is that a physician has to basically order the service and attest that the beneficiary is eligible and needs the service. And to be eligible, there are sort of two main prongs. There's one, they have to have a skilled need, which more or less means nursing or therapy. And two, they have to be homebound, which means they can't leave the home

without severe and taxing effort. And so a beneficiary who meets those two prongs and a physician would authorize the care and then the home health agency would execute the plan.

MR. ARMSTRONG: And then payments dependent on those criteria being met?

MR. CHRISTMAN: Coverage, yes.

MR. ARMSTRONG: Yes.

DR. MARK MILLER: I thought your question was a little bit different, which is how much look behind any of that is, and I would say it's very nominal. And then you also -- and again, I'm not trying to pick it apart too much. It was sort of in contrast to where it goes on in other parts of Medicare. I think, by and large, the resources that are devoted, and I could be caught out here for a second, but the resources devoted to looking at the appropriateness of use have been declining, although more recently there have been sort of the RAC approach to things. But I think one of the concerns there is there's not a lot of oversight here, and I suspect in your system, and actually it might even be interesting to note, do you have some kind of prior authorization or some review that goes on, or is it pretty open ended?

MR. ARMSTRONG: It's not open ended, but what the prior authorization is, I'm not sure. I just know that home health services are such a highly integrated part of our overall care process that a patient wouldn't be getting home health services if it wasn't connected to their primary care provider's care plan for that patient. And if -- so it just wouldn't happen. But it doesn't involve actually formal preauthorization.

MR. HACKBARTH: So almost by definition, in a system like Scott's, it's a clinician that's asking for the home health. At Harvard Vanguard, the issue for us was not the front end authorization, but for a period of time, we were not careful about continuing to monitor and determine when the need was no longer there, and when you didn't do that, not surprisingly, the agencies would continue to visit and continue to bill. And so we had to focus more at the back end to make sure we were constantly monitoring the patient and making sure that there wasn't too much.

DR. CASTELLANOS: Just a clarification question. The recent physician payment rule just came out and there was a big section on therapy in that and it was very similar to what the issue was on x-rays. If it's concurrent, they

pay 100 percent for the first therapy and 50 percent for the second. So I can envision a person with a stroke having speech therapy and physical therapy. Again, I have not read it in detail, but I was wondering if that's going to have any implication on therapy and home health.

MR. CHRISTMAN: I'm not -- I guess I'm not exactly following the question, because the terms for payment of therapy of home health are set in the home health rule and I'm not aware of a relationship of how the physician fee schedule rule would change what's going on in home health.

DR. CASTELLANOS: I don't know, either, but I just remembered reading about that and it just concerned me because therapy seems to be a real big issue with home health. And I'm just putting that out as a clarification question, whether you have any information concerning that.

DR. MARK MILLER: [Off microphone.] We can get it.

DR. CASTELLANOS: [Off microphone.] Thank you.

MR. HACKBARTH: Other clarifying questions? Bruce and then Nancy.

DR. STUART: We're talking about home health, but in counties that have very high home health costs,

presumably, that's going to affect the AAPCC and raise the reimbursement levels for MA plans. Do we have any sense if that's a -- I mean, does it go up high enough so that it would really --

MR. CHRISTMAN: Oh, I think if you -- you might remember back at the September meeting, Dave showed you that when -- after you -- on the geographically-adjusted numbers, I believe, when you pulled out home health, DME, and hospice, there were a significant number of counties who were on sort of the right-hand side of the distribution who were pulled back towards the mean just for pulling out those services, and those services do contribute to all of the things you just listed.

DR. KANE: I was wondering, on your Slide 9, how is cost -- is it cost or number of units of service that you were trying to predict with your case mix thing? I was just trying to get a sense of what data are you using to come up with that, because I thought you were paying on an episode basis, or how do you --

MR. CHRISTMAN: Right.

DR. KANE: I just don't know. How do you know what the input is?

MR. CHRISTMAN: Sure. Now, what we're trying to predict is sort of the cost of each episode and sort of resource cost-weighted minutes. We know the minutes of nursing, therapy, and all the services that they received during the 60-day episode, and we have some standardized labor factors, you know, BLS wage data. So we can come up with sort of a standardized cost of a 60-day episode.

DR. KANE: Okay. So they're reporting the minutes to you along with --

MR. CHRISTMAN: They report the minutes, yes.

DR. KANE: I see. I didn't know that. And then -- so I can see how you just allocate cost to the minutes, then.

And then the other question was, you say you adjusted for demographic factors. Do any of them include the socio-economic factors of the patient?

MR. CHRISTMAN: No, just age, I think, is the big one.

DR. KANE: But nothing about income status or living alone or --

MR. CHRISTMAN: No. Income status is not something that's -- we were using the assessment tool that

they administer at admission sort of to try and predict from, and income status isn't collected on that.

DR. KANE: For language or --

MR. CHRISTMAN: That, again, that stuff directly isn't picked up. You know, the things like cognitive difficulties and communication will get picked up, but as you can appreciate, that's a much broader range of things.

DR. KANE: Okay.

DR. BERENSON: This is very interesting stuff. I want to just pursue, in the paper, you wrote the following in the box on fraud. Likely fraud limits the utility of using payment outliers in the case mix analysis. And you say that in 2008, the year of data available for this analysis, a significant number of agencies manipulated the outlier payment system by claiming payment for fraudulent outlier episodes with very high visit counts. How do we know that? I mean, there are actual investigations of a significant number of home health agencies?

MR. CHRISTMAN: Yes. Yes. There are believed to be -- at one point, I think CMS was throwing around numbers of a couple hundred.

DR. BERENSON: Is that right?

MR. CHRISTMAN: And I think probably the one sentence explanation is there were more blind diabetics receiving 120, 150 visit episodes in Miami-Dade County than there were supposed to be blind diabetics in the whole country, is what I was told at one point.

DR. BERENSON: Yes, and what I'm trying to get at is whether we're sort of extrapolating from places where we really know this has happened to -- so a significant number -- if it's in the hundreds, that's significant, and so you're also thinking that more of this might be going on --

MR. CHRISTMAN: Yes.

DR. BERENSON: -- making this a problem with this analysis.

MR. CHRISTMAN: Absolutely.

DR. BERENSON: Okay.

MS. UCCELLO: Kind of following up on Karen's question about how hospitalization is defined, of those people who therapy is not post-inpatient hospitalization, do you have any sense of what share is post-outpatient?

And then even more specifically, what share of this 32 percent that would be subject to cost-sharing with the exceptions that you laid out, is a big share of that

outpatient?

MR. CHRISTMAN: I think that's a fair question, and I can't give you a good answer. That's certainly something that we can look into. I guess I would -- you know.

An anecdotal answer I can give you is just that we haven't heard that outpatient is becoming a major on-ramp. Now that certainly deserves a more rigorous look at it than what I just told you, but that hasn't been mentioned when people talk about drivers.

MR. GEORGE MILLER: Yeah, a couple of things. One is while I think I understand why you would recommend a co-pay, but it seems to me, based on what you've written here, the reason for that is because of so much fraud. It seems like, and I may be extrapolating that, but it seems like you're penalizing folks because of fraud, to make them have co-pay to try to decrease fraud.

While I don't disagree you may not need a co-pay for this population, but if that's the reason it seems like you're penalizing the folks who are least likely, or they're the victims. It seems like you're penalizing the victims, at least in my opinion, particularly because in the reading,

the chapter that you sent, on Page 4 it says the lack of cost-sharing requirement to deter beneficiaries from seeking care of limited or no value. I don't think beneficiaries go and seek a home health agency and then get lack of care. I don't perceive that to be the case.

And if that statement is the driver for cost-sharing, that doesn't make sense to me. You know. I understand the other reasons why you say cost-sharing should be there, but this statement just doesn't wash with me. I don't know if you have a response.

MR. CHRISTMAN: Right.

MR. GEORGE MILLER: I may be all wrong.

MR. CHRISTMAN: Let me -- you know. Maybe that sentence was a little misconstrued, but what I think we mean is that right now if a beneficiary has health care needs in the community, they can go to the physician and they're going to pay somewhere between 10 and 20 bucks.

MR. GEORGE MILLER: Okay.

MR. CHRISTMAN: For many of the same services, they could also have a home health agency come to their house, and right now that's free. So in a sense the lack of cost-sharing discourages them from considering alternatives

when they might be able to go to a physician's office, which would cost Medicare less.

MR. GEORGE MILLER: Gotcha. But however, that patient doesn't seek a home care agency to come visit them. They go to the physician because they have a problem, but they don't say let me call up my nearest home care agency to get services. No, they don't.

MR. HACKBARTH: Well, patients don't self-refer to home health just as a matter of the design of the benefit.

MR. GEORGE MILLER: Correct.

MR. HACKBARTH: So it involves a physician referral in the first instance.

MR. GEORGE MILLER: Okay, in the first instance. Then all of the therapy they're talking about, the reason it drives the costs up is not the beneficiary who's asking for this additional therapy. The way I read this is that it is home health agencies figured out they can get more reimbursement if they have more therapy.

MR. HACKBARTH: Yeah.

DR. CHERNEW: [Off microphone.] [Inaudible.]

MR. HACKBARTH: So here's the challenge that we face; when we talked about this back in the spring, a lot of

the focus was on well, we've got to get physicians to be --

MR. GEORGE MILLER: Engaged.

MR. HACKBARTH: -- engaged in determining whether the beneficiary really needs this.

And Tom, for a variety reasons that made sense to me, said well, that's easier to say than to do when you're a practicing physician. We're often not in a position to make a really rigorous assessment of that.

Mike, at that time, said well, you know another potential avenue, and these aren't mutually exclusive, is to say if there's a modest co-payment then the beneficiary might be --

MR. GEORGE MILLER: Discouraged.

MR. HACKBARTH: -- think twice about whether they really need the additional home health services.

MR. GEORGE MILLER: Okay.

MR. HACKBARTH: So what we're trying to do is find some combination of steps that might help us make sure that the benefits are going to the patients who most need them in an area that the growth is explosive.

Now that's not to say that either of those responses, physicians or co-pays, is perfect without

problems.

MR. GEORGE MILLER: Okay.

MR. HACKBARTH: Just one other point, then on the fraud issue, I think Bob and maybe Tom as well. Some people said well, if we want to engage the patients in helping us identify potentially fraudulent behavior, which is really damaging the program, if there's some co-pay involved, that gets their attention. So that was the fraud angle.

MR. GEORGE MILLER: Okay. All right. But you also said in the paper that some agencies manipulate the outliers to get better payments also. So I don't know how co-payment would deal with that issue, but I don't disagree with the premise then behind that. I'm just really concerned about that statement, and maybe it's just worded, or I read it, wrong.

Just finally, and Scott mentioned that increased utilization may save the systems. I wouldn't disagree except for where those same, maybe different agencies may be again manipulating the therapy to get higher payment, not dealing with the fact that increased utilization is giving a better service and keeping them out of the hospital. Those are two separate issues here.

DR. DEAN: When you were talking about the cost-sharing, you said one possibility to try to make it fair would be to exempt episodes that had a low number of visits. Does that mean it would be determined after the fact, or? I didn't quite understand how that would work.

MR. CHRISTMAN: Well, I think for example, right now Medicare, if it's less than five, an episode has less than five visits, it pays on a per visit basis instead of a case-mix adjusted standardized payment.

DR. DEAN: I mean I'm asking so what happens if the patient then would get the bill after the episode?

MR. CHRISTMAN: Well, I think you could inform the patient that if you go beyond a certain number of visits in your episode that the cost-sharing is incurred. That doesn't mean you necessarily do at that point.

DR. DEAN: I see.

MR. CHRISTMAN: You could prospectively tell them that I you go beyond this threshold you incur this cost-sharing.

DR. DEAN: Okay.

MR. HACKBARTH: Okay, round two comments and questions; Karen, Ron and Mike.

Karen?

DR. BORMAN: Just one other thought, and then I don't know whether it's practical, but in terms of trying to think to your options here. It's conceivable that if we could identify that episodes preceded by a hospitalized, as now defined, were somehow more valid or more valuable or whatever that ones that didn't, is there an opportunity or would it require less legislation or what would we have to do to say potentially make the post-hospitalization benefit be 60 days and the non-hospitalization one be shorter, say 30 days?

I mean presumably if it got treated in a less intense site of service, then maybe the need for therapy or intervention would not be as long, and that might be a way to think about it -- just something else we could manipulate about the benefit.

MR. HACKBARTH: Any reaction to that, Evan?

MR. CHRISTMAN: I mean the 60 days, it's kind of vestigial to how Medicare was paying for care before PPS was implemented. So that's definitely something that changing the length of the episode is definitely something that's, I think, down the road on our list, and we can think about

that.

MR. ARMSTRONG: Just briefly, I want to affirm that the next steps looking at improved payments for non-therapy services, dealing with the incentives associated with that cost-sharing, I support going further with the analysis that you propose doing around those ideas.

I also just wanted to add that I do think that the role home health plays in some of our other programs too, too easily gets overlooked. For example, our discussion around payment structures for ACOs, maybe we ought to be thinking about how home health services also plays a role there. This whole paradigm on home health just seems to me so focused on how we control what seems to be either fraudulent or overused service. Actually, it's a hugely valuable service, and we want to promote its use more appropriately in some places where it's being underused.

MR. HACKBARTH: I agree, and it's important to keep that in mind. And there's also reason to believe that not everywhere is it being used in that way.

Evan, I don't think that there's much correlation between the high home health use and lower other costs in the Medicare program.

MR. CHRISTMAN: I believe what we talked about in September is in many cases they were positively correlated.

MR. HACKBARTH: Right.

MR. CHRISTMAN: When I talk about McAllen, Texas, Miami, L.A., those are some of the hot spots.

MR. HACKBARTH: So properly used and integrated with a care program, it's a hugely valuable tool. On the other hand, the way it runs in Medicare it can often sort of get off on its own track.

DR. CHERNEW: You're talking MA, though, Scott, right? You're talking MA system.

MR. ARMSTRONG: I am, yeah. But I was thinking about some of the structures we're looking at around ACOs, that this is I think something to consider there.

By the way I don't want to sound like I'm understating the importance of dealing with the issues here, and I really do believe we need to go forward with it. I just wanted to offer a little bit of a balance to that in that this is a service that fits in some other discussions as well.

DR. MARK MILLER: If I could say here, I didn't take it as anything other than trying to balance.

And I would just sort of remind everybody again this part of the conversation is about restraining utilization and that potential, but the first part of the conversation was this concern that the payment system was rewarding a certain kind of care and telling you to avoid strokes in Medicaid patients and that type of thing. So that part is also trying to get at changing the underlying use of the benefit and trying to orient it more evenly, if you will, the incentives more evenly.

DR. CASTELLANOS: I really want to add two points. I want to strengthen what Karen started and what Cori really pressed on, and that's the outpatient surgeries. In urology specifically, I've seen such a move out of the hospital into the outpatient. Today, we do 60, 70 percent of our surgery as outpatients, and it's the home health care that allows us to do that in a certain percentage of those patients, and these people do not have a preexisting hospital admission. I would strongly want you to look at outpatient.

And I would also think observation status. I see a lot of people in observation status that, you know, a person with a broken bone with blood in the urine. She doesn't quality for SNF. She hasn't been in the hospital.

Yet, she requires home health. So I think you need to look at observation and outpatient surgery.

The other thing that I guess we talked a little bit this morning about, these inconsistencies in the number of dates and times that we have in the Medicare system. We talked about a 60-day, a 30-day rehospitalization. Here, it's 15 days. A SNF is 3 days. I understand that you really have to have some judgment, but it's quite, to me, a somewhat confusion this is, the inconsistency sometimes that appears to be in the Medicare system.

DR. CHERNEW: So I thought this was terrific, and I might be at the extreme of people in support of the general notion of cost-sharing here. So I realize that.

So let me first start by saying that I think patients love home care. My grandmother loved home care. My parents loved home care for my grandmother. When the home care ended for my grandmother, my parents were really upset.

In part, they liked it because the home care was great. The home care providers were remarkable people that I really think that we would all be better if we had half of the traits of the home care providers. So I thought it was

a wonderful service.

The challenge I think, and I'll say this personally. I think it's generally true. A lot of the care that's desired isn't really necessarily necessary, and that's really where the challenge is. It's very hard in home care to figure out the distinction between I'm really glad you're coming which my grandmother loved, and I'm really glad you're helping with this as my grandmother needed a lot of help from this is really necessary in society, you should subsidize it because frankly my mom didn't want to go there. And I'm not saying that's all what happens all the time, but that happens I think in some cases, and I think there's evidence that that's a problem.

What I'm worried about, you would think that by supporting cost-sharing for home care that I don't like the home care program. In fact, I support the cost-sharing because I think without the cost-sharing the whole home care thing will collapse because we're going to end up getting to the situation where we're going to lower the rates and lower the payment rates, and I'm worried that the bad home care providers will drive out the good home care providers as we try and get the margin right when there's all this

heterogeneity. And I think that's a really big problem.

So I think that beneficiaries in this area, they know their needs reasonably well, not all them. So it's hard to get these things perfect. Their families know. And some modest cost-sharing can do a lot to make sure that people are willing to pay when they really need the home care and maybe not when they don't. I wouldn't want to have necessarily very high or onerous cost-sharing, but I think some cost-sharing could be incredibly useful in preserving the program, making it more efficient and making sure that we can do a better job of differentiating different types of care.

That said, I think in here a little more thinking needs to go into the exact form of the co-pay, and I've given a little thinking to it based on what was written here, and I'm just not sure.

So, for example, there's this issue of per episode or per visit. It's a very complicated one because if you do it per episode you end up charging a lot, say, for the person that might need a little bit of home care following an outpatient procedure, right, which maybe you wouldn't want to charge them very much for, but they have to pay the

average amount for the episode.

I could see a system where you give them maybe some for free after some procedure, and then it depends how you want to administer it. Then you charge them more at the end because you want to cut out those home visits at the end, but if there's someone really severe you might not. So I'm not sure how to deal.

We dealt with this in hospice, in this inverted U kind of thing. I don't think this deserves an inverted U, but some thinking about how to do the per episode versus per visits I think matters.

It might vary based on type. It might vary based on how we end up bundling because I actually think the way to deal with some of Ron's issues might be to bundle some home care and then not. So I think that matters.

There are issues of risk. So I might want to have a maximum amount you could pay, a co-pay per visit up to a max. That sounds reasonable to deal with the risk.

This issue of co-pays post post-acute, that wasn't a stutter. It was really post post-acute. I guess my general view is a solution to that is not to lower co-pays in that setting but to raise co-pays for the post-acute

because the issue is to get the efficient setting. A lot of the figuring out how to do it -- just because you had a hospitalization doesn't mean, to me, you should have some waiver of co-pays because we don't want to encourage you to go to some other setting. We might want to deal with that in a separate way because those people have the same issue as they get towards the end of their spells, and a whole bunch of other things.

So my general view is we need to think about how to change the form of the co-pays, which I haven't gotten yet. I'm not convinced that this is right to solve all of the problems, but I think cost-sharing is very important.

And the last thing I'll say, somewhat channeling John Bertko, once we do this, we have to think about the role that supplemental coverage plays in all of this. So I could envision that we make some change, and then people are buying supplemental coverage that are filling in where the post-acute, where the home co-pays would have been, and we're not getting the right incentives that we want.

So I think there's a lot of issues about how to do it, but I really think the problem we have with home health in general is it's an extraordinarily valuable service, and

if you put it in an MA plan like Scott's I think you can see how strongly valuable it is. But left to run around in the wild, it's just rife with both blatant abuse, the type of abuse that just makes TV commercials and just you infuriated.

And then there are things which I think aren't really abuse, but it's like well, I'll say my wonderful relatives. I'll just use them as an example, but there are so many examples of this. They're not really abusing the system. They probably should qualify, and they really liked it. But if you were going to have a genuine discussion honestly about do you really think that this is what we meant when we said home health, that's probably, probably not.

So we have to deal with the distributional issues and the co-pay waivers for low income. We have to think about the right form. But I really think the whole system would be better if we did a smarter job of making beneficiaries have at least a little incentive in some self-policing for a service that at least has some discretionary demand.

MR. HACKBARTH: So can I just pick up on one of

Mike's points there somewhere in the middle, the John Bertko point? I'm not going to talk about your relatives, but the John Bertko point, that to change the co-pay or add a co-pay and leave everything else the way it is probably would generate a lot of political flack for very little benefit in terms of changing utilization patterns because it will end up being covered by supplemental coverage and the system will just move on. It will be paid once a month through premiums as opposed to at the point of service.

You will remember that one of the items on our longer-term agenda for the spring is to pick up again our discussion about the benefits structure, and so we may want to think about discussing home health co-pay some more in the context of home health. But it could be that any recommendations that we make maybe would be best packaged in a chapter on the benefits structure and where we may concurrently deal with the supplemental coverage issue as opposed to doing it one-off.

Kate?

DR. BAICKER: Unsurprisingly, I agree with what he says, at least the parts I can remember.

The part that I would add on about co-payments is

that normally when we think about what the right co-payment is we're balancing insurance against incentives -- that you're trying to protect people against uncapped risk on the insurance side, but you're trying to maintain some incentive to monitor use, and you pick the co-pay to balance those.

Here, the thumb on the scale of the co-pay is the fraud component, that there's an extra value to the co-pay because it directs people's attention to having actually received the service, to having the service be consistent with their needs, and that pushes us towards an even greater value of co-pays. At the same time, you don't want people exposed to uncapped, or potentially very large, risk. So what do you about that fraud incentive when you get to some maximum out-of-pocket?

I don't know if we have the tools at our disposal to say something like you get a co-pay waiver, but you still have to fill out the same paperwork to validate that the person was there and that the co-pay would have been this, but because you're over the cap you don't have to pay the co-pay. Maybe you could build in some of the same monitoring without the actual dollar attachment once you get over that threshold, which doesn't solve the problem of his

relatives but solves the problem of the imaginary blind diabetic.

DR. STUART: I'm not sure it solves the problem of the blind diabetic. I'm really concerned about having fraud control being handled through co-payments. I just don't think that it's going to work, given the fact that if you look at the distribution of people that get these services there is a large proportion are not in a position to be able to judge whether they need them or not.

And a large proportion, this is something that has always bothered me about co-pay policy is we say okay, well, let's have co-payments, but we'll exclude the bottom 15 percent, 20 percent, 30 percent, whatever it happens to be, and they get a free ride. So what do you do with those people?

That leads to a question that would be has there been any analysis of the extent of home health use in the dual eligible population versus the non-duals? Maybe even go a little above that and look at the people who are in Part D plans and LIS. They have a little bit higher income, so that you'd be able to see whether in fact there is some correlation between income and receipt of home health

because it's really important if you're going to address this.

And you may well be right, Glenn, that this is not the chapter in which you want to do it. But if you really, really believe that co-pays are the way to go, then you've got to come up with some other alternative for handling the problems of those people who aren't going to pay the co-pays.

MR. HACKBARTH: I'm going to ask a clarifying question, Bruce, about your reference to looking at duals or the LIS population. I'm not sure I understand what you're after there. You have two populations that don't face any out-of-pocket costs?

DR. STUART: That would be the point. It would be what proportion of home health benefits are going to those who might presumably be exempt from co-pays.

MR. HACKBARTH: Okay, I see.

DR. STUART: Because those are obviously not going to be the ones for which the co-pay is going to have an effect on the utilization.

MR. CHRISTMAN: If I'm following you, you're asking kind of simply, for example, what share of home

health episodes are delivered to dual eligibles and things like that. I'm learning identifying duals in administrative data is sometimes a bit of an art, but from what we can tell they are over-represented in home health, and it's somewhere between 30 and 40 percent.

DR. STUART: Thirty to forty percent is huge. And if that is the case, then I think it argues for a slightly different mix of policies to address the issue.

If it turns out, and this would be something else to look at, is it 30 or 40 percent in Dade and Los Angeles County and these others, or is it even higher in those counties? The reason that I would ask that question is that these are very vulnerable people, and you might expect that they would be more vulnerable to fraudulent practices as well, not going along with fraudulent practices but being victims of fraudulent practices.

DR. MARK MILLER: I wanted to ask this, and it's been long enough now since I read the paper before it went out to Evan -- how hard of a linkage in the paper we were making between the co-payment and fraud because my view. Just to kind of reset the table for a second, my view of what we've talked about here were three things, and this is

kind of how it worked, and this is obviously a simplification and all the rest of it.

So we feel like we see this distortion in the system that says you should chase therapy, you should avoid stroke and Medicaid. Okay. And we're trying to get the payment system to deal with that.

The second layer is there's no one in the system, and I'm not talking about fraud yet, there's no one involved in the system who has any reason to say no. Physician Tom was very articulate on this point several meetings back. And just to pull George's point into it, rather than the beneficiary seeking it -- and I think this is what was concerning you -- it's sort of I'm coming to your house and why not, and so there's nothing to slow that down. I don't mean to be facetious at all. There's just no reason to slow that down.

Then the third thing that we brought into this discussion was fraud. What we were saying here is there are some new authorities in PPACA -- such as suspending billing privileges, stopping the number of providers who can come into a market -- that we may also want to talk about to address the fraud thing.

I think there was probably some sense that if the beneficiary -- I mean the co-payment might put some drag on that, but I don't think we brought it into this discussion particularly as a fraud tactic. It's sort of -- anyway, I'll stop.

MR. HACKBARTH: Yeah, and I think that's right. In today's conversation, I was the one who brought it in. It wasn't highlighted in the paper, and I was sort of channeling something that Bob has said.

DR. BERENSON: I'm waiting to talk.

MR. HACKBARTH: Whoops. Go.

[Laughter.]

DR. BERENSON: So I was the one. I was one of the people who brought this up before, and I'll disagree a little bit with Bruce. This is not one where we -- we're looking for a couple whistle-blowers. We don't need to have everybody who receives the benefit to have a co-payment. You'd have to hypothesize that some of the fraud people would only be targeting the duals, and I don't think, I don't see it as a prominent part of the fraud program.

I do think it is a useful thing for patients to, or for beneficiaries to, have even nominal cost-sharing in a

service like this for the just gross fraudulent activities when somebody never even came to their house. We don't need everybody to have that incentive. We need a couple whistle-blowers to be out there.

And so that goes to Glenn's point which I agree with completely, and John Bertko raised it. We would have to change the basic structure of the program, so that we didn't have supplemental providing first dollar coverage except for low income. But on this one, I don't think it needs to be a substantial co-payment. I just think it needs to be a co-payment.

DR. STUART: How about having a substantial payment for a whistle-blowing?

DR. BERENSON: Well, we get in --

DR. STUART: I mean if you're really interested in getting fraud out of the system, then give people a positive incentive to get at fraud.

DR. MARK MILLER: [Off microphone.] But they might not even know.

DR. BERENSON: No, under the False Claims Act, that's how it works, I mean.

But I'm just saying that from my personal

experience -- I won't bring in all my relatives -- I have still not looked into a certain claim that came in relationship to a relative because it was first dollar covered. I keep saying I'm going to call and ask somebody to explain what that service was, and I just never get around it. It was a substantial amount of money that Medicare and the supplemental insurer paid, and I have no skin in that. I don't like to use that term. I have no interest in doing that.

I do think there is some value in people seeing claims. It wouldn't detect sophisticated fraud where they're just using outlier payments. It would detect the situation where nobody ever showed up at somebody's house and a claim comes in for $100 for their share of that episode. So I don't think we give it prominent attention, but I think it probably does belong in the chapter.

With regard to Mike's point, I think it's -- I do think we want to think through whether the co-payment should be on the visits or the episode. By going-in bias is on the episode. There's already an exception for episodes that have only a couple of visits where you don't get the whole episode. It's LUPA, I guess is what it's called.

We need to think it through, but I think there's lower transaction costs if we just have a co-pay for the episode. The payment is by the episode. But I'm all for sort of thinking through that sort of logically to make sure where we would want to come up and how to deal with those exceptions.

And we also have to address the issue of equivalence to hospitalization. You know the issue that Karen raised.

DR. KANE: Yes. I'm going to change the subject. I hope people don't mind. I know you want to talk more about copays, but I want to talk about the case mix adjustment. In this 26 percent predictive -- predicting 26 percent of a cost variation, is that -- relative to other case mix indices that we have out there, is that a good number or is that kind of an inadequate number? I don't get a sense.

MR. CHRISTMAN: Well, I guess -- you know, it does vary and there are systems with higher and systems with lower. I mean, the headline number is 14 percent. That is all the costs. You were pointing to the 26 --

DR. KANE: Yes. So is 14 --

MR. CHRISTMAN: -- and, you know, I think that there's sort of a few responses I would make to that. One is that that is the amount of variation that we can explain using patient characteristics, and it is not out of line with what people have found in the past. To get anything higher than that, what people have done is they throw in things --

DR. KANE: Put the services in.

MR. CHRISTMAN: -- like the therapy visits --

DR. KANE: Yes.

MR. CHRISTMAN: -- or the treatments and the things like that.

Now, why does that number look the way it does? One thing that is discussed is that even people in the home health industry say that there's a lot of variation in how care is practiced, and this is stepping outside of even just geographic variation. But when the clinical folks talk, they talk about the lack of best practices and things like that, and there have been studies that have pointed out that practice just does vary and that a patient with the same characteristics, where they are will determine how they get treated. So this model is trying to distill that variation

and just find the piece that's related to the characteristics, and we're finding that it is what it is. I mean, probably the -- the HCMS-HCC system, it's R-squared is somewhere around 11 percent, for example. So I guess that the message -- I think it's consistent with the other things we've noted about home health, about the broad variation in the use of its benefit. If you want to get up beyond that, you start to add things to the payment pile that can create problematic incentives.

DR. KANE: Well, I'm kind of -- Mike said something about home health just wandering around all by itself out there in the wilderness, and I think that's part of the problem with trying to get your hands around this, is it isn't linked up to a diagnosis or an episode across the side. That's just a home health visit. So I was just wondering if there's any way we could get a handle on are there particular episodes for which the home health benefit can be more contained into, like the post-stroke amount or -- I just sort of feel like there's so many possible things going on on this one, it is really hard to get down to -- I mean, maybe we'd be better off going back to a per visit payment, because we don't really know what's in an episode

or why and why it might vary. It's just very fuzzy.

And then the notion that maybe 30 or 40 percent of these patients are dual eligibles makes me wonder if there shouldn't be some sort of socio-economic adjuster for what we're -- so the whole thing just makes me feel like we don't really know what we're paying for and it's very, you know, just -- I don't like it.

[Laughter.]

MR. HACKBARTH: Well, and I think your discomfort is appropriate. To me, the prerequisite for a robust system of prospective payment is that you have a clearly defined product that you're buying and you can say, this is the product and this is how it varies for different case mix, you know, a case mix adjustment system. Then you can have a robust system.

Home health has never met that test. It's an amorphous product, one, frankly, that can be subject to manipulation, and yet we decided to do prospective payment in sort of a festival of prospective payment systems for post-acute care. It was like, hey, it worked for inpatient hospitals so let's do it for everything, and that was a fundamental error that occurred back in the 1990s.

You know, I think if we were starting with a clean piece of paper, you could make a strong case that much of home health care should never be paid for as an independent service, but as an adjunct to other services so it is well integrated with the other care and there's a clear clinical responsibility for overseeing the home health. That's how you achieve the sort of high-value home health that Scott's referring to. This having it, as Mike put it, running in the wild is really problematic.

DR. STUART: [Off microphone.] Can I respond to this, just very briefly? I've got another take-away on that, because remember, this revised case mix system uses ADLs, among other things. And so the fact that that can predict therapy better than the current case mix system predicts therapy without therapy in it, which obviously you can predict therapy by therapy, tells me that maybe this is the heart of the matter, you know. You've got at least 27 percent of the variation that can be explained by, my guess is that it's mainly ADLs. I don't know, Evan, whether that's true. And then you'd be in much stronger position of saying, okay. Well, people that have whatever the difficulty is, and it could be a stroke, it could be the hip

fracture, it could be the other kinds of things that are going to lead to ADLs and, by the way, need to -- adjunctive therapy. So I thought the take-away was moving us in the right direction here with this new system.

DR. KANE: Well, I'm not against the case mix index being better than it was. I'm just wondering, is there something even better than --

DR. STUART: But that's good. Twenty-six percent is huge. I mean, if you look at --

DR. KANE: For therapy, yes.

DR. STUART: If you look at the HCC or you look at the DRGs, they're not anywhere near that high. Now, the 14 percent is not great, but it's still not terrible compared to the predictive power of the hospital service, prospective payment system, for example.

MR. HACKBARTH: So my take on the case mix was, hey, this looks like a significant improvement relative to where we are. And I would add to that, improving the case mix system is particularly important as we transition to a different payment structure. So as long as there's lots of money flowing into the system and payments are way over average costs, a sloppy case mix system is less likely to do

real harm. If, as you tighten the payment rates and you've got a poor case mix system, the risk that you're going to do active harm to some good providers increases. So now that Congress has put us on a path where there's going to be tightening of the rates, I think it's really important to improve the case mix compared to what it is right now.

MS. HANSEN: Sure. A lot of the points have been well made, and I think Mike covered a lot of it in areas, so I'm just going to highlight one. If we could talk about this case mix and go to Slide Number 10, and one of the things, I must say, that this new method is something that I'm really delighted that the redistribution of a population of concern for me has always been about the other kinds of things that go on with people who have more complex frailties that get adjusted. So it seems like this whole approach, at least, addresses that so that it's not just the therapy as it was before as individual discrete areas.

But I'd like to tie in to have an adjunct comment to the dual eligible, if this is the 30 to 40 percent that's involved. One of the things I just wanted to help distinguish is this whole thing of home health care as compared to home care. Home health care has a more

technical, clinical perspective to it that you oftentimes need a registered nurse or a licensed vocational nurse or a certified home health aide. So those are skilled care kinds of things.

What I do know is that especially with the dual eligibles, oftentimes they're qualified for home care, which are help with the general activities of daily living that go on regardless of these episodes, of whether it's after surgery or whether it's coming home from the hospital. So it's one of the areas to just understand, because this is where it starts to fold into the Medicaid said for the dual eligibles. So I just wanted to point that out, that people like home care, not just home health care. But people -- for us, it's really a technical definition. For the public, it's one in the same oftentimes and it's an area that is further kind of blurry to all of this.

The other aspect was this whole thing of how Scott uses home health care is kind of like the ideal aspect of bundling it together. So I just wonder whether or not we've really thought about this as to whether this episode bundling or episodes of care that's come in the new legislation has been thought of as to what impact that may

have in having any impact on home health care itself, with the post-acute folks starting to roll into this, and then in which case it doesn't become this stand-alone system of home health but it's about the outcome that is there. So I wonder whether we've done anything.

And then my final comment is picking up on the fraud aspect that had some blended conversation here. Or, actually, I have one on copay. On fraud, I think the last time we discussed this, the role of the beneficiary was also discussed as whether or not they could be the whistleblower, and CMS has this program called the Senior Medicare Patrol, but I heard that it was not very successful in the course of its implementation. But I think that was just another effort to have a watchdog approach to it as compared to -- or in addition to the copay side.

The copay side that I would bring up, I think I veer personally on the side of what Bob said, some kind of tiny aspect of being at least aware that perhaps a billing has occurred that you don't even know about, because this is not unusual, that people don't show up and a billing occurs, so how to catch that, that's one. And maybe if the Medicare Senior Patrol was more effective, that would be great. But

I do know, having talked to my AARP colleagues recently, they are still very strong about the idea of no copay. So that's one thing I just wanted, to represent them.

And the last thing about the -- sorry -- the last thing is about the supplemental programs right now, because I saw that it's trying to prevent the supplemental programs from covering this, and I just wonder how hard that would be to kind of change the supplemental programs in terms of the way they're designed. So that was more of a reality implementation question.

MR. HACKBARTH: On that last point, Jennie, the approach that Congress elected to take in the Affordable Care Act was to down the road -- I think it's 2015, if I remember correctly -- that the standard benefit packages would be changed so that the most popular ones, whichever letters they are -- I can never remember -- would no longer have complete coverage. There would be some copays. So that would be the mechanism.

MS. BEHROOZI: Can you turn it to the next slide, to Slide 11? Yes. Just so much of the conversation about what is the benefit and what are we paying for and all of that feels familiar from the time that I've been hearing

this, Bill Scanlon and this conversation. But it certainly does look like one of the things that drives us crazy every time we're doing the updates and looking at the margin spread, it looks like this case mix adjustor would bring those very low and very high margins closer to a middle that hopefully would also not be so skewed toward the high ends. That's a good thing.

And then just on the subject of what's a good provider, it does -- I like that last bar on the bottom. The providers that deliver more services in non-therapy episodes would get paid more and providers that don't deliver more services in non-therapy episodes, as George said, it makes very clear that they're going after the therapy for the payment, not to serve the patient. So this just seems like moving toward a more patient-centric way of paying. So I think that's all great.

On the copayments, I think I've made clear over the years how I feel about copayments applied broadly and generally. But, on the other hand, I do think that having people bear costs when they are accessing low-value services is not a bad thing, and that's a way to use copayments, right. And it seems like what I was reading in the mailing

materials, exactly not targeting copayments toward averting fraud, but there's sort of like this underlying sense of targeting copayments toward driving better value purchasing in home care services so that it's almost like there's a -- you're kind of making a connection that some people have question.

Karen and Cori, I think, have raised the question about whether all episodes that don't follow a hospitalization are, in fact, low value. Maybe there are some that are high value, and Ron also talked about that. And so maybe we need to get a little beneath the absolute line of whether it's just post-hospitalization or not. But it does seem like that's what you're kind of trying to get at when you're looking at the episodes that don't follow hospitalizations. Those might be the lower-value ones because, guess what, it turns out that they're higher profit, right. So maybe less services are needed or whatever.

So I think it's a good idea to keep pursuing this idea of what's high value and low value and use copayments to drive people to higher value services, and that might be also provider-specific. It might be that there are

providers who get to fall into a Centers of Excellence kind of category or whatever where people wouldn't have to make copayments or would have to make dramatically lower copayments rather than for providers who don't seem to be providing high-value services consistently, and that's obviously -- and I'm not just talking about the fraud outliers, but some way of measuring that. I don't know what that is, because this is a very provider-driven thing. As much as there is some beneficiary choice to it, it's much more provider-driven than a lot of other things are. So I think that we need to look a little bit more at what distinguishes low-value services.

And then one thing about how to calculate the copayment in the paper you talked about, a percentage of what Medicare pays for the service, but that's looking at it from a program-centric point of view. From the beneficiary-centric point of view, and this is also channeling John Bertko, he will tell you that small copays drive -- or small changes in copays drive behavior. So you really don't need to do ten percent of a $3,000 episode payment or five percent of it. You could probably do $25 and that would make people -- or I don't know what the number is, but that

would make people think about, I don't need that low-value service. I'm going to go for the high-value service that would have the lower copay associated with it. So I think that's it.

DR. DEAN: I think most of what I have to say has already been said. I guess I'm generally sympathetic to the idea of copay, but at the same time have all the concerns that have been raised about what behavior it actually precipitates. I mean, it will be a greater burden on some people than on others and there are some people that could perfectly well afford it that will say -- and who also need it who will reject it because they don't want to pay anything. I'm thinking of my parents, who did that. We did our best to talk them into it, and no, it wasn't worth that.

Anyway, it seems to me, though, that the more important thing is what Scott said, that to the extent that this is a very poorly defined service, like Glenn said, and if it's going to be used appropriately and efficiently and carefully, it's got to be part of a broader plan of care, and that plan of care needs to be initiated by the caregivers overall and not by some independent service that, to use a phrase, is running around in the wild, because

otherwise you will get clearly inappropriate utilization.

Just to finish, I've been concerned about access to this service in isolated areas and it would seem to me that the prospective payment really militates or incentivizes against the use of the service in isolated areas because it really does add substantial costs. If people have 30, 40 minutes' driving time each direction to a beneficiary, programs will not do that, and we have seen that in our area. They have drawn in. They have cut their distance that they're willing to travel. So that's a concern. And hopefully, as we look more and more at that, we could kind of hope to moderate the effect of those incentives.

Finally, you know, to respond to Jennie's comment, I was really interested in this Senior Medicare Patrol and I believe that we're seeing -- I've seen some -- just recently, there's a new initiative on the part of CMS, which I think comes out of the Reform Act, that there is a "Stop Medicare Fraud" website that has a bunch of really useful information on it, and I've even seen some TV commercials on that thing. So I think even though it hasn't been particularly, or apparently hasn't been very effective in

the past, I think it's trying to be reenergized and I really support that idea.

MR. HACKBARTH: Two thoughts, one about copays and one about revised case mix system. One of the benefits of continuing our discussion about copays in the context of a broader restructuring of the benefit package is that that also brings some other issues into play. For example, you can say, well, we're going to introduce a copay on home health and restructure some other services in order to help finance catastrophic coverage or something that's missing from the system now. These issues are complicated. There are pros and cons on copays, whether it's for a home health or physician services or anything else. But we don't live in a perfect world with unlimited resources and I think we need to think -- the Medicare program, for sure, needs to think about how we get the most benefit for our beneficiaries with a finite and probably ever more constrained set of resources, and I think that needs to be part of the copay conversation, as well, and that's best handled not looking at home health as an isolated service, but looking at the overall benefit package. So that's one thought on that.

And then on the case mix system, like Mitra, I was struck by these numbers and how many of the issues this seems to, if not fully address, at least partially address that we have touched on year after year after year when we look at the tables in doing the update analysis. And so I was struck that, hey, this -- and, of course, it deals with the therapy issue, which has been a chronic problem. So I was really struck by Evan's work and thought maybe we're onto something quite important here.

I guess my question for you, Evan, would be what's the downside of this? Is there a downside that we need to start talking about? There's always the obvious one, that it will redistribute resources. There will be winners and losers. The losers won't like it, and so on. But are there other more technical issues that we ought to be worrying about in the next couple months?

MR. CHRISTMAN: I guess the key one is just that, right now, the system pays better for high therapy episodes than it will under this revised system. Those high therapy episodes, there's a payment group for episodes that have 20 or more therapy visits. So you can imagine that it's going to pay better for the higher groups than this system and

that's kind of the compromise. But I think that that's always been a relatively small number of patients and I think the, overall, the non-therapy services are the more commonly provided ones. So to me, focusing on that -- if you have to make a choice, focusing on that basket of services is trying to sharpen your accuracy is kind of what you do.

MR. HACKBARTH: Is CMS aware of this work? Do we have any initial reaction from CMS about this?

DR. MARK MILLER: CMS is aware of it, but they haven't been aware of it for a real long time. We've only recently brought them up to speed on it.

We did something very similar to this in the skilled nursing facility situation where we had the same kind of thing, where we saw this very disparate performance and then we sort of dug in and it was the same researchers at Urban who helped us do that, and figured out a way, again, to set things on more of a prospective basis.

CMS has shown some interest in that. I wouldn't say wild enthusiasm. And I think a lot of it is kind of workload and a lot of things going on. But they haven't been resistant to it. They're aware of this and their point

was, yes, we want to understand better what you're saying, is sort of where they are in their -- I think that's a fair statement of where they are. So they haven't said no or yes. They want to understand deeper.

I was hoping that, or thinking that maybe your line of questioning was if we didn't see major problems, and in some ways, I hope for those of you who have been around the block a couple of times with us, what you see, and actually some of this is complaints from the industry, as well, and the Hill, as well, where something is not right, and we spent a year and a half kind of messing around with trying to find what isn't right and we feel like we've found something here. Nothing comes perfect and nothing comes without screaming. There's a lot of redistribution here. But if we're going to take the copayment thought and put that on a longer-term track, I was wondering where you were going is could we put this one on a shorter track and begin to even consider it in the context of our update recommendations. Let's bring people on a little more parity as we think about the updates. I hope that was -- I hope I wasn't too out of line. I hope that was where you're going.

MR. HACKBARTH: In fact, that's what I meant to

imply earlier when I said, now that we're embarking on a path towards putting pressure, well-needed pressure, on the payment rate, that means that there's an added premium on trying to get the distribution of a shrinking pool of dollars more accurately distributed. So I think of this as high priority, fast track sort of stuff, and if we could fold it into our March recommendation, a redistributive recommendation along with the update, that would be good. Do people agree with that?

[Agreement by Commission members.]

MR. HACKBARTH: Mike?

DR. CHERNEW: I just wanted to make one last copay comment in agreement with what you said earlier about thinking about this more comprehensively. Copays are never going to be easy, and there's always going to be drawbacks, but we have copays for -- if you have a heart attack, you pay a huge copay for going to the hospital and it's unclear that you would ever want the person not to go to the hospital. If you need to take a statin to prevent you from having a subsequent heart attack, you have a deductible, then a coinsurance rate, then a copay, you know, and all kinds of things. So there's things that we already do just

as a matter of looking comprehensively at the benefit package.

I think it's hard to argue, if you were starting from scratch and figuring out, how are we going to set copays, you would say, oh, you should pay for the deductible. If you have cancer, your out-of-pocket is going to be some huge amount of money. But if you need an extra home care visit, that's free. Not that I don't think that home care visits aren't important; I think, in general, they are. But I think in a comprehensive way, it's hard to argue that you have the system we have.

MR. HACKBARTH: Any other comments, concluding comments?

[No response.]

MR. HACKBARTH: Okay. Thank you, Evan. Good job.

And now we'll have a public comment period.

[Pause.]

MR. HACKBARTH: Seeing none, we are adjourned until 8:00 a.m. again tomorrow.

[Whereupon, at 4:05 p.m., the meeting was recessed, to reconvene at 8:00 a.m. on Friday, November 5, 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

AGENDA PAGE

P R O C E E D I N G S [8:01 a.m.]

MR. HACKBARTH: Good morning. So first this morning is a status report on Part D which Shinobu is going to present. And then we have our panel discussion on Medicare's role in motivating and supporting quality improvement.

Shinobu?

MS. SUZUKI: Good morning. Before I start, I wanted to quickly thank my colleagues Kelly Miller, Rachel Schmidt, and Joan Sokolovsky for their contribution.

In this presentation, I'll be providing you with information on Part D enrollment, spending, and utilization trends, and plan offerings for 2011, as well as some of the changes made to Part D by the health reform.

This chart shows the different sources of drug coverage for Medicare beneficiaries. According to CMS, in 2010 about 90 percent of Medicare beneficiaries had Part D or another source of drug coverage that's at least as generous at Part D, which are called credible coverage, shown here in orange, that includes employer-sponsored plans that receive Medicare's retiree drug subsidy.

At the start of the year, 59 percent of Medicare

beneficiaries were enrolled in Part D. The 59 percent with Part D coverage consists of 38 percent in stand-alone prescription drug plans that provide a drug-only benefit -- those are the blue pieces -- and 21 percent in Medicare Advantage prescription drug plans -- the green pieces -- where enrollees get both medical and drug benefits through a single private plan.

Focusing just on the blue pieces, which are the PDP enrollees, there are over 17 million beneficiaries enrolled in PDPs and nearly half receive Part D's low-income subsidy, which provides extra help with the premiums and cost sharing for people with low income and low assets. LIS enrollees tend to be sicker and tend to use more drugs, which you'll see in just a few minutes.

In contrast, the green pieces show that about 10 million beneficiaries are enrolled in MA-PD plans, with about one in five receiving the low-income subsidy, which is a much smaller share compared to PDP enrollees.

There hasn't been a dramatic shift in beneficiaries' choice of plans from year to year, but I wanted to highlight some of the differences between PDPs and MA-PD enrollees. On the left, you can see that 78 percent

of PDP enrollees are in basic benefit plans. These are plans that have the same benefit value as the defined standard benefit. MA-PD enrollees, on the other hand, are predominantly in plans that offer enhanced benefits which have higher average benefit value than the defined standard benefit. Typically, plans enhance their benefits by lowering the deductible. Currently, about half of PDP enrollees pay reduced or no deductible, or almost MA-PD enrollees pay reduced or no deductible, and a much larger share of MA-PD enrollees are in plans that offer coverage in the gap.

All of this is consistent with the patterns we've seen the last few years. This pattern reflects the fact that many sponsors of MA-PD plans are using some of the Medicare Advantage rebate dollars to lower Part D premiums or enhance the drug benefits, for example, by eliminating the deductible or by providing coverage in the gap.

Here's some information about drug use for beneficiaries enrolled in Part D. In 2008, 92 percent of enrollees filled at least one prescription during the year, and on average, they used 4.1 prescriptions at about $220 per month. But the utilization varied across plans and by

LIS status. For example, average spending for LIS enrollees was about double that of non-LIS enrollees, and some of it's due to differences in medication needs since LIS enrollees tend to be sicker. It also is due to differences in mix of brand versus generics. The generic drug dispensing rate tends to be lower for LIS enrollees compared to non-LIS enrollees, and some of this reflects the fact that they face weaker financial incentives to switch to generics.

In 2008, 31 percent of enrollees had spending high enough to reach the coverage gaps where most non-LIS enrollees pay 100 percent of the cost of the drugs. For LIS enrollees, the cost-sharing subsidy effectively eliminates the coverage gap. Nine percent reached the catastrophic coverage phase of the benefit, and most of them received the low-income subsidy.

Now I'm going to talk about plan offerings for 2011. The open enrollment starts on November 15th, and in the past, a relatively small share of enrollees switched plans in any given year. But the large reduction in the number of plan offerings for 2011 will likely result in more beneficiaries switching plans this year.

In 2011, there will be 11,009 PDPs compared to

over 1,500 in 2010. There will also be fewer MA-PD plans, 1,566 compared to over 1,800 in 2010. In any given year, there could be different plan strategies that could result in the reduction in a number of plans. Some of the reduction in PDP offerings this year issued to CMS regulations intended to more clearly differentiate between basic and enhanced benefit plans. And some are a result of past CMS regulations that required plan sponsors to reduce the number of plans within three to four years of plan mergers and acquisitions.

On the MA-PD side is the continuation of the CMS' effort to reduce plans with low enrollment. Private fee-for-service plans will be required to establish a network of providers beginning in 2011, and that has contributed to the drop in the number of private fee-for-service plans. Even with the reduction, beneficiaries will still have a choice of 28 to 38 PDPs in any given region, along with many MA-PD plans. The share of PDPs offering plans with no deductible remains stable at around 40 percent, and a large share of MA-PDs will continue to offer plans with no deductible.

One change that I wanted to call your attention to is the increase in the share of PDPs offering coverage in

the gap, 33 percent compared to 20 percent for 2010, which reverses the trend we've seen in the last few years. About half of MA-PD plans will offer some coverage in the gap, which is about the same as in 2010, and over 40 percent of MA-PDs that provide gap coverage will cover both brands and generics during the gap phase compared to about 30 percent for PDPs.

You may recall this chart from -- or actually the slide from Rachel's presentation in September that Part D's coverage gap will be phased out gradually between 2011 and 2020 as a result of changes made by PPACA. And I'm not going to go over everything in this slide, but I'll focus on two changes that are going to be in effect in 2011.

First, there will be a coverage gap discount program beginning in 2011 that's going to be provided by pharmaceutical manufacturers. It will cover 50 percent of the cost of the drugs in the coverage gap for non-LIS enrollees. The discount amount will count towards the out-of-pocket threshold, which will likely have the effect of increasing the number of enrollees who reach the catastrophic phase.

Second, cost sharing for generic drugs will be

lowered to 93 percent in 2011.

We've been focused on LIS churning for the past few years, so I'm going to update you on plan turnovers for 2011 and what that means for LIS enrollees. To give you a quick background, each year Medicare sets regional benchmarks for maximum premium subsidy amounts for each region based on plan bids. So there's some turnover from year to year in the plans that are premium-free to LIS enrollees. If an LIS enrollee is in a plan with a premium higher than the threshold and they haven't picked a plan themselves, then CMS reassigns them to a lower-premium plan.

I mentioned earlier that there will be fewer plans overall in 2011, but the number of PDPs that are premium-free to LIS enrollees will be 332 compared to 307 this year.

About 2.1 million LIS enrollees are in plans that will not be premium-free in 2011. That's actually fewer than over 3 million that was affected last year. So a couple of things could happen to these 2.1 million enrollees. If you're one of them and are in a plan assigned by CMS, you'll be reassigned to a different plan. CMS is expecting that will be about 600,000 beneficiaries.

Some LIS enrollees will be reassigned to plans

offered by the same sponsors. This is generally less disruptive because they often use the same formulary. If you're one of the 2.1 million and you're a chooser, which means that you picked your own plan at some point, CMS will not reassign you and you will have to either choose another plan to avoid paying a premium out of pocket or remain in the plan and pay the premium.

Now, this chart shows the year-to-year changes in average bids from plan sponsors. It reflects the expected cost of providing the basic benefit for a beneficiary with an average health. I want to call your attention to two red boxes on the right. The one at the top shows that the overall increase in average bids was 1 percent for 2011. That's the lowest growth we've seen since 2007.

But if you look at the lower box, you'll see that the individual reinsurance component is increasing at a much higher rate of 8 percent. So the lower growth overall was driven by the other components of the bid. The base beneficiary premium remained about the same at $32, and Medicare's direct subsidy or monthly payments to plans actually saw a slight decrease.

In 2009, there was a big jump in the reinsurance

component of the bid. The reinsurance component reflects what plans were expecting in the catastrophic phase for their higher-cost enrollees. Drugs that treat certain conditions like rheumatoid arthritis and multiple sclerosis can be very high cost, and beneficiaries who use those therapies tend to move quickly through the coverage gap and into the catastrophic phase of the benefit, where Medicare pays most of the cost through the reinsurance.

We need to keep our eye on this reinsurance component of the bid because for many of those high-cost drugs, plans are unable to negotiate rebates with manufacturers, and that has significant cost implications for Part D.

So you just saw that, based on bids, the base beneficiary premium will be $32 in 2011. That's not going to be the average of the premiums beneficiaries will pay in 2011. Because of the reductions in plan offerings we just talked about, there is a greater uncertainty surrounding beneficiaries' choice of plans, and we won't know what the average premium will be until we have the actual enrollment.

Beginning in 2011, higher-income beneficiaries will pay a surcharge calculated based on their income. This

income-related premium for Part D is set up just like the income-related premium for Part B, using the same income threshold and same subsidy schedule.

So most LIS enrollees don't pay a premium because the subsidy pays for the entire amount of the plan premium up to the regional threshold. But when an LIS enrollee chooses a plan that's different from the one they're assigned to and that plan's premium is above the regional benchmark, enrollees are responsible for paying the difference between the plan premium and the regional benchmark.

In 2010, about 1.7 million LIS choosers are in PDPs that require them to pay plan premiums out of pocket. Of the 1.7 million, about 600,000 pay premiums of more than $10 per month, and some are paying premiums as high as $80 per month. This raises some questions and concerns. Are these conscious decisions by the enrollees? For example, do they know that they could choose a plan that is premium-free? And given their limited income, can they afford the monthly premiums, especially those who are paying more than $10 per month?

So we looked at the average plan bid in an earlier

slide which reflects plans' expectations about what it would cost to provide basic coverage for a beneficiary with average health. The actual payment of plans, however, is risk-adjusted to reflect the actual health status of enrollees in each plan. Here the chart shows what Medicare paid to plans in aggregate, in reinsurance and direct subsidy, which are the red and green pieces; in addition to cost-sharing and premium subsidy for LIS enrollees, which are in yellow; and at the bottom in blue are the subsidy payments to employers who offer retiree drug coverage.

Incurred benefits have grown from about 43 billion in 2006 to 53 billion in 2009, and CMS expects spending to total 56 billion in 2010. That's an overall average annual growth rate of about 7 percent.

There are a couple things about this law that I'd like to call your attention to.

First, the LIS has grown to become the single largest piece of Part D spending in 2008, and it continues to be so.

Second, reinsurance has been the fastest-growing component of Part D spending with an annual average growth rate of 17 percent. Reinsurance covers most of the

catastrophic costs for beneficiaries who have very high drug spending, and this reinforces what we're seeing in plan bids. That spending for high-cost drugs and biologics are driving the growth in Part D spending.

LIS enrollees take a disproportionate share of the more expensive drugs and accounts for a larger spending above the catastrophic limit, most of which is picked up by Medicare's individual reinsurance.

We can talk about Part D's performance measures. Every year, CMS collects data from a variety of sources to measure the performance of Part D plans. CMS uses this information to rank plans, and beneficiaries can use this information to compare plan options.

There are currently 19 measures that are included in plan ratings. Most relate to customer service and member satisfaction. Two measures relate to patient safety. One measures members' use of medication with high risk of side effects when there may be safer alternatives. The second assesses whether members with diabetes with high blood pressure are getting appropriate blood pressure medications.

In 2008, the Commission convened an expert panel on Part D performance ratings that highlighted the

importance of developing performance metrics that measure cost, access, quality, and customer service. Although the measures now include some quality measures, additional measures of patient safety and appropriate medication use could help beneficiaries choose higher-quality plans.

So, to summarize some of the main points, there will be fewer plan offerings in 2011. More PDPs qualify as premium-free to LIS enrollees. Spending for LIS and reinsurance continues to be a concern. And we also find that some LIS enrollees are in plans that require them to pay premiums out of pocket. And, finally, current plan performance measures focus more on customer service and member satisfaction and less on measures more oriented towards clinical competence, such as patient safety and appropriate use.

That concludes my presentation.

MR. HACKBARTH: Thank you, Shinobu.

Let's begin with round one questions, clarifying questions. Tom, we'll begin on your side. Any over here?

MR. GEORGE MILLER: Thank you, and this was very informative. On slide 4, please, you mentioned while you were talking about this slide the incentives to switch to

generics. What are the current incentives and what are the issues, if you know, why some folks may not switch to generics?

MS. SUZUKI: LIS enrollees, I mentioned that they get extra help with cost sharing, and for some of them it means that they don't pay anything in cost sharing. Some pay nominal cost sharing. They would pay, I would say, about $2 for generics and preferred brands and maybe $5 to $6 for non-preferred brands; whereas non-LIS enrollees would pay something like $5 to $7 for generics, higher amounts probably on the order of $20, $25 for brands, and for non-preferred brands usually even higher.

MR. GEORGE MILLER: But you mentioned the incentives. Are those the only incentives? Or are there incentives to try to get them to use generics other than the price? Or is that the only incentive?

MS. SUZUKI: That's the primary incentive.

MR. GEORGE MILLER: It's not education or --

MS. SUZUKI: Not specifically, you know, the Part D plans would do -- I mean the incentives they try to build into the benefit package.

MR. GEORGE MILLER: Okay. Thank you.

MS. UCCELLO: I know I should know this, but I can't remember. The thresholds for the catastrophic, they increase by what?

MS. SUZUKI: They increase by the growth in aggregate annual spending --

MS. UCCELLO: In drugs?

MS. SUZUKI: Right, for all Part D spending.

MS. UCCELLO: Okay. So the reinsurance is not then -- the growth in that is not an artifact, even in part, of a leveraging effect?

DR. MARK MILLER: It's indexed to something different than the growth. The fact that the reinsurance is growing as a larger proportion when the reinsurance is tied to the total growth, she's trying to explore why that proportion might be shifting. Is that your question?

MS. UCCELLO: Yeah, and I think that's not the case. It is from these other things.

[Comment off microphone.]

MS. SUZUKI: Right. I think that's right.

MS. UCCELLO: And your data don't --

DR. MARK MILLER: Just maybe to -- we don't see -- and you need to watch this here, okay? We don't necessarily

see a mechanical or design reason this is going, and that's why I think we're sort of focusing on this.

MS. UCCELLO: Right, and I'm just confirming that that's the case.

You don't include the risk corridor payments in this?

MS. SUZUKI: The plan level reinsurance you're talking about.

MS. UCCELLO: Yes. No, plan -- yes, yes.

DR. MARK MILLER: [Off microphone.]

MR. HACKBARTH: [Off microphone.]

MS. UCCELLO: I don't think it is because I think you even said here that it's not. And I guess I was just wondering if not now, at some point --

MS. SUZUKI: I'll get back to you. I believe it does not -- I mean, I don't think we're showing the risk corridor amounts. I'm trying to remember if this would be reconciled post-reconciliation or pre-reconciliation. I can double-check on that.

MS. UCCELLO: Yes, I think this was post-reconciliation on the individual reinsurance stuff.

DR. MARK MILLER: And, again, we'll double-check

that, but that's what I take from our discussions and the read of the paper, Shinobu.

MS. UCCELLO: And I guess I'm just curious on the level of the risk corridor payments and how they may have changed over time. It's just something I'm interested in.

MS. SUZUKI: We had some information for 2006-2007. In 2006, I believe there was a net payment back to CMS of about $4 billion, so plans were getting paid a lot more than they actually expected to spend. In 2007, the amounts were much smaller. I'm thinking it was a few millions of dollars. In 2008, I don't think the data has been released.

MS. UCCELLO: Thanks.

MS. HANSEN: Slide 12, please. Relative to the measures on patient safety that are different from the customer service and satisfaction, is that something new that all the plans are going to have to collect relative to every enrollee's or every beneficiary's use of their plan?

MS. SUZUKI: These two measures are already in the Plan Finder, and plans report these measures already. CMS is currently reviewing other measures and actually collects some additional information that hasn't been released to the

public.

MS. HANSEN: And do know how these measures of safety are currently being used?

MS. SUZUKI: Currently it contributes to the overall rating, so they create these five-star ratings for each plan, and beneficiaries can see this on Plan Finder. These are components of the five-star rating that aggregates across the 19 measures, and I was saying that most of them relate to customer service, satisfaction. But two do measure the clinical side of things. But that all gets aggregated into the five-star system, so --

MS. HANSEN: This might be related, but do the beneficiaries use the plan -- the rating system, do we know?

MS. SUZUKI: I don't know.

DR. SCHMIDT: [Off microphone.]

MR. HACKBARTH: Either come to the microphone, or somebody needs to repeat what Rachel said.

DR. SCHMIDT: It's not entirely clear. We don't have our data on it. But the fact that there hasn't been a lot of switching of plans from year to year suggests that, you know, in the aggregate maybe not. But this coming year, as Shinobu said, there's a reduction in the number of plans.

We're expecting more people to switch plans, so this year could be a little bit different.

Could I also say on the patient safety issue, those measures are available to plans by CMS on a separate website. It's actually calculated from the claims data. So the plans are getting feedback on their patient safety, in not quite real time but pretty close.

DR. BERENSON: Just a brief follow-up on the question of the 10 percent who don't have any coverage, either Part D or credible coverage. In the paper you say they tend to be healthier. At least research suggests they're healthier and don't have a lot of drug use. That 10 percent, has that been a stable number over the years? Is it growing? Decreasing?

MS. SUZUKI: It has been about the same since 2006.

DR. BERENSON: So we don't think there's a major problem for those who are not signing up, they basically don't need the benefit? Is that overstated? If that is overstated, I won't ask you -- but, I mean, are there any issues that you're aware of with that 10 percent where there are problems?

MS. SUZUKI: I think I've heard that, you know, some of them could be eligible for low-income subsidy, but I don't think there is a real accurate estimate on how many of them are not getting drug coverage because they are lower income versus, you know, they could purchase a coverage but are choosing not to. I don't think we know too much about this 10 percent in general.

MR. HACKBARTH: Shinobu, remind us what the penalty is for late enrollment.

MS. SUZUKI: For people who do not get low-income subsidy, I believe it's 1 percent for each month that they delay enrolling in Part D, and that gets added to their premium when they do enroll in Part D.

MR. HACKBARTH: In perpetuity.

MS. SUZUKI: Yes.

DR. STUART: I can just add a little tiny bit to that. It has remained constant around 10 percent, but there actually is a dynamic involved in there because there are people that drop out of the program. And it's small, but every year there are people that stop paying their premiums and so, therefore, drop coverage. So the 10 percent is stable, but it probably involves slightly different groups

of people.

MR. HACKBARTH: Does that suggest, Bruce, that some people are opting to pay the penalty and leaving the 10-percent group to go into the covered group?

DR. STUART: We haven't followed people who disenrolled and see whether they re-enrolled, so we don't know whether they were -- you know, whether this was voluntary on their part, whether there was a mistake. But you could follow them, you know, in the claims data -- I mean, in the enrollment data.

MR. HACKBARTH: Okay. Round one clarifying questions?

DR. KANE: Yes. I'm just wondering, how long does it take to get that drug use data? I see we're looking at 2008, and I'm wondering, what's the timing of when data comes and why does it take so long? It's now the end of 2010.

MS. SUZUKI: I think part of it is CMS has to reconcile data, actual spending with what they are paying on a monthly basis in prospective payments. That takes some time. We are expecting to receive 2009 PD data in the next month or two. We actually got 2008 last December.

DR. KANE: So it's sort of a two-year lag before we --

MS. SUZUKI: Mm-hmm.

DR. KANE: And is there any effort to try to speed that up, or is there always --

DR. MARK MILLER: That is about a one-year lag.

MS. SUZUKI: Well, one-year lag.

DR. STUART: That is good.

DR. KANE: Well, 2008 --

MS. SUZUKI: Was last December --

DR. KANE: Yes, so 2009 now, but we'll be in 2011.

DR. BAICKER: No, December of 2010 --

DR. KANE: Ten, yes --

DR. BAICKER: -- so one year --

DR. KANE: Yes, so it's one year lag.

DR. STUART: That's pretty good.

DR. KANE: But you'll get it. Okay. Got it. So will we see updated -- but you probably can't process it for a while.

MS. SUZUKI: It usually takes some time.

DR. KANE: Yes.

DR. STUART: I just have a couple of clarifying

questions, one on this slide in terms of the quality metrics, performance metrics. In the chapter, you had a couple of bar graphs that showed the number of people who were in plans according to the star rankings, and it turns out that whether you're in a PDP or an MA-PD, there's a minority of beneficiaries are in plans that are scored four to four-and-a-half, and practically nobody is in five.

But one of the important things here, and I don't know whether you've had a chance to look at it, is not just the absolute number who are in those plans, but the number who are in regions that could have been in those plans. In other words, what is the proportion of people who are in the high starred plans who could have been in the high starred plans? So do we have some sense of whether it is individual behavior or whether it is plan characteristics?

MS. SUZUKI: Umm -

DR. STUART: The second point I'd like to --

MR. HACKBARTH: Do you have a response on that, Shinobu? Is it possible?

MS. SUZUKI: Well, one of the things is those star rankings are at the plan sponsor level, so it --

DR. STUART: At the contract level?

MR. HACKBARTH: Yes.

DR. STUART: No, that's true, and that's an issue. But even at that point, it would be interesting to see what the ratios are.

The second point is on Slide 10, and this is looking at people that have made a decision at some point or another to pick their own PDP, irrespective of whether it was premium-free or not. The LIS beneficiaries who come in on their own that are not dual eligibles and auto enrolled, the question -- I'm not sure about this, whether they have to choose and therefore are not protected from this auto enrollment.

And then kind of a follow-up on that is whether you've looked at distinctions in terms of numbers and utilization behavior and what not between the LIS duals, who in a sense are kind of the continuing Medicaid population, as opposed to those that were brought in at that -- the distinction between the dual eligible cutoff, which varies by State, and then the 150 percent.

MS. SUZUKI: We haven't looked at it at the individual level. Part of it is that we were using plan level enrollment that doesn't distinguish between partial

and full subsidy enrollees. I guess if you were going to SSA to apply for LIS and you have not chosen a plan, you get facilitated into a plan by CMS. That --

DR. STUART: But you're telling me the plan level data do not distinguish the type of LIS enrollee?

MS. SUZUKI: I don't think they do. The one that I worked with just had total LIS enrollment.

DR. STUART: That information is available, as you know, on the individual level, so if that became an issue, then it could. And we've done a little bit of work on the difference between LIS duals and LIS non-duals and it turns out they're actually quite different, not only in terms of their underlying characteristics but also in terms of their utilization behavior.

DR. BAICKER: My question is also on this slide, which raises some very interesting points. The premium that people are paying isn't a sufficient statistic to tell you if they've chosen a plan that is the best value for them because we don't know their out-of-pocket costs. So I wonder what share of these people -- and this, I think, would be very hard to answer with plan level data, you'd have to look at individual level -- but I wonder what share

of these people are in plans where they're then paying less out-of-pocket per prescription, so it's not such a bad decision to be paying the premium? I know at the individual level, you can run people's prescriptions through different plan features and see maybe people have chosen these plans because they cover their particular drug that another plan doesn't, and so it's a good call.

I also wonder what share of those people who are paying premiums are in more highly-rated plans. Is there any correlate of the choice that makes us think they are choosing for some reasons that we can observe. They are choosing for some reason, but if it is something that make sense from a perspective of either total out-of-pocket spending or quality of the plan or something that makes us less concerned that they have accidentally found themselves in a higher premium plan.

MS. SUZUKI: And we have not looked into that, but we could certainly start thinking about how we can do the analysis.

One thing I'd like to point out is that most LIS enrollees don't pay a lot in cost sharing because they get the subsidy. So -- I mean, we'll have to look into this.

DR. CHERNEW: I want to follow up on George's question, to some extent, about the generic use, which is for the low-income subsidy folks that aren't using as many generics, I wanted to trace through who sort of eats that extra cost. The plans, because they got randomized to them, they had bid a low bid amount, and that to some extent caps the government's payment to the plan. So I first thought that, well, that just means if the plan isn't controlling generic use in some way, it's the plan that has to eat that difference because they bid low, by the definition of the fact that they were low income.

Now, it's possible that that comes out in the risk adjustment for low-income subsidy people, that somehow we're paying plans more when they get low-income subsidy in their risk adjustment. So while you would think that what's going on is the plans bid low and so they have to eat it if they don't do a very good job of managing efficient use, because there's this extra risk adjustment component for low-income subsidy people, maybe it's flowing through there and the government is paying that way. And I wasn't sure which it was.

MS. SUZUKI: I don't think that we know the answer

to that question, but the payments do get risk adjusted and they do get higher payments for low-income subsidy enrollees given the same conditions, which presumably require use of drugs in the same therapeutic class. If low-income subsidy people use more brands or more expensive drugs and they get through the coverage gap and into the reinsurance component, then government also then picks up the spending.

DR. CHERNEW: No, but that's really -- a lot of this is going to be for chronic care meds that -- if they're through the coverage gap, then I understand. But a lot of it, I -- my stereotypical, and I might be wrong, is you're taking a branded statin, not a generic statin, and I guess how I care about that depends on whether or not it's the plan that's paying for the brand or whether it's the -- it's not the person, because they're low-income subsidy, and I don't think it's the government because of the way the bid worked.

MS. SUZUKI: The government -- oh, go ahead.

MR. HACKBARTH: In the long run --

DR. CHERNEW: They would have to change their bid and no longer be low-income subsidy, right? But as long as they bid the lowest amount -

DR. MARK MILLER: But just first think of it on a static basis. I mean, one thing I think it would try and shift the frame, and I feel like this is conversations I've had with you, is the low-income beneficiary isn't necessarily taking a statin. I mean, they're often taking very expensive brand name drugs that are related to much more complicated chronic conditions. And so I think there's a few things here. You get the base payment from the government. You get the cost sharing. If you blow through the uncovered period, you're into the uninsured. And I think one of the concerns, and why we're looking at that growth in the reinsurance portion, is why aren't the plans seemingly being more vigilant on this front, and I think some of it, that's what we're --

MR. HACKBARTH: So the premise is that generic use among LIS beneficiaries is lower. Do we know that?

MS. SUZUKI: We have looked into this. We --

MR. HACKBARTH: Okay. I missed that.

DR. MARK MILLER: [Off microphone.]

MR. HACKBARTH: All right.

MS. SUZUKI: On the generic use side, if LIS enrollees are taking more brands, and, for example, not in

the catastrophic, but maybe in the gap, the coverage gap, then LIS subsidy picks up 100 percent of the cost sharing.

DR. MARK MILLER: Right.

MS. SUZUKI: So in that sense, the government pays for the additional cost.

MR. GEORGE MILLER: So Mike is right. I mean --

DR. MARK MILLER: [Off microphone.] It is a risk-adjusted -- they are covering their cost sharing. If it is an expensive drug and they blow through either the gap or into the catastrophic, then they're into reinsurance --

DR. CHERNEW: [Off microphone.] I didn't -- it sounded -- when George asked his question, it sounded as if, well, we have this inefficiency going on in the low-income subsidy population because they're not taking generics and they should. But if they're taking an expensive drug for arthritis that they need to take the arthritis drug, that's very different than if there's a generic drug that they could switch to and they're just not and it's an inefficiency. And I was confused about who is paying for that inefficiency one way or another, and I think the point that the government is paying by the subsidizing of the copay part might be the main reason why it's flowing

through.

MR. GEORGE MILLER: Well, if we can go back to the original question, it seems to me a plan should have incentive to have someone on a generic drug versus a name brand drug, and what are those incentives? I think Mike asked the question better than I did, but it is still the point. I am not sure I got the answering or understanding, and so maybe that's a better statement. It would seem to me the plan should be incentivized to have the low-income subsidy beneficiaries use a generic drug over a name brand drug, and if they don't, who does pay for it?

DR. STUART: It gets a little more complicated than that because the copay structure is set up such that the only LIS beneficiaries that do not pay any cost sharing are those that are in long-term care facilities. Everybody else faces some differential between the generic and the preferred brand. My understanding is that LIS does not cover non-preferred brand, and you may want to comment on that --

MS. SUZUKI: My understanding is that generics and preferred brands have the same cost sharing because subsidy picks up whatever amounts that plan requires above two or

three-dollar cost sharing requirements for generics and preferred brands. There is a separate cost sharing for non-preferred brands. I can double-check and get back to you on this.

DR. STUART: Yes.

MR. HACKBARTH: George, do you feel like your question was -- so let me provide my answer, and correct me if I'm wrong. So all plans have an incentive to encourage generic substitution just because of the basic competitive structure. They're trying to hold down their premiums. And I think that's true for LIS plans as well as all others because they're trying to stay below the level where they can qualify to receive LIS enrollees. So I think there is a plan level incentive to do that, but the cost sharing structure differs for the LIS patients, which may make it more difficult for them to engage the patients. Does that make sense?

MR. GEORGE MILLER: [Off microphone.] Yes.

MR. HACKBARTH: Round one clarifying questions? Okay.

MS. UCCELLO: The reinsurance is 80/20, right? It is not 100 percent.

MS. SUZUKI: Yes.

MS. UCCELLO: So the plan is still on the hook for some post the catastrophic threshold.

MR. GEORGE MILLER: Is that right?

DR. MARK MILLER: But I think what we -- part of the reason that we're raising this, and back to Mike and George's question, is you could have a couple of things, and I think we really want to understand this. I mean, implicit in all these questions is we're seeing something we're not quite sure we're understanding. It can be that because of the cost sharing structure and the fact that the government stands behind it and all of that, maybe you're not getting the shift to the generics, in addition to the fact that this population is using a set of drugs which often isn't as easy to substitute, and so you may see a couple of those patterns. And I think that's what we want to unpack a little bit, and I think one of the points of the slide presentation is this is an area that we want to unpack a bit.

There's also one other thing I want to bring back into this conversation from some stuff that Joan put in front of you. We were looking at what people do in the gap.

You may remember some of this, and it's kind of good and bad news. The bad news is sometimes people cut their prescriptions, split pills, do that type of thing. But the other thing was there was a big impact on generic use or some sensation that there was a big impact on generic use where the beneficiaries would start trying to figure out how to lower their out-of-pocket, and that doesn't really occur for the LIS population. I think implicit in all of this is that the beneficiary is not participating in a big way -- although, Bruce, I understand your question -- not in a big way in slowing down the utilization, and depending on how the plan is being reimbursed, it kind of goes to your question. Why aren't they monitoring this more carefully?

Shinobu, that was all --

MR. HACKBARTH: Shinobu, to the best of my recollection, the only place the draft chapter talks about beneficiary satisfaction is in talking about the star system and how it's one of the factors there. What data are available from other sources about beneficiary satisfaction with Part D, and should we include some of that data in the status report?

MS. SUZUKI: I believe MCBS had some survey

questions in there about Part D use, access, that sort of thing, and we plan to look into it in the future. We just have not done so yet.

MR. HACKBARTH: Okay. Round two questions and comments. Tom?

DR. DEAN: Actually, as I stop to think about this, it may be more round one, but whatever. On Slide 12, you talked about the measures that relate to patient safety. Do you have more specifics about -- it says, members' use of high-risk drugs. What actually is the measure? Is it just the number of people using high-risk drugs? And then more so, optimal treatment for diabetic patients. How is that judged?

MS. SUZUKI: So the members' use of high-risk drugs, I believe, has a list of drugs that CMS looks for, and I believe it's the percent of -- can you help?

DR. SCHMIDT: It's similar to but not exactly the same as Biers List drugs. It's, I believe, an NQF validated measure.

DR. DEAN: So is it just a listing? I mean, is there any action or interventions on those, or how -- what's the response?

DR. SCHMIDT: Let's see if I can -- I'm not going to get this precisely right, but it is a listing of drugs that are perceived to be high risk and it's derived from the claims information, so it's going to be like the percent of the beneficiaries who filled scripts who have those drugs.

DR. DEAN: I guess what I'm getting at is, okay, we know they're using these drugs. Is there any action to determine whether it's appropriate use, I mean, because I think as we've talked about before --

DR. SCHMIDT: Right.

DR. DEAN: -- this list continues to be controversial, that most of the drugs on that list have some limited justified uses, even though they also get listed as "should never be used in the elderly" and so forth. And so it's a controversial area.

DR. SCHMIDT: Right.

DR. DEAN: But I'm just wondering, what is the response? I mean, we can list them easy enough, but is there any sort of intervention that takes place or --

DR. SCHMIDT: Well, there's, as I mentioned, a website where plans can at least refer to what their ongoing rate of dispensing those drugs and providing those drugs to

their enrollees looks like, and I think that they can go back and actually track it to providers to look at whether those rates are higher for individual providers or not.

DR. DEAN: Okay. So it's kind of at the option of the plan to determine how they use the data?

DR. SCHMIDT: Right, and presumably CMS, if they're seeing some crazy high rates, can kind of put some pressure on.

DR. DEAN: And with the diabetes drugs, it says optimal treatment. I mean, who determines that?

DR. SCHMIDT: Well, I think it's following a guideline that has to do with use of ACE or ARBs, ACE inhibitors or ARBs -

DR. DEAN: Okay.

DR. SCHMIDT: -- if they're already a diabetic, dispensing of those.

DR. DEAN: Okay. And the second question, what is the overall cost of the program? I mean, we heard some claims tossed around during the campaign about this is much more expensive than everything. All of Obama's programs aren't as expensive as Part D, or something. And I was just curious. What is the overall cost and what's happening with

that?

MS. SUZUKI: So total spending, this chart shows you that in 2009 --

DR. DEAN: Oh, there it is.

MS. SUZUKI: -- we spent $53 billion. In 2010, we think we'll spend $56 billion in total.

DR. DEAN: Fifty-six billion. Okay. Thank you.

MR. HACKBARTH: So, Tom, I think at least the pieces of that discussion that I heard was people focused on the projected ten-year cost, which initially was, what, $600 billion or something, and it was lowered to 400. Anyhow, it was hundreds of billions of dollars over ten years, and the fact that there was no effort to pay for that by making offsetting reductions elsewhere.

So let's just do a time check here. We've got about ten minutes left. Our next session involves two guests, so we really need to stay on time. Could I see the hands of people who have second round comments so I can just get a sense of how many? Only Cori?

DR. KANE: [Off microphone.]

MR. HACKBARTH: I actually do have some things about the shape of the chapter that I'd like to raise for

discussion, but let me see the hands of the people who have round two questions or comments. One, two -- okay. Scott?

MR. ARMSTRONG: [Off microphone.]

MR. HACKBARTH: Boy, we are shy this morning. Okay. Cori?

MS. UCCELLO: I'm just going to reiterate the need to look at and try to figure out what's going on in this reinsurance piece and try to understand kind of what -- given that the plan -- I mean, I think it's still on the hook for this 20 percent. What else is going on? Is that not enough, or is the risk adjustment kind of overlooking that? You know, lots of people have incentives that are either there or not there with the low-income people, and this is going to be more important as more people are now going to be hitting that catastrophic threshold with the gap issue.

MR. HACKBARTH: Are you focused on the rate of growth in the reinsurance and why is it growing --

MS. UCCELLO: Yes. Yes.

DR. STUART: [Off microphone.] Or as a portion --

MR. HACKBARTH: Yes, but one --

MS. UCCELLO: Both.

MR. HACKBARTH: One hypothesis that John Bertko used to talk about is that because these are sole source drugs, the plans have very little leverage in negotiation.

MS. UCCELLO: And I think that's the question when looking into that. Is that the answer, or is there something else going on with the incentives that aren't quite aligned correctly.

MR. HACKBARTH: Yes. Bruce?

DR. STUART: It may actually be more serious than it looks, because remember that when the program first began, the plans had very narrow risk corridors for that reinsurance amount and those risk corridors have become wider, which means that the plan is responsible for a larger proportion of the catastrophic cost than at the beginning of the program. At least, that's my understanding.

MS. UCCELLO: I think maybe you're confusing the risk corridor, which is trying to get the right price target, versus the higher spending due to an individual having a catastrophic claim, and the thought was that, over time, as plans get more experience with the pricing, those risk corridors could be widened. And so I think those are two different risks that are trying to be addressed. But in

any --

MS. SUZUKI: Right. So risk corridors, now that it's wider than when it began, presumably, it puts more pressure on plans because they're taking on more risk. Reinsurance is a separate part of the risk adjustment.

MR. HACKBARTH: So we get plan level versus the individual.

MS. SUZUKI: Yes.

MR. HACKBARTH: Jennie?

MS. HANSEN: This is probably a comment, observation, pulling together a few things here. One is looking at the gradual rate of growth on Slide 11 for the total spending for Part D, just looking at that rate of growth tied with some other things we've brought up in the past day or so about the growth of the dual eligible numbers that are coming down the pike and then Bob's comment about just the boomers hitting, and then the sole source drug expenditures that are there, it just seems like the rate -- these are factors that are going to really compound this program, just from an estimation standpoint.

MR. HACKBARTH: Right.

MS. HANSEN: But I'm also then intrigued by a

chapter that we'll discuss later on hospitalizations and that there has been seemingly a slight reduction in admissions. So again, we take a look at the whole program in composite. What are the effects of growth? What are the effects of other parts of the program intended by Part D? And I don't know we're in a position to comment yet, but these are related trends and factors to consider.

MR. HACKBARTH: Yes. Scott?

MR. ARMSTRONG: Glenn, I just -- as we think about the work going ahead around this topic, I just wanted to make sure we didn't lose our recommendation around two topics. First, this whole issue around the incentives, the impact of the 50 percent discount on brand drugs and our desire for generics to be used. So I wanted to confirm, we are going to spend some more time trying to explore that and understand what's going on there a little bit more clearly.

And then, second, with respect to the quality measures and the star rating and so forth, that's not an area I have a deep understanding of, but it sounds to me we're reporting on a lot of information, particularly some of the high-risk areas. There may be some new measures to consider looking at or diving into. But as far as I could

tell, there's actually really no consequence to being a two star-rated plan versus a five star-rated plan. And I just would like us, as we go forward, to think a little bit about how the quality rating may have more relevance to either the patients making choices or perhaps even have some kind of financial incentive or consequence to help encourage the use of the more highly-rated plans.

MR. HACKBARTH: The star system is new and developing. I fear that you're going to turn out to be correct, that it will be incidental. I'm not sure that we know yet that it won't be effective in moving beneficiaries, but that's certainly an area for us to watch and explore as the system develops.

Does anybody else want to get in before I make a couple concluding comments, or actually, I want to frame those questions to get your reaction to. This is very well done, Shinobu, and very thorough, and thank you for that.

The questions I have are a little bit about the framing of this. My personal sort of overall impression of Part D is that it's achieved some important goals. We have dramatic expansion in the number of Medicare beneficiaries that have prescription drugs, which is, of course, the

primary goal. That's a good thing.

I believe that Medicare beneficiaries are largely satisfied with it, but that's why I asked, Shinobu, for you to see if we can bring some more data to bear on that.

As we discussed a minute ago, the program has come in at a lower cost than was initially projected, which, of course, is a good thing.

In the data that we have been presented, I think there are a couple, I wouldn't say warning flags, but certainly things to watch more carefully, and I would say the rapid growth of reinsurance costs are high on that list. And the reason it's high on that list from my perspective is not just because of the budget implications, but because it poses a challenge potentially that the model is not well suited to address. A competitive model has proven successful, for example, in getting people to switch to generics, which is a very good thing. But a competitive model may not be very successful at dealing with the rapid increasing cost going to sole source drugs.

Let me just have one more minute, Mike, and then I will let you react. So that's one thing that I think may be worth flagging and making a little bit more prominent than

it is in the current chapter, and I want reactions to that.

A second thing is the plan switching rate. This model is premised on Medicare beneficiaries disciplining the market by choosing different plans when some under-perform. And this also gets to the star issue, as well. I think we need to, on an ongoing basis, look at that premise and is it playing out. Are, in fact, the beneficiaries able to provide the market discipline that this competitive system depends on?

Now, I don't know the answer to that. I think the switching rate was six percent, is what is in the paper. Is that right, Shinobu?

MS. SUZUKI: That was the switching rate for the first couple of years. We don't have the latest information.

MR. HACKBARTH: And that, as I understand it, is comparable to FEHBP -

MS. SUZUKI: Yes.

MR. HACKBARTH: -- and so I'm not implying that that number, oh, this is bad and we ought to be concerned, but I think it bears watching. I think in particular it bears watching here because of the potential stickiness

around formularies and the like. If particularly high-cost patients have a lot of drugs and they're in a plan and they've got what they need on the existing formulary, the prospect of shifting for a relatively modest per month savings in premium expense just may be too daunting, and if that stickiness is significant, it could affect the market discipline.

So those are some thoughts that I have. Again, I don't mean to characterize either the reinsurance issue or the switching issue as a problem, we know this is a problem, but rather as things that we need to watch because they're so fundamental to the success of this competitive model. Reactions?

DR. CHERNEW: So now I will say in response to this, I think it's extremely difficult to think about how to deal with the sole source high-cost drugs, because if you assume, oh, they exist, now let us get the cheaper price in a competitive market, that gives you one set of things to do. But there's all kinds of innovation incentives and other broad issues related to that. So it's a very different thing, and my own personal opinion is, of course, in cases where they're really providing value, we want to

encourage innovation and so we don't want to have a system that says, this is a new, good drug but we're simply not going to pay for it. On the other hand, we do want to avoid situations where there's a drug that's not giving us very much and for a whole series of reasons we're just paying a ton more than competition is working. And separating that out matters.

But the key point is, recognizing the value of the innovation is important in figuring out how one wants to set the price for these types of drugs. That's the way the system is supposed to work. That's very different than the, you should be taking a generic instead of a branded when there are perfectly good substitutes.

MR. HACKBARTH: And I don't disagree with any of that, and I would think if we were to flag this as an area to watch, that would be one of the messages, is that there are important issues at stake here, including innovation, incentives for innovation.

DR. KANE: Maybe tie it to comparative effectiveness types of priorities? Maybe the priorities in that program should start with those types of drugs.

MR. HACKBARTH: I don't want to wade so -- let me

just be clear here. I don't want to wade into this and start laying out policy options and the like. This is a status report on Part D. And so what I'm trying to do is just highlight some areas that bear watching and give a little bit of a sense of what the issues are at stake and not talk about solutions, not talk about policy options. Bruce?

DR. STUART: Part of this is bringing threads together. We have had that paper on bio-similars. I mean, that addresses a point that Mike raised. So maybe it's just looking across our portfolio of activities in the Part D arena, pulling those together that are focused on sole source drugs, and then pulling those together that are really focused on the reinsurance, and those two are obviously not independent of one another.

MS. BEHROOZI: I also noted in the paper that next time, we'll be getting information on drug pricing in the program, or the impact on prices, and while there are -- you know, there was a lot of discussion about what the incentives are for plans to drive people to generics or get best pricing from pharmaceutical companies, they are still somewhat insulated. I mean, it is really not a perfectly

competitive market because of the imperfect information that beneficiaries have, like is the higher premium going to get me better copays, and do I have the time to figure this all out, and maybe I'll just stay with what I have because it's easier than switching. So maybe plans aren't being driven quite as hard as they could to get the best prices because they can somewhat pass along more than they ought to be, even though they're exposed to 20 percent of the reinsurance costs, you know, they're making it up at the front end or something like that. So I think that's going to be really interesting to look at, too, not just with the biotech drugs.

MR. ARMSTRONG: Just in response to your question, the way you characterized the work going ahead, I totally support that. I like the way you did that.

MR. HACKBARTH: Thank you, Shinobu.

And now we have our panel on Medicare’s role in motivating quality and supporting quality improvement.

Are we all set, Anne?

MS. MUTTI: [Off microphone.] Yes, we are.

MR. HACKBARTH: Okay, Anne, would you do the introductions?

MS. MUTTI: Sure. This presentation picks up on a conversation we started last year, one that asks whether Medicare can better leverage its policies for technical assistance and for Conditions of Participation in order to accelerate quality improvement.

We take this question on because the evidence on the effectiveness of both programs, that is the QIO program and the COPs, is not strong. Also, there is wide variation, and that persists over time, and low performers tend to serve a higher proportion of minorities, contributing to our disparities problem. And third, we recognize that while payment policy may be Medicare's most effective mechanism to motivate and support quality improvement, it may be that by leveraging multiple at once we have the best chance of succeeding in improving quality.

I'll take a moment to summarize some of the ideas we presented in the June 2010 report, and then our panelists, Bob Wachter and Chris Queram, will speak to the problems we have identified and discuss ideas on how these parts of the Medicare program could be improved. And depending on your conversation, we could be coming back to you early next year with draft recommendations for some of

these ideas.

Medicare spends more than $300 million annually on the Quality Improvement Organization program, yet the evidence from the literature on the effectiveness is mixed, and our recent interviews with providers and health quality experts suggest room for improvement. The following six ideas for change are intended to spur your discussion. They do fit together as a package, but they could also be considered individually.

So first, we could target assistance to low performers, and CMS has begun to do this but not across all its priorities in the 9th Scope of Work. Targeting assistance to low performers does a couple of things. It constructively offsets some of the penalty for poor performance that can occur under value-based purchasing policies as well as the readmissions policy, increasing the chance for these low performers to improve. And by directing quality improvement assistance to providers who tend to serve large minority populations, we are in a better position to address our disparities issues.

Second, we could measure performance largely on outcomes measures, and specifically these should include

measures of systemness because improving performance on these types of measures will require that providers working with their technical assistance agents explore strategies for overcoming fragmentation in the delivery system and engage multiple providers in the community, to focus on things like care transitions and access to primary care, and this will help us avoid reinforcing the silos and instead promote systemness through our technical assistance program.

Third, Medicare could change the contract structure to encourage low performers, to better engage low performers. One way to do this is to have the financial support for quality improvement go directly to the poor performer instead of the QIOs or technical assistance agents. In turn, the poor performer would select its own technical assistance agent perhaps from a list of organizations that meet basic requirements. This approach empowers the provider, engages the provider in improvement and makes the provider, rather than CMS, the client.

Fourth, we could broaden the criteria for technical assistance agents that deliver assistance to providers, so a much wider group of organizations would be eligible to function as Medicare technical assistance

agents. Currently, there are legislative restrictions on what type of entities can participate as QIOs, including that they must be able to serve an entire state and be physician sponsored, which limits the types of organizations that can compete to be QIOs. By removing these restrictions, we would expect to see entities currently functioning as QIOs still completing but also other organizations competing for business from low performers, and we might get types of organizations that specialize in helping rural populations or types of organizations that are especially experienced in offering provider collaboratives.

Fifth, we could allow flexibility in the way the technical assistance is provided and the focus of that assistance. For example, the technical assistance may include one, or a combination of, in-person mentoring, participation in a collaboration, or maybe the focus really should be about learning how to use and read your data, that that is a first step that needs to happen and one-on-one assistance would be helpful. The focus could be on anything from best practices for pressure ulcers, if you felt that was the reason for your poor performance, your overall poor performance, or maybe it would be strategies to implement

culture change. Addressing management issues like staff turnover can be one of the types of things you might need to focus on, and also improving coordination with other providers in the community. So it would allow for a broader sense of what kinds of problems need to be addressed.

And lastly, we could pair flexibility with accountability. The provider receiving a technical assistance grant should be accountable for using it to improve performance, and this accountability can be achieved through payment policy that financially penalizes or rewards providers that fail to improve performance, like we have under the current P4P policy and readmissions. But there could be an additional accountability through Medicare's Conditions of Participation. For example, providers that do not improve after having received assistance could be subject to intermediate sanctions, and one example of that could be a corrective action plan that requires management changes. And we see precedence for this approach in nursing home policy and recent education reforms.

Another way Medicare can stimulate quality improvement is by reforming its Conditions of Participation. The COPs are the minimum standards that certain providers

are required to meet in order to participate in Medicare. Millions of dollars are spent annually preparing for and conducting these surveys to ensure compliance with standards. Yet, it's unclear how much these efforts have accelerated the pace of change.

The types of options that we have talked about to reenergize this process are:

To create a voluntary higher standard. Under this option, CMS could create a more rigorous set of standards for which compliance was voluntary, to allow providers meeting these standards to publically distinguish themselves as high performers, and perhaps these would be more outcomes-oriented standards that would be the optional set.

Another option is create mandatory outcomes-oriented standards for select services, and this would be to better direct patients to quality providers for high cost and complicated procedures. The COPs could be amended to incorporate outcomes, volume or other types of criteria for select services, much like it does for transplant centers. So in the end, we wouldn't pay for services unless the facility or organization has passed those Conditions of Participation for those services. A similar approach was

recently taken by the VA to prevent scheduled surgeries from exceeding infrastructure capabilities of the VA facilities.

A third option is to create intermediate sanctions because one problem with enforcement under the current survey and accreditation process is that the consequence for failing to pass the survey or accreditation is so extreme. It's exclusion from the Medicare program, and that action is rarely taken. So intermediate sanctions that had a real possibility of being imposed may be a greater motivator, and examples of these sanctions could be public disclosure of poor performance, requirement to receive the technical assistance that we were just talking about, the corrective action plans with management changes or perhaps even suspension of payment to facilities from performing elective procedures for which there were quality problems.

And lastly, we could update COPs to align them with current quality improvement efforts. Here, some of the ideas that we've thought about focusing on was discharge planning, better engagement of physicians and boards in quality improvement efforts, and focusing on efficiency improvement.

So let me just switch gears here, and we'll turn

to the panel in a moment, but first I want to convey some of the kinds of things that the QIO trade association says to us when we are talking to them about some of these ideas, so that you can take them into consideration in your discussion.

First, I think they might say don't be so sure that we haven't made a big and very positive difference. It is very difficult to measure quality improvement in general, and this is not only for QIOs but other organizations that try and improve quality. They would point to one survey of 11 percent of hospitals which ranked QIOs higher than any other source for technical assistance.

They would also note the fact that not to be concerned that there's been so little change in the organizations that are functioning as QIOs because there has been a lot of stability over time in these. They say that this can be a real positive, that they develop experience and know their communities.

Third, they would point that QIOs are constrained by declining funding. CMS directs a significant amount of the QIO budget to other quality-related activities, leaving QIOs with less.

Fourth, they would say one of the key advantages to QIOs is their local presence and their ability to bring different providers in a community together to tackle systems issues, and this strength might get lost if we were to now have the assistance go directly to providers instead of QIOs.

And I imagine that there are other points. They'll have an opportunity, obviously, to add to this.

So with that, we now turn to our panel. We are very fortunate to have Chris Queram and Bob Wachter with us.

Chris is the President and Chief Executive Officer at the Wisconsin Collaborative for Health Care Quality. He also served on the IOM panel that considered QIOs in 2006, so he's a great resource to ask him about what went on there. And he serves on the board of the Joint Commission.

Bob Wachter is a professor and Associate Chairman of the Department of Medicine at the University of California in San Francisco, is an expert on quality issues, widely published and also generally regarded as the academic leader of the Hospitalist Movement.

So with that, I will turn it over to them.

MR. QUERAM: Thank you, Anne, and thank you for

this opportunity to come before you and share some perspectives on the quality improvement program but also the work of regional quality organizations such as ours.

We have a short amount of time to prepare or present opening comments, so I'll move right into a description of the Wisconsin Collaborative for Health Care Quality.

We're a nonprofit voluntary consortium of organizations -- hospitals, medical groups, provider-sponsored health plans, consumer organizations, business coalitions and employers -- that was formed in 2003 for the specific purpose of using public reporting of comparative performance of health care information, to catalyze improvements in care and to begin to change behavior on the part of not only provider organizations but other stakeholders, in terms of how they use that information to support transformational change in health care delivery.

We've reshaped our vision, and we focus now on trying to bring coherence to the use of performance measures. We live in a time of an embarrassment of riches from the standpoint of performance measurement. Some might call it cacophony. And one of the roles that we seek to

play is to try to bring coherence to the balance between national priorities and local interests, and guide the use of performance measurement not only for public reporting but quality improvement, consumer engagement and payment reform. And our focus explicitly is on not only improving how health care is delivered but also seeking to drive improvements in community health status and individual health status.

Our member organizations -- we are structured as a membership organization -- are many of the major health systems in our state. Wisconsin is unusual in the fact that a large percentage of physicians practice in multispecialty groups. The statistic, I think, is around 40 or 50 percent of the physicians are in these multispecialty groups. So we have a significant market penetration by virtue of a relatively small membership of provider organizations.

And some of these, I think, are probably familiar to you -- groups like Marshfield Clinic, the two academic medical centers, Gundersen Lutheran Health System and others that are listed on this slide.

A couple of comments and perspectives on the Quality Improvement Organization program, and some of this is informed not only by my participation on the IOM

committee, as Anne mentioned, but also our experience working as a CMS subcontractor a few years ago in the Better Quality Information for Medicare Beneficiaries program which was conducted by CMS as part of the High-Value Health Care Project under the previous administration.

And I can resonate with some of the themes that were articulated in the chapter in terms of the lack of flexibility and adaptability because of contractual constraints. I appreciate that CMS takes its obligations as a steward of Medicare trust funds very seriously, but the contractual requirements do have a tendency to stifle innovation and experimentation in this rapidly changing, and very dynamic, environment.

It's been my observation, observing the Quality Improvement Organizations for many years that there is a lack of constancy of purpose, not only between one scope of work to the next but also within scope of works -- rapidly shifting priorities that tend to make it difficult to foment and pursue systemic change.

I already commented a little bit on the disconnect between local priorities and the national agenda. Hopefully, the soon to be issued National Quality Strategy

will bring some organizing frame and principle to that concept, but there are often local priorities that tend to take precedence over national ones.

And I think a critically important point is the inherent limitations of externally mandated interventions, and by that I mean one of the strengths of multistakeholder collaborations is bringing people together, bringing organizations together to establish common purpose, identify priorities, share data with one another and, more importantly, share best practices from within the health care system, the local ecosystem, rather than having that expectation or that change imposed from outside of the consortium model.

In terms of Conditions of Participation, one of the clear opportunities I think we have is to begin to link accountability for performance much more robustly to the Conditions of Participation. Our data systems have matured. The acceptance of performance measures has advanced significantly over the last decade. And I do think that there is a disconnect between the Conditions of Participation and the availability of good data on accountability.

I also think that the Conditions of Participation don't do adequate justice the importance of culture in driving transformational change, both at the board level and at the senior leadership level.

And increasingly, we're seeing again the integration of physician and organizational roles, popularized perhaps by accountable care organization models, but I think the conditions need to recognize the blended interests of physician and hospital organization.

I do think this is a time of opportunity for experimentation and innovation. A number of the themes identified in your briefing materials stand out to me in terms of broadening the criteria of who might serve as what's referred to as a technical agent -- linking flexibility and trying different models to try to accomplish goals of quality improvement, with accountability for improvement and outcomes in health status, and intermediate sanctions for persistently low performing organizations.

I'd like to suggest with all due humility that one alternative model for consideration in this category of technical agents are multistakeholder, regional Quality Improvement Organizations such as the Collaborative.

I say that with humility in part because to a certain extent we represent yet another hypothesis in terms of what will drive systemic change, for the reasons that have been cited by the QIOs themselves in terms of evaluating cause and effect relationship. But the core functions of Quality Improvement Organizations such as WCHQ revolve around use of comparative performance measurement, public reporting, collaborative learning, consumer engagement and payment reform, which I think are the confluence of the levers of change that I think represent some real promise and real potential.

I've compiled some observational data. We've been continuously reporting outcome measures, as well as process measures, in Wisconsin for over years now. These are graphs that simply show the sum of numerators and denominators from the first year or baseline at which we introduced these measures. This one happened to be related to diabetes. You can see a fairly significant increase over time in both process and control measures. The same is true for cancer screening measures, again continuously reported for about five years.

One of the distinguishing characteristics of

regional health care collaboratives as compared to Quality Improvement Organizations is the diversity and the breadth of representation that, by definition, they represent as multistakeholder.

Another differentiating characteristic is the strong reliance upon consensus and collaborative decision-making to identify priorities and commit to shared goals, and this relentless focus on both improving cost and quality, or value, in health care delivery.

And I think these models have shown that there is enormous flexibility in terms of addressing the myriad of issues related to transforming health care at the local level.

There are multiple examples of these types of organizations. Federal policy, as well as private sector policy, has encouraged their development through the Aligning Forces for Quality Initiative sponsored by the Robert Wood Johnson Foundation, the Chartered Value Exchanges launched under the previous administration and continuing on through the Agency for Health Care Research and Quality, and a new organization that brings all of these entities together, the Network for Regional Health Care

Improvement.

And the last slide that I have shows that this is a broad network of organizations that are extant in many states around the country, and it is another infrastructure that I think lends itself to the type of innovation and experimentation that I think these critical important times suggest we give consideration to.

So with that, I'll stop and turn the podium over to Bob and look forward to the discussion.

DR. WACHTER: Thank you. Good morning. It's a pleasure and an honor to be here. I see some old friends around the table, so it's really terrific to be here.

Let me start with a few biases. So I am a hospitalist. I am the Chief of Hospital Medicine at my institution. So my world view is a little bit hospital-centric as you'll hear my comments. I think I know more about what's happening in the hospital world than the rest of the universe.

I am the Chair-Elect of the American Board of Internal Medicine. So you may hear comments that relate to the role of boards in all of this.

And finally, I think Anne partly asked me to come

because I like being provocative, and I will be deliberately provocative in some of my comments.

Because the last time the Giants won the World Series Medicare had not yet been invented, I figured I'd start with this. I bring you greetings from the World Champion San Francisco Giants. I brought my son out to San Francisco for Games 1 and 2, and so I know what it's like to worry about having your trust fund exhausted.

[Laughter.]

DR. WACHTER: I want to start with some observations about things that have worked better than I would have expected 10 years ago as I date the beginnings of the quality and the safety movements to the IOM reports on quality and safety. So both fields, to my mind, are really 10 years old.

Here are things that work better than I would have predicted 10 years ago, and I think many of you are at least as aware, if not more than I am.

Transparency has been remarkably effective, I think, particularly as I see it in the hospital world. That's particularly interesting because if you had asked me 10 years ago whether it would work I would say only if it

engenders consumerism, and there's no great evidence that it has. There are not many real people that go on to Hospital Compare to decide whether to go to your place or the place across town. So the mechanism appears to be some combination of shame and pride rather than consumerism, but I think it's worked better than any of us would have guessed, certainly than I would have guessed.

A dynamic, evidence-based, trusted set of quality and safety metrics can drive change, and I think we've seen that with the core measures, with some exceptions, but by and large I think they have driven important change. The role of the NQF never events I think has been a very important set of focal points for the patient safety movement, which I think without them was too diffuse. The National Patient Safety Goals, there have been a couple of missteps, but I think by and large they've helped drive the safety movement forward.

And I think the development of bundles of evidence-based practice sets, to try to decrease the probability of some adverse outcomes, central line infections being the most prominent, I think have been extraordinarily salutary. And I think we have now a lot of

evidence there are certain techniques that seem to drive these fields forward.

Integrated delivery organizations, without question, have a staggering advantage over what I call 99-1 organizations. Ninety-nine to one is a reference that you may have heard before. That's what do you call a 99-1 vote of the medical staff, and the answer is a tie.

It is a reflection of the ability of any individual doctor to veto anything the institution wants to do under the old order. I think we've seen that organizations that manage to create integration and shared purpose between the physicians and the organization have a major advantage, and that's evident when you look at Geisinger or Kaiser Permanente, or the VA for that matter.

And finally, once there's a business case to improve quality and safety, organizations actually seek help, and I think that's a very important change from the environment as recently as seven or eight years ago.

Just a quick story, just to make real this issue of the role of transparency, this is U.S. News and World Report. It comes out every year, and here is my hospital, the University of California, No. 7. We all know the

methodology for this is imperfect. It does not prevent us from putting it on every billboard in San Francisco, assuming we're on the Top 10 List.

This is our world view of ourselves. We're a big, fancy academic medical center, with people with very impressive pedigrees, and a long and storied history, and great research and great trainees.

In 2003, Medicare began reporting data on our performance on a group of core measures, and here we were on one of them -- percent of pneumonia patients given pneumococcal vaccination, a measure that I think the evidence for it is limited but positive enough that it wasn't unreasonable that it was on the list. And here we are just doing quite terribly.

I think these sorts of measures created, I think, very important cognitive dissonance. And the dissonance was between our world view of ourselves, as being a really impressive organization that does great work and helps a lot of patients, and publically reported measures that show that we're not so good.

To me, every organization -- this makes us sad. Every organization needs its what I call Golda Meir moment.

This is the late Israeli prime minister who once said: Don't be humble; you're not that great.

[Laughter.]

DR. WACHTER: And I think that in many ways is what transparency does. It really gives you -- it makes it quite visible to you that although your world view is that you're pretty slick, you are not performing at the level that you should be.

Again, what I believe has been really very impressive to me is that dissonance is an incredibly powerful platform for change. I think a lot of organizations really want to do the right thing, and doctors and other caregivers want to do the right thing. And seeing that they're not and having it be exposed to the public I think has been very important.

Here are things that have worked less well than I would have hoped, and they relate to the issues that Anne asked us to address: Bureaucratic, static and non-harmonized quality measures are unhelpful, and I believe counterproductive, and I believe that's a good description of many of the Medicare Conditions of Participation that are extraordinarily static and feel very 70s or 80s-ish,

particularly when compared with the extraordinarily dynamic environment that we're seeing in some of the other quality measures and safety measures that are emerging.

In a dynamic, robust quality improvement ecosystem; nimble, connected and often virtual organizations add great value, and I think probably the iconic example here is the Institute for Health Care Improvement. But I think we've also seen this with organizations like Chris's, some specialty and regional collaboratives, the surgical measures. For example, in my own world, the Society of Hospital Medicine has been a major proponent of something called Project BOOST which has really been a transformative effort to improve the discharge process. I think that's one example of what has happened as the system has become more diverse and nimble, and I'd that's not a good description of most Quality Improvement Organizations.

So what should Medicare do in this environment? Well, again with great humility because you have a very hard job trying to figure out these answers, but it seems to me that many of the steps you've taken already are very positive, and I encourage you to do more. The system needs to be driven to produce value.

I think we've learned that pay for performance is not the only mechanism to do this, and I think it's important not to underestimate transparency and even professionalism as important drivers. I really do believe that most people want to do the right thing and that transparency sometimes is a mechanism to tell them that they're not doing the right thing and get them to think about how to do better.

I think at this point, certainly in the hospital world, the physicians in some ways have been bystanders and recipients of trickle-down accountability, with most of the accountability being focused on the hospital, the hospital then needing to try to engage the physician. Every hospital in the country has in its strategic plan the physician engagement strategy, and that's sort of an interesting animal and says something about the lack of integration.

So I think as we go forward it's going to be very important to figure out what are the strategies to get physicians as invested in quality and safety improvement as I think hospitals now are, whether that's public reporting of physician outcomes, which I think is important although methodologically tricky. In my world, the role of board

certification is a very important piece of that.

Obviously, more integration is critical, whether it's through ACOs or some other mechanism. And I believe the value pressure that you and others are putting on institutions is beginning to do some of that, even in the absence of some formally constructed ACO. But clearly, Medicare has a role in facilitating the construction of new organizational frameworks where the docs and the institutions are part of the same thing and rowing in the same direction.

I think it's very important to abandon static and non-harmonized measures. It's an extraordinarily tricky thing to do, but recognizing that the measurement burden that presently is placed on institutions and physicians is not neutral. It is a distraction and, as my boss likes to say, death by a thousand duck bites. We have to be very careful about that and clean up things that are not adding value.

And finally, I think it's a very important role of Medicare to promote capacity-building, and really the observation is that well-meaning poor performers often just don't know how to succeed, don't have the tools.

So I believe Medicare could save many lives by abandoning COPs that are nitpicky, trivial, vague, and arbitrary, create an inspector-inspected environment. And I can tell you we have been visited a few times by our friendly inspectors looking at our performance on COPs, and it's an extraordinarily unpleasant and somewhat adversarial environment where the feeling is the focus is on relatively small, relatively, to my mind, unimportant issues in the big picture of quality and safety. And there is, of course, a huge lack of alignment with all of the other entities that are measuring quality and safety in different ways, and adopting requirements that are meaningful. I've just put two here that are not presently on the list but seem to me that they would begin saving many lives tomorrow if we did them. One would be that 90 percent of hospital discharge summaries are on the desk of the next provider within 48 hours. The literature says two-thirds of the time the patient sees the follow-up provider and there is not a discharge summary available to that person. And hospitals have audited hand hygiene rates of greater than 90 percent. Most hospitals are in the 50 to 60 percent range and struggling with how to do better. If that was a condition

of participation, they would figure out how to do that.

What about the QIOs? I would say as a general principle a monopoly of regional QIOs might have made sense when poor performance had absolutely no pressure to improve, and, therefore, there was a need to push quality improvement in their direction. And so having a regional entity that was the repository of deep knowledge about quality improvement was important. And face-to-face meetings were the main ways people connected with each other in the pre-Web/Facebook era.

Today I believe, and increasingly so, that the business case for quality and safety is driving organizations to seek out improvement because that is what the landscape will require for them to thrive. And we also know that the Web and telecommuting and all of the new technologies are facilitating collaborations that really don't have to be geographic in an organizational framework. That doesn't mean there isn't value to face-to-face meetings. There is. But it opens up the question whether the regionality of your quality improvement entity is the most important attribute or there are others, and certainly in other -- we've seen many examples where regionalness was

much less important than relevance and being a trust agent and having the right expertise and distance learning has worked very well.

So Medicare I believe in this regard should consider giving poor-performing organizations the resources to "buy" support and having this QIO, as Anne said, compete for the business, and I suspect many of them will do quite well in this environment -- but some may not -- and very, very importantly, creating accountability among both the giving and receiving organizations, creating a really well-functioning, high-functioning quality improvement market where organizations need to demonstrate that they're doing the right stuff and that their satisfaction among their caregivers, among the organizations they're supporting is very high, and that their outcomes that they achieve are what we would all hope for for the money that we're spending.

So the bottom line is, I think, that I thought the chapter was terrific, and I think the work that you're undertaking and the directions are all positive, that what we're really talking about here is supporting and nurturing a value market. And it is dynamic, and extraordinarily

dynamic, getting more so every day. Medicare must continue to drive this market. There are obviously a lot of other players, but you are the most important one.

In this market, '80s style, highly prescriptive, non-evidence-based laundry lists of conditions of participation I believe are a painful distraction from the real work. And in this market, provider organizations will seek out help, and in some ways that's part of the job here is to create environment where they want to seek out help because they have so much skin in the game. And their choices to get that help should be as modern and as dynamic as their need.

Thank you for the opportunity to speak to you.

MR. HACKBARTH: Thank you both. Excellent presentations, right on point and on time.

Our custom is to have at least two rounds of questions, and the first round focuses just on clarifying questions. You know, what did you mean, Slide 5, by this statement, that sort of thing. So the first round we'll begin on this side. Let me see hands for clarifying questions.

DR. CHERNEW: There were two important phrases

that went by that I didn't understand. The first one I guess is for Dr. Wachter, which is: What's a static non-harmonized measure?

DR. WACHTER: Let's start with static. Static is a measure that was promulgated in the '80s and hasn't been updated based on new evidence. And there are some measures in the COPs that really don't get touched very often in an environment where the evidence is very dynamic. So there's a real challenge here to make sure that measures are updated based on new evidence as it emerges as we begin to understand what are the processes that lead to improved quality, and we've learned to measure outcomes and do the appropriate case mix adjustment.

Non-harmonized measures, I guess in some ways it's contextual, which is I think if the hospital perspective these days is we understand we're going to be measured, we understand it will be transparent and be reported, but we're being measured on the same thing in five or ten different ways, and that's a distraction and it's resource sink and it's demoralizing. So the question is: How do we come up with a single way of measuring the quality of care for heart failure, for example?

DR. CHERNEW: And I had a similar question for Dr. Queram, which was you mentioned the disconnect between local and national priorities, and I wonder if you could give an example of what a local versus national priority might be.

MR. QUERAM: Sure. One of the best examples I can give you is we have put quite a bit of time and energy into constructing a value metric. We have long been interested in examining ways that we can take the clinical quality measures that we've been reporting in some cases going back to 2004, and pair that with an equally valid measure of resource utilization, episode-based resource use, and do that in a way that has sufficient validity and reliability to begin to look at quality and cost together.

While that has been a national area of interest, there isn't any requirement to report in that context or mechanism to do so, so we have just chosen to invest a considerable amount of time and energy.

There are probably other examples where we have fostered local clinical quality collaboratives in areas that have unique resonance to the provider organizations themselves that may have nothing to do with what the statement of work entails for that period of time for the

QIOs.

MR. HACKBARTH: Other clarifying questions?

MS. KANE: This is for Dr. Queram. I was looking at your list of collaboratives that are around, and I'm from Massachusetts so I'm probably more familiar with them. But one of the -- I just wonder what your thought is on what happens when the providers aren't as collaborative as the collaborative?

[Laughter.]

MR. QUERAM: Well, first of all, I should tell all of you I'm not a physician, so "Dr. Queram" is overstating my qualifications and my title.

MS. KANE: Sorry.

MR. QUERAM: One thing that we are fond of saying is that when you've seen one regional quality collaborative, you've seen one regional quality collaborative. And so one of the strengths and perhaps one of the limitations of this model of bringing stakeholders together is that there's incredible variability. And we happen to have in our state, as I mentioned, a medical marketplace that is concentrated with multi-specialty physician groups and integrated delivery systems. We also tend to be in a part of the

country that's sort of naturally collaborative. We get along. We say hello to strangers on the street, you know, things of that sort. But that's not to say that there isn't tension that exists between and among our member organizations. But we work very hard at building social capital among all of the stakeholders, being very explicit in the goals that we seek to accomplish together, and we have certain behavioral norms that we expect of our member organizations and their participants that so far has enabled us to overcome those tensions. But I appreciate in other marketplaces that those tensions are much more extreme and difficult. That's probably why you don't see in many parts of the country these types of multi-stakeholder groups.

MS. KANE: What kind of sanctions do you actually have? Do you actually eject members who are not -- I'm just curious to know if you've come up with that kind of --

MR. QUERAM: No, we haven't had to resort to that, but one of the things on our website -- and we do abide by these -- is we established a statement of principles and a code of ethics that guides how we operate. One of them, just to cite an example, using Bob's reference to UCSF's presence in U.S. News and World Report and billboards, we

don't allow the use of our comparative performance metrics for marketing purposes. You won't see a billboard in Wisconsin that, you know, "ranks number one in WCHQ's performance measures" because the focus -- while we don't deny that there are competitive realities within and across markets in our state, the focus really is on using measures to benchmark performance and to share with one another in terms of best practices. And that was established right at the very inception of WCHQ in 2003.

DR. BERENSON: Yeah, I have a question for Bob Wachter. First, I'd want to say as a New York Giants fan going back to watching Willie Mays playing in the Polo Grounds, I want to share your jubilation around this -- but I have a serious question here.

If you could go to the slide, what about QIOs, I want to push a little bit on the bullet that says the business case for safety, quality drives organizations to seek improvement. I'm not so sure I understand the business case. You said at the beginning that you're not impressed by consumerism, that individuals are using the information to sort of make their selections, and that pride is pushing more of this. Health plans seem to be responding to demands

for very broad networks, have pretty much abandoned selective contracting, haven't been successful with tiered networks; payment by Medicare and plans tends to be still you get the fee-for-service payment whatever the outcome is, whatever the justification for the service. What's the business case?

DR. WACHTER: Again, Bob, I guess my view comes more from the hospital world than the rest of the world, and in the hospital world, I have been extremely impressed -- and this is not just being at UCSF where I see a narrow sliver of the universe, but I've spent a fair amount of time at other meetings and at other institutions -- that the hospital that previously gave lip service to quality and safety now is focusing quite a bit and increasing resources -- in the beginning, of course, it's talk but after a while it's a recognition that we need people to do this work on how do we smooth the discharge process, on how do we perform well on all the publicly reported measures on preventing health care-associated infections, on preventing falls -- all of these sort of things which I think were not the focus of hospitals as recently as ten years ago. There was an ethical case, but I believe they perceive a growing business

case, and some of it is, I think to a surprising degree, based simply on the transparency, and some of it is kind of prospective feeling that you are going to come out and are coming out with policies where there actually is money on the table that they either make or lose based on their performance in these areas, and it's going to take several years to perform well on those.

So I think that what that means to the practicing physician in a three-person office, at this point I think the business case is weak. What that means to your health plan trying to put together a provider network, I think the business case is not particularly strong there. But I think in some ways hospitals have --in the safety and quality field, hospitals have emerged in some ways as the test case of what does it look like to have an environment where there's more transparency, more accreditation pressure than there was, and at least the beginnings of payment differentials. And I believe they are responding.

MR. HACKBARTH: Actually, I was going to ask a similar question. I was struck by what you said, Bob, about the power of shame and pride, and to me that's almost an independent force. It's like the hospital paths or

consumerism, you know, individual patient choice, maybe payment incentives and the activities of insurers, either pay for performance or steering patients away from low-performing providers. And then the third is shame, pride, professionalism. And I thought what I was hearing you say was maybe of all of those the most powerful is the third. And the key to driving that is effective public reporting.

DR. WACHTER: I think my observation in the hospital world, at least so far -- and I think the Premiere Demonstration Project bears this out to some degree -- is that simple public reporting, the absence of consumerism has led to significant changes in behavior. If you look at the curves on all of the core measures, very impressive changes. You could argue are those the right measures, but at least those are the measures and people are improving without a lot of evidence of consumerism and without -- and so the question of pay for performance to my mind is not does it create more change than simple transparency, but does it create enough more change to be worth all of the hassles, all of the political challenges, your choices, you're paying best performers or best improvers, all those sort of things I think may it far more fraught than simple transparency.

And I think the lesson that I have gleaned from the last ten years of this in the hospital world has been that the transparency is quite transformative and that it's individual shame, pride and it's institutional shame, pride. It is the board which previously wasn't engaged in quality and safety, seeing these data and saying, "What's going on here?" and tapping the CEO on the shoulder and saying, "What's going on with our quality scores?" That creates a huge amount of trickle-down change. It actually creates a fair amount of internal pay for performance within organizations. So even if you're not doing it, the organization may say we have to move money around in different ways to get the physicians, for example, to perform in different ways than they were previously.

MR. QUERAM: I'd like to comment. Most of the measures that we -- we report some hospital measures, but we've increasingly put our emphasis in reporting measures of physician group performance and have been doing that, as I mentioned, since 2004. And the physician leaders, CEOs and chief medical officers from our member organizations, have said repeatedly in various forums that the publication of the performance data has changed the conversation inside

their organizations in a positive way, partly because our data is accurate and it's actionable, because we have built the measures and have a robust validation process that ensures that they're accurate. But it has changed how they approach their quality improvement initiatives internally. As Bob is suggesting, a number of the organizations use our measures as a component of their internal payment scheme for their physicians. And we have actually had pressure for us to move forward both with the value metric but also to begin to move beyond primary care and chronic disease into specialty measures. The impetus for that is coming from the physician groups themselves who want to get more of their physician colleagues engaged in this important work.

So I think I can attest to what Bob is saying. Our experience has been very similar.

DR. BERENSON: I just wanted to follow up because you're both emphasizing the transparency and the responsiveness to the published measures. What is happening to performance on unpublished -- on other activities related to quality? Because our measures are only able to capture a small sliver of care. Is this testing to the test or training to the test or whatever the term would be? Or is

there a real cultural change that is extending across the institution?

DR. WACHTER: I think we're at the tipping point between those two poles. I think in the beginning it was playing for the test. It was: Can we perform well on discharge instructions? We'll hire somebody to run around the building to do discharge instructions and check a box that we're doing that. Those measures that are game-able I think probably should go away, and I collaborated with Mark Chassin and a few other authors from the Joint Commission on an article making that point a few months ago in the New England Journal.

But I think what has happened, which I'm guessing is your intent all along, is that the measures now have become sufficiently broad that -- and by broad, I mean a mixture of outcomes and process and structure covering a bunch of different domains that the institution that was trying to get away with doing this as one-offs five years ago is now recognizing that doesn't work. And as they recognize it doesn't work, really very powerful things happen. They reorganize the way they do quality work. They recognize that they need to build capacity within their

caregivers, that people need to understand the science of quality and the science of safety, and they did not learn any of those things in medical or nursing school. They understand they need robust IT. Obviously, there are other pressures that are pushing that, but they are beginning to recognize that if we don't have a terrific IT system, we can't perform there.

So I think that is the critical point. You've gotten to the point, and I think increasingly we are all getting to the point, where you will not be able to do this as singular one-off kinds of activities. You have to systemically change the way information flows, the expertise.

There, of course, will always be a risk that if you are measuring MI and pneumonia and heart failure and stroke that those will garner more attention than, you know, another problem. And I think the cure for that is as the science gets better we can add in other domains, and we do that. But I think the pressure to create a different kind of organization to meet these demands I think has grown to the point that people are no longer approaching this as a single entity-by-entity endeavor.

MR. QUERAM: If I could just add a comment from our experience, if you look at the longitudinal data of the measures that we've been reporting for some length of time, you'll see that there is separation in terms of both the level of performance but also the rate of performance year over year across the physician groups that are currently members in the collaborative. And I think that speaks to the fact that there are a handful who have really driven quality improvement and data deeply into their cultures and have designed decision support tools and other elements that really emphasize continuous improvement across a broad spectrum.

I think the fact that we're reporting 24 and soon to be 27 ambulatory measures has made it a little bit more difficult to teach to the test, as you were suggesting, but we've also taken some steps to introduce composite measures so that we look at the ability of an organization to drive a complete system and process redesign around an entire disease process -- diabetes is the classic example -- so that we don't find ourselves looking at organizations that have one rate of performance on hemoglobin A1c testing and a different rate of performance on cholesterol testing, but

instead bring those together and reflect system-ness thinking in terms of performance. And I think you'll see some real separation in those organizations that have made this a cultural imperative, not just a project.

MR. HACKBARTH: Okay. Bob and I have to go to the penalty box for five minutes for round two questions in round one. Jennie, you're next. We're still on round one.

MS. HANSEN: We are? Could we go back to the slide right before this one on Medicare can save many lives? And this is for Dr. Wachter. Bob, as another San Franciscan, up until recently I too cheered the orange.

Moving on again to this aspect, you know, I'm struck by this particular slide in terms of, again, the utility of the conditions of participation and then your suggestions on the specific possible recommendations. And these are notable in that these are evidence-produced recommendations of what difference it can really make, so it's like driving actual change.

Where do you see these criteria -- like if these two specific elements were to be adopted, you know, where does that decision point come from in order to affect inpatient care safety, you know, for Medicare lives? So

where might that come from?

DR. WACHTER: Well, I don't understand the intricacies of the relationship between the COPs and the Joint Commission, for example, well enough to know exactly, I think, Jennie, to answer your question, because all I know is that when you're sitting in the hospital world and you know that the Joint Commission may come this morning at 7:30, if one of the things that they will look at are, for example, that you can prove that 90 percent of the encounters your clinicians clean their hands, you'll do that and you'll have it done all the time. We're pretty good at playing for those tests. We do play for the tests. We want the test to be better. And whereas if you look at the conditions of participation around infection prevention, for example -- I was just reading them last night, you know, the infection prevention officer will keep a list of all the infections in the building. It's very static, it's very dated.

MS. HANSEN: Right.

DR. WACHTER: None of it reflects Peter Pronovost's work, you know, what we now know about central line infections, that you will be measuring the rates of

these things and you will be adopting evidence-based practices and bundles and all that.

Now, that's a hard thing to do. You've got to have a very dynamic process that's constantly synthesizing the evidence to come out with appropriate recommendations that can evolve with the times, not only as we learn new science, but -- I've written about the door-to-antibiotic measure. Sometimes we learn that a measure, a well-intended measure, actually didn't have the effects that we hoped for and needs to be discarded.

And so you just need a very, very nimble system that's mining the evidence and mining the experience of the organizations that are the subjects of these measures to see whether they're working and having the intended effects. And my impression of the COPs is they don't have that -- that's not what's going on in them. They feel like they were promulgated many, many years ago. The enforcement is very -- you know, are you doing this or not? They don't seem to evolve with the times in a very, very dynamic environment. Ten, 15 years ago, that might have been fine. The environment and quality was not very dynamic. The research wasn't -- there wasn't funding for research and

safety and quality. That's just not the world today.

So I'm not sure exactly what the interface is, and this may be part of the problem. I know a fair amount about this field. But if you ask me could I tell you to the ninth decimal place where -- whose measure this is, the Joint Commission's or the COPs' or how do those interrelate to each other, I think it's a very tricky thing to do, and I think most people in this business would have no idea where these live exactly.

MS. HANSEN: Thank you.

MR. GEORGE MILLER: Two quick questions, one for both of you, on disparities in health care. I wonder if you've addressed that in either one of your organizations, how you've addressed them. Are there any quality measures that you measure to make sure that all of your patients receive the same quality of care and how you deal with cultural competencies in dealing with minority populations? And then probably the second question is more of a -- if you could describe the difference in quality with your urban health care counterparts versus rural health care, if there's any difference in quality, and if you could highlight positive and negative for either one of them.

Thank you.

DR. WACHTER: Thank you. I think it's a very, very important question. I think in terms of the disparities, we're a member of the University Health System Consortium, which does look at a wide array of quality and safety measures. I think in some ways it makes the point that not only does transparency and your feeling about your performance exist in the Medicare world, there are other lenses that we're looked at, and in that lens, one of the things that is looked at is a disparity measure which basically is the differences in your performance on quality and safety and patient experience standards based on different patient groups. And in that we pride ourselves on doing very well.

As I think about the activity, the specific activities, if you said what are you doing to address this as a specific activity, I'm actually not sure that I could come up with a lot of answers, which I think that's important. I always struggle with disparities, whether the right approach is you figure out a way to provide the best care to everyone sort of systemically or it requires a specific approach to specific populations. So I think we

probably do this better, but I think it is part of the measurement challenge that I'm reasonably certain that organizations and individuals that have disparities often don't know that. And that, again, what we've learned is transparency works, and I think this would be an area where, when we learn that there are differences, I think that's provocative and often gets organizations and people to approach their work differently.

MR. HACKBARTH: Could I just, Chris, ask a follow-up question of Bob? You referred to the consortium that you're part of, and this is one of the focal points at UCSF; there's not a big disparity within your institution --

DR. WACHTER: At least the data would say that we do well on that measure?

MR. HACKBARTH: What about other institutions? Or do you not see that data?

DR. WACHTER: I don't see that data and I'm guessing that this is an issue in terms of, to get to Bob's question, will we shine the light on certain things and forget about others? So it's going to be important, as we report your performance, if disparities are an important concern, which I believe they are, then that should be one

of the things that gets reported out. I believe that shining that light on the issue would create a change.

MR. HACKBARTH: The reason I'm focused on this is that in the earlier work that Anne did for us, one of the issues that we focused on is disparities. As I recall, Anne, and correct me if I'm wrong, there's some recent literature suggesting that a big portion of the difference in outcomes at the population level for the whole country is attributable not to differences within institutions, but rather, where different population groups go.

So it's a difference at the institutional level, not within institutions. I wanted to get your reaction to that, Bob or Chris.

DR. WACHTER: Well, I guess in the system I work in, we have a county hospital, we have a university hospital. I'm based at the university hospital now, but was based at the county hospital for five years. You have the same doctors, essentially the same nurses, a very, very different patient populations, and you need a different set of competencies for those populations, everything from interpreters to focusing more on health literacy in different groups.

I think, at least in my organization, I have seen that. At San Francisco General Hospital, we have built those in probably to a greater extent than we have in the university hospital because I think it's a bigger issue. But I think in none of these areas are we doing as well as we should and I imagine -- my sense is that part of that is because there is a general lack of skills and understanding in this area, and part of that is there is a general lack of -- transparency here is not the right word -- I think just data.

I think in many cases when people are exposed to data that demonstrates that there are disparities, they are surprised by it. They say, you know, I treat everybody the same. But the data are clear. So I think it's a very important part, as we move to this more robust and diverse quality measurement landscape, that building in measures of disparities, that people look and say, you know, it's the Golda Meir question, you're not doing so well, I think, are very important drivers of change.

What we've begun to learn is there are tools, whether it's some of the health literacy tools or others, or cultural kinds of training, there are tools that can help

providers and organizations reach a better place with regard to disparities. I think in many cases, these aren't used because the need to do them -- people don't perceive the need to do them.

I think in many cases, people think that, I'm sure there are disparities out there, those other people aren't as sensitive as I am, but it's only when you see the data about your own practice that you're motivated to change.

MR. QUERAM: A couple comments and I appreciate very much your question. When we started our public reporting, we organized our Web site along the six domains of the quality chasm report, and to this day, if you go to our Web site, you will see nothing under equity.

Part of the reason for that is, we have discovered that we lack a systematic method of collecting race, ethnicity, and primary language data from our physician groups. And so, we are in the early stages of developing a common methodology and a common or systematic approach to gather that information.

Similar to what Bob was just saying, we're a participant in the Aligning Forces for Quality Project of the Robert Wood Johnson Foundation, and RWJ is making a

major emphasis on disparities as part of their grantee requirements.

We were provided with data on the rate of leg amputations for African-American diabetic patients on a statewide basis, but a significant percentage of African-Americans in our state live in the Milwaukee area, and the rate, as you might guess, was quite a bit higher than for non-African-American populations. There was that similar phenomenon in terms of both shock and disbelief and questioning the data.

So that is what catalyzed us to begin to try to be more systematic in how we collect this information. We've contracted with the Population Health Institute at the University of Wisconsin, that other U-Dub that is sometimes referenced in the Seattle area, and we have begun to try to understand that data a little bit better, not so much to question its accuracy or its validity, but to help us identify where the opportunities, geographically, might be most robust for interventions. So I think we're on a journey. We're on a learning process.

And I'll say, in a state like Wisconsin, which is maybe a segue to your second question, sometimes disparities

have been seen in economic terms between what large organizations have available to them and what small organizations have available in terms of resources. So this has been a real cultural or sociological process for us, to begin to think differently about what we mean in terms of disparities.

In terms of differences between urban and rural facilities, we don't have good data on that, in part because we are voluntary and so our best data are for those organizations that are participating with us. There are some large organizations in what might be considered rural parts of our state. Marshfield Clinic, being a good example, is in the northern third of our state, which is pretty rural.

But we are participating in an empirical evaluation of the relationship between our public reporting and interventions that might be explaining the observed trend in quality improvement. As part of the study design for this, one of the control groups is non-WCHQ members, and we're doing a comparison using Medicare data, similar measures for WCHQ members using Medicaid data to non-WCHQ members.

My understanding is that some of the preliminary results that are coming out of this study show that the rate of performance in WCHQ members is consistently higher than non-WCHQ members. So it may not have the granularity to get down to the individual hospital or small physician group level, but on a broad basis, it does appear that participating in this type of public reporting initiative and learning collaborative is associated with higher rates of performance.

DR. BORMAN: As a practicing surgeon perspective, and thinking about this just from not necessarily a large entity perspective, some of what I see is, in thinking about our work primarily, related to a federal regulatory program, if you will, in these areas.

It seems to me what we have is sort of a process by which currently, regulators are throwing out measures that we all accept may or may not be great ones, and the subtitle is inviting you come back with relevant ones. All right?

Part of what I see as the problem here is that time and energy are diverted to meeting these throw-out-there measures, let's start somewhere, as opposed to the

come back with relevant and, as you say, nimble and dynamic. How do we sort of break that cycle? Because, for example, when things come out about not going to pay for UTIs or Meson resistance, staph infections, or whatever, what I see is an enormous defensive response of we screen everybody that walks in the door to prove they had it before we got them, as opposed to -- is there something better we could come back with that tries to get in the same areas?

I think with that is the question, I think, that you brought up, Bob, in your term of harmonizing, the notion of trying to make one measure do as opposed to ten that are circling on different facets of the same thing. Because there's just not enough time in the day for people to deliver care and do some of this stuff, and a spin-off of that is now sort of a quality safety bureaucracy enormously well-intentioned, but now is starting to rival some of the bureaucracies that we criticized as getting us to where we are to start with.

So how have you seen success in intervening in those kinds of cultures? Are there some take-homes from that? If there are, how can Medicare use its leverage to push those things down?

DR. WACHTER: Well, that's an enormously and important and tough question. I'll tell you my own view on this is that there are two views of this world and one is that none of this quality measurement stuff should have started until we had better measures that were really ready for prime time. I just don't believe that because I think we would never have started.

I think this is extraordinarily difficult work. I think it's technically difficult. I don't think we've put the resources into understanding how you measure quality and safety. Up until recently, I don't think the IT infrastructure is sufficient, none of it. I don't think the capability in provider groups is sufficient. We didn't learn how to do this in our training.

So I think I can't see a way of getting to where we want to get without going through this admittedly clunky stage where some of the measures are not great measures and feel a little bit trivial or clinically irrelevant, because I believe that providers had to go through their Kubler-Rossian stages and get to the point where they say, I get it. You're going to measure me, it's going to be available on the Web, I get that. At least make them clinically real

and accurate and timely and don't kill me with a thousand different measures.

I guess when I say harmonized and try to argue for fewer measures, I'm not -- because it gets at Bob's question. I'm not necessarily saying there should be one measure for heart failure because I don't think there is. I actually do think a diverse set of measures around how do we take care of patients with -- I mean, when I need my hip done, I actually want some measures of infection rates and technical skills, if there are such things, but most importantly, I want to know will I be able to walk 18 holes in three months. And I want a mixture of all of those things.

When I say non-harmonized, right now the specific measure of something, some process that relates to the care of patients with heart failure, you may have to measure that one measure five different ways for different stakeholders who are looking in on you. So I think that's the piece that has to get harmonized, not that there is going to be -- I don't believe we're going to have a single roll-up measure to figure out, am I a good internist or even am I a good internist or even am I good internist for a patient with

pneumonia.

But unfortunately, I think we have to go through this difficult stage because I think it is this difficult stage that leads to the industry, providers, organizations, and payers all coming together and saying, this is not exactly what we want, but the direction is the right direction, we just have to do it better.

MR. QUERAM: If I could just add a comment? I don't see this tension ending anytime soon. In some respects, that's what catalyzed the formation of our organization, the collaborative, back in 2001. A business coalition in south-central Wisconsin used administrative data to publish a comparative hospital performance report card that was, as you might guess, enormously controversial.

It immediately catalyzed, however, a very proactive response, both on the part of the State Hospital Association, to try to manage the evolution of quality measurement, but also, it led to the formation of WCHQ because I think physician leaders running many of these multi-specialty groups and integrated systems saw that the transparency imperative was coming their way and it's better to work in a collaborative way to try to balance the urgency

that purchasers feel with the equally strong sense on provider organizations. If we're going to do this, let's at least make sure that we get something that we can use to drive change in our organizations.

We found a way to keep that in balance, but it's dynamic because we don't have enough specialty measures. The specialty societies and other organizations have not stepped up to the plate to bring forward robust outcome measures quite apart from the data issues associated with how we populate those measures.

The other significant tension now is around the efficiency or value of care measures and using administrative data with episode groupers to come up with some portrayal of relative efficiency in terms of delivering good diabetes care.

So I don't see that ending. I don't know that is' necessarily a bad thing. I think how you harness that tension toward creative purposes is really the challenge and the opportunity.

DR. WACHTER: And I think for physician groups, it's our groups now that are saying these measures have to be more relevant and more authentic to our practice. But I

think by and large, we've not been central players to the development of those measures. We've been on the sidelines and we are reaping that to some extent. Other entities are developing these measures, but I think the only way we would have jumped into that pool is to feel that, feel that okay, we're being measured, but we're not -- we need to be more central to the process.

MR. HACKBARTH: Let me do a time check. Can I see hands of people who have questions or comments? Okay. We've got 40 minutes left so please keep that in mind in both your questions and, if possible, on the answers.

MR. ARMSTRONG: So let me briefly say that we are a participant in a program much like the one that, Chris, you've been describing and it's been very valuable. I appreciate many of the comments both of you have made about the transparent reporting of this kind of information and have seen evidence that it makes an enormous difference.

I am interested, though, in thinking about, particularly as we apply this to value we can create for the Medicare program, going further and, frankly, have come to believe that the reporting we've been talking about is just the ante. Now, this is baseline. The question is, what are

the consequences and how can we push this even further?

I guess the question I would ask would be, in particular, we're talking here about quality measures. We tend to think about quality of care. We tend actually to think about either process measures or technical quality measures. We're trying to think about how quality blends with utilization and cost measures for populations as well.

I think inevitably, we need to start more transparently reporting on some of those. I'm wondering what your comment about that might be.

DR. WACHTER: One of the privileges I have is I run a hospitalist group and I think because the field is still relatively new and because we often get money from our hospitals, it's been a field that's been, I think, ahead of the curve in terms of thinking about value and quality. I asked my group several months ago, how many of you -- out of 50 docs -- how many of you were involved in a quality improvement project? About 30 people raised their hand. I asked, how many of you were involved in efficiency improvement projects? Two or three people raised their hands.

So I think what we've done in the last seven or

eight years is created a -- begun to create competencies in quality improvement, but we've sort of neglected the cost reduction efficiency part, and I think part of the challenge here is to create a balanced environment where we care about both equally.

One of the challenges I can tell you in hospitals, they have developed reasonably robust quality infrastructures and the efficiency infrastructure kind of lives in a different part of the building. That's not going to work because often the project is everything. It's how do we improve value, how do we improve quality, how do we improve efficiency. You need the same people around the table.

So I think we have to do a better job of harmonizing these and having the measures be sort of equally important. So I completely agree with you.

MR. QUERAM: I would make a couple of comments. We introduced a value metric for hospitals in 2005. It's on our Web site. It shows the intersection of a bundled set of process measures in all payer-adjusted DRG. It's been interesting to watch the migration of hospitals from various quadrants toward that ideal combination of high quality and

relatively low cost. So we've shown that it can be done.

To do it on the ambulatory side, we need Medicare data, one of the most critical things, and I know it's part of the Affordable Care Act, but the sooner we can get our hands on actual Medicare data for physician services and combine that with commercial data and ASO data and Medicaid data, we have a robust enough data set that we can begin to do much more accurate episode-based resource use profiling of physician groups. Then I think we can get to the point where we can come closer to matching denominators for various conditions and various procedures.

The other thing that I think would be really important to think about is looking to build on the integrated suite of tools that AHRQ and others have built over the years for patient experience with care and begin to look at patient-reported outcomes. I do think if we are moving toward the Triple Aim inexorably and focus on improved community health and individual health status, we need to hear the voice of the patient much more actively and telling what the net effect of their intersection with the health care system has been in terms of their quality of life. I think we need to experiment with tools by which to

make that happen.

DR. CASTELLANOS: Two questions. Chris, the first one is, could you turn on Slide 12? I would expect to see stars all over the country and I just see it in the north-central, northeast, and the west. It's the map with the stars. I'm just curious. I live in the southeast and I'm curious -- and there's a whole central area of the United States that doesn't have anything.

Is there a reason for that? I would hope we'd have it all over the place.

MR. QUERAM: Well, all of these organizations -- I know a reasonable amount about most of them and quite a bit more about some of them. But I think there's one common, maybe two common characteristics. They're all voluntary so there is no mandate that is requiring the formation of these organizations. I think it reflects that unique set of market characteristics, local leadership, other impetuses like rogue organizations publishing report cards or whatever.

But the other common denominator is there's incredible variability in terms of the infrastructure and the capacity to drive change, either in a metropolitan area

or across the state. But all of us suffer from having rich missions and challenging resource requirements. We are thinly resourced. Our organization for a statewide focus has eight full-time equivalents and an operating budget of about $1.5 million a year to do this work. That's true of most of these organizations.

DR. CASTELLANOS: Bob, the question really is to you. I'm a practicing physician, too. I'm a urologist. I think you guys did a great job talking about quality and safety. One of the things that Glenn and myself have talked about in the past is appropriateness. I have not heard that one time, both on the national level and as it trickles down to the hospital, and at our local hospital we're having a real problem with the hospitals with appropriateness of what they do.

I think there's a need, even on the specialty level, because I've had a lot of discussions with my speciality organization, of trying to get some kind of help or resources to be able to look at some of the technical things you have to do when you starting thinking of appropriateness criteria.

Now, we're a Medicare committee and we talk about

SGR. That's a real big thing with appropriateness. I'm just wondering what kind of comments you may have concerning this.

DR. WACHTER: I couldn't agree with you more. I think appropriateness, in some ways, is the intersection of the two, the numerator and the denominator, the value equation. I believe up until recently, we have left appropriateness off the table, in part because it's, I think, more politically fraught than some of the other quality measures. But when you look at the waste in the system, that is, in some ways, a dominant issue, that people are doing things that are not appropriate and not evidence-based, how it has to be built into the next generation of quality measures. It's poor quality care, it's harmful care, and it's costly care.

So you're absolutely right. It should be a key part of any presentation talking about where measurement needs to go. Thank you.

DR. CASTELLANOS: What do you think we can do about it at this point in time, rather than just talk about it?

DR. WACHTER: Stop paying for it.

DR. CASTELLANOS: Thank you.

DR. WACHTER: Glenn asked for pithiness.

DR. CHERNOW: It's hard not to pay for it, of course, if we can't tell what it is, but that's a separate issue. The question I had is, Anne presented a whole litany of possible things we could do that weren't necessarily mutually exclusive and spanned a whole wide range of possible strategies. So I've been trying to synthesize this since we got this list and I've had a little bit of a hard time doing it.

I guess I have a few questions about where you think, in general, we might focus our attention. So one type of thing that comes out of all of this is that the measures aren't as soon as they could be, and there's two aspects of that. One is a very microsense which we go in and say, I don't like this measure, it was developed in 1953, and it doesn't work very well.

Or we could say, well, the process by which these measures are developed and revised and renewed isn't very good and we could focus instead on the process as opposed to the measures, and within the process, we would worry that CMS is going through some process and there's six other

organizations that are going through processes and that's how we end up with measures that are static and not harmonized.

So, I guess, we can't control what other organizations do, per se, so question one is, how much should we focus on the process of the whole measurement setting, renewing it right. The second thing that comes up in sort of Anne's list of things, basically, has to do with money and how the money goes to these Technical Assistance Grants. So there's a notion which doesn't seem to work in most other areas of the economy, which is, you aren't doing well so I'm going to save you money so you can do well, but let's accept that that's okay here.

So the question is, is the problem that we just don't give enough money? Should we give more money to make low performers better? Or is the problem who gets the money and maybe you have some thoughts as to whether or not we should maybe make the business case stronger and step back and let the world work. Or do you think a much more aggressive, targeted, managerial intervention from CMS is worthwhile and how this sort of money goes?

And the third stream that seems to flow out of

this litany of things that Anne laid out and I may have missed something in my little typology is this sort of regulations and conditions of participation stuff. And again, it has the same flavor in my mind as before which is some of this is micro stuff. This would be a lot better if the conditions of participation didn't include this, because this is really not relevant anymore.

So just take this one off and then we're actually fine. Or the whole process by which the conditions of participation are set need revisiting and we need to go back and think about the process and how that works. And so, sort of in these three areas, I realize you're tempted to say well, you need to do all three, but it would be useful if we knew which ones you thought were most salient in places where there's sort of trade-offs between sort of what I would call micro-managing or changing the process, what you think we might want to focus on. I think that was a lot.

DR. WACHTER: Wow. Okay. No, these are all absolutely terrific questions. In general, if the outcome is not what you want, the chances are the process wasn't perfect and it's worth looking at the process to sort of get

to the issue of do you want systemic change or one-off changes. So the sort of the metaphor for what's happening within the provider organizations.

It does strike me that the process for measure development needs to be different than the one that we have, and it is interesting for you to say that we can't control all of these other organizations. They say the same thing about you, and they all say -- everybody agrees in principal on harmonization, but everybody kind of thinks their measures are the best ones. So we end up with this cacophony that I think has to be cleaned up.

So I don't know how to do that. I mean, I think that somehow everybody has to come around the table and agree to a set of principles and agree that we will all together only measure quality of heart failure care in one way.

DR. CHERNOW: So let me ask you about that. There has been some effort to improve harmonization through the National Quality Forum and Congress has begun providing some government funding for that as a vehicle for harmonization. Is that working?

DR. WACHTER: I think it's been helpful, yeah. I

think is it helpful. I think integration is becoming increasing important because as we all eventually have electronic health records. Right now, none of them really support quality measurement and quality improvement very well, but ultimately they'll have to. It will be much, much easier if there's a single way that we've chosen to measure the quality of care.

So I think this is getting better, but it is a fundamental tension with a lot of well-meaning organizations in the same pool trying to do the right thing, and the metaphor, of course, is in our world where you have a bunch of physicians come together and say, I agree on the need for standardization, let's see if I can everybody to agree to do it the way I do it without recognizing that we actually may have to compromise to come out with a single way of doing things. So it's tricky to do, but I do think this is an important thing to work on.

The issue of is there enough money being spent on quality improvement, of course not, but you don't have enough money to spend on everything that you want to spend on. I believe that in organizations that can afford it, that creating a return on investment for investing in

quality will get the kinds of things you want without necessarily having to provide supplemental Medicare money for technical assistance.

I think the challenge is for organizations that can't afford it, where we don't have the luxury of allowing them to go bankrupt if they can't do this well. I think that's a difficult balancing act. But I do believe that it's worth looking at the budget. I think the QIO structure is fundamentally not sound, but I think as you look at the budget for, are we getting bang for the buck for technical improvement, some of that money probably is going to organizations that could do this on their own and previously didn't because they didn't have to. And now they're going to have to and I think they will take money out of their operating budget to say we have to educate, we have to do team work training, we have to do simulation, things that we never would have thought of and we have to train the docs on the science of quality improvement.

Things they never would have done in the past, I believe they will do with sufficient pressure, and that may let you partly off the hook in terms of having to pay for it yourself. You're then going to have to target your

resources on poor performers that simply can't do it.

MR. HACKBARTH: And, Chris, do you agree with it?

MR. QUERAM: Yes. Just a couple of comments. I love Bob's pithiness. It's easy to be pithy when you have tenure.

[Laughter.]

DR. WACHTER: And provocative, too.

MR. QUERAM: And provocative maybe. But another driver to pithiness is the time constraints that we have, so I'll try to be very brief in response to your excellent questions.

I would say that the harmonization issue, yes, the NQF has made some progress, but I think two of the more robust multi-stakeholder groups doing performance reporting in the country is ourselves and, across the river, Minnesota Community Measurement. We're both reporting similar measures in different ways. We use different specifications, we have different denominator algorithms that we use to construct.

So one of the real challenges is to get this thousand flowers that have bloomed over the last few years to adopt exactly identical specifications and methods for

constructing measures so that we can compare mail facilities in Minnesota with mail facilities in Wisconsin and know that it's apples to apples.

But back to your point, I'd say three things. Tie payment to performance. That will make this real for provider organizations. I do think that there are still many, many health care organizations, hospitals and physicians who think this will just pass and therefore we don't have to pay attention to it. We'll just wait it out.

I think when we start to tie payment to performance, that will create a market for interventions. I do think that there should be flexibility to organizations to seek the technical assistance from entities such as ourselves and hold us accountable to drive results over a period of time using data that's accurate, valid, and has a baseline so you can see if we're delivering a result or not.

DR. KANE: This may or may not be a quick question, but how do you feel about -- so one of the areas, a lot of what you're talking about is really hospital-centric or system-centric, where there's some pretty large institution with some kind of resources trying to help upgrade the quality in the community.

But something like, I forget exactly, about 60 percent of practices are small doctors out there in the community who are not yet affiliated, although it's shrinking, but that's still the majority. And one area where -- you know physicians have to renew their license every few years, but so far I don't think there's been any connection to any of these quality activities, and I'm just wondering what's your hope for that if there is any. Is that feasible or is that just ridiculously impossible, to create expectations around maintenance renewals that improve physicians' education or show proof of achieving certain levels of quality, competency?

DR. WACHTER: My bias is the board certification process is the right way to go and that those organizations are more connected to the providers, more nimble, more likely to keep up with the evidence, less politicized than using licensure as the mechanism to drive a level of quality improvement, I think it seems. I think certainly the licensure standards could be raised somewhat, and that would raise the boats, but it seems to me an unlikely mechanism to ensure that providers are keeping up with the literature or evolving their practice the way they should.

And I think you have this other problem with licensure which is a shortage of physicians in certain areas, that if you raise the bar too, too high you may exacerbate some of those challenges.

I can tell you at the board certification level, when I finished my residency in 1986, I passed by boards in internal medicine, and I was good to go for the rest of my life. That assumed that I would be a really good internist at age 67 based on that activity at age 28. That's ridiculous. So the boards now are moving to a much more continuous cycle of having to do something every year or two, pass the test more frequently, engage in quality improvement, and I think that is the leverage point to try to get physicians to be engaged when they are not parts of large organizations.

My final hope I think is that the ACOs, or whatever this turns out to be, will be a mechanism that the two or three doctors office is part of some larger entity that is accountable for their performance and helps enable their performance at a level they couldn't possibly achieve by themselves.

DR. BERENSON: A very quick question for Chris, in

your role as being on the IOM panel, looking at QIOs, to what extent do you think that the 9th Scope of Work was restructured in response to the IOM such that our work in looking at the QIO program should wait until we get some sort of assessment of how the 9th Scope worked out, or to what extent really are we in the same position as the IOM was in 2006 in which we could come to some judgments at this moment?

MR. QUERAM: Well, I do think that the IOM report had an impact on CMS's words. I'm not so sure it had an impact on their actions. I do believe that there was a sincere effort to feed back many of the recommendations and the conclusions.

I apologize if I sound skeptical, if downright conclusive, in my thinking that CMS has its own organization, has its own culture, its own established way of doing things, and I do not believe that that report had a magnitude of impact on how CMS approached that scope of work. I think the field is open to recommendations that could lead to more transformational change.

MS. HANSEN: In the area of institutions paying for some of this quality, if not in the future efficiency,

one other piece of work that we've done on the Commission is really raising some visibility to the use of graduate medical education or indirect medical education funds. I just wondered whether there's been any kind of discussion on the part of where from a universe of again not new Medicare funds, but basically repurposed for these kinds of things in order to assure that this curriculum be done, in tandem perhaps with the certification, but again thinking about existing funds that could elevate the quality and the value of use of Medicare money.

DR. WACHTER: Well, this is a discussion Glenn and I have had a number of times. I think Medicare has -- it's a perfectly reasonable, important question to ask: Are we getting our money's worth in training and are we training? Are we putting out the right product to achieve what we want in this world? I think the answer has been probably not.

And the question is do you use the lever of your control of those funds to drive the system in the right direction? I would say yes, but be careful.

I think this is a -- the environment of how we train medical nursing students, for example, or residents in medicine is pretty dynamic and reasonably well

regulated/accredited at this point. So the ACGMEs and the RRCs have proven to be at least modestly nimble. I mean nobody changes as quickly as anyone would like, but I think the requirements now for training programs to adopt quality improvement training, safety training projects are reasonable robust.

Now the problem is a lot of training programs aren't quite doing this at the level we'd like at this point because a lot of us don't know how to do this or don't have the faculty who know how to teach this, and I think that's an evolutionary phase. But I think that using, sort of taking the IME dollars and saying you must do this I think at this point would be redundant to the things that the accrediting bodies are already doing in the training domain.

That's not to say that this doesn't need to be changed, and I do think the strategy of giving that money to the hospital CEO to spend is not an effective strategy because it does lead to the programs essentially being beholden to the hospitals to give them money that is not fully oriented at the best possible training. So I think that needs to be rethought.

But in terms of using it to specifically change

quality and safety training, I think a lot of that is already happening at the level of the accreditation.

MR. GEORGE MILLER: Yeah, just briefly, since we have so many different vehicles for measuring quality, and I think you addressed it a little bit, but I want to circle around on it again. What is the best mechanism to come up with one set of standards for each of the categories that we're describing here today?

I mean we've got the Joint Commission, got different states, the QIOs, and on and on and on, NQF, and on and on and on. How would we do that and what's the best one?

And then how do you get everybody to engage, to participate since your -- this is under the 99-1 scenario that you talked about.

MR. QUERAM: Well, I think there was reference made earlier to the National Quality Forum, and I do think that many stakeholders have come to look to the NQF as the financial accounting standards board for health care, and to endorse standards and standard methods that can be widely adopted.

I think the problem that many people see with the

NQF, and it's not so much a problem with the NQF as it is the state of the industry or the state of the science, is that so many of the measures that have been endorsed aren't robust and tend to be process measures, not outcomes. So that's a phenomenon that will take care of itself over time, I think.

The other piece that many of us are hoping for, if nothing else, to provide a framework around which we can begin to have some constancy of purpose is the National Quality Strategy. We have dualing frameworks. We've got the Six Domains of the Institute of Medicine. We've got the National Priorities Partnership. Soon we'll have the Triple Aim. So how we integrate all of these into a coherent structure I think is going to be critically important, and many of us want to use that National Quality Strategy as an organizing principle.

But then I think it's incumbent upon organizations like us to resist this deep cultural norm we have in health care, to always want to tweak. Bob alluded to it. Now we want to measure diabetic care this way even though over in Minnesota they're measuring it that way because we've got better knowledge or better science behind how we want to do

it. So we have to find ways to overcome that, and I think organizations like ours are a vehicle to accomplish that, not the only one, but an important vehicle.

MS. BEHROOZI: Let me see if I can articulate this. Dr. Wachter, I wanted to get a little more of your thinking on P4P which I feel like, contrary to your maybe desire to be provocative or whatever, in some other areas you're a little coy about because you say P4P is not the only mechanism to promote, but you don't put it on either of the things that have worked less well or the things that have worked better, whereas you do put the Medicare COPs straight up on the things that haven't worked well. And I imagine that P4P systems suffer from some of the same deficiencies of the COPs with respect to the staticness and non-harmony of the measures.

So the question really is has your organization participated in, or are any of your payers using, systems that you feel like have been successful, or should they just all sit on the shelf until the standards, the quality standards get worked out?

DR. WACHTER: I didn't mean to be coy. I think I'm ambivalent about P4P. I think we're still in the -- we

should be in the humble, we don't quite understand this well phase.

I think we understand some things better than we used to. We understand that the amount of money at stake in most P4P programs is relatively small, and we understand that you can't just pay the best performers or the improvers; you have to cut that small amount of money in half. So there are just these structural issues with P4P that are tricky.

I don't see P4P in terms of the goodness of the measures. I don't see it being separable in many ways from transparency. I think that's its own issue. Are the measures good enough, are they authentic enough, are they real, are they evidence-based, to do something with them that will motivate change?

I think then you have -- once you get -- and I think the answer is we have to make it that way, and they are variable there now. It's getting better. As Chris says, this is a problem that I think solves itself over time, with all of the pressures.

Then I think you have to then be -- you have to be open then to all right now what do we do them? Do we report

them publically? Do we use P4P?

And I think we are at the experimental stage where we're trying both of those, and the reason it's kind of in that middle range.

Transparency worked much better than I would have expected.

I think P4P; I've seen places where it worked very well, and I've seen places where it worked much less well than expected and does lead to, I think even more than transparency, this phenomenon that Bob worried about, which is completely paying for the test. You know. I'm going to do everything for my little bonus -- and in some ways its cultural impact on, and sort of being a threat to professionalism and the internal motivation.

Transparency doesn't seem to do that. Transparency in some ways plays on people's motivation. They can say: I want to b ea good doctor. Here's evidence that I'm not being a good doctor. I'm going to improve my practice because of that.

Once money is at stake, I mean we're human beings. We'll react to the money. We'll jump through the hoop. But in some ways it feels wrong. It feels different than

transparency.

So I'm kind of ambivalent about it. I encourage, I think we should have further experiments and just kind of see how it goes over time, remaining open to the possibility that unlike many parts of the capitalist economy this may not turn out to be the most important driver -- differential payments. There are other drivers that may work well, equally well, be less politically fraught and less cultural challenging.

DR. DEAN: A couple of questions. First of all, thank you both. This has been a wonderful session.

Chris, first of all, you listed as one of the concerns about the Conditions of Participation the lack of appreciation for the primacy of culture. I mean we all know that that's a fundamental issue, and it's been a barrier we've all banged up against in various places. I'm interested in your experience or observation in where that has proven to be a problem what works as to try to -- what should I say -- attack, adjust, fix.

I mean certainly I assume that transparency is probably one of the big tools. What are your comments about that?

MR. QUERAM: Well, I know it's going to sound like a cliche or very trite, but I do think it comes down to leadership, both at the board level and at the executive level. The organizations, I alluded to this before, that have differentiated themselves across time in terms of both their level and rate of improvement -- level of performance, rate of improvement -- are those that have taken on deep cultural change within their organizations. They have adopted principles and techniques that have been shown to be effective in other industries, whether it's Six Sigma or Toyota production principles, and they have completely oriented their operation, not only their administrative processes but their clinical processes, to those philosophies and those tools of improvement.

And their performance shows. They're consistently high across all measures rather than one here and one there, but not all of them.

And the common characteristic in my observation that I would say is true of all of these organizations, and there's a handful of them in Wisconsin, is they have relentlessly passionate leadership at the CEO level that has driven this change. In a couple of cases, it's physicians

who just are unabashed in their belief that there is unacceptably high rates of variation from evidence-based practice and there's no longer excuses for that, and they have tenaciously taken on all doubters and all resistance. It's not easy, and it's not fun, and it's not quick, but they have built cultures of improvement. And they're held accountable to those cultures, to a balanced set of performance measures, by their board.

So I can't think of anything other than that; it's leadership.

DR. DEAN: Thank you.

Secondly, Bob, I'm a family doc. I practice in a very small rural community. So the issue I was really struck by, one of the requirements you suggested about hospital discharge summaries, because we deal with a lot of transfers going both directions. It has been one of the most frustrating parts of my clinical experience -- the inadequate level of transfer. And I mean I know the data show that it's at the handoff phase where a lot of the bad things happen.

Just as an example, just this week, we had a patient with a complex problem -- a guy that had a bad

stroke and a bunch of other complications transferred back from a tertiary care center. The information that was sent with him was six packets that full of printouts. They just took the EMR and hit print, I guess. I don't know. I mean it was almost worse than nothing at all.

And I guess I'm curious because even when we get discharge summaries, we have sat a -- we accept patients for our swing-bed program. We have a requirement which has hit some resistance, but I have said we just have to do it, that we demand that there be a physician-to-physician contact, a phone call from the physician.

And we get a lot of almost pushback from that, from specialists and the docs in the hospital, in the bigger hospitals, like this is a burden that they shouldn't have to contend with. Yet, in my view, it's an absolutely central part of the care. I feel at least I've failed at this point to communicate how important that is.

And when we do get discharge summaries, oftentimes there will be important data that isn't in there, significant changes in regimens that have taken place without any explanation as to why that happened. There are drugs that appear to be probably we don't need to continue,

but I don't have the data to justify stopping them, and so a lot of things get continued that I have real questions about whether they're necessary.

I'm interested in what do we do.

DR. WACHTER: I think, I mean that story is shameful, and we should all be ashamed of having perpetuating a system that created that.

I think the work that you've all done on readmissions is one of the most powerful things I've seen. As I look at lessons, things that I've seen in the last few years that were really impressive and important, I think the central line infection story has that dynamic. I think the readmission story is beginning to have that dynamic.

I think three or four years ago none of us knew our readmission rate. I think Jencks's study that came in the New England Journal was shocking -- 20 percent of Medicare patients are readmitted in a month. Are you kidding me? Then we all looked at our data, and it turns out it's true.

And it turns out it's not that hard to fix. Really, it turns out that there's a group of evidence-based practices that aren't rocket science, calling a patient

after the discharge, getting a good discharge summary, communicating with the primary care doc, getting the patient seen quickly, those sorts of things, not that hard.

We just didn't do it because the environment created this unbelievable set of silos. So most hospitals invested absolutely nothing in the process of making sure you got good information from me about the patient. We didn't invest enough psychological energy in recognizing how important that was, and just putting it on the table, presenting the data.

On this one, I think do having some financial skin in the game, that a readmission, an undue rate of readmission means you're not going to get paid. It will transform things.

And I think what's important is not only will it transform processes, meaning I need to get you a discharge summary, and actually 48 hours is liberal. You should have it at the moment the patient leaves the door, and I should be calling you as well.

But it also creates cultural change. It creates a change in philosophy that we say that our job is not done when the patient leaves the building; our job is done when

the patient is safely back in your care. That takes a cultural shift, and it happened because of the data. It happened because of the pressures, and I think it does happen because of some -- in this one, P4P I think is the right thing to do.

On behalf of the hospitals in the country, I'm sorry. That's a terrible story.

MR. HACKBARTH: Let me get Anne to put up Page 3 from your set, Anne.

By way of summary, I just want to -- yeah, there you go. So I just want to go through these quickly and see if I'm hearing accurately what you're saying.

So Anne has listed here some of the ideas that we came up with in previous discussions about how we might reshape what is now the QIO program. One is as opposed to spreading the money broadly across the system, focus it more on the low performing providers. I think I hear from the two of you that probably makes some sense.

DR. WACHTER: Assuming that low performing and low resource are the same. I guess a low performing provider in an environment where I've got the money, I should be able to pay for that if you've created an environment where there's

skin that game.

MR. HACKBARTH: Okay. The second one, I'm not sure that we discussed all that much in this conversation. So I'm going to skip over that.

On the third bullet, change contract structure to engage low performers, a grant goes to low performers; they select a system agent. What I hear is a pretty strong endorsement of that -- that saying oh, you've got to get this via QIOs that are statewide or physician-controlled doesn't make sense to you. A more flexible system would be better.

The second one I think is a corollary of, the second sub-bullet is a corollary of the first, to help people identify potential agents.

Turning to Page 4, again I heard a clear message that the existing requirements are true restrictive, and a broader array of organizations ought to be eligible to provide assistance.

Well, let me ask this: Again, these are federal dollars. So the natural extinct is to say if we're going to be spending federal dollars to support technical assistant, there needs to be some criteria for who is eligible to

perform that task, but it needs to be looser. It's going to be sort of a difficult thing to say who's good enough or who's eligible, but not make it too restrictive.

Next bullet, allow flexibility, I think we covered that.

Next one, pair flexibility with accountability, I think Chris in particular, you spoke to that, that if an organization like yours is eligible to serve as providing technical assistance there ought to be real accountability. You ought to be measured in how well you're carrying out that function.

DR. WACHTER: I guess, Glenn, there's a broader point on that which I don't think we've talked much about, which is that part of the challenge here is that if you don't do well under the COPs, for example, the threat is you lose all of your Medicare funding. So creating some gradation of what happens, what bad thing happens if you didn't make it, but not the death penalty I think is very important. Right now, it's so terrible that everyone is reluctant to fire that bullet.

MR. HACKBARTH: Chris, what do you think?

MR. QUERAM: Well, yes, I wanted to make just two

quick comments. The criteria for technical assistant agents -- I may reflect a bias here because I know the paper spoke about other models as well, but one of the characteristics of the type of organization we represent is 501(c)(3), not-for-profit, clear mission and clear purpose directed at these same objectives. I think that clearly needs to be one of the criterion, if not a very strong one.

The other idea I think suffused through all of this is what's good for organizations like ours is the flexibility and accountability should equally apply to the QIOs. I think we have an established infrastructure that we need to find ways to unleash, and see what their creativity and what their potential is.

So I think it's important in all of the comments that we've made. It's not an either/or or a zero-sum game. I think there needs to be increased flexibility within the current QIO construct as well as making it possible for other organizations to participate.

MR. HACKBARTH: And what do you think, Chris, about the idea of intermediate sanctions so as opposed to just having the death penalty exclusion from the program?

MR. QUERAM: Oh, no, very strongly in favor of

intermediate sanctions.

MR. HACKBARTH: Okay. Then the next page is about the Conditions of Participation. We didn't talk, I don't think, about the first point, which often comes up in the certification context for physicians, of having not just a base level but having sort of meritorious levels. Any quick thoughts on that?

DR. WACHTER: In general, I favor it. In general, I think it's part of transparency. It's making transparency a little bit more customer-friendly in that people can look and see where you are on that, and then the challenge is how you set the strata. But I think in general it's better than just yes or no.

MR. HACKBARTH: Yeah. Okay. Let's see.

I don't think we've talked too much about the second bullet or -- well, we talked about the last one as a pressing need, that the COPs are rigid, outdated, blah, blah, blah.

Any other thoughts that you want to offer on this set of bullets?

Okay. Thank you very much. Terrific presentations and very, very helpful. We appreciate your

taking the time. Thanks.

We now need to move on to our last session on "Hospitals' Capacity to Serve Medicare Patients." So this is like a first installment on our hospital payment adequacy framework. Zach?

MR. GAUMER: Okay. Each year as a part of our hospital payment adequacy analysis, we assess Medicare beneficiaries' access to hospital care by evaluating trends and a set of indicators that measure hospital capacity, the scope of hospital services offered, utilization, and the financial stability of the industry as it relates to capacity and capacity growth. Collectively, these measures provide context to draw general conclusions about the availability of hospital services to Medicare beneficiaries.

This year, we're presenting hospital access information to you in November because our work includes a few new measures, such as hospital consolidation. We'd like to gather your perspective on whether these new and old measures adequately inform your decision making.

Please keep in mind that this is the first of two installments, as Glenn said. In December, we will present data on other hospital issues, such as margins.

As a result of our evaluation -- you can see a summation of the conclusions here -- we believe hospital capacity has increased and Medicare beneficiaries' access to hospital services remains good. Contributing to this conclusion are the facts that hospital facility and bed capacity increased, the level of hospital consolidation remains steady, hospitals have expanded their scope of services, the industry has demonstrated continued investment in capacity and maintains access to capital to do so, and the change in utilization appears reasonable.

The number of acute care hospitals entering the Medicare program exceeded the number of hospitals exiting the program in 2009. Specifically, 31 hospitals opened and 17 hospitals closed, and as a result, this was the eighth consecutive year in which hospital openings exceeded closings. Among the 31 hospitals that opened, the average bed size was 54 beds. Just over half of them were for-profit hospitals and most opened in urban areas. More than half of the new hospitals opened in four different States, Ohio, Texas, Oklahoma, and California.

By contrast, the 17 hospitals that exited the program were larger than those that opened and a larger

share of these were nonprofit hospitals. These hospitals had an average bed size of 190 beds. Over half of them were nonprofit hospitals, and all were in urban locations. Five of the closed hospitals were in Pennsylvania, but not in the same marketplace.

In response to reading the chapter, Peter asked a question this past week about the trend in bed capacity as opposed to facility capacity, which we showed in the paper. In our chapter, we noted that hospitals' openings and closings resulted in a net decline of about 1,600 beds in 2009. However, this figure does not include the volume of beds being added to existing facilities. What we know from the AHA survey data is that from 2006 to 2008, the number of hospital beds increased by approximately 11,000 beds nationally, from about 740,000 beds to 750,000 beds, and this recent increase comes after relatively consistent decline in the number of beds throughout the decade.

The analysis of hospital consolidation is new to our assessment of capacity and access. The trend in hospital mergers and acquisitions may be an indirect measure of access to hospital services because they may affect access to care if consolidation of the marketplace results

in price increases or bed capacity decline.

In general, we find that the volume of hospital merger and acquisition data have been steady in recent years, and smaller deals have been the norm over the past two years. In 2009, the hospital sector saw 52 mergers and acquisitions of hospitals in which 80 individual hospitals were acquired. The green bars on the chart above illustrate that the number of hospital deals has hovered around 50 or 60 deals for the last five years, and the red bars suggest that the number of hospitals involved in each deal has become smaller. Many of the deals completed in 2006 and 2007 -- you can see the spike there -- were multi-hospital deals, whereas more recent deals have included just one or two hospitals.

Deals made in 2009 differed from earlier years because the majority of deals involved regional hospital systems acquiring smaller local hospital systems or just smaller local independent hospitals. For example, 64 percent of hospital merger and acquisition deals in 2009 involved the regional systems as opposed to large national systems.

In addition, a disproportionate share of the

acquirers were for-profit entities. The majority of acquired hospitals were small, having less than 200 beds. They tended to be more financially solvent than they had been in past years, and nearly all of them were nonprofits. Data through the first eight months of 2008 suggest that the level of merger and acquisition activity is on par with what we saw in 2009.

A variety of sources have suggested that the rate at which hospitals are acquiring physician group practices has increased in recent years. This trend would suggest that hospital consolidation is broader than just hospitals acquiring hospitals and it would suggest that hospitals are diversifying their service lines, also expanding their referral bases and in turn maybe increasing their leverage with payers.

Data from the AHA survey revealed that the share of hospitals with an integrated physician employment model increased from approximately 31 percent in 2004 to 38 percent in 2008. Different data from Irving Levin Associates reveals that the majority of hospitals' non-hospital acquisitions in 2009 were physician group practices. Among the acquisitions made by hospitals and

health systems in 2009, 66 percent were, in fact, hospitals, but 21 percent were physician group practices and eight percent were ASCs and about three percent were labs or diagnostic centers.

Finally here, PricewaterhouseCoopers concluded in a June 2010 publication that the number of individual physicians involved in merger acquisition deals spiked at the end of 2009. Over one-third of all physicians involved in merger and acquisitions from 2007 to 2010 occurred in deals that took place in the last two quarters of that span, the fourth quarter of 2009 and the first quarter of 2010.

Shifting to service offerings here, hospitals and their affiliated providers expanded the scope of their service offerings in 2008. Overall, 42 of the 50 clinical hospital services we tracked were offered by a larger share of hospitals in 2008 than in 2004.

The most pronounced expansion of services during this time was for translation services and for robotic surgical services. For example, translation services were offered by 65 percent of hospitals in 2004, and by 2008, 74 percent of hospitals had translation services. That is an increase of about nine percentage points. Other services

that grew most rapidly were palliative care, cardiac catheterization, and neurological services. And many of the services that grew most rapidly were either relatively new services or very specialized.

By contrast, eight of the 50 services we track were offered by a smaller share of hospitals in 2008 than in 2004, and most of these declined by just a percent or two. Urgent care centers are one of these, declining by one percentage point from 2004 to 2008. Other services that declined included burn care, cardiac ICUs, and a variety of different in-patient post-acute care services.

The majority of hospital services grew more rapidly at urban hospitals and slower at rural hospitals. For example, in the first block of services pictured in the lightest shade on the slide above, you can see three examples of this. You can see that the share of urban hospitals offering palliative care services increased by ten percentage points from 2004 to 2008, but the share of rural hospitals offering palliative care increased by three percentage points. More rapid expansion of access to hospital services at urban hospitals may be a consequence of the relative complexity of a given service.

In the slightly darker block directly below, translation and MRI services are examples of those that grew more rapidly at rural hospitals than at urban hospitals.

And in the last block, we see that while the majority of services increased to some degree, to the extent that there were reductions in service offerings, they tended to occur at rural hospitals and they tended to be associated with services that were relatively more complex. For example, up on the slide you can see that cardiac ICU services are an example of a service that declined in the rural setting relative to the urban setting.

On to employment. Hospital industry employment slowed in 2009, but remained positive and the industry continued to add jobs. Bureau of Labor Statistics data reveal that the number of individuals employed by hospitals increased about four percent over the last 36 months. This industry added approximately 180,000 jobs during this time, and as of September 2010, about 4.7 million people were employed by U.S. hospitals.

The industry's employment growth was slower than the rest of the health care sector, which grew by about 7.2 percent. The segments of the health sector that expanded

the most rapidly were home health, outpatient care centers, and physicians' offices.

In contrast, hospital employment growth can be viewed as strong relative to the rest of the economy, which as you can see declined by about 6.6 percent in the past 36 months. Very few sectors of the U.S. economy experienced positive employment growth over the last 36 months.

Over the last two years, hospitals continued to hire a broad assortment of staff, but certain occupations were added more rapidly than others. Among those that were added more rapidly were computer and math science occupations, which increased about ten percent from 2007 to 2009, and others that increased rapidly were pharmacists, management occupations, social workers, and nurses. Very few occupations experienced an overall decline in hospital employment.

Two somewhat related measures of hospital industry investment in capacity displayed similar trends over the last decade. The first, non-federal hospital construction spending, represented in green on the chart above, declined slightly from 2009 following numerous consecutive years of increases. In 2009, hospitals invested about $32 billion in

construction projects, a billion dollars less than they had in the previous year. In the context of the rest of the decade, the level of construction spending remains high. Hospital industry executives suggest that in addition to the slight decline, for the first time in several years, the majority of hospital construction projects were devoted to renovations of facilities as opposed to the building of new facilities.

The second indicator of investment in hospital capacity is the level of tax-exempt hospital bond issuances. This is represented in red on the slide above. In 2009, the level of bond issuances declined from about $51 billion to $44 billion. This decline follows numerous years of increases, and similar to what was observed with construction spending, the level of bond issuances in 2009 remains high in the context of the decade. Financial analysts suggest that in the last year, hospitals have focused on controlling their capital expenditures by scaling back their construction projects and avoiding taking on new debt.

Last year when we discussed this one specific indicator of bond issuances, we described the general freeze

in the bond market at the end of 2008. Since that freeze, the bond market has opened up starting at the beginning of 2009, and as of October 2010, interest rates had declined to their lowest levels in three years. We have heard that some hospitals have experienced difficulty accessing capital in 2010, but judging from the low interest rates and the relatively high level of bond issuances, it appears that hospitals largely remain able to access capital at this time.

The number of overall inpatient discharges has declined over the last seven years and the overall number of outpatient services has increased. Medicare fee-for-service beneficiaries had approximately 11.2 million inpatient discharges in 2003 and slightly less than 11 million inpatient discharges in 2009. Beneficiaries also had approximately 123 million outpatient services in 2003 and approximately 160 million outpatient services in 2009. Various quarterly financial reports concerning hospital systems suggest that admissions volumes are down for all payers this year, including Medicare and non-Medicare patients.

The growth rates in inpatient and outpatient

services are somewhat clearer when we look at them in the context of the cumulative percent change in volume on a per beneficiary basis, and that's what we have pictured on the slide above. In this context, the red line displays that from 2003 to 2009, the cumulative percent change in inpatient discharges per fee-for-service Part A beneficiary was negative 3.6 percent. Medicare inpatient discharges declined about 2.3 percent per beneficiary from 2008 to 2009, and this was the fourth consecutive year of decline and also the largest single year decline during that period. For 2003 to 2009, the cumulative percent change in outpatient services per fee-for-service Part B beneficiary was over 30 percent, as displayed by the yellow line above. And from 2008 to 2009 specifically, hospital outpatient services increased about 4.8 percent per beneficiary.

In light of this decline in inpatient discharges, we have also observed a slight decline in the share of beneficiaries who use inpatient services in a given year. From 2003 to 2009, the share of Medicare fee-for-service Part A beneficiaries who had an inpatient claim declined from 23 percent to about 22 percent. We observed wide variation in the share of beneficiaries using inpatient

services in different geographic locations, across different age groups, and across different racial populations. Therefore, we cannot definitively say that this decline in inpatient services represents a decline in access.

Moving to our discussion on the subject, I just wanted to remind you that Jeff Stensland and others will be presenting a second installment of the hospital update measures in December.

And also, at our retreat this past July, some of you raised questions about the access to capital and capacity measures that we usually present and did today as a part of the update process. Therefore, we would like to gather from you your opinions about whether the measures, such as hospital consolidation or construction spending or bond issuances, are useful in making your update recommendations for hospitals.

Thanks for your time, and I'd be happy to take your questions.

MR. HACKBARTH: Okay. Thank you, Zach.

For the benefit of the new Commissioners, let me put this in a little bit more context. So as you know, each year we make recommendations on the updates and we go

through what we refer to as a payment adequacy analysis to help inform that decision. And so we look at information on a variety of different factors, including access to care, quality, access to capital, supply of services, and margins, Medicare margins, where that data is available. So this is one installment.

As Zach indicated and as we discussed at the retreat, there have been questions about the utility of some pieces of that framework. So to focus on this material in particular, information about changes in the supply of hospital beds is obviously influenced somewhat by Medicare, but influenced by factors that go well beyond the Medicare program. So in that sense, it's not a highly powerful tool in telling you whether Medicare's payments are accurate or not.

So one of the questions that's being raised is, is it useful to provide such information or are there ways that it could be reformulated that might make it more powerful in making a decision about Medicare payment rates. So let me give an illustration.

On the supply of hospital beds, maybe what I would really want to know is are hospitals closing in areas where

there is a shortage of beds or a really tight supply. That would be an indicator of -- it still wouldn't be Medicare-specific, but if it's a tight market and we see hospitals closing, that would be an indicator of some real financial distress. Conversely, if we see lots of hospitals opening in markets where there is real low occupancy rate on average and a lot of excess capacity, that might be an indicator of quite a generous payment, again, albeit not Medicare-specific. So there are ways that we can somewhat increase the power of the information, even if it's not necessarily Medicare-specific.

Did that help at all? Do you sort of understand what we're trying to get at here? Whether it helped or not, we're going to go to round one clarifying questions. Karen, I think it's your turn, Scott, and then Ron.

MR. ARMSTRONG: Actually, your comments were very helpful, thank you, and spoke directly to a question I had, and that was I would be more familiar with, and I think it might be helpful to look at beds per thousand. And then you also have -- you're looking at the admission rates. That's interesting, but I would always ask as a complement to that the base rate to go with the admission rate, whether it is a

rate per thousand or whatever that might look like.

DR. CASTELLANOS: [Off microphone.] Slide 6, please. With the translation services, I could be mistaken, but that's -- I thought under limited English proficiency was a non-funded mandate that all hospitals have to provide that and all physicians have to provide that. And I'm just curious, the percentages, I thought it was a Federal law and a mandate that they had to provide that.

MR. GAUMER: I need to look into that, actually. I'm not sure --

DR. CASTELLANOS: Yes. It is a Federal law --

MR. GAUMER: Okay.

DR. CASTELLANOS: -- and we have to do it in a physician's office. It's non-funded, also.

MR. GAUMER: Okay.

DR. CASTELLANOS: Could you put on Slide 8?

MR. HACKBARTH: [Off microphone.] Before we go on --

DR. BERENSON: Yes. I was going to ask exactly the same question. My hypothesis is that there are these phone-in services that hospitals can use to get translation and what we're capturing is an in-hospital dedicated

activity, but that we still -- I was going to ask exactly the same question.

DR. CASTELLANOS: Okay. Well, you know, you could be correct on that, but I know it needs to be provided, however.

Could we go to Slide 8 for a second? Of the four percent of hospital employment, you mentioned computer, pharmacy. What percentage of physicians are being hired in that four percent?

MR. GAUMER: Well, we didn't include the physicians in the breakout of occupations because the BLS data, I think, are not optimal for the physician counts. There's a little uneasiness on our side about what's in there and what's being reported in the larger BLS survey that's collecting this, because it's a sample. So I think, generally, the feeling is that more and more physicians are getting hired directly by hospitals and we can see that if we go to -- let me see if I get the right -- right here on Slide 5, the first bullet here, where we looked at AHA survey data and we showed that -- what we found, that basically 31 percent of hospitals in 2004 had an integrated physician payment model working, and we interpret that as

more physicians being hired directly by hospitals. And so we're seeing some growth here, I think, generally, in that measure.

DR. CASTELLANOS: And the last question, and it's part of, I guess, the hospital beds. Since you brought it up, let me continue on that. I'm a little concerned, because there's no mention -- we have an aging population and the people are living longer. We have the baby boomers coming up. Under PPACA, we have, what, 31 million people now perhaps going to be insured and will be using hospital beds. I know in the article you mentioned we had a loss of 1,600 beds, and I look at Chart 2 and you still think there's a slight increase in the beds.

MR. GAUMER: Mm-hmm.

DR. CASTELLANOS: I just wondered, did you take into consideration the aging population, the baby boomers, PPACA with the need?

MR. GAUMER: That was a very similar question that Peter fed to us earlier in the week, as well. And so that 1,600 bed loss was specific to the hospitals that were entering or exiting the program. But what's not in that 1,600, net 1,600 bed count, is the beds that are being added

by existing facilities -- added or subtracted by existing facilities. So overall, we are seeing a more recent increase in bed capacity on a raw level. We haven't looked at it per beneficiary, and we can do that.

DR. CASTELLANOS: The reason I'm bringing this up is that I recognize there's regional variations. In our community now because of the winter visitors, we have a bed shortage now. People are out in the halls. People are here and there and everywhere. We have a lot of old buildings that are going under construction now. A lot of the three- and four-bed wards are now being cut back to one bed and some of the small rooms, we're losing beds. So I just think the bed capacity, at least as a practicing physician, is a concern in my community and I just -- I look at this slight increase and I'm just concerned.

MR. HACKBARTH: And I think you're making a good point, a logical point. We're not making any statement about the need for beds. We're simply reporting on what the trends are, and so you're identifying factors that, at least in some communities, may justify an acceleration in the rate of growth in beds, which is part of what I was trying to get at. On the other hand, if you see beds being added at a

significant rate in communities where there's lots of excess capacity, that also at least raises a question in my mind.

Round one clarifying questions?

DR. BAICKER: On Slide 10, I was a little uncertain about how to interpret the units. If I think about some potential substitutability of outpatient care for what used to be inpatient care, would one inpatient discharge translate to one outpatient service, or ten outpatient services because you go through a series of things that are billed separately? I just wasn't sure how to interpret the axis for the two different measures.

MR. GAUMER: Yes. There's not a one-for-one relationship because of the volume of different outpatient claims that are coming in, and there was an attempt in this data that Dan very well does every year to pull these together and consolidate them as much as possible. So it's not a one-for-one relationship, but it's somewhere between that and the very raw relationship of all outpatient claims --

DR. BAICKER: So what is --

DR. CHERNEW: [Off microphone.] This is on a different base, though. The base --

DR. BAICKER: Sure. Sure. But what -- I'm just trying to figure out what the unit of observation is. Is it a claim or is it a --

MR. HACKBARTH: It's the unit in the outpatient payment system, isn't it?

MR. GAUMER: That's right. It begins with a claim.

MR. HACKBARTH: Yes. And so they are, generally speaking, pretty small units as opposed to discharges, which are bundling a lot of services together.

DR. BAICKER: [Off microphone.] So this is all normalized to zero.

MR. HACKBARTH: Yes. Clarifying questions?

DR. MARK MILLER: And I think, too, the conceptual point, I don't think you look at this as strictly substitution, which I think is what you were asking. There may be some of that going on, but certainly not one-to-one.

DR. BERENSON: My question has to do with reporting on closures and acquisitions. If a hospital is acquired but remains as an operating hospital, it doesn't show up as a closure, I assume. It's still a licensed hospital.

MR. GAUMER: That's right. So we took the efforts to weed out all of those kind of gray areas and run through the list each year and figure out which ones are actually still open but may have a different provider I.D. number. Where this starts is with provider I.D. numbers, you know.

DR. BERENSON: Right.

MR. GAUMER: If 400 new provider I.D. numbers pop up, we try and track down what is actually coming and going and not just getting a new name and a new lobby.

DR. BERENSON: Okay. So you think you've cleaned that up?

MR. GAUMER: Yes.

DR. BERENSON: Okay.

MR. HACKBARTH: Round one clarifying questions? George?

MR. GEORGE MILLER: Yes. Back to Ron's question on bed capacity, I don't know if you said this or not, I apologize, but I've missed it. Are you talking licensed beds or occupied beds as on the cost reports? What are you using for beds?

MR. GAUMER: We looked at staffed beds --

MR. GEORGE MILLER: Staffed beds, okay.

MR. GAUMER: -- as reported on the AHA survey.

MR. GEORGE MILLER: Okay, staffed beds. And so you're talking about the increase of about 1,600 beds, did I hear that correctly?

MR. GAUMER: No. When comparing the beds associated with those hospitals that are opening and closing, we saw a decline of 1,600 beds coming and going.

MR. GEORGE MILLER: Okay.

MR. GAUMER: But that doesn't factor in what else is going on out there.

MR. GEORGE MILLER: Okay.

MR. GAUMER: But the general trend over the last two years has been a slow increase, and I say the last two years, from 2006 to 2008, which is the most recent data. There's been a slight uptick in the number of beds out there, about 11,000 beds, which is small relative to the 750,000 that are out there.

MR. GEORGE MILLER: And what's the timing of the data again from the AHA survey?

MR. GAUMER: That would be 2006 to 2008.

MR. GEORGE MILLER: Okay. Okay. So since that time, again, I'm just thinking in my community, we closed

beds, didn't staff beds because there was a new hospital, doctors' hospital opening in town, and to save dollars, we're not going to close a hospital, but we'll certainly close services. So your survey wouldn't include any changes in the last two years, just since 2008?

MR. GAUMER: Right.

MR. GEORGE MILLER: Okay.

MR. GAUMER: It wouldn't match with the time period of the chart above, which is 2009 as the earliest. But yes. So we wouldn't have 2009 and 2010 data in there.

MR. GEORGE MILLER: Okay. And then quickly on the slide dealing with the inpatient and outpatient, Slide 10, is there a correlation between the increase in outpatient and the decrease in inpatient to the bed capacity at all? It's probably hard to figure that out, because this is only Medicare data and not the total. But I wonder if there's a correlation.

MR. GAUMER: We haven't looked at the correlation specifically with bed capacity.

MR. GEORGE MILLER: Okay.

MR. GAUMER: We can do some thinking about that.

MR. GEORGE MILLER: Yes. But the problem would

be, this wouldn't be all the data --

MR. GAUMER: That's correct.

MR. GEORGE MILLER: Yes. Okay. Thanks.

MR. HACKBARTH: Round two? Karen?

DR. BORMAN: Zach, I wanted to go to your question to us about is this helpful, and just can answer for myself. I certainly think that I try to look at this in the sense of more big picture, and so I think having more information, albeit biopsies, if you will, and not necessarily the whole specimen, are helpful to me. I certainly can't pretend to think that I can look at what you present to us and in some very numerically driven scientific calculation come out to say, this is what we should recommend as an update, or whatever else. That's way past me. But I do find the notion of multiple snapshots or biopsies or data points, recognizing that they're not all specific to the Medicare program, do help me frame a more general concept from which I can try and develop some principles to look at consistently from time period to time period. So in my world, these information are helpful as long as you present to us their limitations and positives, as you do so well.

The one comment I would make is that from my

perspective, in addition to the question of how do we sharpen these up to be helpful, is are there analogous kinds of things that we can ask about the other parts of the program that we look at that would give us a more fully fleshed-out big picture in order to make evaluations in those, because I think hospital is a place where we have sort of gone out of the beginning update box that we lived in and now we have built a bigger box, and I just wonder if part of our thinking should be, can we build some bigger boxes for the other parts of the things that we consider. So I know that's not your job, but I just throw that out there as a concept.

MR. HACKBARTH: About other provider groups?

DR. BORMAN: Right.

MR. HACKBARTH: So I think in all of them, we provide data that are roughly comparable to these in terms of capacity, trends and capacity, capital investment, and the like. Now, the data aren't always exactly the same. In some, they may be stronger or weaker. But there's analogs to this, I think, for the other provider groups.

DR. BORMAN: I mean, I know we look at some of the company data in some of the home health agency DME, some of

those kinds of things. I just wonder, for example, albeit not necessarily a clear mandate for us to make a physician update, there might be some data about physicians per capita and some of the other distributions --

MR. HACKBARTH: Some ratios or --

DR. BORMAN: -- that might help us a little bit in thinking about that. We talked a lot about what is the right distribution, but maybe just in terms of saying some big trends, can we think about that a little bit. Just a thought.

MR. HACKBARTH: Yes. Home health is actually an interesting example of how, depending on the sector, there can be special challenges. So thinking about home health capacity is always difficult because it's not bricks and mortar dependent, so the data that we have is counts of agencies which tell you almost nothing about capacity. So there are particular challenges for some sectors.

Scott?

MR. ARMSTRONG: The one comment I would make, which I think is kind of in the same neighborhood as this last comment, is that this relationship between inpatient utilization and outpatient utilization that's hospital-based

is kind of interesting, but I'm spending a lot of time worrying about the movement of physician practice-based outpatient procedures to hospital-based outpatient procedures, and it may be outside the scope of a hospital evaluation or profile that we're doing, but for what it's worth, that may be driving part of that yellow line in the slope there and it just might be worth looking at if that's in the scope of this report.

DR. CASTELLANOS: I guess I'm fixated on hospital beds. I forgot to ask, where did the observation beds fit into this, since they're not hospital admissions?

MR. GAUMER: The observation bed unit doesn't necessarily get captured in the same way that a staffed hospital bed gets captured because it's kind of an amorphous thing. But related to this slide, the observation issue is tied in here and such things. But we don't have a count of specific observation beds, and I guess to give more detail on that, that's because they aren't counted by a lot of the surveys specifically, and also some hospitals don't identify what's an observation bed versus what's an inpatient bed or an observation unit, even.

DR. CASTELLANOS: But it's still a bed that's

occupied by a patient that prevents other patients from using that bed.

MR. GAUMER: Right.

DR. CASTELLANOS: So shouldn't it be counted?

MR. GAUMER: It gets folded into the staffed beds count. I think that more directly answers your question.

MR. HACKBARTH: I'm confused now. I thought I heard you say that it was not included in the staffed bed count because --

MR. GAUMER: Sorry. What I meant was that they're not folded in or counted by a hospital specifically. They're all lumped into the same staffed bed on the AHA hospital survey.

MR. HACKBARTH: Oh, I see. I see. They're not --

MR. GAUMER: Sorry.

MR. HACKBARTH: There's not a separate subcategory for observation beds. It's just staffed beds versus --

MR. GAUMER: Yes, exactly.

MR. HACKBARTH: Okay. I have got you.

MR. GAUMER: But you might get a different answer from an administrator who may have different counts in their mind.

MR. HACKBARTH: Yes. But to the extent that it is used, it shows up in the outpatient category. The expense would show up in the outpatient category.

MR. GAUMER: They show up in both places, depending on upon what happens to the beneficiary. So if the -- to go back --

MR. HACKBARTH: I'm going to be sorry I asked this question.

MR. GAUMER: No, no --

[Laughter.]

MR. GAUMER: The observation patients that end up as inpatients get folded into that red line, right, because they -- okay, but the observations that never go to inpatient show up in the yellow line.

MR. HACKBARTH: The yellow line.

MR. GAUMER: Yes.

MR. HACKBARTH: Okay.

MR. GAUMER: That's the majority of them.

MR. HACKBARTH: Yes. Mike?

DR. CHERNEW: So you asked if it is useful, and my general sense is, compared to not seeing it, it's clearly useful. That doesn't mean, as you alluded to, I might want

to see it in some other way. And I guess the challenge that we always face is we control the general hospital payment level, but we often worry about what is going on in specific places. So if you look in the chapter, it says the hospitals opened in Ohio and they closed in Pennsylvania and it's very hard to tell what that means because there's a mix.

So if I were, I guess, I was trying to pick what I would want to see, I'd like to see sort of maybe a Dartmouth-style map of bed capacity to see if there's places in the country where the bed capacity is very high. Now, that doesn't mean we need more beds there. So I guess I'd also like to see maybe a utilization rate per capita in some way to see -- because the problem is if you see there's 95 percent bed capacity in Ron's place, I don't know if that's because they don't have enough hospital beds or they're just sending too many people to the hospital, right. So you want to see some comparison of those two to try and figure out if there's trouble places.

And then I think the issue is, even if you found on that that overall it looked good for the country but there were some places that didn't look good, you'd want to

ask, well, are there hospitals opening there, which is where you would want, or are they closing there, that might be a problem. And I guess the solution I would infer wouldn't be, oh, we need to raise the update factor, but you'd worry about the geographic factor one way or another.

So what I guess -- the reason why this is useful, just to bring it all full circle, is it tells me that, on balance, it doesn't seem like we have a big problem with access. Whether or not there are markets where there are problems is a separate thing where we need to see more disaggregated sort of Dartmouth mappy - you know, however Dartmouth got that adjective, now all maps like Dartmouth maps. I mean, this is a wonderful trademark, now.

DR. BAICKER: Dartmouth Map, TM.

DR. CHERNEW: Yes, right, exactly. But some map like that to give you some idea of how the distribution is, I think, would help. But I think this is extremely useful in at least answering the first order question, do we have to worry, particularly the one part I like most. The fact that investor-owned hospitals are entering in places suggests that at least somewhere -- either the geographic factors are really messed up and those are just really well

ordered places, or there is adequate average payment for hospitals, because investor hospitals aren't going to go entering if there's not adequate --

DR. MARK MILLER: [Off microphone.] To do that -- I will think about it. There's a technical thing, but I will think about it.

MR. HACKBARTH: Okay. Round two? Nancy?

DR. KANE: Well, I was thinking along the same lines as Mike. It does seem like it would be nice to see the distribution of the hospital resources. But I also thought it would be useful to kind of see what the national average -- how Medicare compares to all beds per thousand for the whole population, for the under-65, and get some kind of a norm that then you can look at the different areas and say whether or not it seems like Medicare is getting the same or less or more on average than it would nationwide.

DR. CHERNEW: [Off microphone.]

DR. KANE: I agree with that. I'm saying the standard would be there's a national average Medicare per thousand --

DR. CHERNEW: [Off microphone.]

DR. KANE: And then let's just say it's six per

thousand for Medicare and two per thousand for non-Medicare, and then how does that vary across markets, about HRRs or whatever convenient way to allocate, just to see. You know, we're trying to get a sense, is the bed supply adequate. Well, let's assume the standard is the national average ratio of Medicare per thousand to non-Medicare per thousand and when where does it vary, because I think it's hard to tell just on Medicare alone. And the private sector theoretically has some levels, some types of maybe -- we all say it's maybe more efficient, but it would be nice to know whether we vary from the national average. I don't know how you bring in the -- I don't know how you -- I guess you just do it by HRR and you count both MA and regular fee-for-service Medicare beneficiaries in an area as the population.

And I guess the other piece that would be useful to see is the technology services per thousand. So not just the beds, but the robotic surgery, so the range of services that are available per thousand Medicare beneficiaries, access to high-technology services.

And then on the list of are any of these measures helpful, I think they are helpful. Again, I'd like to see them more -- I don't know why you left off the employment

and the volume per capita. Those are actually quite useful, too. So, yes, I think it's better than not having it, and all we're asking is maybe some more disaggregate metrics, because I think Glenn mentioned when we were talking about updates that we might want to start thinking about how might we want to redistribute not just single measure, but what are the distributional issues we might want to be considering.

DR. BERENSON: Yes. My general view is that these measures are helpful, but I would point out that a couple of them, I think, are lagging indicators. Hospital construction, hospitals opening to a lesser extent, bond issuances are based on decisions made three or four or five years ago. And the interviews that I'm doing with health system change suggest there's been a change that will not be reflected until a year or two from now, probably, that first the October 2008, that hit, and then the PPACA is changing behavior. So it's better to have this information than not, but I do think those, in particular, are lagging indicators whereas employment isn't, and so we just have to keep that in mind.

MR. GAUMER: Okay. Thanks.

MR. GEORGE MILLER: Just to reflect, Bob covered what I was going to say because they are lagging indicators, and some other economic indicators from a hospital perspective dealing with changes in our environment. Again, the new hospital opening, you don't have the license yet, you don't have that information, but that's going to affect one way or the other in the market. Again, these are two-year lag indicators. We're making a decision now for next year about the hospital margins. While this is good information, there may be other more relevant information. Margins obviously is the one we will look at, but I agree with Bob.

MS. BEHROOZI: I like the information, Zach, about -- you alluded to it, Glenn -- about how at capacity the neighboring hospitals were as to the hospitals that closed and opened. It did strike me that among the hospitals that closed, there was more density of occupancy around them than where the hospitals were opening. And more of the ones that are opening are investor-owned, as Mike said, so what's in it for them if there aren't a lot of -- if there doesn't seem to be a lot of demand based on how full the other hospitals are. And then you also note that 11 of the 31 are

likely to be specialty hospitals by their name.

So I feel like it would be worth drilling down into that and maybe over a period of time, not so much to go to the one national update, but maybe there are inequities in payment somewhere that we could have an influence on, because that just --

MR. HACKBARTH: Let me pick up on that and the specialty hospital piece in particular. Was it 2005 that we did the specialty hospital --

DR. MARK MILLER: We did it twice.

MR. HACKBARTH: Right. When we did the specialty hospital report, I think it is fair to say that there were some Commissioners who favored an outright ban, you know, this is an unethical arrangement, it is destined to cause problems. And then there were other Commissioners who said, well, the first step should be to correct the obvious payment problems on which specialty hospitals seem to be particularly focused, for example, around cardiac services. We made a series of recommendations which were largely adopted, have now been implemented by CMS and have resulted in significant changes in the relative payment rates, reducing some things and increasing others.

It would be interesting to me to know whether, in fact, that slowed the rate of growth in specialty hospitals. So that is a particular type of information that might be useful. And I suspect that could be a debate that is reopened now in the new Congress. It was a facet of the Affordable Care Act to do basically a prohibition. There are some people in the new Republican majority who have very strong feelings on the other side, and whether this is an issue that might be separated out and negotiated, I don't know, but I suspect it could become an issue again. So if we could somehow shed some light on whether the payment changes were effective in slowing what was very rapid growth, that would be useful to know.

DR. BERENSON: And my only point is the tricky data issue of separating out physician-owned specialty hospitals from hospital-owned specialty hospitals. There's a whole bunch of joint ventures that were going on, and now, in fact, I know of at least one and maybe more in which the physician owners are selling their stake to the hospital and it will show up as a specialty hospital.

MR. HACKBARTH: Yes. That is an important issue, although the argument I made at the time, maybe didn't

persuade anybody, is I really don't care whether it's a physician-owned specialty hospital or a not-for-profit specialty hospital if what they're trying to do is exploit problems in the payment system. It's all the same to me. And so --

DR. BERENSON: Well, if the dollars are merged, I mean, if, in fact, it's a hospital system that starts a specialty hospital and they're siphoning patients away from one hospital --

MR. HACKBARTH: Right.

DR. BERENSON: -- but the dollars are all flowing, then it's a different situation, I think.

MR. HACKBARTH: Okay.

MS. BEHROOZI: I think also, Glenn, it goes to the motivation, right, but it also goes to what is it that we see when we are looking at a map. You could also look at what kinds of beds they are. They are not all the same beds. Do you have a high concentration of certain types of beds in one place and not in another, you know.

MR. HACKBARTH: You know, I am being too glib in saying it doesn't matter to me, although I would say, Bob, that even if it is a system and what they're doing is

reallocating their resources and saying, oh, we're going to take resources out of psychiatric care or caring for medically complex patients and put everything into our new cardiac center, that's a problem.

DR. BERENSON: Well, that's a second order question which we can't get at just by --

MR. HACKBARTH: Right. Any other comments?

DR. MARK MILLER: Yes. I will just say a couple of things, and I want to preface this comment by saying we can and will drill down. This will be forgotten by the time I get to the end of the comment, but I'm going to say it anyway.

Keep in mind, I mean, the kinds of things you will find will be the products of things like supply-driven competition, admission rates that are peculiar to those areas. And so when you start to disaggregate and then say, well, these represent different standards, just like when you got into the geographic utilization stuff, there were a lot of other things that you needed to kind of -- and I say this as a caution, because what that sets off is never a search for what we think is the right, at least in the larger debate. It always says, why aren't I at the highest?

And so just kind of keep that in mind, that the direction that this can go is, by definition, why aren't I up here in the larger policy debate, and I assume there will be some comments.

There's just one other thing I wanted to say. What I'd also like to hear, and we can't do it today, and I don't know how to orchestrate it given the limited time that we have, I think the discussion on beds is really interesting on a couple of fronts. Ron, you are saying I actually don't have enough beds, and there is an issue of admission rates in that part of the country, but how are hospital people -- Herb, Peter, George, people like that -- thinking about hospital beds? They are looking at inpatient trends, if they are declining. But then the baby boom. How are hospitals thinking about it? And there is construction going on. There is a net increase in the beds, at least up to the point that we have data. So how are hospital people thinking about it? And we actually have some people here who could potentially help us with that. I would like to hear the continuation of that conversation with some of the hospital input.

But I know I said some things that were going to

set you off, so --

DR. CHERNEW: I think one of the biggest challenges is the hospital decisions about entry, exit, and beds has to do with what they think payment rates are going to be for a long period of time. And one of the challenges, of course, PPACA signaled what that might be, and we're doing an update factor which is like one year. And so we're almost, and I hate to say this, we're almost now -- I'm thinking about whether to say this -- we're almost like the Fed, right, which is not only we want to give an update, but there is some sort of guidance as to what our principles would be, because at least in this area, people are looking, are we -- and that is so politically fraught, because imagine we wanted to say, we think that the PPACA cuts aren't sustainable and that we have as a matter of policy a belief that our trajectory -- so if we wanted to change beds for whatever reason, and I don't think we do, which is why this was useful, but if we did, a one-year update factor kind of strategy isn't what would solve that problem. We would need to think about the trajectory of what we were saying, like the Fed has to give its guidance, and that becomes really hard in this particular area.

So I think the best we can say is it doesn't look like there's an access problem yet, and I'll let you and your political wisdom decide how much one wants to signal or not what MedPAC's general thinking is about this new baseline and trajectory and what it will mean for access, because what's going to happen is the ramifications of that won't be felt when those cuts get really draconian. The ramifications of that will get felt in the investment decisions that are made now, for better or worse -- I think.

MR. HACKBARTH: Yes.

MR. GEORGE MILLER: And just to that point, if I could just piggy-back, from a hospital CEO perspective, a hospital bed can cost between $120,000 to $200,000 per bed, and you're talking about a one-year update and that's a 30-year amortization. That's a critical piece in dealing with it.

DR. CHERNEW: Right. I agree.

MR. HACKBARTH: So I think it won't be soon that we are providing that long-term forecast on what our update recommendation is likely to be. You're right, that would be politically difficult and hazardous. But beyond that, even more important than that is that the structure that has been

created, at least as I see it, in the Affordable Care Act is they have set this baseline, and what they want from us is sort of a year-by-year assessment, you know, how is this going, not us to add our voice to what the long-term update should be. They want us as a check. Our role in the system is as a check as opposed to trying to replace them, or second-guess them for the long term. Do you see --

DR. CHERNEW: That's a very difficult thing to do if we thought the baseline was problematic and it had ramifications --

DR. BAICKER: I know Mark said not to focus on the substitutability aspect, but when I go back to why I care about hospital beds, I care because I care about people's access to care that they need and because I think our payment rates drive supply in a way that may be more or less efficient. So then that makes me want to look at hospital beds relative to use of other services for the same patient group to see, are we talking about substitution across modes of achieving the same health outcome and is that substitution better or worse? Have we set margins on these different ways such that people are substituting towards a more efficient way of getting to the same health outcome or

a less efficient way, and what are the measures of access that might help us know that, and that speaks to the decomposition across areas in a way where I want to be capturing the bundle of services consumed by beneficiaries towards a specific outcome.

DR. MARK MILLER: [Off microphone.] And I hope my comments are narrowly right.

DR. BAICKER: [Off microphone.] Right.

DR. KANE: One of the reasons I'm interested in the differentials across the country is sort of the socio-economic issues that happen. So you often get a lot of older people sort of stuck in an area and all the young people leave and the beds will follow the money and it tends to be the private money, not the Medicare money. And I just don't know if we need to rethink even the Medicare disproportionate share or whether we be just keeping an eye out for markets where -- I think the rural argument was also along the same lines, is you've got a lot of people who aren't going to be moving to the areas where there's a great new population growth and more affluence. So I'm kind of interested in just seeing how much variation there is and whether areas that are predominantly elderly and not

particularly wealthy are losing access to hospital services. So that's the reason to disaggregate to me.

MR. HACKBARTH: Others? I think we're done, Zach. Thank you.

MR. GAUMER: Thank you.

MR. HACKBARTH: Now we'll have our public comment period.

MR. KETCH: If I could keep you here just for a minute --

MR. HACKBARTH: Sure.

MR. KETCH: My name is Todd Ketch. I'm the Executive Director for the American Health Quality Association.

MR. HACKBARTH: Yes.

MR. KETCH: We are the organization that represents the National Association of Medicare Quality Improvement Organizations.

MR. HACKBARTH: Okay. And if you're familiar with the ground rules, a couple minutes --

MR. KETCH: Yes.

MR. HACKBARTH: -- and when the light comes back on, that's the end of your time.

MR. KETCH: I will keep it brief.

MR. HACKBARTH: And we've got people who need to go catch airplanes.

MR. KETCH: I fully understand. I'll just take a minute here.

I just wanted to thank you for taking up the discussion of quality improvement technical assistance again. I particularly want to say we agree with much of what was said by the two panelists as well as in the report in June about the need for more flexibility for quality improvement organizations to innovate within the program as it exists. The contract requirements can often be very limiting, and so we think that would be a great opportunity to allow for there to be more innovation within the program by loosening up some of those restrictions so they can do more. We know that this is something that CMS is looking at now and going into the new scope of work and that Dr. Berwick is really committed to.

The idea of diverting funds away from the QIO core contracts to grants to low performers is problematic from our point of view, primarily because when you look at the amount of funds available, that would be available for that

kind of thing, that actually would ultimately be pretty limited.

I won't argue that the amount of funding going to the QIO program in total is not substantial. It's a lot of money. Forty percent of that, however, goes off to other activities outside the QIO core contracts for the work they are doing on the ground, so that's a significant chunk that goes away, and that was addressed in your report in June and by the IOM, as well, so we need to look at that.

But then when you divide it out over three years across 53 contracts and all of the providers, if you were to then divvy up whatever chunk of money that might be there for these low-performing providers, it potentially looks pretty small from our point of view and may not be an adequate amount of money for them to really get the kind of help that they need.

The QIOs in doing this through a single contract can use efficiencies in those contracts. They're just by nature, because of the amount of funds available for a fairly broad contract, they have to be efficient. And so you would lose that, potentially, by just doing it through a grant process, not to mention then there is the

administrative aspect of this. It's hard enough for CMS to administer 53 contracts. You can imagine with potentially what would look like hundreds of grants to administer that that would be a real burden on the administration.

And the QIOs are moving already in the 9th Scope of Work, as you mentioned, to working with low-performing providers. But what we found is that they're not necessarily being driven to pursue quality improvement assistance. They're often lower resourced. They're often in far-off areas. They don't necessarily have quality improvement technical assistance readily available to them. So it's sometimes a challenge even coming to them with free assistance technically to get them to engage.

And so we don't see any evidence that a grant of some modest amount is necessarily going to drive some of these organizations to engage in quality improvement technical assistance, so we think that would be a problem in moving away from the efficiencies that the QIOs can offer.

And then finally, I would say the QIOs are very, very involved in many places with the regional collaboratives and often are providing data analysis in those situations, quality improvement, technical assistance

in those situations, and in even some cases some credibility to the organizations that may be new, where you've got an organization, a QIO that's very well established and respected in the State.

And so we think that there's an opportunity there for the QIOs, collaboratives, and all these other players to really work together, as Chris Queram had talked about, where it's not necessarily a zero-sum game, but we need to put all of these resources together and use them as best we can.

The 9th Scope of Work is almost finished. The Tenth Scope of Work, we expect is going to look very different. The 9th Scope was a step in the process from where IOM was recommending. So I think we'll see a Tenth Scope here soon, at least the rough draft of it, and I think it'll open up a lot of new doors and questions about how the program is going to proceed forward. Thank you.

MR. HACKBARTH: Okay. We're adjourned.

[Whereupon, at 12:10 p.m., the meeting were adjourned.]