MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, November 6, 2008
9:44 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair
JACK C. EBELER, M.P.A., Vice Chair
MITRA BEHROOZI, J.D.
JOHN M. BERTKO, F.S.A., M.A.A.A.
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WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, Ph.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: I'd like to welcome our guests in the audience.

Today we do have a final vote scheduled for after lunch on the disclosure recommendations that we discussed for the first time at the last meeting. We will also, later on today, discuss draft recommendations on hospice services.

This morning we have two sessions on Part D and then one on delivery system reform. To initiate the discussion on Part D, Rachel.

DR. SCHMIDT: Good morning. Before we get started, I'd like to acknowledge work of Shinobu Suzuki and Hannah Miller, who contributed to this analysis.

Part D is about to start it's fourth year, and we're approaching almost 26 million enrollees and about $50 billion in benefit spending. This morning I'm going to walk you through what we've learned from looking at Part D enrollments for 2008, as well as what plan sponsors are offering for 2009. Remember that the open season for Part D runs from November 15th through December 31st, so now is the time of year when beneficiaries have the opportunity to choose among their plan alternatives.

Let's start with the overall sense of how Medicare beneficiaries get prescription drug benefits. CMS estimates that about 90 percent of beneficiaries either have Part D or another source of drug coverage that is at least as generous, which we called creditable coverage. The 10 percent of beneficiaries who either have no coverage or coverage of lesser value are shown at the top of this pie chart.

I'm going to focus on the beneficiaries in Part D plans, so going clockwise around the pie there, the next two pieces of the pie.

At the start of 208 there were about 44 million Medicare beneficiaries. Over 17 million, or 40 percent, were enrolled in stand-alone prescription drug plans. So those people usually get traditional fee-for-service Medicare benefits for their Part A and Part B services and a stand-alone plan for their drug benefits. Nearly 9 million beneficiaries or 18 percent were in Medicare Advantage prescription drug plans where enrollees get their medical and drug benefits combined through one private plan.

If we look just at the stand-alone PDP enrollees, about 8 million beneficiaries or 18 percent of all Medicare

beneficiaries receive Part D's low-income subsidy, which is extra help with premiums and cost sharing. Another 9 million, or 22 percent, are in stand-alone plans but do not receive the low-income subsidy. So nearly half, 45 percent, of PDP enrollees receive the low-income subsidy. That's important to note because LIS enrollees tend to be sicker, tend to use more drugs, and are therefore costlier and also pay less in cost-sharing.

Among Medicare Advantage drug plan enrollees about 1.5 million, or 3 percent of all Medicare beneficiaries receive the low-income subsidy and about 6.5 million, 15 percent, do not. That means 18 percent of Medicare Advantage drug plan enrollees receive the low-income subsidy. So a much smaller proportion of MA-PD enrollees receive the subsidy than PDP enrollees.

During the first two years of Part D, the market shares among PDP sponsors were pretty concentrated and didn't move much. In Part D's third year, 2008, they are still pretty concentrated but we've seen a little more movement.

These pies, on the left-hand side is 2008 and on the right is 2007. I know the printing is small but we'll

just focus on the larger chunks of the pie. The largest sponsors, United Healthcare and Humana, each lost a few percentage points of the market share, picked up by some of their rivals. Both of those sponsors had some sizable increases in monthly premiums for 2008 and their loss of market share mostly had to do with not bidding low enough to keep their premiums below the maximum amounts that Medicare will pay for enrollees who receive the low-income subsidies. Bot sponsors loss LIS enrollees for 2008 because their premiums were too high to qualify and CMS reassigned those LIS enrollees to other plans with lower premiums.

Just to go over this quickly on the MA-PD side of things, market shares have remained pretty stable. The same two sponsors, United and Humana, combined have about a third of the market and their market shares haven't changed much.

On this slide, I'm going to talk about the distribution of enrollees in 2008 in terms of the kinds of benefits they're getting now. So just to be clear, we're talking about percentages of people, not percentages of plans.

In 2008, enrollees in Medicare Advantage drug plans are much more likely than PDP enrollees to be in a

plan that has enhanced rather than basic benefits. Enhanced means a higher average benefit value. The most typical way that sponsors enhance a plan is by charging no deductible, but they can do other things like charger lower copayments or cover certain drugs in the coverage gap. You can see from comparing the columns in the table that a larger share of MA-PD enrollees are in plans with enhanced benefits rather than PDP enrollees, and a larger share of MA-PD enrollees do not have to pay a deductible and more of them are in plans that cover some drugs in the coverage gap.

MA-PDs can use some of the financing from the MA payment system -- called MA rebate dollars -- towards lowering Part D cost-sharing and premiums or enhancing their drug benefits. At the same time, don't forget that nearly half, 45 percent, of PDP enrollees receive the low-income subsidy. The LIS fills in the coverage gap. Most beneficiaries who receive the LIS were auto assigned into basic stand-alone prescription drug plans rather than an MA-PD. So while these individuals are in basic plans, they have more complete benefits because of the LIS.

You may be wondering how many people hit the coverage gap. Last week CMS organized a symposium to look

at 2006 and 2007 Part D data. Now let's go over their coverage gap findings. Let's focus on the right-hand side of this slide, which is for 2007, when more people had been enrolled in Part D for a full year.

CMS estimates that 32 percent of Part D enrollees had spending high enough to reach the coverage gap. A little more than half of these individuals, 17 percent of all Part D enrollees, received the LIS, which fills in the coverage gap. A few percentage points of the remaining 14 percent of Part D enrollees were in plans that provided some benefits in the coverage gap, and usually those were just generic drugs, not brand name drugs.

CMS estimates that in 2007 9 percent of Part D enrollees had drug spending high enough that they passed completely through the coverage gap and into Part D's catastrophic phase, where Medicare picks up most of the costs. Most of these individuals received the LIS, which for full benefit duals eliminates copayments entirely once they reach that level of spending. So 2 percent of all Part D enrollees have spending that is at the catastrophic phase and do not receive the low-income subsidy.

Now let's turn to what plan sponsors are offering

for 2009. This time I'm going to be talking about percentages of plans, not percentages of people. You can compare the PDP offerings to MA-PD offerings down the two columns of the slide. There will be about 7 percent fewer PDPs in 2009. Even though sponsors are withdrawing some plans from the market, the median region of the country will still have 49 PDPs available. By comparison, there will be about 6 percent more Medicare Advantage drug plans and the distribution of those plans is changing. There will be fewer private fee-for-service plans and growth that more than offset them in local PPOs and HMOs. A larger share of MA-PDs have no deductible, 88 percent compared with 55 percent of PDPs.

In 2009, a larger share of MA-PDs than PDPs include some gap coverage, 52 percent compared to 25 percent. About a third of the MA-PDs that include gap coverage cover some brand name drugs as well as some generics during the gap phase. By comparison, nearly all of the PDPs that have some gap coverage cover generics but not brand name drugs.

Once again enrollee premiums are increasing. The bars on the left of this slide show what the average

enrollee paid in 2008 and the bars to the right show our estimates of what enrollees would pay if they remain in the same plan for 2009. We know for certain that some beneficiaries will switch plans. For example, some low-income subsidy enrollees will get reassigned. These estimates do not take that into account. But to give you a sense of things, when CMS looked at the same sort of thing, they estimated with reassignments and voluntary switching that it would reduce the average premium by about $2.

On the far left, the average enrollee in a PDP paid about $30 per month in 2008. And that's an average for basic and enhanced benefits combined. If they remain in the same plan, enrollees can expect to pay $37, or $7 more per month. MA-PD enrollees pay a combined premium that covers their Part D benefits and their regular medical benefits. But if we just look at the portion of that combined premium that is attributable to their drug coverage, we estimate that the average MA-PD enrollee will pay $15 per month in 2009.

You can see that the dollar amount of MA-PD premiums is a lot lower than PDP premiums. Now some of the MA plans are probably managing their benefits better, but

the difference also reflects what we talked about earlier, the fact that MA-PDs can use rebate dollars from the Medicare Advantage payment system to lower their opinions.

Overall, the average enrollee paid about $25 per month for Part D coverage in 2008 and if they stay in the same plan their premiums will increase by about $6 next year. That's about a 24 percent increase.

This is several years in a row of premium increases which are probably more noticeable to PDP enrollees. Since most of the low-income subsidy enrollees pay no premium, this chart takes them out and then looks at the distribution of premium increases for the remaining PDP enrollees if they stay in the same plan for 2009. In the dark blue you can see that 7 percent will see premiums decrease but the other 93 percent will face higher premiums. For about 60 percent of these people that increase will be $10 per month or less and about a third will face premium increases of $10 or more per month.

So why are premiums going up? One reason is that for 2009 CMS moved to full involvement weighting to set plan payments and enrollee premiums. In the first few years of Part D, CMS used general demonstration authority to phase in

enrollment weighting. This meant that Medicare was subsidizing Part D payments and premiums more than called for by law. For 2009 we'll be at the statutory level of subsidy and premiums will be somewhat higher as a result.

The other major explanation is simply that plan sponsors bid higher and there are several reasons to bid higher. One is just the drug costs are going up and, of course, plans need to anticipate that and build that into their bids.

But another reason may be that since a few Part D enrollees seem to switch plans voluntarily -- even in the face of premium increases -- there's less pressure for sponsors to bid low.

And finally, we've heard anecdotally that some sponsors do not think they are paid enough to cover the costs of providing drug benefits to low-income subsidy enrollees. If that's true, some sponsors may not want to bid too competitively. They may prefer that their plans have premiums higher than the LIS thresholds.

We just talked about enrollee premiums going but costs are likely to increase for the Medicare program as a whole, too. This chart shows the year-to-year change in

what, on average, plan sponsors bid as the cost of providing basic benefits. I want to call your attention to two things on this slide. First is the drop in the average bid between 2006 and 2007. Since sponsors didn't have past claims to look at when they were bidding for the program's first year, many of them bid too high. That's one reason why the average bid for 2007 fell. When CMS reconciled payments with plans for the 2006 benefit year, plans owed Medicare over $4 billion because their prospective payments had been too high.

CMS recently completed that reconciliation process for the 2007 benefit year and this time the net amount plans owe Medicare is just about $18 million, with an M. That's another piece of evidence that plan sponsors got better at bidding.

The other thing I want to point out on this chart is the 11 percent increase in the average bid between 2007 and 2009. That's the two right-hand bars. This could be troubling but let's look a little more closely at this. The thing that's driving this increase is what plans are now expecting in the way of catastrophic spending by their enrollees. In particular, there are certain drugs -- like

for conditions like rheumatoid arthritis and multiple sclerosis, that are very high cost and users of those therapies tend to have very high spending that puts them all the way through the coverage gap and into the catastrophic phase of the benefit where Medicare is picking up most of the cost through individual reinsurance.

The increase in average bids for 2009 may be an artifact of people focusing on this catastrophic spending more than before because CMS just started asking sponsors to provide more information with their bids about spending for very high cost drugs. Still, we want to keep our eye on this category of spending. Even though the numbers of people who use these types of drugs is very small now, it's growing, as are the prices for these drugs.

For 2009 there's a large turnover of plans that bid low enough that they qualify to remain premium-free to enrollees who receive the low-income subsidy.

One thing that was new for 2009 was that CMS moved to a different method for setting the maximum amount that Medicare will pay for an LIS enrollees premium. In the past, CMS was phasing in a method that would have weighted each plan's premium by its total enrollment. Instead, CMS

used each plan's LIS enrollment. They did this out of concern that in parts of the country where many enrollees are in Medicare Advantage drug plans the ability of MA-PDs to buy down their Part D premiums with MA rebate dollars would lead to lower LIS premium thresholds and fewer qualifying PDPs. CMS believes that its new method led to less turnover among qualifying plans than would have been the case under the old method.

Still, even with the new method, there was a big reduction in qualifying plans. Across the country 308 PDPs qualify in 2009 compared with 495 in 2008. The median region of the country will have nine PDPs available at no premium to LIS enrollees, compared with 15 last year or 2008. There are a couple of regions where there are only one or two PDPs that qualify, Nevada and Arizona. Those are areas where there are more LIS enrollees in Medicare Advantage drug plans.

All together, CMS expects to reassign 1.3 million LIS enrollees to lower premium plans offered by a different sponsor. That means those individuals may need to change some of the medications they use if the new plan's formulary doesn't cover their current drugs or seek formulary

exceptions. 1.3 million is about the same magnitude of assignments as we saw for 2008.

I will leave you with a list of topics that you may want to discuss. The first two are related to each other in that they reflect the two blocks of beneficiaries for which Part D plans compete. The first bullet is about the low-income subsidy, the fact that one trade off beneficiaries make when they sign up to receive Part D's extra help is that they may get reassigned to a different plan from year to year. Those reassignments are one way to maintain competitive pressure within Part D but there may also be consequences in terms of beneficiaries' medication adherence, their health outcomes, and other types of Medicare spending.

Another issue is that among beneficiaries who choose a plan on their own, few seem to be switching from year to year. If this continues, what are the implications for plans' incentives to bid low?

And finally, you may want to discuss the increase in plans' average bid for 2009, particularly plans' expectations about catastrophic spending.

Thanks.

MR. HACKBARTH: Okay. As we did at the last meeting, we will use our three round approach to the discussion. The first round is just clarifying questions for Rachel, and then we'll go around and give everybody an opportunity to make a brief comment or ask a question. And then in the last round we'll try to focus in on a few particular issues that came up in the earlier discussion.

So first-round from Arnie.

DR. MILSTEIN: Rachel, at the very beginning of this program we discussed what could be done to make it easier for beneficiaries to ascertain which plan might be a better deal for them. Has there been any progress along those lines in terms of -- if I'm a Medicare beneficiary, my claims history is known. From that, there's such a thing as software that could predict which drugs I might use and allow me to figure out of the plans available to me which would result in the least amount of total out-of-pocket spending, including my monthly premium. Is there any progress along that line so it becomes easier for beneficiaries to discern which plan might be a better deal for them?

DR. SCHMIDT: The tool that is most available to

folks is the plan finder that's on in Medicare's website, Medicare.gov. There have been some improvements in that over the years. I think, when we initially started talking about Part D, you mentioned wouldn't it be nice to be able to pull up past claims history and that's a not something that is available on the plan finder so far.

Among the same lines, you recall we had some presentations by Jack Hoadley about beneficiary-centered assignment, just for the particular population of LIS enrollees who gets reassigned from year to year. So we've had some discussions about the pros and cons associated with that. I don't think that that is something that CMS is going forward with at this time.

DR. MILSTEIN: Can you address anything that's been done or not done to reduce -- again if I want to get the best deal -- minimizing my switching costs, so there isn't chaos in my medication flow if I try to pick a better plan?

DR. SCHMIDT: Let's see, there's been some discussion of trying to -- the policy now is that there's a 30 day transition period. If you switch a plan they have 30 days in which to get a temporary fill of your current drugs.

That is supposed to give you some time to go back to your position and either ask them to get a formulary exception for you or consider other medications that are on your new plans' formulary.

There is not been a change of policy with respect to that. There are different policies, for example, for people who live in nursing facilities. They have a longer period of time for that transition.

In terms of other things that one could do, I think there's been some discussion in the past of trying to standardize the sort of information that beneficiaries receive at the pharmacy counter if they find, during course of switching plans, that they need to prior authorization and that sort of thing. But my sense is that that's not routinely used by all plans and can still be a complicated hurdle to try and manage.

DR. CASTELLANOS: Rachel, I appreciate the discussion. What I want to focus in on is the 1.2 million people in the LIS program. These are an extremely vulnerable population. Most of them have multiple comorbidities. They have Medicare and Medicaid. And with Medicaid, especially in my state, Florida, a lot of them

have a hard time finding a primary care doctor. Medicare does a good job, Medicaid for reimbursement doesn't. And with a limited number of primary care physicians this population has a hard time getting a physician. We talked about consequences of switching.

To take off on Arnie's point, these patients are not getting help with plan changes. I know in your material that you sent out to your preliminary work, you mentioned on page two that they can get a transitional supply and then they should ask their physician to help navigate the coverage rules.

I'm going to be honest with you, I don't know anything about that. And I don't know where -- if I don't understand it, I don't understand how they understand it.

And I know you talked a little bit about going online. I think you should go online and look at it. I did and it's totally confusing to me.

So what I'm saying is that we have a very vulnerable, vulnerable population with multiple comorbidities and we need to do a better job.

MR. GEORGE MILLER: Thank you. Thank you, Rachel.

Along the lines that Ron just talked about, I was

wondering if there -- and it may be that this information is too new. But have there been any studies on the impact of beneficiaries who need to change plans and either are being forced to change or they chose on their own to change? And if so, what does that data show? And have we been able to measure the impact?

Or maybe it may be just too new, quite frankly.

DR. SCHMIDT: I think you're right, it is too new. We do know there are a small number of individuals who receive the low-income subsidy who do switch plans on their own. I think last year it was on the order of 400,000 so out of 9 million.

We, as you know, just received the Part D claims information, and that's what we think are one of the more important studies that research organizations or ourselves need to accomplish, is trying to track what's happening to these individuals who are switching plans. Is it affecting their medication adherence? Are we seeing increases in hospital utilization or not? Does it vary by the therapeutic category? Those kind of questions.

MR. GEORGE MILLER: And if they're able to make a smooth transition, they get the same type of drugs or if

it's different, what impact it has on them? Do they go to the hospital more? As Ron said, primary care is a difficult thing.

Thank you.

DR. CROSSON: ,Rachel with respect to the number of PDP plans who have now failed to qualify, I guess there's a trade-off between incremental increases in the premium, a cutoff point, and then the number of affected beneficiaries and all of the chaos that could take place.

So my question is do you know what the range of let's say overage for those disqualified plans is? I mean, are these mostly falling a few dollars over? Or is a much broader range than that?

DR. SCHMIDT: To tell you the truth, I don't have that data at my fingertips but I'd be happy to come back to you with that information.

Last year I think we did, in the chapter, include how much would an LIS enrollee have to pay if they wanted to stay in the same plan. They would have to pay that marginal amount difference. In most cases, I think it was $5 or less.

MR. HACKBARTH: Any other clarifying questions?

If not, I have Bruce and John and Mike and Tom.

DR. STUART: I have a question on something it isn't a part of this chapter at this point, and that is the benefit structure with respect to the copayments. We know that most of the plans that are actuarially equivalent are using copay structures rather than coinsurance.

Last week CVS announced that it was going to offer 400 generic drugs, a 90 day supply, for $9.99. And if you work the math out, it comes out to $3.33 a month, which isn't significantly lower perhaps than Wal-Mart and Target and all of the others that have this large number of generic drugs that are available for $4 on month.

So that's really the motivation for my question in terms of do we have any idea how many plans have a generic copay level that is higher than the amount that individuals would pay if they went just out of plan and went to one of these retail establishments?

The second question I like to ask, it actually gets -- if you could look at slide eight. The way the Medicare program works is if individuals reach a certain level of true out-of-pocket payments and there is still some of the year left, then the additional expenditures will be

picked up in part under that the catastrophic level.

But if an individual reaches the initial coverage gap and does not expect to hit the catastrophic coverage, then there's no point at all in terms of keeping track of out of network use or anything else. And it's just going to look as though, if you're tracking the actual use in-network, it's going to look like there's a big drop and researchers are going to examine that and they're going to say oh, well, demand increase.

But it could be out of plan use. So there are several threads here but they get back to that question of the distribution of the generic copay level.

DR. SCHMIDT: Yes. In terms of the second topic you raised first, we aren't going to know for sure until MCBS data -- your favorite dataset -- becomes available for the first few years of the Part D program to try and get a sense of when people hit the coverage gap whether they are seeking other coverage, they out-of-pocket on their own and not having that increase to their true out-of-pocket limit or not. So we don't know the answer to that.

In terms of your first question, stay tuned because next month we hope to be back and we'll provide some

information about what's happening with cost-sharing. I will also try and look into the question of how many plans have generic copays that seem to be higher than some of the things that you're seeing out there available to everyone.

DR. DEAN: To Bruce's comment, I can tell you definitely that it happened with the VA system. The VA copays are significantly higher than a lot of these things. And I've had a number of people that get their drugs through the VA system who drop that for certain ones and get it from what Wal-Mart because it's cheaper.

MR. BERTKO: Good report, Rachel. I wanted to mainly make a comment here, which is to say something you said a little differently. Connecting the low-income comments here to the presentation we had last month from John Hsu of the Kaiser Foundation. If you remember his chart roughly, the difference between the 108 percent payment and the amount needed for the low income was about another 5 to 8 percent or so. So that says on average across it, if a plan enrollees a low-income person, you're probably underpaid by that 5 to 8 percent, which is a significant amount of money and could account for some of the plans bidding higher because in the bid, the actual

costs have to go in to drive the bids upward if you have a significant portion, 45 percent again on average, or to get rid of them by bidding higher to exceed what the expected threshold is.

Patient-centered stuff like that Jack Hoadley thing would only have a perverse incentive of saying if you're actually going to assign it to people even more so because you've got a wide formulary or low hurdles for management. And those plans will have to change the way that they operate.

I would only comment here that we need again emphasize the need for CMS to improve the risk adjuster so that, in fact, the churning and the reassignment here is reduced by paying the appropriate amounts, as opposed to letting this somewhat flawed part of the competition mechanism continue to operate as it is in the status quo.

MR. HACKBARTH: Remind us, Rachel, of the next steps on the risk adjustment discussion?

DR. SCHMIDT: We do intend to have some discussion of John Hsu's work in our March chapter. We're also going to be discussing with CMS some -- I think they've done some internal looks at the risk adjuster. So we're going to be

comparing notes with them and having some discussions about that.

DR. CHERNEW: First, I have what probably was a clarifying question, but I wasn't sure so I will ask it now. Are the plans eligible for the low-income subsidy enrollees, is that computed by region as opposed to -- so you're not worried about some --

DR. SCHMIDT: Yes.

DR. CHERNEW: So you always have at least one.

DR. SCHMIDT: Right. There's an average that's calculated in each of the 34 PDP regions. But another component of it is that it's that average or the minimum PDP premiums. So there's at least one PDP premium available.

DR. CHERNEW: What happened, of course, as the number of plans eligible for the low-income subsidy shrinks, the number of low-income subsidy enrollees going to any one plan rises, exacerbating the problem that John and John were talking about.

And they sort of can't get away -- there's always some plan in those regions who are going to get those enrollees, one way or another. So you could see those premiums elevate quite a lot more rapidly in those regions.

That would be interesting to see.

DR. SCHMIDT: Right. Actually, we have some concern about using LIS enrollment as the way of weighting to figure out this thresholds because necessarily some will have higher than average premiums and some will have lower than average. So it's kind of guaranteeing some turnover.

DR. CHERNEW: My second question is I've seen this number a lot, the 10 percent of people without any creditable coverage from your first slide. Has there been a tracking of how the new enrollees each year, the 65-year-olds who are coming into the program new each year, how their choices have or haven't changed with regards to Part D participation? Are we seeing -- particularly if some premiums have gone up are we seeing fewer of them participate? Are we seeing people -- there's this penalty if you wait to get in you have to pay a higher premium for waiting. Are we seeing any of the people who maybe didn't start originally now participating? Or if you don't join when you're 65, you're just out because you have to pay this penalty?

DR. SCHMIDT: That's an interesting question. I have not seen any analysis on the entering cohorts thus far.

But you're right, that would be something good to look at.

DR. DEAN: This is partly a clarifying question and partly a comment. In the data that you have, was there any comments about access to pharmacy services? I think I've raised this before, that there is a real serious concern in rural areas about loss of pharmacies period. I've got some day here about there's just been a steady decline of rural independently owned pharmacies over the last years and it looks like the rate of decline is increasing. And even more worrisome is the pharmacies that are the only pharmacies in their community, there's been about a 10 percent decline over the last five years and that rate seems to be accelerating, as well.

So I wonder, I know that it's happened with individual selection of plans. They sign up for a plan and then they realize that it's not accepted by the one pharmacy that they have easy access to. I wonder, just as a question, is the -- when people are reassigned, is that a factor that's taken into consideration, to make sure that the plan they get reassigned to is actually accepted by a pharmacy in their area?

And secondly, on the broader question of the whole

access to pharmacy services in general in rural communities is a serious issue.

Now obviously Part D is not the only issue, but most of the pharmacists will tell you that it is a significant issue in the ability to maintain independent pharmacies.

DR. SCHMIDT: No, pharmacy access is not an explicit criteria when thinking about where to reassign beneficiaries.

But having said that, if a local pharmacy is an out-of-network pharmacy, any pharmacy that has a LIS enrollee who comes to fill a prescription has to charge the copayments that are appropriate to LIS enrollees, which are reduced copayments. So by virtue of the LIS benefit itself, those copayments are set.

Rural independent pharmacy access is, as you said, a wider issue. There are some trade-offs. There is wider availability of mail-order prescriptions. But if you have an acute condition and you need an antibiotic right away, that's not necessarily going to help you. Yes, that's a continuing issue.

I think if you recall a presentation from earlier

in the fall, we talked about that being something that we'd like to look at, how is cost-sharing different for rural enrollees in Part D versus others that live in more urban areas. We might be able to pick out whether they're using mail order more extensively, whether they're having to pay out-of-network copays, which tend to be higher, or not. Those kind of questions.

DR. DEAN: A quick follow-up, mail-order is an option but it has a lot of problems. Without getting into a long discussion of that, there really are a lot of problems in terms of timeliness and knowledge of the pharmacist as to what else is going on with that particular individual. Anyway, I could go on for a long time, but I won't.

MR. HACKBARTH: Let me ask you a question, Tom. In your initial comment, you phrased it as independent pharmacies, as opposed to pharmacies in general. Could you just explain why, just focus on the independents as opposed to pharmacies in general?

DR. DEAN: I'm not sure, that's the data that I have, it's how it's broken down. I think the assumption is that they are really the only ones that are there. Wal-Mart and CVS are not going to be in my community. The only

chance that we have are the small independents.

Now there may be some smaller or middle sized communities where maybe that isn't true. But at least the ones that I'm -- that's a good question. Let me find out. That's how the data has been collected, but I'm not sure I can really honestly answer that except that, like I say, in most small communities they are the only ones that are there.

MR. EBELER: Thank you, Rachel.

Two questions. One is in the chapter you mention there's about 12.5 million LIS eligibles and about 2.6 million who we've not yet reached. Do we know if that number is declining? And if not, are there efforts underway to figure out how to help the firms reach that population?

DR. SCHMIDT: It's kind of hard to compare these numbers from year to year because the numbers of eligibles kind of the depends on rough guesses of people's assets and income. The data on those are imperfect. So we don't know for sure whether that number is declining or not.

I think that CMS is trying to make some effort at better outreach towards finding these individuals. For example, there's a little bit more tailored information

that's available through their website for states that are trying to reach out, and SHIPs and that sort of thing.

This is just a very, very difficult population to reach and I'm not saying that we've necessarily made all of the strides that are necessary yet, but I think there are some efforts.

MR. EBELER: Thank you.

DR. MILSTEIN: We are in the first round of comments now; is that right?

MR. HACKBARTH: Right.

DR. MILSTEIN: This program is one of Medicare's attempts to test whether or not markets work for Medicare. For this to just be a reasonable test I, first of all, totally support John's comment about getting the adjustment right.

Secondly, I think we're not even close to doing everything that current technology allows in reducing beneficiary burden in finding the best deal, the best option for them. I think most of us have had the experience for an aunt or an uncle or a parent, going on the chooser website. I think it's better now than it was before.

My intuition is, certainly from hearing from

beneficiaries on this, is that particularly for perhaps lower income or less well-educated beneficiaries it's still too darn hard and too easy to get confused. I'd like to suggest we consider a suggestion that rather than say the only way you can find a better deal among these plans is to find a patient, friend or relative to help you figure it out, is that we consider suggesting that Medicare use what's called wizard technology where you don't have to even -- it doesn't even have to dawn on you that there might be a better deal. There's software that is sort of looking at your claims data and your claims history, actively evaluating the plans available to you, and actively letting you know when there is likely a better deal for you to pick, and facilitating you're picking that better deal. It's called wizard software. I think that's more along the lines of what might be a better fit for my parents, than what's going on now, which is them dialing for kids to try to help them figure it out, and kids sometimes coming up with different answers. It's not easy.

The second thing is that if this is going to work better and be a test of whether or not exposing people over the age of 65 to the opportunity to improve the value of

their care through more discerning consumer decisionmaking, it sounds like we should think about in this chapter things we could suggest to CMS that would reduce the beneficiaries' risk in making a switch.

Because it sounds to me like okay, you can do it but you have to line up all your doctors and get them to -- is that something, for example, for which there should either be, if not a third-party, is that something for which we might have higher expectations of the receiving plans? What can we do to aid and abet the receiving plans taking on that burden for the beneficiaries so that beneficiaries don't have to call every doctor that has prescribed for them and explain what needs -- I think, for example, if one is trying to change your primary financial services firm, one of the burdens in making that switch is filling out a billion forms to tell the firm you were with you want to switch over, et cetera.

Now what would often be the case is the firms who are receiving the new account will take care of all of that for you. They send you like nine forms to sign and then it's done.

Is there an opportunity in this chapter to suggest

options for doing something equivalent so that the clinical risk of making a switch, in terms of interruption of flow is something that my parents don't have to try to figure out? That there's a receiving plan or a third party that might give them some help on that?

Because unless we do more to make it easier for beneficiaries to gravitate toward the better value options, the possibility of using this market mechanism to improve value received by the beneficiary seems to be low.

DR. REISCHAUER: This is just a comment on what Arnie is talking about, and I could be dead wrong here. If we had some magic machine that would tell us what the optimal plan was for each person and the government contribution stayed the same, then premiums charged would have to go up because there would be less of it being paid. And those who have the least usage would have more of an incentive to gravitate towards plans where there aren't a lot of people using a lot of drugs, which puts then a bigger burden on the risk adjustment process.

There is no right or wrong answer to this. It's a matter of values. But it's not just sort of a real simple gee, if we could get everybody in here, everybody would be

better off. There would be a whole lot of people who would be worse off because they would be the ones who were paying the higher premium but not taking usage of a lot of these things.

DR. MILSTEIN: This is actually an interchange that we've had before and I completely agree with the point but I think it leaves out another component, and that is that there are other opportunities within these plans, if they faced much more value sensitive customers, to improve the value of their product. It's the dynamic effect that I think is the main rationale for this because I think the point you make is right, there will be a certain amount of just pure redistribution.

MR. BUTLER: Agreeing with Arnie, as I almost always do -- I think you said that last meeting -- it almost feels like we're all a little bit shocked that we made it through this first wave and got everybody signed up and it's been fairly stable and provided a lot of value, and that we're about to go into a new period of destabilization, maybe in part because retirees' income because of the market is suddenly not there and they're going to have to look at the cost proposition again. And how we can make that easy

and impractical seems like a little bit of a daunting task.

But more specifically, I'd like to go to slide 13 because you asked questions at the end about three issues. The last was related to the catastrophic spend. This one got my attention when you see 25 percent increase in one year from the 28 up to the 35.

If the system is about to go haywire or go in directions that we think might not be what we were thinking a couple of years ago, tell me a little bit more about how you look at that 35 and how we should be thinking about that?

DR. SCHMIDT: I gave the caveat on this slide that it may be just that people are focusing on it more in the bidding process than before. But I also raised it as an issue because by and large the catastrophic spending, a lot of it takes the form of individuals who are taking very high cost drugs.

I think in the future the Commission intends to start taking a look into the issue of biologics a bit more, the category of one type of these high-cost drugs.

There has been broader discussions across the government in terms of things like patent protection, the

length of patent protection, and that sort of thing. I think we'll come back to you with some informational briefings on the state of that discussion. That's not something that we've gone into in the past in terms of MedPAC's purview, but I think it has strong implications for the costs of the Part D program. For that reason we'll probably be coming back to you with more information about it.

DR. MARK MILLER: The only thing I would say about that, which is this is not anything in terms of the technical response, is sometimes we see things like this -- and this is for the public too to know -- and we bring it in front of you because there's people here who might have particular insight from their experience about what might be going on. So sometimes it's a two-way street on some of this.

MS. BEHROOZI: Thanks, this is a really great, I think, beginning of the use of the data, along with things about program structure and things that we've been looking at before.

But it seems to me, and I might be transferring from one substantive area to another here, but that when we

didn't really have Part D drug data we did focus groups, the staff would do focus groups to ask beneficiaries for some of the information that now we're going to be looking to the data, it seems to me, to get information on.

In the paper we asked the question how have reassigned beneficiaries, the LIS beneficiaries, fared in past years. The paper talks about looking at either press coverage or looking forward to Part D claims information. But I would suggest that we really ought to return to the focus groups, or not exclusively but add data to the focus groups and continue doing the focus groups.

It kind of goes to Arnie's point which still, as perfect as that wizard can make the presentation of options, it still assumes rational economic behavior on the part of the beneficiary. There's already some evidence that non-LIS beneficiaries faced with higher premium payments aren't looking to change. Maybe there's other stuff going on and it's maybe not stuff that we can necessarily guess at or make be the burden of the receiving plans.

Maybe there's just stuff people are scared of or comfortable with or receiving misinformation about. Maybe information is part of the issue. So I think we really need

to understand more about why people don't act economically rationally or what the burdens are for them when these changes are made so that we can develop policy proposals to address those things.

DR. SCHMIDT: Just to put in a plug for my colleague, Joan Sokolovsky, we do think that the focus groups that we've brought to you in the past have been extremely useful and we're going to be doing more focus groups on a continuing basis. It's somewhat difficult to get together focus groups of people who are receiving the low-income subsidy and talk to them, especially ones who have had to go through this transition. But we will look at other types of research data, not just some of the program information data, to get at those questions.

MS. HANSEN: This is relative to the low-income subsidy populations that oftentimes is both more expensive and uses more drugs. When there is the behavior of switching, one of the things it would be great to look at in the focus groups is particularly people have health literacy limits in terms of their understanding, as well as language differences and what barriers that produces.

The thing that is -- and I don't know what policy

lever can do as it's really a marketplace issue -- but I sense that we might find in the focus groups when they switch from one plan to the other what happens is the clock starts again. Besides filling out the forms, it's going through, testing the formularies, and finding out whether or not they have to switch drugs and all of this.

I just wonder what that kind of ultimate impact is. I think you alluded to it, that we would do some more studies. But since this is typically a higher use population, and the clinical implications might be greater, it would be just great to kind of keep a spotlight on that group.

I fully agree that one of the things I would like to make sure that that kind of work is done on the risk adjuster your so that the plans, whether they are MA-PD or stand-alones, have enough financial incentive to keep the LIS population. What I fear, of course, is that the squeeze continues to occur, that the tiering of, on the one hand, intentionally making it available as a benefit but then when you have no plans to really offer it, we end up creating a lack of access for this population.

That's it. Thank you.

DR. CHERNEW: This idea of switching is important in part because it disciplines plans in terms of what they do and it looks that there's a lot of potential variation across markets. So I was going to encourage you to both look at switching and how that varies across markets, to see if some places where there's a density of plans maybe more switching seems to perform better. Or maybe worse because, as people have mentioned, there can be a lot of drawbacks to switching as well; right?

But I think understanding in the spirit of how these things are working across different markets with different attributes, in terms of different numbers of low-income subsidy people, different numbers of plans, different amounts of switching, given the variation across markets, tracking that at a more regional level or smaller level I think would be really important to understand where this problems is that might need to be addressed.

MR. HACKBARTH: I think I heard three really big themes. One is the switching issue and the ease of switching and what can be done to facilitate.

A second is access related issues.

The third is this risk adjustment, which seems to

me very important because of its potential for destabilizing the basic model that the programs build on.

So as always, Rachel, great work and we look forward to hearing more on those issues.

Our next item is also Part D related, medication therapy management.

DR. SOKOLOVSKY: Good morning, everybody.

Last spring, a number of you -- and in particular you, Jack, Bruce and Jay and Mitra -- expressed a lot of concern about the lack of information, particularly about the quality of pharmaceutical care that beneficiaries were receiving under Part D. As an interim step, we have been looking into medication therapy management programs because that's the one aspect of the Medicare drug benefit that is specifically designed to improve the quality of care received by high-risk beneficiaries.

Today we're going to tell you about what we know and what we don't know about these programs.

Congress requires all PDPs and MA-PDs, with the exception of private fee-for-service plans, to offer this program to beneficiaries with multiple chronic conditions, multiple prescriptions each month, and high drug costs --

estimated at least $4,000 a year in drug spending. The programs are designed to increase medication adherence, improve appropriate prescribing, educate beneficiaries about their medications, and detect and prevent potential drug interactions or other adverse events.

Clinical pharmacists have been providing medication reviews and other clinical services to patients for many years, but no generally accepted definition of medication therapy management existed in 2006. Since the programs that did exist targeted different types of patients, provided different kinds of interventions, and measured results in different ways, CMS had no clear way of proscribing exactly how the program should work in Part D. As a result the programs offered by plans, as you'll see, are very variable.

We interviewed about 30 stakeholders, including pharmacists and representatives from health plans, PBMs, pharmacies, companies that provide MTM services under contract to health plans, and representatives from trade associations. We asked them about their experiences with the program and if they had any suggestions about how the program could be improved. We'll talk about some of the

ideas for strengthening the program in this presentation.

I should also mention that we asked physicians and beneficiaries about medication therapy management in our 2007 focus groups but none of them had any experience with the program.

Now Hannah is going to tell you some more about what we do know and what we don't know about these programs.

MS. HANNAH MILLER: We do not know exactly how many people are enrolled in MTMPs. According to CMS, 8.4 percent of beneficiaries enrolled in plans with MTMPs were enrolled in their plan's programs in 2007. Our interviewees agreed that MTM enrollees make up a small proportion of Medicare beneficiaries. We estimate though that approximately 14 percent of Part D beneficiaries, which would be about 3.4 million, spent more than $4,000 per year on Part D drugs in 2006. This number shows the potential for MTM enrollment.

Plan sponsors must provide descriptions of their MTMPs as part of their annual Part D bids. Their descriptions must include information about their program's eligibility requirements, enrollment methods, intervention strategies, and outcome measure.

Plans have taken varied approaches to these aspects of MTMs. They may use more or less restrictive criteria to target eligible beneficiaries, use different enrollment methods, provide different sets of interventions, provide services in a variety of settings, and collect a variety of outcome measures.

CMS is used information from bids to compile some summary statistics about how MTMPs look under Part D. In the follow, I will describe differences in eligibility criteria, plan interventions, and outcome measures used across plans.

CMS requires plans to provide MTMs to beneficiaries with multiple chronic conditions who are taking multiple drugs. Plans have interpreted this standard in different ways. The minimum number of chronic conditions required for beneficiaries to qualify for MTM ranges from two to five. Despite this range, the vast majority of plans have beneficiaries have just two or three chronic conditions to qualify for MTM, and only 4 percent of plans require that beneficiaries have five or more chronic conditions to qualify.

In addition to specifying the minimum required

number of chronic conditions, plans may choose to target specific conditions. According to CMS, 90 percent of 2008 MTMPs indicate that specific chronic conditions apply for eligibility into the MTM program. The mostly targeted conditions are listed here. There appears to be some consensus regarding the specific conditions to target. About 99 percent of plans include diabetes is one of their targeted conditions, for instance, and these same conditions were the mostly frequently targeted in 2007.

Plans must also designate a minimum number of prescription drugs to qualify for their MTMPs. CMS data reveals great variation among plans. In this chart, which shows the distribution of minimums, you can see that the minimum number of covered Part D drugs ranges from two to 15. Despite the variation, about 86 percent of plans require that beneficiaries take eight or fewer covered Part D drugs to qualify for their programs and less than 1 percent of all plans target only those who take 15 or more covered Part D drugs.

Each plan sponsor provides a unique set of services under its program. The 10 most common interventions in 2008 are listed here. A plan could satisfy

its MTM criteria by doing any one or part of these interventions. For instance, a plan could run a program that includes just a newsletter while another plan could run a program through which community pharmacists visit beneficiaries' homes to review their medication regimens in person.

Once a beneficiary is enrolled in the program, the plan must arrange for program interventions to occur. Plans employee a variety of models of service delivery. If a plan contracts with community pharmacies to provide MTM, it will provide the enrollee's name and contact information to the nearest participating pharmacist. The pharmacist will then contact the beneficiary and arrange a time and place for a medication review.

Generally, participating pharmacies will set aside a room for private consultations. Sometimes the pharmacist will meet with the beneficiaries at their homes. Alternatively, plans might use in-house call centers to administer MTM over the phone.

Our interviewees disagreed about the most effective way to provide MTM services. Some believe that beneficiaries benefitted most from face-to-face interaction

with community pharmacists. Others argued that centralizing the program at a call center allowed the plan to provide more specialized services to beneficiaries with specific conditions. There is insufficient data to support any particular method.

After a pharmacist conducts a medication review, he might call the physician to let her know that the review occurred and to inform her of its findings. Most MTMPs interact with both the beneficiary and his or her prescribers. However, as you can see here, about 10 percent of plans do not reach out to physicians. In these cases, if the program identifies that an enrollee is taking inappropriate drugs or drugs that are causing side effects, it is up to the beneficiary to address the issues with his or her prescriber.

Plans collect data on a wide spectrum of outcomes that include process measures, economic measures, and quality indicators. Many plans also monitor patient satisfaction. However, plans are not required to report these outcomes to CMS. The Agency currently collects a limited set of data on MTMPs. All plans must report their number of eligible beneficiaries, number of enrolled

beneficiaries, the method of enrollment, the number of disenrolled beneficiaries and a reason for disenrollment, and total prescription drug cost per MTM beneficiary per month.

Since 2007 plans have been required to report the number of covered Part D 30-day equivalent prescriptions per MTMP beneficiary per month. And most recently, CMS has begun requiring plans to report the names of plan members enrolled in MTMPs. The Agency may be able to use this information in the future to measure the effect of MTMP interventions on beneficiary health outcomes, drug costs, and other medical spending.

DR. SOKOLOVSKY: Jack and Bruce, you both expressed concern that stand-alone drug plans or PDPs face misaligned incentives and insufficient data to assure quality pharmaceutical care to beneficiaries. So we've tried to look at the difference between the programs provided by the stand-alone plans and Medicare Advantage plans.

Whereas Medicare Advantage plans, or MA-PDs, might save on medical costs if they provided MTMPs that increased beneficiary adherence to appropriate pharmaceutical

regimens, PDPs will not benefit by that. In fact, they may have increased spending if drug adherence increases. Furthermore, PDPs would not have the additional medical data to tell if the pharmaceutical care is appropriate.

However, we found no evidence that PDPs, in the aggregate, provided less inclusive programs to their enrollees than MA-PDs. Our interviewees noted that they provide identical programs to health plan and stand-alone drug plan enrollees who meet their criteria for enrollment. In fact, CMS data indicate that PDPs tend to have more inclusive MTM eligibility criteria then MA-PDs. The minimum number of chronic conditions and the minimum number of drugs required for beneficiaries to qualify for services both tend to be lower in PDPs than MA-PDs. However, MA-PDs much more likely to have contact with member physicians than PDPs.

After almost three years, analysts have very limited information about whether MTMPs are improving the quality of care for their beneficiaries with multiple medications. For example, given the small number of enrollees and the variety of eligibility interventions and outcome measures, we have no systematic evaluations as of yet. For example, we don't know, do the programs improve

patient adherence? Do they result in more appropriate prescribing? Do they affect drug spending? And do they effect utilization of other medical services? We don't know any of that information yet.

CMS is trying to see what they can take from the experience of the past three years. They have established a work group within the Agency and they hope to analyze data to see which programs show the most positive impact on medication use. They have also hired a contractor to help identify standardized outcomes that could be measured by all Part D sponsors. Staff will closely follow the results of this program and report back to you about it. However, it's unlikely that we will have results for several years. In the interim, you may want to discuss whether there are some steps that the Agency could take right now.

Many of our interviewees suggested that the program would be improved if requirements were more standardized. For example, we spoke to one plan representative who directs a program with very inclusive eligibility requirements. For example, plan members need no more than two chronic conditions to qualify for enrollment in the program. And the plan provides multiple

interventions to enrollees. He told us that without more standard requirements he had to justify his program two different ways. He had to answer questions from corporate officers about why their plan had such an inclusive program when other programs could be approved that required enrollees to have 10 to 15 separate prescriptions each month. On the other hand, he sometimes had to answer to outside groups who questioned why the program did not provide more services.

I'll talk about how requirements for eligibility, interventions, and outcome measurements could be more standardized next, but first I want to mention the issue of documentation and reporting. Pharmacies emphasized to us that current MTM practices leave them with very high administrative costs. Pharmacists must be trained separately to participate in each plans' program because plans use different types of documentation and different modes of reporting. These added costs affect the willingness of pharmacies to participate in multiple plan programs, especially given the small number of referrals that they tell us that they're currently receiving.

Remember, to participate, a pharmacy has to create

a private space for patient counseling, and it may have to increase staffing. A dispensing pharmacist cannot stop dispensing prescriptions in order to provide medication therapy for an enrollee. So the pharmacist has to set up an appointment with the enrollee and the pharmacy must have another pharmacist available to dispense prescriptions.

This multiple documentation and reporting may make it harder to make a business case for pharmacies to participate in a program. Some interviewees suggested that stakeholders have to work together to create a standard operating platform and an implementation template.

As Hannah showed you, some programs have very restrictive requirements compared to all other programs. CMS provided very flexible criteria because it didn't know -- - and in fact still doesn't know -- what program structures are best. However, there are some programs that seem unlikely to have much positive impact. And I should mention here that our interviewees all agree about this, as well. And remember that costs for these programs are built into the bids and Medicare is paying for these programs. These are not demonstration projects.

Since plans have to describe their program in

their plan bid, and CMS has to approve the bid, the Agency has the ability to strengthen requirements by not approving programs that are so different from the average program. For example, it could limit the number of required chronic conditions. It could require more significant interventions than plan that solely send newsletters to their enrollees. It could require programs to notify prescribing physicians in cases where they discover potentially dangerous drug interactions or side effects. Remember, no matter what the pharmacist discovers about the drugs, it is the physician who must decide whether to change prescriptions.

One addition it could make to requirements, the research literature suggests that many patients are confused about their physicians' instructions when they leave the hospital. For example, they may be switched to a new hypertension agent and not realize that they are supposed to stop taking the old one. They may not know why they are taking a new drug and neglect to take it as a result. They also may not understand when and how they are supposed to take it. CMS could require MTMPs to undertake a medication review when an enrollee leaves the hospital or post acute care setting.

Lastly, they could require plans to measure and report certain standard outcomes. Although we may not yet know which outcomes are most likely to be improved through participation in an MTM, CMS could define outcomes of most importance and move quickly to see if MTMPs can improve these outcomes and what kinds of interventions are most likely to be effective in doing so.

You may want to discuss whether you wish this chapter to make specific statements about standardization or whether there are other ideas you would like to emphasize.

MR. HACKBARTH: Thank you. So we'll do the three rounds. Round one is clarifying questions. And by clarifying questions, I mean like what does column two in table A mean? Or what's the statutory requirement for this?

The second round will be an initial comment or a question, and we want to keep those brief. The goal there is to make sure that everybody gets a chance to contribute to the discussion before we delve into any issues in detail.

And then the third round is to do that more detailed discussion.

So let me ask for clarifying questions first.

DR. STUART: Thank you both. This is really

interesting. The clarifying comment is really the assumption -- and I think I helped drive that in my comment earlier this year -- which was that you would expect that the financial incentives would encourage the managed care plans to provide a product that would result in reduced spending on the A and B side because they would get the opportunity to take advantage of that.

And then when we find that there's no difference between the two, my question is really about the assumption. Is that a legitimate assumption? Or is it really that both types of plans treat this as essentially a tax that they have to bear and really have no expectations about successful outcomes?

DR. SOKOLOVSKY: I'm going to take that as a rhetorical clarifying question.

[Laughter.]

MR. HACKBARTH: That is always the presenter's prerogative.

MS. BEHROOZI: I think it's sort of along the lines of tax.

As I understand it in the -- I'm not going to say all that stuff about what a great paper it was, because

that's for the next round.

As I understand from the paper the plans, the PDPs and MA-PDs, can incorporate the cost of their programs as part of their administrative costs. So they essentially are getting reimbursed for the cost -- in their bids. They're getting reimbursed for the costs of the program; is that right?

DR. SOKOLOVSKY: [off mic] [Inaudible]

MS. BEHROOZI: Do you know whether the plans make any payment to the pharmacies associated with participating in the programs?

DR. SOKOLOVSKY: Part of what they have to describe in their bid is if they're going to use outside personnel -- some use contract in-house people. But if they're going to use outside personnel, they have to describe the reimbursement structure. And it's generally a fee-for-service to the community pharmacist.

MS. BEHROOZI: Thank you.

DR. CASTELLANOS: This is just a clarifying comment on your initial introduction, and we talked about it ahead of time so it's not going to be blind sided. Let me just clarify this.

The physician writes the prescription, and the patient takes it. And then there's a whole bunch of people in between, the health plans, the pharmacists, et cetera. You said in your focus groups to talked to everybody. And I know you talked to the physician and you talked to the patient. But you said none of them knew -- the physician or the patient didn't know very much about it. Maybe you could explain that.

DR. SOKOLOVSKY: Again, we don't know how many people are in these programs. But from everything we've heard, it's a small program. We could not find a physician who was familiar with the program, who had heard of the program at all, nor any of the beneficiaries. We did find some pharmacists who did not themselves participate in the program but knew of other pharmacists that had.

DR. CASTELLANOS: Thank you.

DR. CHERNEW: On page eight you listed the 10 most common interventions. My question is did you include as a possible answer to that modifying copays or some other method to increase adherence utilization of these services? Or was there a list that they had to check off and these were the things they checked?

DR. SOKOLOVSKY: This information comes directly from CMS. Plans have to talk about what interventions they provide and CMS essentially listed the information that the plans gave them. So if there were some that very few plans did but some did, it might have made the list.

DR. CHERNEW: But if they had some other program outside of their medication therapy program to achieve these goals which aren't limited to just medication therapy programs, those interventions may or may not be on this list?

DR. SOKOLOVSKY: They wouldn't be on this list because this is specifically the MTM.

MR. BERTKO: Joan, clarifying question. If I heard you right, you mentioned that some of the push back or comments from the pharmacists were that they needed to get a second pharmacist in order to administer the MTMP. I live in a relatively small town and typically when I get a prescription filled I call it in or I await. Any push back? I mean, that's the circumstance to require two pharmacists?

That's also in the context of knowing in most of our pharmacies there is a little area where people can talk to the pharmacist about how the drug works.

DR. SOKOLOVSKY: In no case can somebody who's enrolled in a program come to a pharmacy and say okay, I'd like my medication reviewed. In every case it has to be scheduled in advance.

If this was a larger program, so that there were a fair number scheduled at a given time, a pharmacy would have to provide a different pharmacist to do the dispensing because somebody could not stop dispensing for these reviews, which tend to take about an hour.

However, we talked to one pharmacist who has been providing these services at a chain pharmacy for two years and in this past year he's had two clients. So I don't think that would strongly affect the staffing of that pharmacy.

MS. HANSEN: I'm intrigued with the fact that this is a benefit, of course, but that all groups don't seem to really know about it. It's interesting to go on to the website itself, Medicare.gov. If you typed in MTM, you have no hits whatsoever. So even in the course of trying to find it it's not there.

So is there any reason we know as to why even the fact of this benefit isn't even known on our website?

DR. SOKOLOVSKY: Largely I think it's because again each plan would decide who was qualified and then reach out to try to get them to enroll, as opposed to a beneficiary seeking it out.

But I should say that two of the largest plans that we spoke to make the service available to any beneficiary that's in their program, although they only report back to CMS on the ones that would qualify under the $4,000 a year spending and the multiple chronic conditions. So there are some plans that will presumably in the enrollment information that an enrollee receives understand that they can get a medication review by their plan.

MS. HANSEN: To clarify, the medication review could be as simple as a letter to say you should be reviewing your medications?

DR. SOKOLOVSKY: No, a medication review would have to be the pharmacist looking at all of the drugs that you are taking. And also, in the kind that we heard about from pharmacists who have been doing this for multiple years, they are also questioning about over-the-counter drugs and nutritional supplements. But they're not necessarily getting all of that within this programs. But

at least they would know all of the drugs that somebody is taking.

MR. HACKBARTH: Let's move to round two. Let me see hands. We'll go the other way this time, starting with starting with Jay.

DR. CROSSON: Thank you. Just a couple of comments.

In our program, this is a relatively small piece of our activity, despite the fact that we have probably as low a threshold as you can have, two conditions/two drugs. The vast majority of our beneficiaries can't be projected to hit the $4,000 threshold, and therefore don't qualify. That has a lot to do with drug use management, but particularly the use of generics and the acceptance of generics.

In addition, as Joan had mentioned, because of the reasons that Bruce brought up earlier -- that is, the fact that we have a combination of Part A, Part B, and Part D -- we do, in fact, employ the vast majority of that list as a regular part of the clinical management of our patients, not just Medicare -- not all Medicare beneficiaries, not just Medicare beneficiaries, but also our younger members.

One thing I would say, though, is that our

experience suggests that any of these types of interventions really only succeed in the long run if they are incorporated into the clinical care of the patient and the further that they are removed from that. And the fact that in 10 percent of instances the physician is not notified of a problem is pretty shocking. It would seem to me that at the very least we should make a recommendation in that area.

And further, I think if it's possible to suggest to CMS if this program is going to continue or perhaps be expanded that efforts be made to incorporate it as closely as possible into the clinical care of the patient as it can be designed.

DR. CHERNEW: The comment I want to make is that I'm very interested in making sure that people take the appropriate medications. That said, the side that we don't know if it works, we don't know -- there are so much things we don't know, I'm extraordinary hesitant to suggest any ways that we try and improve or prescribe a change to the program.

It strikes me that until we know, we should let the plans try and do what they want to do and hope -- for example, this idea that the MA-PD plans aren't doing more

even though they have incentive to do it, my guess is that they're just doing a lot -- I hope they're doing a lot of other types of things and other activities to try and improve the care, although again we don't know that.

But in response to this, and all the set of questions you had at the end, my view is I'm very hesitant to try and improve the program until I know more about the merits of the aspects of the program.

MR. EBELER: Let me build on Mike's comment a little bit. I think this presentation links, in part, to a slide that Rachel presented that Peter flagged, which is the portion of the Part D bid that goes to the high-cost/high-risk beneficiaries, which is also who we're talking about here. It strikes me we want to know more about how to make sure they are getting the best clinical care at the best value we can achieve.

I had the same reaction. That strikes me as the critical task. I had the same reaction to the chapter that Mike did. Until we know more, it's hard to figure out against which benchmark to standardize as you go forward here. I guess it may be possible to flag some outlier programs but it's just hard to go down that path.

It seems to me you also flagged, on your final two slides, the idea of pushing hard on outcome measures. I guess it strikes me that's a more logical short-term way to go so that we can try to learn more and push towards that as we get this clarification.

DR. KANE: I actually probably have a clarifying question, as well as my comment. Is this meant to be just a community based program? Or does it also address people who are in the institutional settings?

DR. SOKOLOVSKY: People who are in institutions, the plan can divide their program in terms of community and institutional.

DR. KANE: So they have both.

DR. SOKOLOVSKY: Apparently the literature suggests that this is for community and institutional. They're essentially depending on the consultant pharmacist.

DR. KANE: I remember a year or so -- I can't remember, it's been too many years now. I had this picture in my mind of the pharmacy management challenge of nursing homes with this new benefit. And it looked like 16 different plans kind of converge on some poor nursing home benefit management company and then they have to somehow

figure out how to administer that.

It seems to me that would be very interesting to focus on. I think the community setting piece maybe there's just not enough going on to care about. But the people who are most likely to be eligible for this, with all of these chronic conditions and all these drugs, it seems to me many of them are in institutional settings. If I were going to put some energy and research into this question, I would want to know more about how this was working out where the really vulnerable people are, who can't really fend for themselves. That's where medication management, it seems to me, will have biggest bang for the buck.

So that's one comment, is I'd like to know much more about the institutional patients.

The other comment is do they actually articulate how much they're spending in the bid or planning to spend in the bid?

DR. SOKOLOVSKY: If they have -- if they are using community pharmacists, for example, they have to have a fee schedule.

DR. KANE: But they're not saying how much the total amount of their administrative costs -- they are? I

think it would be very --

DR. SOKOLOVSKY: It's not broken out for us.

DR. KANE: But they have some kind of total cost in the bid about MTM - I mean, I think just at a minimum we should have some idea of how much they're asking for in the bid and how many beneficiaries seem to be served by that, just as a starter. And then some sense of what's the costs -- in their bids what are they saying they want to be paid for this? And then how many people are being served by that? And get a sense of the variability there as a way to gauge how much this is -- you know, whether we're paying for something we're getting nothing for.

DR. STUART: I would like to also build on the comment that Mike made, and this is this extraordinarily thin evidence base that we have. But the problem is actually twofold. The first part is that if you look at that list of interventions on slide eight, we know very little about whether these things work in any population group. This literature is not well developed. So this is an area that I'm concerned about.

But the second piece is even worse, and that is the targeting of this benefit to people who have -- and the

first element of that target actually is you have to have an expectation of more than $4,000 per year in drug spending. Now that is pure blue sky. There is nothing out there that provides any evidence at all that that is a reasonable way to target the benefit.

In fact, it probably doesn't make sense to target on the basis of drug spend at all. If you're going to target, it probably makes sense to look at other factors other than drug spend because, among other things, people who are more adherent on their drug regimens are going to cost more. So you may be focusing on the people who are actually doing pretty well.

So I think these two elements combined make me, again, very, very hesitant to recommend that we develop further standards here.

As optimistic as I am that some of this is going to become better known through the CMS Work Group and the contract that they've developed, I think this is something that MedPAC itself should develop a more intensive agenda than just simply focus groups. I think the idea of trying to figure out ways that you can identify problematic prescribing and targeting with some data mining activities

would be well worth it so that you can at least address that particular issue.

DR. CASTELLANOS: Joan, again I appreciate you talking with me ahead of time about this.

To me, carrying on from what Jay said, this needs to be incorporated in the clinical program. And if there ever was a place, it would be in the medical home. This is one of the things we want the medical home to do, recognize the MA plans don't have medical homes but the PDPs do.

As far as outcome measures, something Mike said was very important and it's really important to the physician community. I don't want to know if the patient has the medication. I want to know if the patient is taking the medication. So adherence is really important. But more important, and you can correct me, but I understand the outcome measures are not going to be reported to CMS. And I don't understand that.

DR. SOKOLOVSKY: Right now the list of outcome measures which I think are in your mailing materials are really more about how many people are enrolled, many people are disenrolled, and so on.

The other outcomes that plans measure, and they do

measure, they report to CMS what they measure. But so far they have not reported those outcomes, the ones that they find internally usable.

DR. CASTELLANOS: Thank you.

DR. DEAN: As is evident by the comments, this is a very complex undertaking, and I certainly appreciate your efforts to try and describe it because it's a sort of a nebulous thing. But it's terribly important.

Just in response to Nancy's question, at least in our area medication reviews by pharmacists are a standard part of nursing home care. I get regular reports from pharmacists that look over the list of medications of all the patients and everything. So I think it's already happening there.

I was going to say exactly the same thing that Ron just said and follow-up on what Jay said, that this has got to be part of clinical care if it's going to have any effectiveness. Because neither the physician nor the pharmacist has all the information that's necessary to make these decisions and to decide what is appropriate or what is inappropriate. There are a lot of drugs that have relative indications or relative contraindications. And if the

pharmacist doesn't know why that particular drug was prescribed and all of the information about it, they are going to make some recommendations to stop something that was maybe done for a good reason but it may not appear in the clear indications.

And likewise, a lot of times we, as physicians, don't have access to some of the more esoteric pharmacologic information or possibly some of the interaction information, or especially the options in terms of more efficient use or other drugs that might be less costly and so forth.

So it's really got to be a joint effort and, as Ron said so well, it is the ideal responsibility for a medical home structure or ideal indication for a medical home structure where you've got these different disciplines working together.

And finally, I think probably the biggest reason for the relatively low participation is the fact that a lot of -- at least in my patients -- the people that need it the most are the ones that are least likely to ask for it because they simply don't realize that they're getting this all mixed up. I have some relatives that I can point to, some very close relatives, that were bad offenders on this

category. I thought my parents were taking their medications properly and they clearly were not.

So I think just offering it is clearly not adequate. There needs to be a much more aggressive approach to supervising medication use.

DR. BORMAN: Certainly, as a surgeon, I don't prescribe lots of different classes of drugs for lots of people over the long term, so I really have no dog in this hunt as a practitioner, other than to say I think the practitioner does have to be fairly central to this, as Jay and Ron and Tom have already said. I agree with Jay, it's appalling that 10 percent of the time, at a minimum, physicians weren't involved in the loop. Given the expense level here, you would think this might be something of a proxy for relatively high risk patients who are on some rather intensive drugs like Biologics.

My question would be from a very broad level. What I think I hear a bit is we're not really sure that we need this entity as we think of our delivery system going forward, rolled out in this particular way. I think we all agree that there's an important place for medication reconciliation, medication management, in a value cost

effective way. Where this particular activity fits into it, I think is hugely unclear. I think John has wonderfully highlighted the fact that it's even less clear when we look into it.

I agree with the sense that the Commission, particularly important staff time/resource, going way far down this road seems to me to be counterproductive given the other things that are on our plate. I would see this maybe as more of the stay tuned or perhaps a focus question or two. Because as this rolls into medical home or, in my view, for example the discharge from the hospital medication piece, that seems like it ought to fold into our consideration of A plus B quality and where patients are vulnerable, what we do to address that, as opposed to again this sort of isolated little piece that's out there by statute.

Which gets me to my question of, on the first slide, you introduced this by saying that Congress required Part D plans to offer this to enrollees of a certain level. Am I correct in that since this is a legislative mandate stipulated benefit if, as a result of other changes in delivery, this became unnecessary or from data became

evident that it were superfluous, would it take legislation to make it go away?

DR. SOKOLOVSKY: Yes.

MS. HANSEN: It's interesting because I actually have some thoughts just to maybe counter a comment, Karen, that you had relative to this that. A, that it is in statute and it's hard enough to get it in the statute. So is it an opportunity to really look at this, one way of looking at this very complex component of medications in the life of Medicare beneficiaries?

So if it's there, as I said, it's not really readily available as a piece of information to the public when you go on to the Medicare site. And here we have a statutory piece here. So I would go, in the interim, the fact that it is already built in, to at least have all of the plans identify what their MTM program is about. So just as a point of information, that all of the plans be able to say what their process and structure really is.

The second part is I fully agree, I think it's a very messy period right now. But what we do know is that many people take multiple medications for these conditions. And whether you hit the $4,000 mark, and especially if

you're in a Kaiser-like plan, that gets kind of buried in there. But people do have a lot of screw up of medications, which tips it into the quality issue that you mentioned, into hospitals.

And then what's been, I think a body of evidence is known is that that transitional period post-hospital that people do take medications perhaps incorrectly for a number of reasons or don't adhere to them for a number of reasons. So it just is both a high cost and it is about medication management and counseling. And we don't know about the intervention being the best. But it seems like -- I would just almost do the opposite, by taking a look at the fact that it is in statute and to get something out of statute is quite difficult. So if we have that, what do we do with it in terms of making the most of it?

So the targeting I think is real important. And the ability to tie back to what I think we have covered in previous Commission meetings about re-hospitalizations. Rehospitalizations, I think, for benes within 30 days is anywhere from 17 to 20 percent. My recall -- and please I'm going to ask staff to help me be accurate -- but it might be about 60 percent due to medications, medication problems of

one sort.

So it seems like there are targeted types of things to be able to do it with this. And I would just like to delve into it a little bit more deeply before we let go, that this is not as useful.

So one point of information, that if we have it we should let the public know about it. And it should be available in terms of what the plans are offering, since this is already submitted as part of their bid to CMS.

Number two, I think the ability to understand the nature of this and the impact of targeting much better.

And then an outlier thought completely, and that is if the beneficiaries are now, of course, taking more responsibility for managing or paying more cost and being participants in it, I wonder if, in fact, there might be a consideration of allowing a drug consult privately to be paid and be considered a part of your Part D costs. So in other words, if it has to be a paid for service over and beyond what the plan would offer to really sit down with the pharmacist to go through a full pharmacy regimen.

That's an outlier thought, but this is such a big area and medications do weave through the entire

epidemiology of what goes on with the quality and the costs and the utilization of hospital care as a result of potential errors.

DR. SOKOLOVSKY: Can I just make two clarify remarks here. The $4,000 is not in statute. That is something that CMS has put there. So what's in statute would allow very flexible definition of what a program should be.

The other thing I wanted to mention was that these pharmacists that we've been talking about, who have been doing this for many years, are in fact privately paid by the patient. So that is a mode that's out there.

MS. HANSEN: But the question is could that be an allowable cost built into their Part D costs at all?

MR. BERTKO: It is.

MS. HANSEN: It is already? Thank you.

MR. BUTLER: You've got a theme in the remarks so I've been adjusting mine as I've heard the rest. This is a little bit like a solution in search of a problem or a not clearly defined problem. If we're talking about the $4,000 and above expenditures for chronic conditions, which I think is a very appropriate focus, we've highlighted the fact that

the caregivers, whether they're clinicians, doctors or others, need to really be much more involved in this. I think we'd all agree with that.

I think which is a little less clear is we've made references to medical homes, skilled nursing facilities. I don't think we've clarified enough of the caregivers that we're talking about. For example, I would see a retirement community that has the full continuum of care as an ideal place to partner with because they typically will have the nurse that, even if you're in independent living, often gets involved in the dispensing and monitoring of the drugs. And as you move up the chain to the assisted living and then skilled nursing, it's an ideal environment to kind of say can we make inroads there? Not just in the nursing home piece but in the continuum of care that's offered in the retirement communities. We might get more bang for our buck.

And they may not even have the appropriate role in this but I think we need to think about those structures a little bit more.

My only other point is that one that says trying to get directly involved in medication reconciliation at the

time of discharge -- we've got enough people involved in that. That probably would not be a good intervention if you're trying to do something timely. I just don't think logistically that would work very well.

MR. BERTKO: Two quick comments. The first is something that might be easy to follow up on. Through data mining you could look at adherence if you defined a set of maintenance drugs where you expect them to be prescribed and filled every month. My cholesterol medicine fits into that particular one. There we go, Mike, with HIPAA again.

A second is, Joan, to point out that there a couple of vendors out there that actually do outreach, push technology to physicians saying our algorithm has shown that you're prescribing this and you should check on it or something like that.

I have to say that my limited experience, in the absence of medical homes or other kinds of things, is that physicians don't do much with that. That might be part of the whole incentive structure.

So the goal of saying here's something that we should talk to physicians about might be like going outside and yelling down towards the other end of the mall. It

happens but it's not very effective. We need to think about that in the context of other changes that we've been talking about.

DR. MILSTEIN: A few brief comments. First, people like Jennie who have looked into this, I think would tell us -- and others around the table -- that medication management is potentially very valuable and there's a lot of evidence of patients not understanding and not taking -- seriously chronically ill -- not taking their medication. Obviously, in the fee-for-service system where I, as a doctor, don't know what anybody else is prescribing the upside here is potentially large.

And I think, therefore, this program is potentially useful in the short term while we're waiting for accountable care organizations and medical homes to evolve.

However it's clear, Joan, from looking at your list of what is the information set that CMS is attempting to use to judge the program, including the individual vendors. It's not even close to the information flow you would need to judge the vendors. It's far off. It's crazy.

We are being asked to make a recommendation in the absence of any reasonable information base on this program.

Would it be possible for us to, within the limits of our capability, to synthesize what people who have been successful in such programs, either inside or outside of Medicare, know about best practices. So at least in the interim we could build into our recommendations known best practices that ought to be requirements of these programs.

And I would include on that list of best practices the most likely agent for these programs. Because it strikes me that the plans, for reasons that I think, Joan, you articulated may not be the best agents since every time they succeed in getting a patient to be more adherent in potentially threatens their economics, their business model.

DR. SOKOLOVSKY: The one problem is again that the research literature does not clearly define what works. For example, one of the things is that they target different kinds of people. The best literature is on working people who have say diabetes or asthma and no other chronic conditions, and getting those people to understand how to use their drugs. There's fairly good studies that show that that can be very effective but it's a very different kind of population.

And then one of the other issues is that all of

the people who provide these suggest that they save money by eliminating polypharmacy, by getting people to use more cost effective drugs for the same condition. But the measurement is not probably what you would be happy with. For example, some of it is based on costs that are avoided, but that's not compared to any other group. It's well, there's X percentage of adverse events and they cost so much, and we've eliminated some adverse events so we're saving this money.

MR. HACKBARTH: Okay, clearly an important problem, management of patients, especially complex patients on lots of different drugs. But I think we are well short of solutions, in general or in particular, in how to modify this particular program. So more research and information would be helpful.

Thank you very much, and we will move on now to our last session before lunch, which is Medicare's statutory to support delivery system reform.

MS. RAY: Good morning.

The pace of delivery system reform and improved efficiency in Medicare is slow at best. The Commission has made recommendations for changing how the payment system

works. In some instances, Medicare cannot implement these strategies because it does not have statutory authority. For example, we have recommended P4P for various provider groups. Medicare does not have the authority to adapt these strategies without a change in the law.

In addition, Medicare has had mixed experiences in trying to implement policies to improve the program's inefficiency because the statute is not always clear. Some policy experts have recently suggested that Medicare needs more flexibility in carrying out its mission.

The issue that we would like Commissioners to discuss are the pros and cons of giving the Medicare program more flexibility to implement strategies to reform the health care delivery system. In this session we are going to focus on giving Medicare more flexibility to adapt value-based payment policies. Of course, there are other types of policies that we could be looking at as well.

To be clear, we are not discussing potential changes to Medicare's governance and structure. The focus of this session is on Medicare's statutory authority to change how the payment system works.

Here are some examples of value-based payment

policies that either Medicare cannot implement without a change in the statute or where the statute is not clear, including pay-for-performance, competitive bidding, establishing centers of excellence, using prior authorization policies, using shared savings policies, implementing reference pricing -- that is setting the payment for clinically similar services based on the least costly service -- and payment with evidence. This means paying no more for a service unless evidence shows it improves outcomes compared to its alternatives.

Some of the challenges that Medicare has faced when trying to adopt value-based policies have come from the courts. Most recently the court has potentially limited Medicare's use of one type of value-based policy reference pricing.

In other instances, the challenges come from the statutory language itself. Detailed language is sometimes difficult to carry out and it does not give Medicare much latitude to exercise discretion.

I'm now going to talk about four case studies that highlight these and other challenges that Medicare has faced when adopting value-based policies.

The first case study concerns Medicare's use of least costly alternative policies. Medicare's contractors have set the payment rate of a service based on the payment rate of a less costly, clinically comparable service. For example, it has used least costly alternative policies for paying for inhalation drugs covered under Part B. Medicare has done so under its statutory authority to cover services that are reasonable and necessary for the diagnosis or treatment of an illness or injury.

However, a recent court ruling may affect Medicare's flexibility to carry out LCA policies. The U.S. District Court for the District of Columbia ruled that Medicare can no longer use LCA policies to pay for Part B inhalation drugs. The court concluded that the statute's specific provision that sets the payment rate for Part B drugs based on its average sales price precludes Medicare from using least costly alternative policies under the statute's broader authority of covering services that are reasonable and necessary.

So I think the takeaway message from this case study is that Medicare's statutory authority to use least costly alternative policies is not clear and that this court

ruling, this recent court ruling, may affect Medicare's flexibility to carry out such policies in the future.

The second case study describes Medicare's use of a functional equivalence policy. The functional equivalence policy is similar to the least costly alternative policy but Medicare implements this policy on a national level. Specifically, for two biologics Medicare set the payment rate of these two biologics that are close substitutes based on the least costly product. Medicare adopted this policy in 2003 in the hospital outpatient setting. Similar to the least costly alternative case, Medicare adopted this policy based on the statutory provision of paying for only reasonable and necessary services.

Subsequently the BBA, passed in 2003, limited its use. Specifically the Congress prohibited the use of this standard for other drugs and biologics in the hospital outpatient setting. However, the Congress did not preclude the Agency from continuing to use the policy for the two biologics in the hospital outpatient setting or for setting the payment rate the same for other clinically comparable services in other settings.

So what have we learned from this case study?

One, the statutory authority to use the functional equivalence policy is not clear. And two, legislative guidance can sometimes be conflicting.

The third case study is about the inherent reasonableness policy. The statute gives Medicare the authority to deviate from the payment methods specified in the statute if the application results in the payment rate for a service or group of services that is determined to be grossly excessive or deficient, that is not inherently reasonable. The Congress mandated this policy based on the finding that the Secretary lacked adequate authority to make adjustments to ensure that the payment rates were reasonable and equitable.

To use its inherent reasonableness authority, CMS would generally go through the rulemaking process and setting forth the factors and the data that contributed to its decision to use this policy. If this policy were to be implemented by Medicare's contractors, then the carriers would contact the affected suppliers.

The legislative history behind the inherent reasonableness policy is lengthy. In 1997 the BBA streamlined the process for Medicare to use this authority.

Medicare's contractors then proposed to use the authority to set the payment rate of various supplies, including test strips and lances. Following an outpouring of concern from industry groups, CMS suspended the proposed payment reductions. In 1999 the BBRA prohibited Medicare from using this authority until GAO issued a report about the impact of using inherent reasonableness, particularly the contractors using the authority, until Medicare published a notice of final rulemaking that responded to GAO's report and reevaluated the factors used to determine if the payment is too high or too low.

GAO issued its report and the final rule was subsequently issued in 2006. So Medicare was without the use of this authority for about seven years. In recent years Medicare has not used its inherent reasonableness authority.

So the lessons learned from this case study include the authority granted by the statute is sometimes difficult for Medicare to exercise, and that legislative guidance is sometimes conflicting.

The DME competitive bidding program is our last case study. The use of competitive bidding for DME by

Medicare has a long history, starting with a demonstration mandated by the BBA. In that demonstration competitive bidding lowered payment rates for selected DME items by between 17 and 22 percent and did not cause access or quality problems.

Subsequently, the MMA gave CMS the authority to replace the DME fee schedule with a new competitive bidding program. As we discussed during the September meeting, CMS implemented the first round of the bidding process and announced that it resulted in a 26 percent savings for both the program and beneficiaries. However stakeholders, suppliers, raised concerns about the bidding process. Subsequently MIPPA delayed the new current competitive bidding process because of implementation concerns.

At least four lessons are learned here. Medicare needs explicit authority to adopt competitive bidding programs. Statutory requirements are very detailed. The legislative guidance was conflicting. And the influence of stakeholders, the suppliers, impacted on Medicare's ability to adopt these policies.

This case study also raises the question of how Medicare can be given the authority to use competitive

bidding so that it would lead to a successful and lasting program.

This concludes my presentation. To summarize, Medicare's existing authority is sometimes difficult to use to implement value-based payment policies. And in other cases Medicare does not have clear authority.

Commissioners may want to discuss the pros and cons of increasing Medicare's flexibility to adopt value-based policies. And specifically, Commissioners may want to discuss an explicit statutory change that would permit Medicare to use value-based policies such as paying providers differently based on their quality or using reference pricing. We would like Commissioners to discuss the advantages and disadvantages.

And in addition, we would also appreciate your input about other topics that we should be looking at.

MR. HACKBARTH: Okay, round one will be clarifying questions. Let me see hands of people with clarifying questions.

DR. CHERNEW: All of this pertains only to the fee-for-service Medicare part, outside of that MA program and all other things, all of the things that they don't have

the authority to do could be done by a plan. It's just Medicare in the fee-for-service part?

MS. RAY: That's correct.

DR. SCANLON: It should also be an issue of Medicare versus -- or not versus, but in dealing with the managed care plans. You can have pay-for-performance for managed care. In fact, there's a MedPAC recommendation to that effect.

DR. MILSTEIN: Just for clarification of your answer to Michael, the plans have a certain amount of discretion but isn't it also true that CMS is limited by statute in the flexibility it can give to the Medicare Advantage plans? In other words, it's...

MR. HACKBARTH: Give an example, Arnie, of what you think is a limit.

DR. MILSTEIN: I don't know whether I can. But presumably, the people that I hear from on the Medicare Advantage plan side say that their ability to be even better than they may otherwise be at value purchasing is significantly limited by Medicare rules.

I guess my question, following on your answer to Michael's question, is do we have any reason to believe that

Medicare's authority in regulating Medicare Advantage plans is as limited or is as problematic or challenged as what you've described on the fee-for-service side?

MS. RAY: I think that's something that we would need further investigation on.

DR. MARK MILLER: In my experience, and we've got some managed care folks sitting here so there may be some other views on this. A lot of what I have heard has been the restrictions that are put on them in administering the program, particularly in areas of things like marketing materials and that type of thing as opposed to you must administer the benefit this way. I'm getting some nods there.

I think what I would say, if I were Nancy, is this is a good question, we'll look into it deeper...which she did.

I think there's two parts to this question that I think I've heard here, which is the legislative authority inside MA plans, and then the point that was raised up over here, which is Medicare's posture relative to the MA plans.

DR. CHERNEW: [off mic] Medicare to pay the MA plans.

MR. HACKBARTH: So if I were Mark pretending to be Nancy, what I would say is certainly within these areas the case studies were discussed, and what price to pay for particular services and how to identify participating providers, Medicare Advantage plans have broad latitude. That's not to say that there aren't restrictions in other areas. But in the ones covered by these four case studies, they do have broad latitude.

Okay, we will go on to round two.

MR. EBELER: Thank you for the presentation and chapter. This is very interesting.

It seems to me that you start, because of the size of the program, the nature of the program, with strong statutory grounding and framework. And of course, the ability for Congress, anytime it doesn't like what CMS is doing, to undo it. So that's sort of the important statutory given here.

You flagged a couple of directions here that are worth talking about for CMS. One is clarification of these potentially conflicting areas, where there is least costly alternative language, there is equivalence language, there is the inherent reasonableness. Just so that Congress

clarifies for CMS how to use that language, because that's potentially a valuable tool.

Second, it strikes me that there's a difference between thinking about how CMS would change an overall payment policy -- the entire DRG system -- versus the potential clarification for CMS to be able to try some things that are -- is there a path where CMS could try some things as a payer and see how they work, which is helpful to both CMS and the Congress in figuring out future payment directions.

It strikes me that those are two potential paths for us to think about going down as we try to clarify this area.

DR. SCANLON: I guess I feel like I have a history in this set of issues, having spent about a decade looking at CMS and HCFA and their implementation of some of the statutory authorities, in particular inherent reasonableness and DME competitive bidding.

I guess for me the core issue here is, in some respects, the awesome power of government and the need to be able to have some protections from that power. It's kind of like if you had a pet, the safeguards that you would take

would be very different if your pet was a tiger versus a house cat. And that is, in some respects, what we've got here. We've brought in the courts and that's one of the sources of redress.

The Administrative Procedures Act is another. You can't just implement the statute in any way that you choose. You have to be very transparent about it.

And recourse of the Congress is another.

All of them I think are important and we need to -- I think to understand it best is put yourself in the position of what would happen if government decided to do something that would devastate your profession. That's kind of what it can potentially come down to.

Having said that, the need for a better Medicare, more efficient Medicare program, is profound. But the question is how do we get there? One of the things that I found sort of very striking during those 10 years was that I was both a defender and a critic of HCFA and CMS. The defender was in terms of not that their performance was great but that their task was overwhelming relative to the resources that they had, that they were given an impossible job and therefore how could you expect them to do more with

it?

I think that that's particularly true in some of things that we're talking about here in terms of reform because the kind of strategic thinking, the kinds of data that you need to be able to design and defend the policies that you want to make sort of in these areas, they're quite significant and we don't have them right now within Medicare's capacity.

And when we bring into the discussion we're letting the contractors do this, that compounds the problem. Instead of making it simpler -- you know, physiology is not geographic. And therefore, why are we having each one of the contractors make policy separately, as opposed to concentrating resources and having a much more well informed policy and being able to defend it?

I think as a first step, I'd go back to the things that we have recommended in the past in terms of trying to improve CMS's resource capacity because you've got to build confidence before people give you more discretion, more authority. There's too many cases where it's not just the stakeholders that are going up to the Congress and saying this didn't work out right. It's a source like GAO going up

to the Congress and saying this was implemented with flaws and you need to think about changes. And you want to reduce those so that there's greater confidence and then there will be more receptivity to providing flexibility.

DR. BERTKO: I think we're going to be bookends here. With all deference to Bill's cautions about doing this, we've had a robust discussion over the last couple of months on the urgency of the fiscal status of the Medicare program in general. And so the need for CMS and Medicare to be a better value purchaser, I think, is just overwhelming and we need to move that way. There is, I think, a decent history of demonstrations, perhaps to lead into these rather than jumping into it. And clarifying -- Nancy has done a great job of saying clarification, clarification, clarification. And being able to do that and help CMS be able to better implement the demonstrations and good ideas that have been used around, I think it's really time for that.

DR. REISCHAUER: There was a little discussion at the beginning about the authority of Medicare MA plans as opposed to fee-for-service. What I would be more interested in is the extent to which plans serving the non-elderly

disabled population use these mechanisms, reference pricing or functional equivalence. Is this something that everybody is doing and we have some kind of basis for what kind of changes would result in terms of relative prices and how much savings we would have? Or is it a situation in which those who are at the other end fear that if Medicare does it then Humana, United Health and everybody else is going to do it, too? So maybe we can learn something from the private sector.

DR. KANE: France, England, Germany, Italy, Canada, a whole lot of countries have accepted having the tiger as the house pet. I have to say, I think some of this is just political will. But then some of it could be other things.

So I think in thinking about what do you want to recommend fundamentally about Congress, are we just seeing interventions from the past seven or eight years that are a function of a political ideology that doesn't believe in government? Or are we seeing what we would expect to go on forever of the more ambitiously Medicare acts, the more it's going to get more -- the more vulnerable it is to stakeholder interest groups coming in and trying to lobby

that out?

The latter, I think, is the kind of thing where we really should be saying we need to make a change. But if this is just this swinging political ideology of is government a bad guy or a good guy, I have a feeling -- certainly in the last set of eight years I think we've had a real strong sense that the leadership thought government was a bad guy and less is better. That swings back and forth, I think.

But what doesn't swing back and forth is interest groups feeling threatened if Medicare becomes more ambitious and wants to do more to contain costs. And it's very hard to do that in a politically vulnerable, politically accountable place. But other governments have figured out how to do it.

Then we should, I think, say what can we do to make it easier for Congress to let Medicare do what it needs to do? I don't know. I can't tell from the way you described it whether it's because Medicare has tried to get more ambitious that we've had more Congressional intervention? Or whether it's just been the ideology of the most recent Congress.

MS. RAY: I think I would answer that question by saying that, in some instances, the 1965 law has not kept up with what perhaps some may want to do to improve value and efficiency.

DR. KANE: That's one perspective. I mean, I think the 1965 law is quite anachronistic myself, but it has been adjusted and changed over time. So I'm not so sure we're still stuck in 1965 still.

But are we worried that these interventions by Congress at the level of value-based purchasing is really just a fear of government? Or are we worried that every time we do this you're going to have an ability to create a structure that can resist stakeholders?

MR. HACKBARTH: It's an important question, a difficult one to answer. My own perception would be that this isn't particularly ideologically driven but more driven by concern about the impact of particular decisions on constituents. And both Republicans and Democrats can react that way. I don't think it's a big government/small government philosophical issue. That would be my perception.

DR. CASTELLANOS: First of all, I think this

discussion needs to take place. We need to have a thoughtful discussion. Because there's no question we make certain recommendations that have been very appropriate but perhaps not implemented.

I think specifically the LCA has been a significant savings to the Medicare program. However, on the other hand, this recent case was brought up by a patient. And that patient must have had a good reason. And that the patient had to have a reason why he or she filed that case.

As a physician, I live under LCA. And a lot of times I have to make clinical decisions based on reimbursement rates that perhaps are not appropriate for the patient. I think that patient has a right to somehow appeal. It's unfortunate that he has to appeal in the court system, but it is a checks and balances system that we live in.

MS. BEHROOZI: This might go a little to the point that Bob was making. I just want to say, on behalf of the private plan world that's not the Humanas and the Kaisers and the big players, a lot of the coverage decisions and the payment decisions that are made by the little guys or women

are often tracking Medicare. And the thought is that Medicare has made a rational, clinically based, economically base or whatever decision. And it does not immediately leap to mind that the coverage decisions or payment decisions or whatever are the results of political compromise which, the way things are, I am learning more and more, is much of what drives payment decisions.

So I think we need to recognize the broad impact of Medicare not being able to make decisions that are justified on a basis other than political compromise.

MR. BUTLER: I guess I'm a book on the bookshelf between the two bookends.

We've got to create change faster than we do. We have a saying in academic medical centers that a 99-to-one vote means a tie, so it's kind of hard to move things forward. There's some truth to that in some of these kinds of things.

I'm having a hard time in defining the continuum. The obvious ones to me are the ones that are not actually quality oriented, that's kind of an obvious price list and we're just not purchasing wisely and somebody is interfering with that and it's just easy cost savings. I suppose DME

would fall in that category.

Where there gets greater angst is where you're really tying specific quality to the payment and it's not an opposition to it. It's just that, as Bill pointed out, does CMS have the resources, the clinical, the quality competency staff within them to help push that along in a realistic practical way.

And is it going to be in sync with what everyone else does? We've talked about synchronization, and there are an awful lot of forums where these kinds of things are coming forward, too. So just the process of making sure it gets rolled out correctly and in sync with what others are doing is probably the anxiety around that end of the continuum.

DR. CHERNEW: I'm torn a little bit because I think my personal opinion is it's difficult when you see some of these examples to argue that there shouldn't be more flexibility. And certainly in other discussions we've had, we've seen ways which at least it appears as if the system has not responded in the way you wanted the system to respond for a number of reasons, which one you would pick would depend on how cynical you are.

But in any case, what I haven't heard and the reason why I -- it's not clear what the limits on this added flexibility would be. In other words, if the proposal on the table were CMS should be able to use any mechanism however they wanted in any way to do whatever they thought was appropriate for policy, I think we'd say that's just way too much flexibility and there needs to be oversight and a whole series of other things.

So right now we have a system where perhaps there's not enough flexibility. Certainly in some of these, particularly I agree price-listy-kind of you're just not purchasing well areas, and would like to move it to allow them to do some of these things at least on the face of it seem pretty clear.

But I would like to hear and I'm not sure I've heard what the actual alternative is, as to where we would limit that flexibility and where we think the appropriate authority of say CMS to do what they think the latest buzz is for whatever reason.

The first MedPAC meeting I went to was the retreat. And one of the things that struck me is the vast number of demonstration projects that were going on. And

they were going on in all the right areas. Many of them didn't have results yet. But none of them had the sort of oh, if we could only do this result...

I guess when you're unsure, you should just say thank you, that's all I have to say.

MR. HACKBARTH: A couple of thoughts here. I think Bill presented well the concern that many members have, the exercise of this overwhelming power. They should be very concerned about that.

However, as our other bookend pointed out, there are real bad consequences of the path that we're on. And so, if we lean too far towards the direction of protecting against the exercise of great and arbitrary power, we are going to buy ourselves some huge problems. The world is not fair in that regard.

And so how do we find a path between these two things? One point that occurs to me -- it hasn't been mentioned by other people -- is that to the extent that you limit CMS's ability to act aggressively to pursue higher value, it becomes even more important that you have a Medicare Advantage program that is a focused on efficient delivery of care, which is my big gripe about the current

program, is it rewards models that don't enhance efficiency and value.

So if we're going to limit Medicare, we really need to create options where people can aggressively pursue higher value and are rewarded for doing so. And we are failing on both ends of that right now. It's a real strategic problem.

A second thought is that, as Nancy's presentation pointed out, there is just real confusion in some areas around the legislative authority and there are sort of conflicting signals around CMS going after lowest price for some particular services. And so one path that we can do is just some clarification, make some recommendations for clarifying that authority where it's particularly muddled.

A third idea is one that has come up in other contexts, which is broader authority, greater resource commitment to testing new ideas. We've got, as we've noted in previous discussions, we've got a demonstration model that really isn't working for the program. And if we were to invest more heavily and approach that task differently we might be able to generate new ideas that could then go through the legislative mill and be embraced based on data

as opposed to the alternative of saying let's just give CMS broad authority to do things that it wants to do. But again, we're not doing that either.

So we've got a model right now that sort of fails on multiple fronts. We constrain CMS. We don't have an effective model for developing new approaches and testing them. And we've got a Medicare Advantage program that doesn't provide appropriate incentives for value and efficiency. It's just sort of -- we're struggling on all three fronts.

So I'll stop there. Reactions to that, or anything else?

DR. SCANLON: I just wanted to make clear that where my bookend was was not a no action. It's the issue of doing things better with some of the authorities we have now. If there are issues of real confusion about particular statutory provisions, raised those, ask the Congress to address those.

But to give you -- to use the competitive bidding for DME as an example here, we've talked about that at other meetings. I said that when I was at GAO we were looking at that. We wrote a report that was very positive about that.

But the concern in that report and the concern I still have today, is that when CMS did that demo they invested more resources than they would ever be able to, doing this on a national basis or even in a rollout in terms of major metropolitan areas.

The question is how much of the positive results that came out of the demo a function of the level of attention that CMS was able to give to that? And how much of that is going to be replicable wen you have to cut back that oversight by a dramatic amount.

I have no idea about the merits or lack of merits in terms of the objections to the current competitive bidding demonstration or rollout. The issue now is CMS is going to come back and do this again presumably within 18 months and their ability at that point to be able to present something that is defensible -- and it's exactly in the terms that you said, Glenn -- which is the issue of beneficiaries are not going to be harmed. That's the core that is constantly being struck in terms of making an argument to the Congress about why something shouldn't be changed. It's because there's going to be a negative impact on beneficiaries.

It's the ability to say no, there's not there. Here is both the reasonable case and/or the evidence to show that that's not going to occur is, I think, the power you need to move things forward.

Nobody that is trying to protect the beneficiaries is going to be comfortable when there is lot of doubt shed upon an action in terms of what it's going to mean for beneficiaries.

DR. CROSSON: Glenn, I just want to lend support to what you said. I think you've pretty much nailed this difficult question for us.

I had two takeaways from it in terms of things that we might consider. One I think we've talked about before, and that is the interpretation of the mandate we received to examine the way Medicare Advantage plans are paid. As I've said before, I would urge us when the time is right to interpret that rather broadly and to use it as a tool to perhaps re-sculpt the Medicare Advantage program along the lines that you described.

The second one, in terms of what I thought I heard you say, was that perhaps there are some ideas that we could develop -- I'm not sure what the right term is -- perhaps

urge a safe harbor of some sort for Medicare demonstration projects beyond what has been provided. That would be up to Congress to model, but urge some sort of safe harbor so that some more aggressive, if that's the right term, more aggressive or more value-based techniques could be employed long enough to determine whether, in fact, they work and can, in fact, protect and preserve beneficiaries. That's probably some work that we could consider looking at.

DR. KANE: I agree, I thought you summarized it well. I think, though, the beneficiary harm argument is incredibly important but it can't be done in a vacuum. If you want to talk about potential beneficiary harm of lack of access to a DME supplier, that's one kind of harm. But the other kind of harm is the Part B/Part D cost share premium and potential insolvency of the trust fund that really is a much bigger, to me, harm that we really have to make more paramount than the possibility of some minor harms.

Balancing that out is obviously -- that's actually Congress' job, I think. I think the more we can clarify that in our recommendations and in the kinds of policy recommendations that come before us, say there may be some harm here and here's the things we're worried about. But up

against the savings that might make this program more solvent and might make it were financially viable and more affordable, I think it's a risk worth taking. I think we just need to keep making that trade-off very evident.

DR. CHERNEW: I guess the question I have is is there a discrete number of particular issues like DME and maybe a few others that one could maybe then say the program isn't flexible enough because we need to relax the following three things, and make very specific recommendations about things? Or is it more of a blanket, the program needs to be more flexible going forward as new things arise?

As long as it is the former, where we could come up with a handful of things that we would like to see reformed, my gut would be let's look at each of those particular things and then come to some recommendation about whether the program should have the authorization to do X, Y or Z, as opposed to a broader redesign of the program transferring authority.

MR. HACKBARTH: You know, I think that focusing on specific things is probably much more likely to be effective -- effective here defined as Congress doing something about it. As opposed to broad grants of authority, let's work on

these particular problems, like these pricing issues where I think we might be able to make a compelling case that the current situation is muddled and not particularly effective for the program.

Any other comments before we close this one for now? Good job, Nancy, in framing the issue for us. Thank you.

We will now have our public comment period. As always, the ground rules are these: please limit your comment to no more than a couple of minutes and begin by identifying yourself and your organization.

MS. SCHLOSBERG: Thank you. My name is Claudia Schlosberg. I direct policy and advocacy for the American Society of Consultant Pharmacists.

Our pharmacists are consultant pharmacists who work in nursing homes, providing medication reviews. They've been doing it for years. Many of our members are also in the community, providing medication therapy management services to seniors. They are not dispensing pharmacists. They provide medication therapy management.

There was so much discussion about important issues this morning, I could probably stand up here for two

hours and comment. But let me try to limit it to the discussion on MTM.

Medication related problems, particularly in the elderly, are significant. Some estimate that they're costing us $200 billion a year. They are everything from people not being on the right meds to being on inappropriate meds to not being able to take their meds appropriately.

As the government is spending more and more on Medicare Part D, it is quite I think disturbing that three years into the program we really can't say anything about what's going on in MTM. We have the data about the variability but we really know nothing about the outcomes.

I heard a little bit in the discussion that since we don't want enough, maybe we need to just walk away from this and we can't go further. I'd like to suggest the opposite. I think we have to do something and we have to look at medication therapy management very, very seriously because the problem is only going to get worse and more expensive, particularly as the baby boom generation ages.

When we don't have data -- and I'm not a researcher. But when the data is lacking, the one thing that MedPAC has done and one thing that Congress has done in

the past is to mandate that CMS, through demonstrations or through pilots, create programs that could then be studied and analyzed. We know that medication therapy management services work. We know -- and I want to certainly support the comments of commissioners who said we have to have a collaborative process between pharmacists and physicians. Right now pharmacists who dispense see safety edits pop up on their screen all the time. They're not paid to resolve those safety edits, they're paid to dispense medications.

We have pharmacists who make recommendations to physicians, and I don't know what the percentage is, but it does happen that physicians don't accept those recommendations.

We need to promote the collaborative practice between the pharmacist and the physician. We have to come up with ways to align payment for clinical pharmacy services that are not tied to product dispensing. And we need to make sure that we're supporting those collaborations.

If we have to do it outside of D or if we have to create a pilot that looks at paying pharmacists under Part B and being part of a medical home, that's a recommendation that needs to be made. Let's do the comparative

effectiveness review. Let's look at Part D services versus other services that we can come up with models that make more sense.

But I think we cannot ignore this problem. We know that there are ways to intervene. Our health care system, unfortunately, doesn't support that at this point in time.

So thank you.

MR. HACKBARTH: Okay, we will reconvene at 1:30.

[Whereupon, at 12:21 p.m., the meeting was recessed, to reconvene at 1:30 p.m. the same day.]

AFTERNOON SESSION [1:33 p.m.]

MR. HACKBARTH: First up this afternoon is disclosure of physician financial relationships, and we will have a vote on final recommendations. So, Jeff, are you leading? Ariel's leading. Somebody lead.

MR. WINTER: It's a tag team. Good afternoon. As Glenn just mentioned, we'll be discussing our revised recommendations on public reporting of physicians' financial relationships with drug and device manufacturers, as well as Medicare providers.

We presented draft recommendations at the last meeting, and the goal today is to have final votes on these recommendations so they can be included in the March report. I will be walking through the recommendations related to physicians' relationships with drug and device manufacturers, and Jeff will be presenting the recommendations related to hospitals and other providers. And we want to thank Hannah for her help with this work.

Before we get to the recommendations, I'll quickly review the key findings from our draft chapter. Financial relationships between physicians and drug and device manufacturers are pervasive, and these relationships carry

both benefits and risks. There have been efforts by the private sector and the government to regulate these relationships, including laws in several states that require drug manufacturers to report their payments to physicians.

We've been considering whether the Federal Government should collect national data on physician-industry relationships, and here we've listed some of the potential benefits of public reporting: First, it could discourage inappropriate arrangements; the media and researchers could use the data to shed light on physician-industry relationships; and payers and plans could use the data to examine whether physicians' practice patterns are influenced by their financial arrangements with the industry.

A national database would also have costs and limitations. There would be compliance costs for manufacturers and administrative costs for the government. There is also the concern that public reporting might discourage beneficial arrangements between physicians and industry. And the information may be of limited use to patients because patients usually lack medical expertise and tend to trust their physicians' judgment.

Notwithstanding these concerns, there appears to be a growing consensus that the benefits of a national reporting system would outweigh the disadvantages. As I walk through the revised draft recommendations in the next few slides, I will highlight the changes that were made based on the last meeting.

Here we have draft recommendation one: the Congress would require all manufacturers and distributors of drugs, biologicals, medical devices, and medical supplies, and their subsidiaries, to report to the Secretary their financial relationships with physicians, physician groups, and other prescribers; pharmacies and pharmacists; health plans, pharmacy benefit managers, and their employees; hospitals and medical schools; organizations that sponsor continuing medical education; patient organizations; and professional organizations.

The first change we made to this recommendation was to add distributors in the first sentence to capture payments that might be made by distributors of drugs and devices. We also added several groups to the list of recipients. We added physician groups, pharmacies and pharmacists, and health plans, PBMs, and their employees.

Here are the implications for the first recommendation. There would be administrative costs for the government to implement and enforce the reporting law, and we would be asking the Congress to provide sufficient resources to the Secretary to do this. The Medicare expenditure implications are indeterminate. Regarding the beneficiary-provider impacts, although the information may be of limited direct use to beneficiaries, they would benefit indirectly if public reporting leads to more appropriate use of drugs and devices. Hospitals, academic medical centers, and health plans should benefit from a source of information on physicians' financial interests. Manufacturers will incur costs to comply with the reporting law. However, if a uniform Federal law replaces multiple state laws, this should reduce their overall compliance costs. And physicians who receive large payments from manufacturers may receive public scrutiny.

The specific design issues for the reporting system are described in the text of your paper, and I will review them in the next few slides. For the sake of brevity, we have left them out of the recommendation itself.

Based on the comments at the last meeting, we

propose that manufacturers would have to report payments if the total annual value of payments to a recipient exceeds $100, and this threshold would be adjusted annually for inflation. Once this threshold is reached, all payments or transfers of value to a recipient, regardless of the amount would have to be disclosed. A relatively low aggregate payment threshold would enable the Federal Government to collect data on most payments.

In terms of the next issue, we propose that a comprehensive list of relationships should be reported, which are shown on the slide. We propose excluding reporting of discounts and rebates because this information is considered very proprietary, and public reporting of this could make it difficult for purchasers to negotiate price reductions.

We would also be excluding free samples from the reporting system under recommendation one, but we do have a separate recommendation on reporting of samples which we'll get to later on.

We also propose that companies should report the value, type, and date of each payment; the name, specialty, Medicare billing number if applicable, and address of each

recipient; and if the payment is related to the marketing, education, or research of a specific drug or device, the name of that drug or device. The Medicare billing numbers are important for linking the payment information to claims data, but these numbers in our proposal would only be available to researchers through a data use agreement with the Secretary.

We also propose that companies would be allowed to delay reporting of payments related to clinical trials until the trial is registered on the NIH website. Companies would be permitted to delay reporting of other payments related to development of a new product until the product is approved or cleared by the FDA, but no later than two years after the payment is made. And this would ensure that payments related to products that are never approved by the FDA are eventually disclosed.

We propose that the Federal law should preempt state laws that collect data on the same types of payments and recipients, regardless of the state's dollar threshold for reporting. For example, if a Federal law excluded reporting of discounts and rebates, a state law could require such reporting. We don't think that preemption is a

major issue because very few states have reporting laws, and a uniform, comprehensive Federal law would probably discourage additional states from passing their own laws.

Next, the Secretary should have the authority to assess civil penalties on manufacturers that violate the law. And, finally, as Nancy suggested last month, the Secretary should monitor the impact of a reporting law on potentially beneficial arrangements between the industry and health care providers. This is to address the concern that such arrangements may decline due to a public reporting law.

Here is draft recommendation two: The Congress should direct the Secretary to post the information submitted by manufacturers on a public website in a format that is searchable by manufacturer; recipient's name, location, and specialty, if applicable; type of payment; related drug or device; and year. The goal is to maximize the accessibility and usability of information in the system. We have deleted the Medicare billing number from this version of the recommendation because they would only be available to researchers through a data use agreement.

And here we get to the spending and other implications. There would be administrative costs for the

government to establish and maintain a public database. The Medicare expenditure implications are indeterminate. Although the information may be of limited direct use to beneficiaries, they would benefit indirectly if public reporting leads to more appropriate use of drugs and devices. Hospitals, academic medical centers, and health plans should benefit from access to information submitted by manufacturers, and physicians who receive large payments from manufacturers may receive public scrutiny.

Now we'll turn to the topic of free drug samples. The industry provided free samples with a retail value of over $18 billion in 2005. Samples offer benefits to many patients. They may allow patients to start treatment sooner. Physicians can use them to test the effectiveness of different drugs before the patient purchases the full prescription. And they're a source of medical for those without health insurance. On the other hand, samples may lead to the use of more expensive drugs instead of cheaper drugs that may be equally effective, and there is some evidence that samples influence physicians' prescribing decisions. Better data on samples would enable researchers to conduct more detailed analyses of their impact on

prescribing behavior and overall drug spending.

Under the Prescription Drug Marketing Act of 1987, manufacturers and distributors are required to keep information on drug samples distributed to practitioners and pharmacies of hospitals and other health care entities. If the samples are sent by mail or distributed by detailers, the companies must keep written requests from the practitioners and receipts that acknowledge delivery. If the samples are distributed by detailers, manufacturers must also keep an inventory of all the samples that are distributed. This inventory must include the name and address of the recipient, the drug's name, dosage, and quantity, and the date of delivery. If the samples are delivered by mail, there is no similar requirement for an inventory.

These records only contain the name of the practitioner who signed for the delivery of the samples rather than the names of all the physicians in the practice who may dispense samples to patients. Although the FDA and other government agencies have the right to request these inventories to ensure that companies are following the law, there is no requirement to report this information to the

government on a regular basis.

So we asked whether the information on samples could be useful for researchers and speaking here more broadly than the inventories of samples distributed by detailers, but also about the written requests that are required of samples distributed by mail or by detailers. Linking data on the samples to claims data on prescriptions could facilitate research on the impact of samples on prescribing behavior and drug spending. But in order to link data on samples to claims data, the government would need to obtain the names and Medicare billing numbers of all physicians in the practice, not just the practitioner or physician who signed for the samples.

Even with this information, it would still be difficult to examine the use of samples by individual physicians because we would not know how many samples each physician used. But the information could be used to analyze the use of samples at the practice level and the geographic level. In addition, collecting information on physician specialty would allow for analyses by specialty.

Based on your discussion at the last meeting, we propose the following for draft recommendation three: The

Congress should require manufacturers and distributors of drugs to report to the Secretary the following information about drug samples: each recipient's name and business address; if the recipient is a physician practice, the names, specialties, and Medicare billing numbers of each physician in the practice; the name, dosage, and number of units of each sample; and the date of distribution. The Secretary should make this information available to researchers through data use agreements.

The reason we're proposing a separate recommendation related to samples rather than including them in recommendation one is: because we would not be requiring manufacturers to report the value of the samples because free samples are provided to a more limited set of recipients than the types of payments in recommendation one; and, finally, because the data on samples would not be on a public website.

This recommendation would not apply to free drugs provided by manufacturers under prescription assistance programs to low-income, uninsured patients because the drugs provided under these programs are not considered samples.

Here are the implications for recommendation

three: There would be administrative costs for the government to establish and maintain a database on free samples. The Medicare expenditure implications are indeterminate. The beneficiaries may indirectly benefit from research evaluating the impact of free samples on physicians' prescribing behavior and overall drug spending. And manufacturers' administrative costs should be minimal because they currently collect much of this information.

Now we'll turn to Jeff for the final two recommendations.

DR. STENSLAND: Now we're going to shift gears away from talking about drug and device manufacturers to talking about physicians' relationships with other health care entities that bill Medicare.

Currently, CMS requires that hospitals and ASCs disclose physician ownership to patients. However, payers and researchers do not have access to this information. These payers and researchers need ownership information in order to evaluate the effects of ownership on referrals, quality, and cost.

To make ownership information public, we have the following draft recommendation: The Congress should require

all hospitals and other entities that bill Medicare for services to annually report the ownership shares of each physician who directly or indirectly owns an interest in the entity, excluding publicly traded corporations. The Secretary should post this information on a searchable public website.

The difference here from last month's draft recommendation is that we are now requiring disclosure by all providers who bill Medicare, not just hospitals and ASCs, and this reflects the discussion you had last month.

Because CMS is already collecting most of this information and entering it into its PECOS database, there would be minimal additional costs for CMS to make the data comprehensive and public. While we expect that beneficiaries will rarely change their care decisions to provider disclosures, beneficiaries may indirectly benefit from research on the relationship between physician investment and referrals and outcomes.

The Commission has expressed some interest in hospitals' disclosing more than ownership. Disclosures could include physician-hospital relationships, such as equipment leases and medical directorships. The difficulty

with broadening the disclosure mandate is the need to balance the desire for transparency with the desire to limit the administrative burden on hospitals, and the question is: What exactly should we require hospitals to disclose?

CMS currently plans to collect data on physician-hospital relationships from its own survey of up to 500 hospitals. Now, this is a follow-up to an earlier survey they conducted in 2006 as part of the CMS-mandated study of specialty hospitals. In 2006, CMS surveyed hospitals regarding physician ownership, management contracts, and other issues as part of their mandated report. However, a majority of hospitals declined to respond to the 2006 voluntary survey. Afterwards, CMS decided to have a follow-up survey, this DFRR, that would report on these types of relationships and be mandatory. The current plan is to have all 290 hospitals that declined to answer the 2006 survey respond to the DFRR and add up to 210 additional hospitals to provide for an adequate sample for statistical inference.

Now, it should be noted that roughly 65 of the hospitals that did not return the original survey were specialty hospitals, the subject of the initial investigation. The size of the survey sample may be reduced

down from 500 if CMS concludes that it can make accurate inferences with a sample of less than that number of hospitals.

Now, the DFRR would be of interest to us because it could inform future decisionmaking on what physician-hospital relationships should be reported by all hospitals. The idea is that if we wait to analyze information from the DFRR, we will be able to do a better job of balancing the desire for disclosure from all hospitals with the desire to keep administrative burden on the hospitals low.

Thus, we propose recommending that the Secretary submit a report to Congress on the prevalence of the different types of financial relationships. The draft recommendation reads as follows: The Congress should require the Secretary to submit a report based on the disclosure of financial relationships report of all the types and prevalence of financial relationships between hospitals and physicians. The implications are little for CMS. Because CMS plans to collect the data, the only other cost for the agency would be the cost of the mandated report.

So those are the draft recommendations, and now we

look forward to your discussion.

MR. HACKBARTH: Thank you.

Okay, first round, any clarifying questions?

DR. CASTELLANOS: I just wanted to clarify on draft recommendation five. I think it's extremely important to have transparency, and the transparency with the physician ownership of the hospital, ASC, or other providers is very evident. However, hospitals also employ physicians, own physicians, and also have arrangements with other facilities. Now, one is going to be publicly reported. The other under the DFRR is going to be reported and then sent to Congress by the Secretary. I want to make sure that the hospital relationships between employment and ownership of hospitals is definitely reported and that data will be available.

DR. STENSLAND: I don't think that CMS is currently planning to collect employment information. I think they're trying to balance the administrative burden with the desire to have as much information as possible. We can follow up with them on that. But even if CMS doesn't do it, there's nothing to say that in the future, when we re-evaluate what information should we require from all

hospitals, you collectively couldn't decide to have that as one of the things that would mandatorily be reported.

DR. CASTELLANOS: That means we will have an opportunity to review this again in a year or so?

DR. STENSLAND: I think that was the original plan -- that first we would see what CMS comes up with, and then have our own deliberations on what types of things we think should be reported by all hospitals. First, let's look at the sample of hospitals and see what they're doing and what's prevalent, and then come up with this other decision on what should be reported by everybody.

MR. HACKBARTH: So, Ron, we can address this in the text and say, you know, this is an area of interest and something that we may well go back to, and just leave it out of the boldface.

DR. CASTELLANOS: Fine. Thank you.

DR. KANE: I guess one question was the timing of the report. When is it going to be done? And the other question is: Are we going to only see the report, or would we also be able to take a look at the questions and the data responses? Because it might be that there are maybe -- we may learn that there are better ways to ask some questions

from that. So I just wondered how much detail do we get in our report. Is it just what CMS summarizes? Or can we actually see the questions and the responses? And how long will it take?

DR. STENSLAND: We have talked to CMS, and they've expressed some willingness to talk to us about maybe how the data would be packaged and presented and how it could be most useful to us. And so we plan to go through with that. I'm not sure where they'll stand on the degree of access we will have to the individual documents, the individual contracts. I'm not even sure I want to see all those individual contracts. But we'll try to work with CMS to have enough access to the information and have it packaged in a way that's useful.

The time frame is uncertain in that CMS is still finalizing internally the document. They sent out a few earlier drafts, but they still have to get it finalized internally, and then they have to have OMB approval, which they don't have, and then it would have to go in the field and then it would be analyzed. They have a contractor lined up to analyze the data, but I think you're looking at at least a year, I think, before that information would come

back.

DR. STUART: I have a question about the language in draft recommendation four. The first sentence says, "Congress should require all hospitals" -- and this is the key piece -- "other entities that bill Medicare for services." Now, the way I would read that in a technical sense, that would only apply to services that are providing under Part A and Part B and would exclude services provided under Part C and D, since those are not billed directly to Medicare. Was that the intent of this?

DR. STENSLAND: Yes, I think there was some concern. Right now, when anybody wants to get a billing number from CMS, they've got to fill out an application for a billing number, and as part of that application, they have to say who your officers and directors are and who are all the owners. And so we were going to piggyback off that information, and they could put that into the database, and then it could become public.

Right now, if somebody supplies something to a Part C or a Part D plan, they wouldn't have that direct relationship with CMS, and I think it would be much more difficult to go out and find out who they are and get that

information from them.

DR. STUART: So this was excluded not because it might not be important, but because of the difficulty of actually getting the information?

DR. STENSLAND: That was one part. I don't know if we -- the initial examples of the kind of things that we were most concerned about weren't so much directly C or D either.

DR. STUART: I'm not challenging this. This is a clarification. I'm trying to understand why this was worded the way that it was.

DR. DEAN: I was just wondering if there's a conflict in recommendation one. You said they should report all relationships with health plans and PBMs, but then on page 7, the rest of it said should not report discounts, rebates, et cetera. I would suspect that most of the financial relationships that exist with PBMs are discounts and rebates. So is there a problem with that wording?

MR. WINTER: You're right; we intended to exclude -- or the recommendation was to only collect information on other kinds of payments from plans -- from drug companies to plans and PBMs, and there may not be any. So we may have

learned that there aren't any, or there may be grants or other kinds of arrangements that we don't know about. And so part of this is we don't know what's really going on there -- at least at the staff level. Maybe Commissioners have insight into that.

DR. DEAN: So the discounts and rebates would be the dominant guide here? I mean, they would not report those.

MR. WINTER: We would not report that information.

DR. DEAN: In a lot of ways, I think that's unfortunate because that's, I think, very important information, although I understand the problems with, the reasons why, you know, you don't want -- or why they don't want to report it. But we know that it affects a lot of decisions about drug selection, and some pretty important decisions get made on that basis. I wish we had access to that data, but maybe we won't. I don't know.

DR. STUART: I think it's important to note that actually PBMs do get money on a regular basis from manufacturers for research contracts, and so on the basis of medical school, wanting to understand how a faculty are being paid by drug companies, the same thing would apply to

PBMs.

MR. GEORGE MILLER: This is probably a follow-up for Ron, but under the reporting under the DFRR, are you also talking about a relationship with physicians who may be employed by a system but assigned to hospitals? Or have you thought that process through?

DR. STENSLAND: I'm not sure how that would work out in the DFRR. I haven't seen the detailed instructions on that, but I'm guessing they would say even if the physician is an employee of the system working at the hospital as a director --

MR. GEORGE MILLER: But as I understand this, this will go directly to the hospitals, not necessarily the systems. But there are some systems that employ physicians that may be assigned to a hospital and not directly employed by that hospital.

DR. STENSLAND: We could bring that up with CMS and ask them how the instructions will deal with that situation.

MR. HACKBARTH: Round two, questions, comments? Why don't we just go down the row here, so I have Peter, Tom, Mitra.

MR. BUTLER: Just a clarification here, Glenn. Are we going to do one recommendation at a time, or you're looking for comments on the whole thing?

MR. HACKBARTH: Good thought.

MR. BUTLER: I think it might be better if we -- well, you can --

MR. HACKBARTH: Yes, why don't we do one at a time, just to focus the discussion. Thanks, Peter.

MR. BUTLER: Because I think some of them are pretty difficult.

MR. HACKBARTH: Let's start with recommendation one and do --

MR. BUTLER: I'll still go first if you want.

MR. HACKBARTH: No, you forfeited your place. Okay.

MR. BUTLER: I just have one brief comment on -- really, it's a predecessor to one. I think this whole paper is very well written, and I think it captures a lot what we want. This sounds like nitpicking, but in the very first paragraph, I think the tone is good and the overall writing of this. But in the very first paragraph, it starts by saying, "Drug and device manufacturers have extensive

relationships with physicians, academic medical centers, professional organizations, and health care entities. Although these financial ties often lead to advances in medical research, technology, and patient care, they may also create conflicts among the" -- "between the commercial interests of manufacturers and the physician's obligation to do what is best for their patients."

I really think it would be great if the second sentence could say, "These relationships have been critical to the advancement of medical technology" -- recognize their value and then say, "However, they often lead to..." I think it just sets the tone right in the beginning. Otherwise, the whole thing is cast in a negative light, and I think there are various productive relationships that make us world leaders.

So a very subtle but suggested recommendation to the wording.

MR. HACKBARTH: While we are doing one, why don't we also do two, since one and two are really related.

DR. BORMAN: I would just echo first what Peter said about -- I think what he suggests is very important, to put some of the positive here and not have this be

potentially in a totally negative light, because it clearly is an emotionally charged subject. Just the word "disclosure" has such meaning in our society anymore, we need to be a little bit careful about that, particularly when we want to engage many of these people as stakeholders in the big issues that lie before us relative to health care delivery reform.

Just in terms of the comment and question, I'd like to particularly support the part about the Secretary having a review mechanism to look and see if beneficial arrangements are, in fact, suffering and whether or not we should give some examples in the text of what one or two of those might be. And I'm sure Nancy or I or some other people could work with staff on that.

We see so much in the way of unintended consequences, and there certainly are lots of these relationships that play out in the continuing medical education world. And I think, you know, some of what has made us a leader in a lot of fields does relate to the ability to have that kind of increasingly expensive education be financially underwritten to some degree. So I would like to just raise the question of whether we have the

room, the capability, and interest in maybe offering -- fleshing out that piece of it in the text, or whether staff could just do that, I would advocate for that.

DR. DEAN: Just a quick comment on the continuing education issue. At least in a large part of the continuing medical education that currently exists, this already is in place. At least in family medicine, at the approved conferences the speakers are required to divulge any relationships they have with the industry, and they're also required to divulge if they're going to talk about any unapproved or experimental uses for any of the products they're going to talk about. So like I say, some of this is already in place.

MS. BEHROOZI: So our methodology here is to say "What I like about this but," right? So what I like about this -- and, actually, this applies to all four --

MR. HACKBARTH: [off mic] You can drop the "but."

MS. BEHROOZI: Stop stealing my thunder. This applies to all four recommendations. What I like about this is that you have done an amazing job of being really comprehensive in terms of incorporating all the commentary by all the Commissioners, I think, and researching

thoroughly what's going on in the field. It's so timely, as Tom says. A lot of things are going on in a lot of different places, and I feel like you have really incorporated everything and made an excellent framework to bring together all of those efforts and offer real leadership and guidance, and I am really impressed. And there is no "but," so there.

[Laughter.]

DR. KANE: I was going to go on to three and five, I think. I was going to pass.

MR. HACKBARTH: We're still focused on one and two.

DR. KANE: Except to say I support one and two.

MR. HACKBARTH: All right. Thank you.

One and two, Mike?

DR. CHERNEW: Very quickly, I'm also supportive of the recommendations and think it's very well done. The only question I was going to have is: In general, in much of the things that we've seen here, you've gotten a lot of feedback from people that are not around the table here but outside, and you've spoken with a lot of -- I'd be interested I knowing if you've received a lot of general push back about

aspects of the administrative costs and reporting requirements from folks that are not around the table.

MR. WINTER: In terms of the administrative costs, what I have read and heard from stakeholders, particularly manufacturers, is that the big issue is preemption; that if you're going to require us to report this to the Federal Government, then don't force us -- or make sure we don't have to also report all this information to 51 or 50 different states. Even though there are only five right now, plus D.C., other states have been considering this kind of legislation. And so their concern is if you can have just one Federal uniform requirement system, that might make it easier. Or certainly if you're going to do that, don't make it harder on us by also making us comply with all the different state laws.

DR. CHERNEW: Let me respond to that. So you perceive this as sort of a middle ground and that you preempt -- you force states that are less stringent in this to come up to this, but you don't preempt states that are -

MR. WINTER: No. What we're saying is we're not -- states would not be able to have systems that are similar to the Federal system. So it's not that states would have

systems that are equivalent to it. It's that they wouldn't be collecting this information because the Federal Government is already collecting it. And if they wanted to go and collect additional kinds of relationships, then they could do that.

DR. CHERNEW: If they had a $50 threshold, that would be a different threshold.

MR. WINTER: Our proposal is to preempt that law as well, even if they have a lower threshold, because we've already set a low threshold for aggregate payments, and there's no threshold for each individual payment. If it's $1 -- once you get past $100, if it's $1, you report it.

DR. CHERNEW: So this effectively -- I'm sorry. I don't understand. So this effectively does preempt -

DR. MARK MILLER: Yes.

DR. CHERNEW: Okay.

DR. STENSLAND: It wouldn't preempt if there was different types of information they wanted to collect. Like if Massachusetts wanted to know about relationships with health economists and drug companies, they could do that.

MR. WINTER: And states that collect information on discounts and rebates would be able to continue doing so,

and there are two state laws that do that.

DR. CROSSON: I'd just like to say I support the first two recommendations. I think it's about time. I've, you know, been distressed over some 20 or so years, as an infectious disease physician, by the apparent influence that some -- not all -- pharmaceutical companies have not just on individual prescribing practices but on the pattern of use by whole hospitals in terms of new antibiotics, for example; but even more so, the influence over the research base, the practical research base that physicians and other clinicians use in determining what is appropriate treatment. This is not a solution for all of that, and I don't in any way discount what Peter had to say. I think that, yes, I mean, to a large degree, the collaboration between pharma and the industry in this country has produced top-quality health care for Americans. But I think there is a dark side to this, which I experienced early on as a clinician, that I think is unfair, and I think it differentiates among physicians, between those who are willing to accept this sort of gratuity and those who aren't. And I think it's time that it began to cease, and this sort of disclosure is a beginning of that sort of work.

MR. HACKBARTH: Any more on one and two?

DR. CASTELLANOS: I'm just wondering if there's going to be any provision to be able for these entities to review, correct, or explain any of these decisions before it becomes public.

MR. WINTER: What we talked about in the text is that if a recipient -- recipients would have the right to challenge the accuracy of information that's been reported by a manufacturer, and manufacturers would have to investigate and correct any errors in a timely way.

DR. CASTELLANOS: Thank you.

MR. HACKBARTH: Let's move to recommendation three.

DR. KANE: Just a little background, we debated earlier whether this should be a public domain or a researcher-only database, and I think we've come to this consensus that probably it makes more sense, at least for now, to have it only available to researchers through data use agreements. But part of my concern in accepting that as a recommendation is that the definition of researchers not be overly restrictive, that there be a timeliness expectation in terms of both making the agreements, you

know, signing these agreements and delivering the data, and that the definition of researcher would include those who want to use the data for practical purposes such as counter-detailing, going to beneficiaries using the physicians and actually trying to deal with, you know, what's going on based on their analysis of the data.

So I would like to be sure that we have, if not in the recommendation then in the supporting text, a concern that the data use agreements not be overly restrictive and that they foster the use of this data by commercial entities, plans, and others who want to use this not just to publish something but to actually intervene in the way drug samples are being used.

MR. BERTKO: Now I only need to second Nancy's comments. So if that would go into the text and explicitly say that, I'm happy.

DR. STUART: I think you could just remove the "to researchers" and then put it in the text.

DR. KANE: Although I think you'd still need to modify what a data use agreement is, because that could be another way of restricting access.

DR. MARK MILLER: That's what I heard Bruce

saying, is to take the actor out of the sample -- sorry. I had a sample earlier today. Take the actor out of the recommendation and in the text make a statement that we expect this is broad availability if people can sign data use agreements and talk about the purposes.

DR. STUART: And I agree with John that we want to also have language in there that indicates that the data use agreements are not going to be difficult to get through.

MR. HACKBARTH: Any objection to deletion, Bruce's proposal to delete "researchers" from that last sentence?

[No response.]

MR. HACKBARTH: Okay.

DR. DEAN: I'm a little bothered by this one. I totally agree that the distribution of samples affects prescribing behavior and that that is a concern, and I certainly share that concern. I am just uneasy that we're going to be able to get the kind of data through this mechanism that we need or that it's likely to affect any of the kind of behavior changes that we're interested in, I guess especially the statement that if the recipient is a physician practice, the named specialties and Medicare billing numbers of each physician in the practice need to be

collected. Well, the larger the practice is, the more difficult it's going to be to get all that information; and, secondly, the less valuable it is because within that group you're going to have huge variations in terms of the behavior of individual physicians. And I think I'm afraid that it's just going to be a blend that is going to be less and less meaningful. Even in a small practice, I can tell you that the very small practice that I'm in, there are big differences in the way that these samples get used, even though they will be attributed to whoever happens to be there at the time when the representative comes through.

So I'm just concerns that, yes, this data is potentially important, but I think it's going to be very difficult to interpret.

MR. HACKBARTH: So do you have a proposal for modification?

DR. DEAN: I just think this whole route of transparency is not the way to go, but I don't really have a good suggestion, no. And I'm not in any way against transparency in general. It's just I'm not sure for this particular issue that it gets at the concern.

DR. CHERNEW: I think this might be related. I'm

not sure. I am concerned/curious about the feasibility of, I guess, the second bullet point, which is if the recipient is a physician practice, the named specialties and Medicare billing numbers of each physician in the practice would be provided. And I'm concerned about that because for large physician practices, with perhaps residents or other people circling in and out and maybe changing over time, administratively that is more complex to do. Maybe Peter has some sense of how that might work at Rush. I don't know. But it strikes me that that might be a challenge to present, and it might be that, in fact, if you just presented the name of the physician practice, that would be sufficient anyway for doing the analysis.

DR. REISCHAUER: [off mic] In a single number.

DR. CHERNEW: In a single number. Now, you might have to worry about how you would tie in different physicians to that practice so I understand there's complexities. But I can envision going to one office which is part of a much broader practice and asking for the names of all the people that worked there then, and that data is not kept for the other practices at that one site, and they have to go -- so it might be possible, so I wouldn't argue

but I would be -- it struck me in the settings where I was familiar with that that might be complex information to get and report for the people who are giving the samples.

MR. HACKBARTH: The effort was to get at one of Tom's points in the earlier discussions. Physician A may be, you know, standing there and signed a piece of paper, and if you just have that physician having received these samples, the implicit message is, well, this one physician is using it all. So the effort was to say, well, there may be multiple physicians, in fact, using these samples. You know, you have raised a legitimate question about the practicality of that. Do you have a proposal?

DR. CHERNEW: I don't know if my proposal is any more practical. I envisioned a world in which you would say, you know, John's medical practice or St. Good Health Medical Group, and then all of the people who are in there would be implicitly included. So you wouldn't say, you know, Tom Dean. You would say -- I could look here and find the name of the practices. But apart from that, you would just say the practice name and have a number, instead of -- that just struck me as easier than having to make sure that someone reported all the names of all the people who worked

in the practice at the time.

MR. HACKBARTH: Any thoughts on that?

MR. WINTER: The way it's currently being collected, the information, you have the name of the practitioner is collected by the manufacturer, and not the name of the practice. I'm not sure if practices are sort of -- I guess they're formal legal names. So that would have to be, I guess, a change to what's currently being collected.

If it's being delivered to a pharmacy at a hospital, then the name of that entity is collected, but not if it's a physician practice. Then in that case it's just the practitioner.

DR. CHERNEW: But if it was delivered to a pharmacy at the hospital, would they have to report the names of all the physicians and all of their specialties and all their billing numbers at the hospital?

MR. WINTER: Not under this recommendation. That's why we have the qualifier "if the recipient is a physician practice."

DR. CHERNEW: But if you were Harvard Vanguard or something...

DR. REISCHAUER: But what would you do with this information? I mean, if you have a hundred physicians' names and numbers and then a lot of stuff that's been given to them, I mean, you can't relate it to individual people anyway.

MR. HACKBARTH: But if you have just one physician name and a hundred physicians using the samples, you've got the same problem, which is part of Tom's general reservation. So I don't think this makes it worse. It may make it modestly better, although at some administrative cost.

DR. REISCHAUER: It's more complex and equally unusable. Right?

MR. BERTKO: I think it could still be useful in the sense that if you're looking for counter-detailing, a PBM or a PDP would know who the paid scripts were for, and they could look backwards and see where the samples went and generated the paid scripts and know that that's the time to do the counter-detailing. So it would be kind of a retrospective look at these things, and it would be useful.

DR. CASTELLANOS: It's a clarification. In a

large group, there's only one billing number for every physician. Every physician has the same number, so there's not going to be any clarification on the number, who prescribed it.

DR. STUART: I had the same request or the same issue. It seems to me that Medicare could do that, and maybe the onus should be on Medicare, that the manufacturer gives information about the individual who receives the samples, and then we use the billing number and the individual ID numbers to flesh that out in terms of the organization.

MR. WINTER: I've actually done some work on trying to aggregate physicians into practices, and there's no sort of precise way of doing that. We've been using the tax ID as a proxy for a practice, but we've heard that's not always accurate. And so CMS could do that, use the tax ID as a proxy, and group them together, but that may not always -- may not be accurate in every case.

DR. CROSSON: We're still on number three?

MR. HACKBARTH: We are, right. But we need to move on. Is it on this particular issue of the second bullet that Mike raised?

DR. CROSSON: Yes, it is.

MR. HACKBARTH: Okay.

DR. CROSSON: Well, I just wanted to say I support the recommendation. It's important to note that this is a very different issue than we were dealing with in recommendations one and two, which is a conflict of interest. This is an issue of the impact of samples on the cost of pharmaceuticals for beneficiaries and for the Medicare program. This is a very early effort. This is an effort to try to get some rough data about the relationship between the use of samples and the cost by geography and perhaps by practice.

I have to say, after listening to Tom and Mike, I am a bit concerned about the second bullet point myself because, just thinking about our own situation, it would be difficult administratively and probably not provide any useful data. So I wonder whether we either strike that and in putting together the text we come up with a better recommendation rather than doing it on the fly here, when the recommendation would be probably that the practice be identified in some way.

DR. MARK MILLER: Ariel, is that the first bullet?

Is that the practice?

MR. WINTER: The recipient's name and business address?

DR. MARK MILLER: Yes. Would that be the practice in the instance that the sample was given to a practice?

MR. WINTER: In terms of the information that's currently collected, it would be a practitioner or the practice. It would not be the name of the practice itself. So we could ask them to collect -- we could ask Congress to require them to collect the name of the practice, but that would be additional information. And maybe that's where you'd want to go.

DR. CROSSON: That is what I think the recommendation should be, that if the recipient is a physician practice, then the name of the practice be collected, and strike the rest of it.

MR. WINTER: What about the billing number? Because the billing number is really key for being able to link to claims data. So would you want the billing number of the practitioner assigned for the samples?

DR. CROSSON: Well, that was my concern about trying to manufacture this on the fly.

MR. EBELER: Jay, as I hear you, you're saying if you drop bullet point two, the technical definition that we might want to articulate, underneath one we could put in text, but not in the recommendation.

DR. CROSSON: Yes, that was my initial suggestion.

DR. KANE: Is there a difference between a billing number and an ID number? Because Ron's point is that a practice is a single billing number that accounts for multiple ID numbers of physicians. But if you just get the practice's billing number, that's the billing number through which multiple physicians bill in that practice. And so all you really need is the billing number.

DR. MARK MILLER: Actually, in the data it kind of goes both ways, is the problem. It may be true in your practice, but there are also practices where it kind of goes the other way.

But here is what I'm hearing, and I'm trying to work with Jay: We basically drop the second bullet, and we spend time in the text defining what the first bullet refers to in an individual physician's circumstance and in a physician practice circumstance. And I think we understand the concerns that are raised by the Commissioners here, and

we'll address those in the text. And then, of course, you guys can review the text. But for purposes of getting through today on the vote, I think what we can do is take the detail out in the second -- take the second bullet out which has that detail and navigate it in the text. I think that's where you were headed anyway.

MR. HACKBARTH: Right. Any objection to that proposal?

[No response.]

MR. HACKBARTH: Hearing none -

MR. WINTER: And just to be clear, we'd be dropping "billing number" from the recommendation itself, from the language of the recommendation.

DR. MARK MILLER: The second bullet.

MR. WINTER: Yes.

MR. HACKBARTH: Anything else on recommendation three? Yes, Tom?

DR. DEAN: My concern is I think we already know we have a problem. The question is how to address it, and I would prefer to go to something more direct, like something along the line of the counter-detailing that John has brought up. I don't know exactly how you do that. I mean,

that's obviously a much bigger undertaking, but I guess I'm just not sure that this is going to help us to address the problem.

MR. HACKBARTH: That's a discussion for another day. So we are now finished with questions and comments on number three. Let me see hands for number four, and I guess we ought to do five together, they're sort of related, four and five.

MR. BUTLER: First, I'm supportive of both recommendations four and five as stated, no changes in the wording. My comments relate to recommendation five in the narrative, and I would suggest two specific things be included in the narrative.

The first is there are loose references to this applying to perhaps more than just the cost and quality of Medicare services. There's some that would like to use this as a compliance database, as a Stark database. I think that those kinds of violations should be handled elsewhere and are not part of the scope of this. This is all about our responsibility as MedPAC Commissioners to worry about the cost and quality of services to Medicare. So I think that distinction should be made.

The second relates to how you kind of practically gather the data through the DFRR. I'll make the general comment that in my mind 500 hospitals, and having read and tried to apply the survey to our own institution, the amount of information being requested is way more than is necessary. I realize that I think the horse is out of the barn a little bit on this so that the ability to make some of those modifications may be limited, and I also understand maybe CMS is already trying to address some of the administrative burden.

Now, as significant as the administrative burden is, I actually am more concerned about the ability for the CMS staff to practically use the mounds of paper that will come in and convert it to some findings that we can look at and really make a difference in terms of recommendations, which I am very much interested in doing, because I do think in general the cost of the Medicare programs are largely, as I think we've shown before, due to volume kinds of issues, and some of these relationships are the very ones that, you know, incentivize inappropriate or unnecessary volume, and we need to get to that.

My specific suggestion then in the language would

be to create, call it a technical advisory committee that would help work with CMS in terms of perhaps not the survey itself but the receipt of the data and how it could best be digested in a practical, efficient fashion to get to the results. This would address the kinds of things, for example, that George brought up and say, okay, what happens if you get data from a system and a hospital level? That would be very hard for CMS to kind of sort through on their own, and there are multiple questions like that. So I think some advisory committee would be useful to kind of expedite and create the most productive set of results we could get.

MR. HACKBARTH: Just to make sure I got it right, Peter, you're saying put that in the text.

MR. BUTLER: Both of my comments in the text -- the compliance issue and the technical advisory, yes. The recommendation as stated, fine.

MR. HACKBARTH: Thank you.

DR. KANE: I basically agree with both four and five. I just wanted a point of clarification. When you say "all hospitals and other entities that bill Medicare for services," do you want to have the ownership of all physician practices, even if it's the primary base from

which the physician sees patients, or do you want to have only those things which are ancillary to? And in a comment that I wondered if you really wanted to know the ownership of every LP out there of physician practice. I wasn't sure that was the intent. Maybe it's just too hard to define the border between the physician's primary practice and something they own separately to which they refer patients. But if it isn't too hard, I would say let's go for trying to define the line there.

DR. STENSLAND: Right now any limited partnership, physician limited partnership that applies for a Medicare billing number has to list all of the partners already, and then that goes into the database that CMS has. So that's already happening. So the amount of extra work it would take then to put that on this database is minimal. I think we could go either way in the text of saying physicians should be in or physicians should be out.

The one example I can think of in my own experience of talking to folks is I was talking with somebody who said -- you know, his practice was bought and he said, "Well, when I owned the practice and I got the ancillary revenue, well, maybe I did order more ancillaries

than I do now when I don't own the practice." So, conceivably, there could be some use of this information if a researcher wanted to say, "Is there a difference in imaging ordering between people who own their practice which has an imagine machine and people who just work at the practice but don't have the imaging machine?"

DR. KANE: I was thinking of that, also. So maybe we want that. But then should we also then have a list of what services they can bill for within that practice, or are you just going to use the claims data to figure that out?

DR. STENSLAND: Just claims.

DR. KANE: Then you need to have the ID numbers -- I mean the billing numbers. This is going to be on a public website. How are you going to get from that to the claims data to know what they're billing for?

MR. WINTER: I believe we contemplated that they also would be reporting the billing numbers, and that would be available to researchers through a data use agreement. I'm not sure if that's in the text or not, but that was our intent, because currently they do report the billing numbers of all physician owners. It's just not public.

DR. KANE: Do you want to make it public?

MR. WINTER: No, no. We're saying not. Consistent with number one and number three, it would not be public. It would be available to researchers. But the public database could have, would probably have the names at least.

DR. KANE: So do you want to clarify that people who want to get access to this data and the ID numbers would have to go through another data use agreement? Or is that just a given? Should we clarify that this is going to be data that you can't just go to a website and figure out much? Because you don't know what services are within that entity. You can only find that out by the claims data.

DR. MARK MILLER: Actually, I think there is value in just understanding kind of, you know, entity ownership. There is value to that, even in a public data set. I think some of the issues that you're raising, the way I contemplated resolving those issues, which all came out of a conversation in the last meeting and was driven, I think, by a number of people but certainly Karen, is we should not be posting physician IDs on websites. And so what I would say is as a blanket statement in our discussion here, that information is collected but only available through the DUA

process. But on the public website, you know, the notion of the entity and the owners and their ownerships would be available. And then if you wanted to do claims data analysis, you would have to go through the process of getting the ideas and linking the claims.

DR. KANE: It might just be worth clarifying that in the text.

MR. WINTER: It is in the text right now. It's on page 35. But if you think it's not clear enough, we'll work on that some more.

MR. HACKBARTH: Yes, Jay?

DR. CROSSON: I support both of the recommendations. I just have a comment with respect to the tone and the text, and it has to do with the fact that if you were to pick up previous work that we've done on physician-hospital relationships and physician-hospital integration and read that separate from this one, you might decide that there was a bit of a schizoid point of view on the Commission, which there isn't. Because, in fact, I think while we're dealing with this set of issues, transparency and concern about inappropriate relationships, we also have been discussing at another time the fact that

if we're going to move to more delivery system integration, we probably need to encourage certain types of physician-hospital integration through gain sharing or shared savings or whatever we want to call it.

So my only suggestion is that somewhere in this chapter, because these stand alone often, we refer to the other work and make some distinctions here between what we're trying to do here and other work that we've done.

MR. HACKBARTH: The stance that I'd like to see us take on this overall set of recommendations is that this is about transparency. It's not about condemnation of these agreements. If we knew that they were all uniformly bad, then we ought to propose that they be eliminated. But as Peter and some of the other comments illustrated, there is some real complexity here. So this set of recommendations is about transparency, and that's point number one.

Point number two is I very much agree with your comment, Jay, that there are certain types of relationships that we want to foster, and there are other types of relationships which may be counterproductive, and the nuance is very important here; and I think it would be good to discuss that in the text. But I don't want that point to

imply that all this is bad, because I think we get into trouble if we say it's all stuff that we want to get rid of.

I think that's our last comment, and we're ready to vote. And as we go through these, Ariel or Jeff, please remind me if we've agreed to any modifications of these so we can just remind people of that.

I think number one is as written. I don't think we agreed to any modifications, so on recommendation number one, all opposed to recommendation one? All in favor? Any abstentions?

Okay. Let's go to number two. I think number two is as worded, no modifications. All opposed to number two? All in favor? Any abstentions?

Okay. Number three. And on number three, as I recall, we said we would delete bullet two. All opposed to number three? All in favor? Any abstentions?

Number four. All opposed to number four? All in favor? Abstentions?

And number five. All opposed to number five? In favor? Abstentions?

Okay. Good work.

DR. CROSSON: A point of clarification. On number

three -- could we bring back number three? I thought we had made -- did we not strike "researchers" in the last sentence?

MR. HACKBARTH: Oh, yes. Thank you, Jay. So let's put it up just so the audience knows. Good catch. So in the last sentence of number three, we also agreed to delete "researchers." Delete the "to" also, yes.

Okay. Thanks.

MR. HACKBARTH: Okay. All right. Our next item is the Medicare hospice benefit, which we discussed at some length last spring and now we're moving to the next step of that analysis, which is what, if anything, should we do about our findings. And Jim, why don't you lead the way.

DR. MATHEWS: Thank you. Good afternoon. As Glenn just mentioned, the work that we are about to present builds on work that we began last year, throughout the course of the last 18 months or so. I would say up front that some of the material in here does assume this prior knowledge, but for purposes of keeping the presentation to a manageable length, we have had to kind of cut right to the chase in some of our analyses. But if there are any things that are unclear or if you need the background that's not in

the paper, we'd be happy to take that on question.

MR. HACKBARTH: Could I just make an editorial observation? I looked at the title for the session, "Critical Evaluation of the Medicare Hospice Benefit." I think you're using "critical" in the sense of analytic, careful evaluation --

DR. MATHEWS: That is correct.

MR. HACKBARTH: Yes. Okay.

DR. MATHEWS: Before we begin, I would like to acknowledge the work that Zach Gaumer and Hannah Miller put into getting us to this point today

Our presentation today will consist of a couple of distinct parts. First, we'll provide some brief background information on the hospice benefit, building on, again as I said, analyses that we started last year.

Second, we'll discuss several policy areas that the Commission identified last year as needing additional analysis and policy development with a goal of reaching the draft recommendations that we'll present today. These fall into three general categories. First is payment system reform. Second is the need for greater accountability within the hospice benefit. And third are additional data

needs that would help policy makers better manage and modify the benefit going forward.

There are two fundamental principles that we would like you to keep in mind as we walk through today's presentation. First, hospice provides an alternative form of care for beneficiaries who do not desire aggressive conventional treatment at the end of life. It is a voluntary benefit. Beneficiaries must explicitly elect hospice. In order to do so, the beneficiary needs certification of likely death within six months. In electing hospice, beneficiaries forego curative treatment for their curative conditions.

The second tenet that we have up on the slide here is that the benefit was -- in addition to giving beneficiaries this choice about their end-of-life care, the hospice benefit was implemented with the presumption that it would be less expensive than conventional end-of-life treatment and would result in lower Medicare spending. Our work over the course of the last 18 months has suggested that Medicare's payment system, however, contains an incentive for providers for long stays in hospice. This incentive potentially undermines the presumption that

hospice would indeed be less costly than conventional treatment.

As I mentioned a moment ago, in our recent analyses, we identified these three areas of Commission interest with respect to the work that we'll present today.

To lay the groundwork for these issues, we'll first discuss a few trends and statistics. Everyone is probably aware that since 2000, Medicare's hospice benefit has grown considerably. Roughly 900,000 beneficiaries were in hospice in 2006, an increase of almost 80 percent since 2000. This growth represents in part a growing awareness of the benefit and an increasing acceptance of hospice as an end-of-life alternative for the Medicare population.

Growth in spending was even more significant, reaching $9.2 billion in 2006, more than triple the 2000 spending level. Medicare spending for hospice will exceed $10 billion in 2007, more than the program spends on inpatient rehabilitation hospitals, critical access hospitals, long-term care hospitals, comprehensive outpatient rehab facilities, or ambulatory surgical centers. So it's no longer a niche benefit within the Medicare program. Additionally, hospice spending is expected to grow

faster than most other components of Medicare over the course of the next ten years.

To accommodate the increase in beneficiaries' use of hospice, the number of hospice providers has also grown. Currently, nearly 3,300 hospices participate in Medicare, up by 1,000 providers in the last seven years. The majority of the growth in hospices since 2000 has come from entry of for-profit hospices into the market, which is the yellow line on the left-hand side of the slide here.

The number of for-profit hospices grew by nearly 230 percent over this time, or about 12.5 percent annually, while the number of non-profits remained flat. Much of the new entrants were small, independent hospices and many operate in areas of the country with considerable market saturation, as we had discussed last year.

Over the same period, there were pronounced changes in hospice length of stay, which you see on the right-hand chart. The median length of stay for a hospice was nearly unchanged, at a little over two weeks. Stays below the median were very short and also didn't change much between 2000 and 2005. Length of stay above the median, by contrast, changed significantly. It got much longer,

especially at the 90th percentile and above. As we discussed last year, very long stays in hospice can result in higher Medicare spending than would have been incurred had the patient not elected hospice. Thus, very long patient stays undermine one of the statutory principles of the benefit.

Some of the increase in length of stay reflects changes in the hospice patient population. Some diagnoses typically have longer length of stay than others. However, diagnosis does not explain all of the increase in length of stay. There are some hospices that have longer lengths of stay for all of their diagnoses.

There are many explanations for these differences and we can talk about them during the Q&A. Some of them are articulated in your chapter, in the draft chapter. But one of the most compelling is financial. At the extreme, some hospices may be operating a business model based on extending length of stay in hospice to maximize profitability. The consequence of this approach, however, is that hospices that pursue such an approach are likely to exceed Medicare's payment limit, the hospice cap.

Last year, we showed that there was a pronounced

relationship between length of stay and profitability, as shown on this slide. We arrayed hospices by length of stay decile and calculated margins for each length of stay group. In all years we looked at, we found an almost linear relationship. Hospices with the longest stays were the most profitable and hospices with extremely short stays were actually unprofitable. While it's not shown on this slide, our preliminary analysis of 2006 data indicates that this trend holds almost exactly for 2006, as well.

Here's a graphical illustration of why longer stays are more profitable. As discussed in your paper, Medicare payments are generally flat through the course of an episode. Variations in the level of care, such as the use of inpatient respite care or continuous home care, do have an effect, but most hospice care is routine home care. Routine home care is paid at a fixed rate per day for each beneficiary who is enrolled in hospice, regardless of whether the beneficiary receives a service on any given day, so a relatively flat stream of payments across the episode.

Hospices' costs, on the other hand, follow a U-shaped curve. Hospices have higher costs at the beginning of the episode associated with the intake of the patient and

higher costs at the end of the episode associated with the higher level of activity that hospices perform at the time of the patient's death. The intervening period is generally less costly. So the hospice's profits related to the episode relative to Medicare payment and their own costs are shown in the green area of these charts. By extending the length of stay, as you see on the right, hospices can increase their profitability.

Arguably, the payment system should better, although not necessarily completely, reflect the normal curve of hospices' costs throughout the episode to reduce the incentives for extremely long stays. Still using a per diem construct, a relatively high rate of payment could be set in the earlier months of a hospice episode, cognizant of the benefits to all parties, the patient, the Medicare program, and indeed the hospices themselves, that accrue with appropriate lengths of stay. Payments could be constructed so that they decline over time, and in order to provide incentives for hospices to closely monitor patient length of stay, could even be calibrated so that they approximate or even dip below hospices' costs at a given point in the episode. Payments could then be structured to

provide a higher payment reflecting hospices' greater level of effort at the time of the patient's death. We'll come back to this point in a moment.

We modeled a new payment system using such an approach. We calculated payments under the current system and simulated what payments would be under a system where per diem payments were stepped down over the course of the episode using the weights shown here, or relative payment amounts shown here. For purposes of this model, we simulated moving to the new system in a budget-neutral manner. Thus, we set payments for each of these weights to ensure that aggregate payments under the new approach were equal to aggregate payments under the current system.

We want to point out very explicitly here that this model does not yet reflect the additional payment that would be made to hospices at the time of the patient's death, reflecting that higher level of effort. We will continue to work on our model here and bring this back to you the next time we present on hospice.

DR. MARK MILLER: Jim, could I also just get you to remind people that these payments, even though they step down, would continue throughout the stay of the patient.

DR. MATHEWS: That is correct. Once they reached a certain level, the payments would continue as long as the patient was enrolled in hospice.

The new system would redistribute payments among groups of hospices basically as a function of length of stay. It would shift payments from hospices with very long stays to those with shorter stays. Since length of stay is rather correlated with hospice type, this redistribution results in differential impacts among the various categories of providers that we typically analyze.

Among the specific highlights, payments to for-profit and freestanding hospices, which are highly correlated groups, would be reduced by about three percent, respectively. Payments to non-profits would increase by about two percent, and payments to provider-based hospices would increase by 11 percent. Payments to rural hospices under the new system would increase by about five percent relative to current policy.

I do want to be clear on this point, though, that the policy doesn't favor one provider type over another but is completely a function of length of stay. And so to the extent length of stay is correlated with specific provider

types, that is what accounts for these impacts, and again, we can discuss that more completely if you would like during the Q&A.

Again, I also want to be clear that these impacts do not yet reflect the payment adjustments that would be made at the end of the episode with the patient's death. Such an adjustment we anticipate would be financed by reducing the base payment amounts under the new system, possibly by around five percent. It would also have the effect of magnifying the redistributive effects of this stepped-down payment system that you see here.

Lastly, we are in the process of estimating the impacts of the new payment system on the number of hospices that would exceed Medicare's payment limit. Tentatively, we estimate that the number of hospices exceeding the cap would be reduced by a third from the nearly 300 that we estimate for 2006 to just under 200 under the new system.

We believe there are several merits to the approach that we have outlined here. First, it reinforces hospice as an end-of-life benefit and incorporates incentives to ensure that hospices provide the optimal balance of benefits to Medicare beneficiaries and the

program itself. It also better matches hospices' actual cost curve in the course of an episode, and it does include payment adjustments to make hospices more sensitive to the impacts of long lengths of stay. It will also likely, as I just mentioned, reduce the number of hospices exceeding the cap.

Additionally, it provides higher reimbursement for patients with very short stays in hospice under the current system, which are in the aggregate unprofitable. As a result, this payment system revision may provide an incentive for hospices to take greater efforts to appropriately lengthen the stays for very short stay patients.

Given the Commission's prior discussions, the first recommendation appears on this slide. The Congress should change the current Medicare payment system for hospice to reduce payments per day as the length of the episode increases. The revised payment system should include a payment adjustment to reflect hospices' higher costs associated with patient death at the end of the episode.

We have made a first cut at implications of this

draft recommendation and for those that follow. The formal assessments will need to come from the Congressional Budget Office, however, and we anticipate having these for you once the recommendations are final. We believe that this recommendation will not have significant spending implications in the first year due to the goal of implementing it in a budget-neutral manner.

The effects on patients are likely to be mixed. Some beneficiaries with conditions likely to have short stays in hospice may be able to receive more hospice care, but there would likely be fewer beneficiaries with long hospice stays.

The proposal would have significant impacts on providers with redistribution of Medicare payments, as indicated earlier.

We will now move on to the second policy area that we flagged in the spring, the need for greater accountability, which Kim will discuss.

MS. NEUMAN: We're next going to look at the accountability safeguards currently in place under the hospice benefit and whether there's a need for additional safeguards, for example, in the areas of certification and

recertification of patients' hospice eligibility and Medicare program oversight. We will first look at the hospice patients with very long lengths of stay and then we will consider special issues related to nursing home referrals to hospices.

First, the long-stay patients. Length of stay in hospice is increasing, particularly for patients with the longest stays. The top ten percent of beneficiaries in hospice had a length of stay of at least 212 days in 2005. That's up roughly 50 percent from the level in 2000.

Patients can have long lengths of stay for several reasons. First, there is uncertainty in predicting life expectancy. This means there will always be a certain percentage of patients that live longer than expected and have long hospice stays.

Second, some patients may be admitted to hospice too early or not discharged when their prognosis improves. MedPAC's work in the June 2008 report showed that there were certain hospices that had longer lengths of stay across every diagnosis. This suggests that some hospices may be pursuing a business model that focuses on long-stay patients, potentially spurred by the profit incentives

associated with long stays under the current payment system which Jim just discussed.

We asked an expert panel of hospice providers we convened in October to give us their perspective on very long hospice stays. Before we talk about the expert panel's feedback, I am going to walk through the current hospice eligibility process.

To enroll in hospice, two physicians, the beneficiary's personal physician and a hospice physician, must certify that the beneficiary's prognosis is terminal. As Jim mentioned, terminal is defined as a life expectancy of six months or less if the disease runs its normal course. After initial enrollment, the beneficiary's continued eligibility for hospice must be recertified at 90 days, 180 days, and every 60 days thereafter. Recertifications only require the signature of a hospice physician.

The Medicare claims processing contractors have devised Local Coverage Determinations called LCDs that provide guidelines for determining if a prognosis is terminal. If a beneficiary does not meet that criteria, the beneficiary may still be eligible for hospice if a physician certifies the prognosis is terminal based on their medical

judgment concerning aspects of the patient's condition not considered by the LCD.

Last month, we convened an expert panel of eight hospice administrators, medical directors, and nurses. The panelists came from both nonprofit and for-profit hospices and from a wide range of geographic areas. A medical director from a Medicare claims processing contractor also participated.

We asked the panelists about the reasons for increasingly long stays. The panelists cited a number of factors, for example, uncertainty in predicting life expectancy and changes in the mix of hospice patients in terms of the types of diseases they have. At the same time, panelists indicated that some long stays are due to a lack of compliance with Medicare eligibility criteria among some hospices. Panelists uniformly asserted that many hospices comply with Medicare eligibility criteria. However, they also indicated that some do not.

Panelists cited a number of reasons for non-compliance among some hospices. A lack of physician engagement in the certification and recertification process was one factor cited. For example, we heard that some

physicians delegate responsibility for recertifications to non-physician staff and just sign off on the paperwork. And at the extreme, some hospices reportedly prohibit physicians from visiting patients for recertification purposes. In addition, inadequate charting and a lack of physician or staff training can reportedly lead to some patients being certified or recertified for hospice when they may not truly qualify.

Finally, some panelists pointed to financial incentives associated with long-stay patients and cited examples of questionable practices among some providers in their communities. For example, we heard anecdotal reports of some hospices never discharging patients for improved prognosis, enrolling patients who had been turned away or discharged by other hospices, disregarding the eligibility guidelines in the Medicare Local Coverage Determinations, aggressively marketing to individuals likely to have long lengths of stay, like nursing home patients, or marketing hospice to patients without mentioning the terminal illness requirement.

Consensus emerged among panelists about the need for more accountability and greater oversight with regard to

long-stay patients. Panelists offered several suggestions. First, some panelists suggested that Medicare could require a physician or an advanced practice nurse to personally visit the patient to assess continued eligibility at the 180-day recertification and every second recertification thereafter, that is, every 120 days thereafter. This type of requirement would result in more direct physician engagement in the recertification process. Given the strong financial incentives for long stays, however, there may be compelling reasons to require a visit at each recertification beyond 180 days, that is, every 60 days.

A second suggestion offered was that all certifications and recertifications could be required to include a brief narrative statement from the physician about the clinical basis for the terminal prognosis. Panelists felt such a requirement would focus more attention on accountability and spur more physician engagement in the certification and recertification process.

Third, a suggestion was made for CMS to increase its medical review of long-stay patients, focusing on providers with exceptionally high lengths of stay. Panelists felt that the existing LCDs, or Local Coverage

Determinations, were reasonably effective in identifying patients appropriate for hospice, but that a perceived lack of enforcement of the existing guidelines was leading some hospices to enroll individuals of questionable eligibility.

In addition to these suggestions, the expert panel discussion also highlighted special issues with regard to hospice referrals from nursing homes. Both nursing facilities and hospices have incentives to enroll nursing home patients in hospice. For example, nursing facilities may seek cost savings from having a second entity partly responsible for the patient's care. Nursing facilities may also gain an additional stream of revenue if they contract to provide certain services on behalf of the hospice.

Hospice providers also have incentives to admit nursing facility patients. First, hospice providers are likely to realize cost savings by providing care to several beneficiaries in one nursing facility rather than traveling to individual homes. Hospices may also see less demand for their services since the patients have access to nursing facility staff.

Second, for dual-eligible beneficiaries, the Medicare payment for nursing facility room and board --

excuse me, the Medicaid payment for nursing facility room and board is made to the hospice, who is then required to compensate the nursing facility for room and board at a rate no less than 95 percent of the Medicaid rate.

Third, nursing facilities may be a source of long-stay patients for hospices, a group that typically requires fewer visits per week and tends to be profitable, as Jim discussed.

Medical directors of nursing facilities typically serve as residents' primary care physician and as such are likely to be the physician who refers a resident to hospice and certifies that the prognosis is terminal. As a result, nursing facility medical directors can be at the center of potential conflicts of interest concerning referrals to hospice.

In addition to the general financial incentives to refer nursing facility patients to hospice discussed previously, there are certain circumstances where the potential conflict of interest may be enhanced. First, there may be added financial incentives for referrals to hospice when the nursing facility and hospice have joint ownership.

Second, the conflict of interest is further enhanced in situations where hospices put nursing facility medical directors on retainer or make other financial arrangements to compensate the medical director for serving as a referral source for the hospice provider. Some of our expert panel members provided anecdotal information indicating that such conflicts of interest do exist among some providers.

Based on the Commission's guidance and prior discussions of hospice for the June 2008 report, there's a two-part draft recommendation for consideration. The first part focuses on enhanced accountability for long-stay patients in general, and the second part focuses additional attention on nursing home referrals to hospice and hospice marketing practices.

The first part of the draft recommendation reads, "The Congress should direct the Secretary to: Require that a hospice physician or advanced practice nurse personally visit the patient to determine continued eligibility at 180 days and at each subsequent recertification and attest that such visits took place; require that certifications and recertifications include a brief narrative describing the

clinical basis for the patient's prognosis; and require that all stays in excess of 180 days be reviewed by the applicable medical director of the Medicare claims processing contractor for hospices with an average length of stay greater than 120 days."

Given the concerns the Commission has previously expressed about the adequacy of CMS resources to administer and oversee the program, the text of the report would potentially include the following draft language. "The Congress should provide CMS with the resources necessary to enforce existing policies applicable to the hospice benefit and any new policies adopted on the basis of recommendations herein."

The implications of this draft recommendation, which are pending feedback from CBO, are: In terms of spending, the direct spending effects are indeterminate, but the draft recommendation would require additional CMS administrative resources. In terms of beneficiary and provider impacts, the draft recommendation would reduce the likelihood that a beneficiary ineligible for hospice would receive hospice care. There is a potential positive impact for hospice-eligible beneficiaries by promoting increased

physician engagement. Finally, cost to providers would vary following disproportionately on hospices with long lengths of stay, and there would be minimal burden associated with the requirement for a narrative explanation of prognosis in certifications and recertifications.

Turning to the second part of the draft recommendation, it reads, "The Secretary should direct the OIG to investigate the prevalence of financial relationships between hospices and nursing facilities that may represent a conflict of interest and influence admissions to hospice, differences in patterns of nursing home referrals to hospice, and the appropriateness of hospice marketing materials."

The implications of this draft recommendation are, with regard to spending, there would be no direct Medicare spending implications but it would require OIG administrative resources. In terms of beneficiaries and providers, there would be no direct or immediate impact.

And with that, I'll turn it back over to Jim.

DR. MATHEWS: Finally, last year, we also identified the need for additional data in order to better understand and manage the Medicare hospice benefit.

Administrative data are currently collected via both Medicare cost reports and from hospice claims, but improvements and enhancements can be made to both of these instruments. We will talk about claims first.

Historically, hospices have had only to indicate the number of days of each type of service they were billing for a given beneficiary on their claims. In 2008, CMS began requiring hospices to report additional information on claims, notably the specific type of personnel who provided a visit, such as physicians, nurses, or home health aides. We believe that there is tremendous value to CMS collecting both this information as well as additional information via hospice claims.

In particular, CMS should collect information on all practitioners who provide visits. The agency should also collect information on the duration of visits, similar to the requirements on home health agencies, who report visit times in 15-minute increments. It's worth noting that at least one of the major hospice industry associations has also recommended that CMS collect this information. There is more detail in your paper on this point. A recommendation in this area would be particularly timely, as

CMS is developing the next phase of its hospice data collection effort as we speak.

So draft recommendation three reads, "As a condition of payment, the Secretary should require that hospices report information on all visits provided to the patient on hospice claims, including length of visit."

The preliminary implications of this draft recommendation are shown here. As was the case with our -- we do not see immediate direct spending implications, although CMS would incur some administrative costs in revising hospice claims. We also do not anticipate any immediate implications for beneficiaries, but there could be some beneficial long-term effects. Lastly, hospices would likely incur some costs in adapting to these claims requirements and in ensuring staff are adequately trained to log and report visit time increments according to Medicare's requirements.

The second component of our analysis of data needs dealt with hospice cost reports. The content of existing cost report data could be improved and new data could be collected via the cost reports. During the course of our work, we identified a number of data quality issues with

cost reports. These are described in detail in your paper, but generally consisted of missing information, inconsistent or contradictory information, or information that was simply wrong.

We also identified information that either was collected only on some providers' cost reports, for example, only on free-standing hospices' cost reports, or was not present on the cost report at all. In particular, we identified four types of information that cost reports should include: Consistent information on Medicare payments across all hospice types; information on visits consistent with CMS's collection of this information from hospice claims; uniform reporting of days of care; and other revenues, such as charitable contributions, that may help provide a fuller picture of hospices' overall financial performance.

In light of your confirmation last year that more data is needed, draft recommendation four reads, "The Secretary should change cost reports to reflect new data collection on hospice claims, add new data fields to capture the full range of hospice revenues in order to provide a more accurate picture of hospices' financial performance,

and increase the accuracy of cost report data through audits or other processes so that these data can be used in setting, adjusting, or rebasing payments, as warranted."

The preliminary spending implications of this recommendation are shown here. We do not see immediate direct spending implications, although CMS would incur some administrative costs in revising cost reports and establishing more stringent review and audit criteria. Similarly, there are no short-term implications for Medicare beneficiaries, but there could be long-term effects if these data are subsequently used to improve the accuracy of hospice payments. We anticipate that hospices would incur some costs in adapting to the new cost reporting requirements, both in terms of upgrading and integrating claims and cost reporting software and in ensuring staff are adequately trained in these new elements.

To summarize, then, we hope these draft recommendations on payment system reform, accountability, and data needs are consistent with the expectations you may have had at the end of the last analytic cycle. At this point, we will look forward to your discussion and stand by to address any questions you may have.

MR. HACKBARTH: Good job, Jim and Kim. These are draft recommendations, so no votes today. Depending on how this discussion goes, possibly in December, or will we do it in January?

DR. MARK MILLER: I've got to think through the schedule a little bit more. We have a heavy load in December when we come to the update, so this may move to January for the return on this.

MR. HACKBARTH: All right. I need hands for clarifying questions, and Bruce, why don't you lead off.

DR. STUART: This was a superlative job. I learned more about hospice reading this chapter than I knew before this, so I want to commend you on that. Now we know after you have presented it that the "critical" in the title actually refers to something more than just analytical, and that actually --

DR. MARK MILLER: For the record, no it doesn't.

[Laughter.]

DR. STUART: The question I have is -- and the chapter goes into this a little bit -- by assuming budget neutrality, what you are in essence doing is you're transferring some funds from longer stays to shorter stays,

and when we saw that chart on margins by length of stay, I mean, it seems to me that that is not unreasonable.

However, it also appears that these longer stays, the difficulty here is not just overpayment. There are some really, there is some bad behavior going on here. And so the question is, why would you want to have this completely budget neutral, or is it necessary to be completely budget neutral? Couldn't you save some money in this area?

MR. HACKBARTH: Why don't we come back to that? That's a little bit more than clarifying.

[Laughter.]

MS. BEHROOZI: At the risk of also sounding a little bit like a statement, it really is a question. Who is minding this candy store? Kim, on page 18, you talked about the eligibility requirements and Local Coverage Determinations. Is it just the Medicare claims processors who are responsible for enforcing that the eligibility requirements are met?

MS. NEUMAN: Right, so the --

MS. BEHROOZI: And to whom are they accountable?

MS. NEUMAN: So the physician has to certify the patient's eligibility and then the certification is kept in

the medical record and it is only requested upon audit. So the way --

MS. BEHROOZI: And who audits?

MS. NEUMAN: The Medicare claims processing contractors would audit and the amount of audit would depend on the level of their resources.

MS. BEHROOZI: So who audits the medical claims processors auditing or whatever, that they are doing what they are supposed to be doing?

MS. NEUMAN: They're CMS's contractors, so they are CMS's hands in the field, so they would oversee them.

MS. BEHROOZI: Okay, and on page 19 and in the paper, you talked about the suggestion that I think came from hospice operators themselves that the certification include a narrative. So then my question is, if it doesn't include some clinical evidence, what does it require now, just a single term of diagnosis and checking the box that the person is terminal?

MS. NEUMAN: So they need to say that the prognosis is terminal. It needs a physician's signature. And then if the file was audited, they would send the medical record and the medical record would need to support

the clinician's certification that the prognosis is terminal.

MS. BEHROOZI: Okay. So the certification itself just has to have the prognosis and the signature?

MS. NEUMAN: Yes.

MS. BEHROOZI: Thank you.

DR. MARK MILLER: Overlaying this, and Kim, just make sure I'm right here, overlaying this is pretty much CMS doesn't have a lot of resources to do any of this, and so --

MS. NEUMAN: Right.

DR. MARK MILLER: -- our take-away from the medical directors that we talked to in the hospice, for-profit, nonprofit hospices that we put together was they didn't think much of this was going on, if any, and it was quite striking that they were asking for more oversight, which --

DR. CASTELLANOS: Jim, Kim, great job, I really thought you did. Jim, this is really a clarification on a subject you brought up last year. It was not mentioned in the meeting briefs or today's discussion. You mentioned a little bit about caps last year and you said a very high percentage of those caps occurred under one of the Medicare

fiscal intermediaries. And my question to you is, does this still exist, and if it doesn't, great. If it still exists, have you looked at it?

DR. MATHEWS: We have done a preliminary assessment of the number of hospices that will exceed the cap in 2006. I believe it's discussed in your paper. With respect to the distribution by intermediary, yes, the pattern we observed last year does still hold in 2006, that 80 percent of the cap assessments are attributable to one fiscal intermediary.

Again, I would stress, as we did last year, that that distribution does not appear to reflect anything that that fiscal intermediary is doing differently by way of assessing the caps, calculating cap overpayments, but rather reflects the length of stay distribution of the hospices in the geographic areas covered by that fiscal intermediary. It does not look like that fiscal intermediary is doing anything different.

DR. KANE: On your page ten of your -- so if we are to suggest that this type of payment system should be perhaps implemented, have you already figured out how much they should be and how they be stepped down? I mean, how do

you know the schedule and the amount? What's the basis upon which you would come up with that model, or is the model already come up with? Where is that coming from?

DR. MATHEWS: This borders between a clarifying question and a very substantive question, but to try and briefly -

DR. KANE: It's a clarification of --

DR. MATHEWS: To briefly answer your question, this is one potential way that you could step down payments. It is not necessarily the definitive way. We came up with this schematic here based on the distribution of current length of stay, average payment for hospice patient, what the current cap amount is, what payments would look like at 180 days under the current payment system, and try to change payments under the new system relative to current system in order to shift length of stay away from the long-stay patients.

DR. KANE: So it's not a cost model. It's sort of a revenue model?

DR. MATHEWS: That's correct.

DR. KANE: Okay. That was my question.

DR. MATHEWS: Other ways of doing this would be to

base the distribution on a hospice's provision of visits, as reflected in the claims data that CMS is currently collecting.

DR. CHERNEW: On this topic, did you have any assumption about any sort of behavioral response when you got budget neutrality? In other words, if you put this in and there's a change in distributions of things, was there any adjustment made, or you assumed the exact same --

DR. MATHEWS: That's correct. We've made no behavioral adjustments here.

DR. CHERNEW: My second clarifying question is, when a physician goes to recertify somebody per the recertification, I think it was 2(a), I'm not sure, one of those, the recommendation was, who pays? Do they bill separately for that extra visit or is that billed in some other bundle or by some other organization, that recertification activity?

MS. NEUMAN: If a physician visits a patient just for recertification purposes, the payment is considered to be part of the per diem payment that they get and there's no extra payment.

DR. MARK MILLER: The hospice pays the physician

for a recertification visit if that's the only thing that the physician does during that visit.

DR. CHERNEW: I'm just trying to figure out how the cost of that extra set of activities is being borne.

DR. MARK MILLER: I think the other way to say it is that was assumed in the payments that are going out to the hospice. And in this panel that we had, there were several hospices, or there were some medical directors who said when a patient begins to have a very lengthy stay, the physician may actually go and say, I want to see this patient and see what's going on, and they pay for that out of the hospice payments that they get, because this is the medical director of the hospice making the visit in this particular instance. Other hospices, as Kim was saying, is that there are policies where they don't do that and the question is, is it clinically they don't need to, or is it because of the payments, the issue that you're raising.

DR. CHERNEW: [off mic] Right. I was actually mostly concerned if we made them do a lot more than the accountability thing, is there a real cost of that? And how would that...

DR. SCANLON: There was a procedure set up for

recertification, which there was a payment to physicians, and I'm not sure if it only applied to home health, and it didn't necessarily involve a visit, but it was for basically signing the form, reviewing the form and signing it. And the question is whether or not it applies to any context other than home health. This was set up maybe around the year 2000.

DR. MARK MILLER: I think what Bill is referring to, and I'm also looking for Evan here, is the attestation -- - no, okay. Then speak up, please.

MR. CHRISTMAN: [off mic] I think your recollection is correct, Bill. There is a physician billing for certifying a home health admission. I believe it's only for home health, though. I don't believe it's for hospice.

MS. HANSEN: This is just a question on the point of the medical directors potentially having a conflict of interest factor, and I just wondered, since we had a whole recommendation on Medicare and physician relationships whether this potentially falls into just a disclosable relationship. So that is one question.

And the second question is related, too. With these long length of stays, do people just stay on ad

infinitum, or if they really go beyond the caps, what happens to the patient?

MS. NEUMAN: On the second part of your question, they can continue onward. There is no finite limit. As long as the physician continues to certify them as being terminal, they can continue in the benefit indefinitely.

DR. MATHEWS: On that point, for example, when we did our analysis last year where we compared patients in 2000 to 2005 and looked at the difference in their characteristics, in the course of doing diagnostics on those data files, we found slightly over 1,000 patients who had uninterrupted hospice stays that spanned from 2000 to 2005.

MR. GEORGE MILLER: If you could turn to slide 11, please, and just to clarify and question, if I am a rural provider-based not-for-profit entity, do I get five plus 11 plus two percent, or do I --

[Laughter.]

MR. GEORGE MILLER: Or If I'm a provider-based for-profit, do I get to subtract three from 11 percent? Have you thought that through or --

DR. MATHEWS: We'll see if we can break down those impacts at that level of detail, but --

DR. MARK MILLER: But they are not simply added to it.

DR. MATHEWS: They are not.

DR. MARK MILLER: Right. You would have to run the analysis with the interactions of the characteristics to come up with that number, but people should not be looking at those numbers and accumulating them. They aren't added to --

MR. GEORGE MILLER: But do I get to choose which is --

DR. MARK MILLER: I completely misunderstood your question.

[Laughter.]

DR. MATHEWS: We're not setting up a new business model here.

MR. GEORGE MILLER: The second part of my qualifying question, if you could help me understand the for-profit entities. I was very stricken -- and this is an excellent report and I loved reading it -- could you give me a profile of what a for-profit entity looks like? The reason I'm asking, I've heard anecdotal stories competing with ours in my home town that there are a lot of ma-and-pas

out there who are not clinicians who own hospices. So do you have a profile of what --

DR. MATHEWS: It's varied. They range from individually-owned for-profit enterprises, you know, locally-owned, to large publicly traded corporations that have multiple sites across the country. So I don't think you can broadly characterize what the for-profit slice of the hospice community looks like.

MR. GEORGE MILLER: Okay.

DR. MARK MILLER: They don't tend to be smaller?

DR. MATHEWS: The for-profit cap hospices are distinctly smaller --

DR. MARK MILLER: That's what I'm thinking.

DR. MATHEWS: -- than hospices that do not exceed the cap. But I don't think we could characterize all for-profits that way.

DR. CROSSON: Yes, I just had a question on the data portion. I was surprised when we first started talking about the hospice benefit or the hospice issue to realize that, in fact, hospices were not reporting the actual care that was being delivered. It struck me as odd compared with other parts of the Medicare program and still does. I

wondered, in the new claims reporting information, because I couldn't tell from the text, to what degree of granularity is that issue resolved. Is that going to actually enable someone to tell on any given visit what sorts of services were provided to an individual?

DR. MATHEWS: No. The current data collection effort only requests that hospices provide information on the type of practitioner who provided the visit, so, for example, physician, nurse, home health aide. It does not break down in any more detail what services that practitioner provided nor does it provide information on the duration of the service. So a physician visit or a nurse visit is the same as a nurse visit under the current collection effort, and that's one of the reasons that led us to suggest that CMS also begin to include information on visit duration.

DR. CROSSON: But the suggestion does not include that information about what kind of services was provided be provided?

DR. MATHEWS: That's correct.

DR. MILSTEIN: Managing lengths of stay, as you've pointed out, involves a fair number of moving parts and

players. This may have been in the background materials and I missed it. Has MedPAC previously considered the pros and cons of a fixed-price approach to this benefit, which is obviously a very different way of managing length-of-stay abuse, if we think it's common?

DR. MATHEWS: By a fixed-price approach, do you mean a single payment for the beneficiary who elects hospice? I think we might have mentioned it briefly in passing in the set-up for describing the step-down payment system revision that we've presented here, but we have not developed that extensively.

MR. BUTLER: The data in the chapter shows that the growth in the last seven years has been all on the for-profit side and it's been flat on the nonprofit side and that non-profits represent now about a third of all the hospices. I think that's what it says.

My question, though, is on this slide. You have the nonprofit and provider-based, which I assume is almost exclusively a subset of the nonprofit. Probably most are nonprofit on the provider-based. So my question is, how many are provider-based as a percentage of the total and do you know anything about the trends in the last seven years

of the provider-based hospices, because I don't think I saw that in the -- I assume those are mostly hospital-sponsored.

DR. MATHEWS: Let's see what I have here. Just a point of clarification. I think the way we have characterized the distribution by ownership is that slightly over 50 percent are for-profits. The remainder are the non-profits, the government, and then there are a small subset of sort of mixed ownership type, county and nonprofit collaborations, that sort of thing. There are charts where we don't show --

MR. BUTLER: It doesn't add up to the total. That's why I --

DR. MATHEWS: Yes. We don't show the government providers. So that's how we would characterize that distribution.

With respect to the percent who are provider-based, probably a third to 40 percent tops. So I'll say 30 to 40 percent --

MR. BUTLER: Of the nonprofit, and they're almost all nonprofit.

DR. MATHEWS: The majority are probably nonprofit. I would not say all. There are some for-profit provider-

based hospices. The provider can be a hospital or a home health agency are the predominant parent provider types. There are a handful of skilled nursing facility-based hospices, literally nine or ten that are in our most analytic file.

DR. REISCHAUER: This really is a clarification. On eight, where you have your illustrations of costs and revenues from length of stay, it suggests that it's less costly when somebody dies after 12 months than after six months. Does that come out of your data or is that just --

DR. MATHEWS: This is purely an illustration.

MR. EBELER: Just to follow up on Peter's question, if we're going to clarify the data on number of hospices, it might be also useful to include a column on the number of beneficiaries served by those categories, because if we're talking about entities with different sizes, we just need to understand both denominator of hospices and denominator of beneficiaries served, I think.

MR. HACKBARTH: Are you ready, Jim? I'm going to set Bruce free here.

DR. STUART: I've already asked my question.

MR. HACKBARTH: You're just waiting for the

answer. Why don't you go ahead and restate it, Bruce.

DR. STUART: The question, in brief, is why did you assume budget neutrality for this analysis?

DR. MATHEWS: We thought it would be the best starting place for the Commission to begin its deliberations.

DR. MARK MILLER: Just to follow up on that, something that Mike said earlier is that we don't have a sense of the behavioral impacts and there could be changes over time from that. And also, the way we've been proceeding for the last year is kind of what's this benefit and what's going on and it hadn't come up as an objective in and of itself, but also to integrate it at some point in time into our standard kind of financial analysis and update type of analysis. And so, really, the direction to Jim up to this point has been we should be looking at the underlying payment structure of the benefit and haven't really taken on the kind of total expenditure thing. But it's a completely legitimate question.

DR. STUART: Well, I think there are two parts to this question, and Mike raised one of them, and that is have you factored in behavioral responses to these suggestions,

and the fact that obviously at some point you are going to want to do that. So that gets to the accuracy of the estimate. But that still doesn't get to the issue of why you are assuming that this should be budget neutral as opposed to generating savings from what appear to be bad actors.

MR. HACKBARTH: Most of the time, if not all the time that Medicare has moved to a new payment system, it does so on a budget neutral basis, not to sanctify the existing level of spending, but really as a practical consideration. If you say, well, we are going to do a new payment system and that step one, we're going to reduce expenditures by some significant percentage, you've made it politically, practically, more difficult to get the new payment system adopted. Not only do you have the people who would lose under the redistribution, you are also shrinking the size of the pie, which just means that many more potential votes against you. Of course, on the other side of the coin, you don't want to add to the expenditure problems that we have already got.

So it is common to start with budget neutrality and then over time you may get dynamic effects that reduce

expenditures or you may want to make system refinements that reduce expenditures.

DR. STUART: I'd like to hear what Bill has to say about this, since he's our institutional historian, because it goes back to the home health issue, it seems to me, in 1997. Clearly then, there was an assumption that the payment levels were just simply too high and you had to get them down.

DR. SCANLON: There's no question about that, but at the same time, when you do do something other than budget neutrality, you take on for yourself an analytic responsibility to demonstrate that your cut is going to be something that is acceptable. And the logic that's been used in terms of adopting some of these new payment systems with budget neutrality is we're not experiencing a problem now, so therefore we're not going to be experiencing a problem if we spend the same amount of money in a better way. And so you kind of take that one analytic task that you have off the table.

In all of these things about changing systems dramatically, you're faced with this problem that you have no data on the world that you're creating, and so it becomes

-- your analytic task is very hard and your ability to convince people is very hard. So it is this issue of trying to reassure people who are ultimately responsible, namely the policy makers, that you're not going to cause harm. I mean, it's again this issue, can we make improvements over time as opposed to instantaneously and where we increase the risk when we do try to do it instantaneously.

DR. SCANLON: I just want to say, this is an excellent sort of report and I'm fully supportive of the recommendations. I think that particularly the reimbursement recommendation, the idea of this new structure is, I believe, very much in the right direction and reflects the fact that we have a payment system that is, what, it's close to 25 years old and was based upon a benefit that was very different. This reflects, in some respects, the new structure of the benefit.

Having said that, I think Nancy's point is very important, that the structure for the reimbursement system or the payment system may be correct, but we really do have to worry about the parameters. And one of the things to think about is whether or not we want to say that if it comes down to it, the existing data are non-adequate to

provide good estimates of the parameters that we want here, that there should be a data collection effort, some sort of short-term, very intensive that allows us to move forward.

We did this with respect to SNF payments. We don't rely on administrative data to set the SNF payment system. We have to do special data collection and we should think about it sort of in this context, as well.

In terms of the recertification, I'm behind that, as well. The issue for me would be, and Jim, I agree with you that even though we have a geographic concentration of the cap issue, it's probably not the contractors and not related to the contractor. But I would prefer that we have something other than Local Coverage Decisions being enforced and that really we should have national standards for what constitutes appropriate hospice care, because in this whole issue, there's two parts of the local coverage versus national coverage decisions.

One is the efficiency thing. Why have every contractor reinvent the wheel and go through the evidence and come up with a decision as to what's going to be covered?

The second aspect of it is the equity, the fact

that you can be in one State and get coverage under Medicare for something, and be in another and have it denied. That just is not appropriate sort of in a national program.

On the IG study, I don't know if your panel raised this at all as an issue, but residential long-term care has changed dramatically sort of over the last 15 to 20 years, to the point now where we have about a million people living assisted living. I guess they're some of the same types of issues. There's not really in many instances a big difference between a nursing home and an assisted living facility and whether we should be looking at the same kinds of questions for hospice and assisted living facilities as we are looking for hospices and nursing homes is something to think about.

The last thing, which is not sort of among the things we're doing now, is a different kind of certification, and that's survey and certification, and that's the issue of are the people that are coming into this program capable of being hospices? This is something I have heard sort of in a variety of contexts. We don't spend much time looking at whether the organizations can comply with the conditions of participation and do so on a continuing

basis, and that is another part of this. I mean, we've got to make sure that we have capable providers. I've even heard this from the hospice industry itself, saying we really would like to be looked at a little more frequently than we are now. Sometimes it's five to ten years between surveys.

MR. HACKBARTH: We're in round two now, just for those who are keeping score.

DR. CHERNEW: I have two sort of broad points to make about this. The first one is, loosely, it's not clear to me what the optimal length of stay is given that we have to think about this in the broad care for the people, not just always hospice and assisted living and home care and nursing home care. If the person is not in the hospice over a long period of time, they're somewhere else, maybe just in the community, but it's not clear to me necessarily. I do believe there's something wrong with the payments or the margins, but it's not clear to me inherently what the right level of hospice care we want in general would be.

For example, if we make these payment changes, we're going to have a bunch of behavioral responses. I'm not sure what they all are. And if I knew what they all

were, then I'd have to ask, are they good? Are they good in terms of financially or are they good in terms of clinical quality? And so I'm not sure yet that I know once we make a change what the ramifications would be. All I really know is right now, the incentives don't seem to be right, but that doesn't mean that the outcomes we're going to get broadly for the beneficiaries are going to be better if we go to some other way because it interacts with a whole bunch of other services that we're sort of not dealing with here.

The second comment that I have, and this is just sort of an intuitive sense, is I believe that more accountability is important and some of the things that it sounds like happen are really appalling. All of that said, I think there's potentially a lot of administrative costs in some of the accountability things that we conceivably could force people to do in terms of data and stuff and sometimes I believe, and I'm not sure I believe it in this case, is if we got the payment right or got the payment better, that could mitigate a lot of the need for micromanaging various things that went on.

For example, if we had the right payment, I would be willing to spend a lot less resources on verifying people

very frequently if we had the right incentives in the first place.

MR. HACKBARTH: That would be true, Mike, if you had a bundled payment and moved away from per day, for instance.

DR. CHERNEW: Right. For example, if we had a bundled payment, I wouldn't need people to be certified. There might be other things I would worry about. I might worry about quality. So there's a whole series of things that one would want, but there's interaction between the payment and the information one wants, and so what we know now is the stuff isn't happening. We have a bad payment system and a bunch of bad things going on. But once we fix one, it's not clear the other one is going to need to be fixed in the same way.

MR. HACKBARTH: So the model presented here is continue with the per day payment system, change the level at different points in this day. So long as you have a per day system, you're going to need some checks on the appropriateness of the stays.

DR. CHERNEW: Not if you lowered the payment low enough for some of the per days.

DR. MARK MILLER: You should say that with the microphone on, well, just so everybody hears it.

There's also one thing I want to clarify, just in case it's crept into people's minds. On the accountability recommendations, two of them are sort of clinical. The physician ought to see the person at some set points in time and ought to document reasons. The real oversight one, the one that you're referring to, it had two pieces. It is stays that are beyond six months in hospices that have high lengths of stay, on average. So it's not hitting the entire distribution. Just in case anybody else is unclear on that, it is designed to be at the right-hand tail of the distribution and the long stays in that tail, if you see what I'm trying to get at. But it still will incur costs.

DR. SCANLON: Theoretically, I think, Mike, you're exactly on target, I mean, this whole issue that if we could do a good job in setting the payment rates, we wouldn't need to be as concerned about some of this accountability. But if you look at the distribution on page six between the 90th percentile and the tenth percentile in terms of length of stay and you combine that with what every clinician says about sort of the difficulty of making a prognostic

prediction about sort of death, we are talking about sort of an incredibly challenging task here and it's not something -- right now, we're limited to mostly diagnostic information, and I'm not even sure if you asked clinicians what else they would want on the menu in terms of saying variables that are going to influence this they could come up with a list that had much explanatory power at all. So we really probably need to stay in this context because it's the one that's feasible for the intermediate term. Daily payments, right.

DR. REISCHAUER: Can I just say something about what Mike said? Changing the payment system shouldn't change the demand for the service. It might change the number of suppliers out there wanting the service. If you do this in such a way so there is a normal margin, you know, normal being defined with the appropriate care, you shouldn't worry about what you're worrying about, I don't think.

DR. CHERNEW: [off mic][inaudible.]

DR. REISCHAUER: Whatever you were worrying about.

[Laughter.]

DR. CHERNEW: I worry about a lot. Yes, if you get the payment right, then there's less to worry about.

DR. REISCHAUER: People who are saying at this point, I think the right thing is to give up on aggressive care and go into palliative care, and that's in a way a personal decision for each family, it will sort of average differently for Alzheimer's folks than from cancer folks from other folks like that. As you said, there is no right average length of stay, probably no right one even for all cancer patients. And so it's really are we letting people avail themselves of this option and is there an appropriate supply of these services available? It seems there's more than appropriate right now and there might be some marketing going on which in the end is inappropriate.

MR. EBELER: Thank you for all the work. I mean, these three directions you've laid out here are very much on track, getting the payment right, getting some of the clinical criteria right, and getting more data.

I tend to agree with Bill that it is worth thinking about national standards for what are the clinical issues here rather than all those being local. And on the supply question, at least until these policies are put in place, I do wonder if it's worthwhile thinking about moratoria in certain communities as these things crop up.

The supply impact of these changes would not occur for several years, at best, and it's just worth thinking about.

The two things I want us to think about longer term, the budget neutrality question has two features in the case of hospice, the one that Bruce mentioned, and I think the way you've laid this out is the more traditional way to do it in Medicare. But the second one is the policy question, is hospice saving or costing Medicare money, and I don't think we're going to be able to address that in this chapter. I don't expect to. But I think long-term, we still need to look at that.

The second, again, is something to mention toward the end of this, not as a recommendation. This is an effort to fix the current hospice benefit as it's been designed and as we've known it. I think we had a discussion maybe two meetings ago on this issue of at some point sort of thinking longer term about what a different end-of-life benefit may look like. Again, I don't think we have a clue what to recommend in that area, but I just think at the same time we pursue these three very appropriate vectors for the fix, we keep those longer-term issues on the plate for the future.

DR. CROSSON: Thank you. I want to compliment the

work, also. I like and support the payment changes and the recertification recommendation.

I have, as some others have mentioned, a predilection towards prospective payment and the idea of a case rate here seems to me perfectly reasonable, one to pursue if we're going to stick with a fee-for-service system. I still have a question about why we don't have information about what types of service are being rendered. It would seem to me somewhat odd and potentially manipulatable.

So it's possible that, in keeping with what Mike said, that we might not be recommending that because it is a lot of administrative burden to do that, I would imagine, and maybe the services that are rendered don't vary that much from visit to visit, from provider to provider, which would be one reason to not capture the data and apply that sort of burden.

Another one might be our assumption that the payment change recommendation, since it goes down in the middle of that curve to about five percent of the peak, might render this information less valuable because the payment change itself is going to be enough to change the

dynamics. But I don't know that we've had that discussion, and so I was wondering whether in terms of the recommendation for more data it was actively discussed and rejected or not.

DR. MARK MILLER: I'm going to take the first pass at this, and I think my fundamental answer is I'm not sure. When we were talking about the claims data and getting the visits and the lengths of the visit, we're thinking that a lot of what goes on here in terms of service is the kinds of visits that are rendered during the stay, or during the hospice episode.

I guess what I'm a little confused in, and Jim, if you have a sense of what he's asking, then you should jump right in, is what are the kinds of services or types of care are we thinking about here?

DR. MATHEWS: So you would be interested in knowing, for example, if a registered nurse goes to visit a hospice patient in their home, what service that person is doing. Are they administering narcotics to alleviate pain? Are they doing dressing changes for pressure sores? If a home health aide goes into that patient's home, are they bathing the patient? Are they providing assistance with

activities of daily living? Is the hospice providing relevant durable medical equipment in the course of a visit? That's what you're asking, if I understand you correctly.

DR. CROSSON: That's the question, because, of course, in most of the rest of Medicare, we have that information. At least in fee-for-service, we're billing for things that we do or things we provide and the like. In this particular case, we don't do that. Now, it may be, as I said, again, that there's enough uniformity here and lack of ability to manipulate the level of service that it's irrelevant, but I'm just asking the question. If we're going to ask for more data, have we thought about and rejected that type of information for some reason?

DR. MARK MILLER: One other thing I would ask, Jim, and again, I may be way off point, and it seems to be the whole day I've been off point, so I'm going to go ahead and be off point again. There was a discussion at one point in time based on some data that you had from a given provider about differences in treatment between types of patients with different diagnoses, cancer versus -- and I vaguely, and maybe a couple of other people are vaguely recalling, there wasn't a lot of difference. Is that a

correct recollection?

DR. MATHEWS: Yes. To clarify, what we were looking at there were claims or encounter-level data from a national chain provider who stepped up and volunteered this information for our use, and we were able to conduct our own independent analyses of utilization across a hospice episode by different patient types. We did see that the mix of visits changed over time, that with very long stays, the mix of visits shifted more towards home health types of personnel and less towards skilled personnel, and that change in the mix of visits was irrespective of patient diagnosis. If you were a cancer patient at 160 days, your mix of visits was similar to an Alzheimer's patient at 160 days.

The problem is that data does not contain the level of detail that you are interested in, that it was purely a visit by a given practitioner that began at one point in time during the day and lasted for 90 minutes, lasted for 40 minutes. So it did provide who provided the visit and how long the visit lasted, but did not provide any information as to the content of the visit, what that person actually did with the patient.

DR. MARK MILLER: So in answer to your question, I don't think we have actively rejected this. I think probably the right thing to do at this point is to kind of go back, let us churn on it a little bit, and come back to you.

DR. MATHEWS: But just to be clear in terms of guidance, I mean, is this something -- never mind.

MR. HACKBARTH: Jim, do you want to just quickly address Jay's first point about why not a per case system? Arnie has raised that and Mike sort of alluded to it. You've proposed a new payment approach but continue to use per day as the structure.

DR. MARK MILLER: Do you want to do it or do you want me to? I think that the reason that we did this is given -- and some of it occurred over here, and I can't remember exactly who the actors were, but it was on this side of the table. I think it was Bill.

This is a very difficult -- and I want to be really clear -- this has been a very difficult area to analyze. It's highly emotional and very complicated. Despite the fact that we focused on some of the things that the expert panel has told us at the extremes, also what went

on in the panel is the difficulty in predicting how long somebody is going to need is just -- it's incredibly difficult. This notion of could clinicians even tell you, if I had all this information, could I get better at it, it still remains very much an art and not a science.

And so I think what drove us in this direction is if you start moving towards capitated payments, you need a couple of things. You need to have a sense of how big that is and if it varies by characteristic, whether it's diagnosis or ADLs or some other characteristics of the patient, and we didn't feel that we had the wherewithal to do that and some concern that at least the per diem leaves you a little bit of latitude if you're dead wrong that the hospice -- oh, wow.

[Laughter.]

DR. MARK MILLER: My resignation will be tendered at this time.

DR. REISCHAUER: But it sets up exactly the wrong incentive, which is to go get people just before they're about to expire.

DR. MARK MILLER: Right, and that was the other point I was trying to come to. The other thing that we're

trying to do with this is we really do think that there is this -- and now I'm going to really slow down and think about what I'm saying -- there is a spike in cost, and anybody who's been through this process with their family knows this, when it comes to the end of the episode and the end of the person's life. And we also thought that it was really important that we have that incentive at the back end so that there isn't this very strong incentive to say, okay, great. Let's just get short-stay patients.

Because the other thing which we don't often have time to go through in detail is back to the length of stay stuff, which is right there, is the perplexing thing about this is that it's the right tail that's growing and the rest of it isn't, and we don't want to push really short stays. We want to curtail the very extreme right-hand tail and we're thinking that with that adjustment for the end of life, we can give something better of an incentive along those lines.

But the capitation stuff just kind of -- there's a fair amount of information there that you feel like you need and a fair amount of variance in people's ability to predict what somebody is going to need.

DR. MATHEWS: On that point, given the fact that if you did have a capitated payment system and wanted to adjustment payments by a diagnosis in order to reflect the patient's likely use of case, given the fact that diagnosis can be strongly correlated with length of stay, you basically get a capitated payment system that varies as a function of length of stay.

DR. SCANLON: And the one last thing, which is that setting the rate right doesn't mean that you've established that you're going to have the product that you thought you were going to get. You have to be able to monitor the product that you're buying, and in this case, this is exactly like home health. We don't have a definition of what is appropriate care for an episode, and so we would be at a total disadvantage in terms of trying to say, we paid you this. You didn't deliver.

DR. KANE: Well, I guess I'm going to -- since the payment issue has already been on the table, but I do support Bill's suggestion that under draft recommendation one, that we make some modifications on what kind of the basis of the payment system should be and that it should be driven by cost and as much data as we can get on what the

content of those visits is before we come up with that payment system, and it shouldn't just be how would I reallocate the payments that we're currently giving to get the right length of -- some more normal length of stay, that it should have some decent cost data in it.

So the only other question I had or topic that I really don't even know how we would go about it but I just wanted to hear what people had to say was do we need to look at some of the incentives that go beyond just the providers' incentives to the incentives of the families and the incentives maybe even of the beneficiaries themselves, because a lot of the people that are going into hospice have, particularly when you look at the Alzheimer's and the mental -- I mean, there were some pretty difficult diagnoses here, organic psychosis, dementia -- and a lot of those people, when they are not in hospice, if they are not in a nursing home, they're trying to cope on their own or out of pocket.

Obviously, when you get into hospice, you do at least get a support system, and I think that's a good thing on the one hand. On the other hand, that's not Medicare's intent, I have a feeling. So should we be also trying to

understand the decision to go into hospice on the part of the beneficiary a little better? There is a financial incentive for many of them to go ahead and do that, or by their families, who are often the guardians by the time they do it.

I think we need to understand better why people choose it and what's going into that thought process and does it need a little modifying if, in fact, it is being used as a substitute for custodial care for people who are just difficult to take care of -- not that I want to deny them care, but maybe the hospice benefit isn't the right one and this isn't the place to put it. So I feel like we haven't talked much about the beneficiaries and their choices at this point and I think it would help to address that in thinking about who is going in and why.

DR. CASTELLANOS: Just a couple of points. I think we talked about payment. We talked about recertification, which I totally agree with.

One of the things that I'm a little concerned about is the data. We're just looking at the medical data, but hospice is a better benefit than that. There's a benefit for the patient with massage therapy, music therapy,

respite service for the family, and it doesn't end with life. There's benefits after life with a support group, a bereavement process. I mean, it's not just a finite period and finite care. So I think if we could expand the data, I think we'd be all a little bit surprised about how much they provide, and it is different end-of-life care than the normal end-of-life care.

One of the things that bothered me when I read this, and I guess from a personal viewpoint, people elect to go into here. As I said, it's a benefit for the beneficiary, but it's a significant benefit to the family and the surrounding family, the community, and society. The better they do, and they really feel very, very welcome and very, very appreciative of the care they get, and a lot of these people give donations. Why are we requiring hospice to report the donations? Is there any other Medicare service where we kind of collect the data of donations to that society? Maybe there is. Well, then maybe it is appropriate, but to me, the donations are going to show that that's the best group.

And one last point about outliers. I couldn't say it better than anybody else. You know, everybody doesn't

follow the normal curve, and just because you're an outlier doesn't mean you live in Florida and you're a criminal.

[Laughter.]

MS. BEHROOZI: Thanks. This was really great work, and Kim, as you know, I was focusing a lot on the accountability stuff. I appreciate in draft recommendation 2(a) on page 22 that you were taking into account the recommendations of hospice providers whom you spoke to and at the sort of extreme end, at the outlier end when the cases exceed 180 days and they're in a hospice that routinely has long lengths of stay, that would be a good way to get to the ones, those that have routine excessive lengths of stay.

But you talked in the paper about abuse and you mentioned it in your presentation, at the going in it, where hospices are certifying as eligible patients who have been discharged by other hospices for failure to meet eligibility criteria in the first place. So I would be a little concerned if we are talking about abuse. I mean, that's very clear in the paper that we're not talking about people not making good judgments or it's not about the families making choices to offload their care needs because the chart

that shows what some of these diagnoses are show that it's institutionalized patients, nursing home patients that more often have those long length of stay kind of diagnoses, like Alzheimer's and whatever.

I don't know exactly what I would recommend as a way to kind of get at that, to make sure that the initial certification is really appropriately rendered without gaming in mind, frankly. I mean, it looks like if there -- now gaming the system, we don't want to let them game it up to 180 days, either. I mean, that's a lot of money that Medicare would be paying that if you do a budget neutral adjustment in the payment, you might not end up with savings, but if you keep people out of the hospice payment stream to begin with who shouldn't be there, that might result in absolute savings. So, like I said, I'm not sure what I would recommend, but I would suggest trying to figure out how to stop the abuse at the front end.

MS. NEUMAN: Just one comment. I think the second piece of the recommendation that requires certifications to include a brief narrative describing the clinical basis is intended to create greater accountability so that a physician would have to say, I believe this person is

terminal because of X, Y, and Z, in a very brief way, and I think our panel felt that that would help some in terms of focusing accountability. But again, if somebody is truly trying to game the system, that wouldn't necessarily go all the way.

MS. BEHROOZI: I actually also forgot to mention this, that one of the areas of great concern relating to our earlier discussion is in the area of conflicts of interest and common ownership and kickbacks, frankly, to medical directors for referrals and things like that. So I understand that that would be a sort of a front-end kind of safeguard, but easily circumvented, it seems.

DR. MARK MILLER: The only thing I would say is also remember the payment. A piece of the payment is linked to the end of life, and if you're really consistently -- again, at the extreme, because I don't want to characterize an entire industry -- at the extreme just ignoring eligibility requirements and bringing people in who are in for long periods of time, under a revised payment system, there would be a block of payments that you would not see, or at least not in a timely manner.

DR. MATHEWS: If I could also add something on

this point, you might recall, and it pertains to the discussion of whether or not we should develop national coverage decisions, the implication of what you are saying, if you were saying we should control eligibility better on the front end, last year we discussed this a little bit and it relates to the difficulty in prognosticating the end of life for a specific patient. If you have the criteria relatively loose, you will admit a larger share of patients who do not die within six months. However, if you make the criteria too tight, you will exclude people from the benefit who will die within six months, and so that's the balance that the FIs who developed the coverage determinations and the hospice medical directors themselves are walking in trying to apply those criteria and it's a balance that we need to be cognizant of, as well. Nonetheless, we'll see what we can think up by way of items that could address your concerns.

MR. BUTLER: The first comment, on the recommendations directionally, I think are all very good, given my limited knowledge of some of the technicalities. But I also would support the per diem or some manipulation of it as opposed to a case rate, and I'll explain why in a

minute. So I think you're right on target where you're headed.

Now to make my other two points, I'll use my two experiences with hospices to do it. One, a community hospital, a community teaching hospital with a very strong relationship with a large nonprofit hospice. The reason I found this a little bit heartbreaking is that I worked for two or three years with an exceptional medical director, exceptional integration and education of the medical staff, including rotations for the internal medicine residents to be exposed to the palliative care concept, to take it beyond hospice to treat some of the very diagnoses that are being, quote, "abused," and tremendous education for students and residents at a very early time that minimally invasive treatment to handle pain of all kind in an aging population is a good thing, and it started to have an impact on the culture of the hospital. And so when you see that it is having unintended effects in others, it kind of casts a shadow on all of the non-cancer diagnosis advancements we've made in hospice care and I hope we don't lose that.

For that reason, too, I think the case payment, no matter how you manipulate it, I'm skeptical, because that

very invitation to kind of let the normal doctor let go or at least partner might be inhibited and you don't want to do that. So that's point one.

The second experience is where we sold a hospice and it was one of those provider-based. It was not making money. We were having trouble with it, and that was part of my question before, because now we let it go and it is kind of the same pattern as we looked at in psych or in skilled nursing or others where you see growth and you see growth in for-profit freestanding pieces of our continuum. At the same time, we talk on that side about -- we watch that go on and we talk about episode of care and bundling and accountable health care organizations, so we see a disaggregation over here of what we are trying to aggregate over here. Where it becomes very real for somebody like me is as we've got our electronic health record and we are literally making decisions today about how we scan in and what we need to scan in from these other continuum of the care so we have the whole picture instead of just a piece of the picture.

So that's just a general observation as we watch the trends in these things. How do we try to reintegrate

what we disintegrated in some respects while recognizing that some institutions, like hospitals, aren't always the best to run some of these entities because it's not a core competency, but it's a real dilemma that we're in that if we're really going to get around treatment of the fragile elderly patient, we have to find a way to make sure we're continually reinforcing collaboration and partnership as opposed to silos that are kind of tough to reconnect once you've disconnected them.

DR. BORMAN: First, I would say that I generally support the direction that we're going in this very fine analysis, which even as a Plain Jane general surgeon, I think I understood, which is scary.

I would wonder where we view this work fitting in terms of is this a piece generally of evaluating different parts of the payment system, almost like a piece of the update process or related to that, or do we see this more interdigitating with some of the sustainability issues about looming problems and things we have to do better. I guess I need a little bit better sense for that. I'm not sure it's appropriate, and the answer to that would help me a little bit about knowing whether surrounding this stuff, or maybe

it's somewhere else in the context after something, that we need to comment about -- just reiterate the percentage of expense that happens in the last year of life, some of our thoughts about how sensitive an issue this is, the cultural pieces that we all understand and that we want to be very up-front about, but that as a fiduciary and professional obligation of this Commission we have to look at it, and a sense of where this fits into our evolving notions about delivery systems and where some of these dialogues should happen.

Hospice, presumably, follows on some conversations between -- or that include patients and families and providers, and certainly the issue of medical home and all those kinds of things will wrap up into this a bit. Some of the conversations, or some of those activities might, in fact, ultimately impact are the right people being considered for hospice and do we have a benefit that meets those kinds of needs in that delivery system that we think we're working toward.

And so I have a feeling it kind of doesn't belong here, but I guess I am asking where that contextual piece belongs and would we refer to it from here? Would we have a

cross-reference from that part to here? Just kind of how does that background and context stuff relate to this very specific evaluation of a benefit and some recommendations about where we go with it. A rhetorical question.

DR. MARK MILLER: All right. Then maybe I'll take the first shot at it. When I think about some of the things that we do, there's kind of, particularly for December, for example, we're going to be talking about ongoing payment systems, what do we think about what the payment rates should be. But we also have had conversations within administering given Medicare systems about the guts of the system and kind of the underlying equities and whether distortions are occurring. A real good recent one was the skilled nursing facility, where we felt non-therapy ancillary is way out of whack, needed to bring that back.

I see this more in that category. We're sort of stepping into this, because we had to educate ourselves over the last year, which you were also part of, and now we're up to can we get kind of the underlying dynamics of this correct. It would be later, but again, to Bruce's point, no, not later, to talk about, well, what is the proper amount to be paid here. I would see that as kind of coming

later.

In terms of sustainability, this, like many other things, and I know this frustrates some people out in the more general policy world, when something is going really fast and going up, it tends to attract attention and this, like other types of service, was one of those. I mean, to Bruce's point on the payment, is when you have supply increasing at this rate, it certainly raises the question of whether your payment rates are inadequate.

So in my mind, the context of this is, like a lot of things, kind of hit the sustainability radar, but it's really more about sort of the patterns we are observing here that struck us as a payment system badly out of whack, which some of that came up again over here. That's the context that that, in my mind, is in.

MR. HACKBARTH: Yes. To me, it's how do we achieve -- improve the accuracy and equity in the payment system with an eye towards the original goals of this program, which to me were twofold. One is to provide a humane, compassionate alternative for patients, and the second was potentially to reduce Medicare expenditures if that alternative didn't rely as much on heroic measures.

And so those are sort of the beacons for our effort to revise the payment system and improve its accuracy, if you will.

DR. MATHEWS: If I could add a couple of things on this point, and they are more related to the relationship of hospice to larger delivery system reform issues, and I'll pick up on two things that Peter mentioned. One, going back to the slide on length of stay, we talked a little bit about the short-stay patients. Very short stays in hospice tend to reflect very late referral in the course of the patient's terminal disease trajectory and it usually indicates that the referral to hospice has occurred after a period of intensive, say, Part A interventions at the end of life. So in those situations, arguably, the patient hasn't gotten the benefit of everything that hospice has to offer, nor has the program gotten the benefit in terms of hospice's potential to result in lower expenditures at the end of life.

Now, the reasons for those short stays are several-fold and they're fairly complex. At a very crass level, I mean, the Part A provider has an incentive to hang onto a patient and do as much as they can for that patient before discharging them to hospice. There are also

individuals' sort of mindsets regarding hospice, and these occur both at the patient level where the patient is not willing to concede that the end is near, and it also goes back to that it invokes medical education, where the physician is trained not to give up, to do everything they can to preserve the patient's life.

And so to the extent you can involve hospice in medical education programs the way that Peter just mentioned, and this was a theme that some of our panelists mentioned, as well, if you can change the medical community's mindset in a way to recognize the value of hospice to the patient and the program, you could see hospice as sort of an integral and proactive part of delivery system reform.

DR. BORMAN: Just a follow-up comment. It sounds like this piece is particularly sort of more nuts and bolts and that's fine, and as I've said, I support the direction that we're going. When we were talking a while back to some degree, if I recall right, it was in the context of medical home and coordination of care, I'd just like to take this opportunity on this subject to say that I think somewhat related to this -- this being a downstream effect, that we

really do need to think about a piece of coordination of care is some conversation about advanced directives and thoughts. Thinking about this reminds me of that and I'd like us not to lose track of that, because I think hospice and a whole host of things are the downstream of not paying attention to that when the decision is less pressured.

As a surgeon, I have the opportunity to have these kinds of discussions routinely under pressured circumstances, at two in the morning about somebody has asked me to come comment on an operation on somebody that's essentially moribund. Those are very difficult conversations to have and frequently it uncovers that there's been very little thought generally about what Great Aunt Minnie would want, and it becomes less about what Great Aunt Minnie would want than about what the relatives' values are and their guilt about the fact that they didn't visit with Great Aunt Minnie. So having seen that this clearly is in more of a nuts and bolts context, then I would make the pitch that we not lose that other contextual piece in our other work.

MS. HANSEN: Well, by now, I think many of the points are made and I will definitely pick up on Karen's

point, but I have three short ones.

One is I just want to build on what Bill has brought up and other people have said about some universal national way to define the program. And in addition, besides the nursing home facilities is to consider the assisted living, but there's also a tremendous number of people living in residential care facilities, and that's a whole another group of people if we are going to be looking at populations in terms of their characteristics and where they potentially pass away and the need of hospice care.

The other thing is relative to -- I just want to acknowledge, really, the leadership of the group of focus individuals who came together to ask for some greater accountability about the program, and that is a leadership role rather than saying, no, don't look at us. We really have heard, I gather, that people are saying, let's make sure that we are producing quality for patients and families but also for Medicare.

One of the things that, just kind of thinking about just the description of the types of programs, I know one of the signature pieces that hospice programs have traditionally had was that of the volunteer program that was

accompanying it that was deeply done with volunteers as part of their workforce who had to actually get education and training for 100 hours. I just wonder if that's part of the profile now of hospices as we start to see today, just so that we get an understanding, much as Ron has pointed out that traditionally hospice provides care for family members for a year afterwards. So are those services still part of what hospice as we know it and define today, whether it's operated by a not-for-profit or a for-profit, truly offer?

The last point I have is relative to Karen's last point, and Jack, your earlier point about just where does this fit in the total cost of saving money or being a part of the Medicare side of it. I just wonder, that since hospice historically had been so modestly used for years, but at the same time we have so many Medicare expenditures in the last six months of life for people as a whole, I wonder if we look at this from a continuum standpoint if hospice was an appropriate resource and used much earlier, whether there's any research or modeling that can be looked at as to what the dollars are that are expended.

And there's a bit of an illusion that this is where providers may not want to let go of people while

they're in acute care because of all the added, quote, services and billing that comes with it, but it's oftentimes because advance directives were not really done, and whether that whole kind of continuum of looking at it from the Medicare beneficiary, what the impact to Medicare dollars expended might be arrayed a little bit more fully.

So I just don't remember what Medicare spends on the last six months of life, but that always seems to be a big number and we could begin to try to attach that somewhat as a context piece to why the hospice program is not only a compassionate program and humane program, but it may have some Medicare levers of savings if used appropriately.

MR. GEORGE MILLER: Thank you. And Jennie teed up what I was going to say a little bit about what Peter talked about, the integration of care. At a hospital in Illinois, we hired part-time a palliative care physician who part-time was the director of the hospice program and she worked with us to review patients in the ICU and the CCU to see and determine if it was appropriate for them to be there versus should they move to a palliative care with a full integration. And over time, we were able to, and I realize this is anecdotal, but we were able to lower costs because

of her intervention. So I think hospice has a very good place and is part of the full integration of care and it's a very good program.

The other side of it, though, to Ron's point, it appears to be from the data in this report there are some abuses and we've certainly got to address those abuses from the fringe. I want to ask the question on the third recommendation in 2(a), have we considered and looked at the Joint Commission as part of the process? Less than six months ago, I went through a Joint Commission audit and they asked some of the same questions of us that you alluded to that were not being asked by the FI here.

I'm wondering if you had stratified that. If someone had a Joint Commission certification, did they have the same type of problems that your report seems to indicate, because they would deal with appropriateness of care. They would make sure that the medical records by the physician and had certification, all those things were being done. I don't know if, of all of the programs you looked at, if there was a demarcation line if a hospice program was Joint Commission certified and they did not have the same type of issues and problems.

DR. MATHEWS: We have not looked at that particular characteristic --

MR. GEORGE MILLER: You have not.

DR. MATHEWS: -- but it is something we can pursue and get back to you with.

MR. GEORGE MILLER: Okay. Thank you.

DR. CHERNEW: Thank you. This has been a fascinating discussion and I think it's a troubling one because there are so many different angles, but I guess where that leaves me is the academic side of me feels like saying that I'm not comfortable with a lot of the recommendations until there's a more detailed behavioral component to the policy analysis. In other words, I'm just not sure how whatever we would ultimately recommend, what would that do, not just on the hospice side, but on the other things that aren't hospice. What would that do to the acute care? What would that do to all the other things?

The sort of more managerial side says, given what's presented, I'd hate to hold hostage improvement in policy for want of sort of the perfect policy, and so I do think that I'm sympathetic to potentially doing something.

So I guess where I would come out to reconcile

those two sides, given this whole debate, is perhaps a little better discussion of what if. If we were to do something like this, and if the length of stay were to drop back to where it was in 2002, these people wouldn't be getting hospice care, or they were getting shorter hospice care. That means they would be spending X months longer prior to admission to hospice and that would suggest things would be just as good, they'd get two more admissions in that period, their family -- I'm not sure what the "what if" is. But I would be thrilled but I doubt it's possible to have a really analytic answer to the policy analysis behavioral response question, but at least some sense of how the world would change apart from paying less for the exact same services, in fact, in this case, paying the same for the same services, just differently, would be really useful for me as we move on to recommendations with some teeth.

MR. HACKBARTH: Okay. I think it is going to be difficult to have an analytic answer to that question, but I agree wholeheartedly that that's a logical question, an appropriate question for Congress to ask in considering this sort of a change. So I think we need to take a stab at it as best we can.

Okay. Good discussion, and obviously more on this later.

Our last item for today is improving payment accuracy for imaging.

MR. WINTER: Good afternoon. I'll be talking about payment accuracy for imaging services in the physician fee schedule. This is one of the topics that came up during the expert panel that we had on imaging at the September meeting. Much of the material I cover today has appeared in prior MedPAC reports and comment letters on proposed rules. We plan to discuss this issue in the physician update chapter for the March report. I want to thank Nancy Ray and Hannah Miller for their help with this work.

Just some background to start off with. There has been impressive technological progress in imaging which has increased its importance for diagnosis and treatment and expanded the availability of imaging services in free-standing centers and physician offices. However, the rapid growth of imaging services within Medicare, geographic differences in imaging use, and variations in the quality of providers have raised concerns about whether imaging is sometimes used inappropriately. Over the last few years,

the Commission has focused on improving both the quality and payment accuracy for imaging services.

This slide reviews or describes Medicare's physician fee schedule. The payment for service is based on its relative value units, or RVUs, and there are three types of RVUs: practice expense, physician work, and professional liability insurance. Practice expense accounts for almost half of spending on physician services. It includes direct costs, which are non-physician clinical staff; medical equipment and medical supplies; and indirect costs, which are administrative staff, office rents, and other expenses.

In 2007, CMS made important changes to the practice expense method and data which affected payments for many services. This was a budget-neutral change. It shifted RVUs from imaging services and major procedures to other procedures, tests, and evaluation and management services. Despite the impacts, we believe that there are opportunities to further improve payment accuracy for imaging.

So let's review for a moment why payment accuracy is important. Inaccurate payments can distort the market for physician services. Overvalued services may be over

provided because they are more profitable. Some providers may not furnish undervalued services, which may threaten access to care and affect the supply of physicians. Other providers may increase the volume of under-valued services to maintain their overall level of payments. In addition, when services are misvalued, Medicare is paying too much for some services and not enough for others, which means it's not spending taxpayers' and beneficiaries' money wisely.

On the topic of payment accuracy, it's important to remember that the Commission made several recommendations in 2006 for CMS to strengthen the process by which it values physician services, such as creating an expert panel to help identify overvalued services and to review recommendations from the RUC.

Although CMS has not created this expert panel, they have recently taken some steps to identify potentially misvalued codes. For example, in the physician fee schedule final rule that was issued last week, CMS announced that it has sent a list of about 100 codes that experienced rapid volume growth to the RUC for review.

Here we see how the physician fee schedule pays for imaging services. There are two portions to an imaging

service: the technical component, which is performing the study, and the professional component, which is interpreting the study and writing the report.

Medical equipment accounts for a significant portion of the practice expense payment for the technical component of advanced imaging services. By this I mean CT, MRI, and nuclear medicine.

Now we're going to focus on how CMS estimates the cost of medical equipment for a service. The cost of the equipment for a service equals its estimated cost per minute times the number of minutes it is used for that service. To determine the cost per minute, CMS uses a formula to spread the machine's purchase price over the number of minutes it is projected to be used during its useful life, taking into account the cost of capital and maintenance costs. In this formula, CMS assumes that all equipment is used at 50 percent of the time that a practice is open for business. CMS uses this number for all equipment because it was unable to obtain data on use rates for specific equipment.

If equipment is actually operated more frequently, the cost per service declined. This is because the fixed cost of the machine is spread across more units of service.

In 2006, MedPAC's sponsored a survey by NORC of imaging providers in six markets. The survey found that MRI and CT machines were used more than 50 percent of the time that providers were open for business per week. As you can see on the chart, providers in these markets used their MRI machines about 90 percent of the time they were open for business on average, and that's the red bar at the far left. The median use rate was 100 percent, which is the green bar. On average, CT machines were used 73 percent of the time that providers were open for business with the median of 75 percent, and those are the two bars at the right. Although the survey results were not nationally representative, they are representative of MRI and CT providers in the six markets that were surveyed.

These results raised questions about whether CMS underestimates how frequently providers use MRI and CT machines. In addition, Medicare's use rate could be encouraging lower-volume providers to purchase expensive machines. CMS acknowledges that its 50-percent assumption is not accurate for all types of equipment, but says that it lacks sufficient evidence to justify an alternative rate.

Here we'll look at two options for updating the

equipment use rate for expensive machines. First, you could base the rate on empirical evidence from a survey of providers, and the AMA is fielding a national survey on physician practice costs, which includes questions about the use of high-cost equipment. However, if the survey shows that providers are operating these machines infrequently, do we want Medicare's payment rates to be based on a low-volume, inefficient level of use?

Another option would be to set a standard based on an expectation of efficiency; in other words, providers who purchase costly imaging machines would be expected to use them at close to full capacity, with some allowance for down time for maintenance and patient cancellations. In fact, the NORC survey found that several providers operate their MRI machines more than 90 percent of the time. In this approach, Medicare would be encouraging efficient, high-volume use of expensive equipment through its payment rates. We would also be discouraging low-volume providers from purchasing these machines, which may reduce excess capacity.

This principle could be applied to machines that cost more than $1 million, such as MRI, CT, and PET machines; or even extended to machines that cost more than

$500,000, which would include the cameras that are used for nuclear medicine procedures.

We contracted with NORC to estimate the impact of increasing the equipment use rate for imaging machines on practice expense RVUs. This model assumes that the changes would be budget neutral -- that is, dollars from imaging services would be redistributed to other services. It does not account for the effect of the outpatient PPS cap mandated by the Deficit Reduction Act, which I will get into more later.

In addition, the baseline assumes that CMS has fully phased in the changes to practice expense RVUs that it began making in 2007. In reality, CMS is phasing in these changes over 4 years.

So if you look at the table, you'll see that if CMS were to increase the equipment use rate to 75 percent for MRI and CT machines, practice expense RVUs for imaging would decline by about 6 percent, while other categories of services would increase. About $600 million per year would be redistributed from imaging to other services. If CMS were to increase the equipment use rate to 90 percent, imaging practice expense RVUs would decline by about 8

percent. About $900 million a year would be shifted from imaging to other services.

We also modeled increasing the use rate for the cameras used for nuclear medicine procedures. This would redistribute an additional $100 million a year from imaging to other services under either the 75-percent or 90-percent rate.

Now I'm going to switch gears to discuss how CMS estimates the number of minutes equipment is used for a service. Here, again, we see the formula for calculating equipment cost per service. It's a function of the cost per minute times the number of minutes it's used for that service. CMS bases its estimate of the number of minutes imaging equipment is used for a service on the amount of time it takes a radiology technician to perform the study. These time estimates were recommended by a practice expense Committee established by the RUC, and this committee developed the time estimates for most MRI and CT services in 2002 and 2003.

Recent advances in CT technology, such as the development of 64-slice CT scanners, have made it possible to scan patients faster. Similarly, the introduction of

more powerful MRI machines has reportedly reduced imaging times and increased patient throughput. Even providers who are still using older machines could be performing more studies in less time as they become more familiar with the procedures and the equipment, and this is the process of learning by doing.

The time estimates used by CMS for MRI and CT studies may not reflect reductions in scanning time, which could result in overstating the equipment and radiology technician costs. CMS could request that the RUC review the time estimates for these services to ensure that they are up to date.

As I mentioned earlier, CMS recently sent a list of about 100 codes that experienced rapid volume growth to the RUC for review. There were 13 CT codes and one MRI code on this list. But there are many more codes that use these machines, and these other codes might also merit review.

Up to now, we've talked about two changes that CMS could make to the practice expense RVUs for imaging. If CMS were to make these changes, their impact would be affected by a policy from the Deficit Reduction Act that caps the fee schedule rates for the technical component of imaging

studies at the rates paid under the outpatient PPS. In other words, Medicare will not pay more for an imaging study performed in a physician's office than it pays in a hospital outpatient department.

Before this policy was adopted, physician fee schedule rates were higher than outpatient rates for many imagine codes. This provision reduces the fee schedule amounts for these services and returns the savings to the Part B trust fund; in other words, the policy is not budget neutral.

A recent GAO study found that about two-thirds of advanced imaging tests were affected by this cap and were, therefore, paid at the outpatient rate in 2007. Thus, reducing practice expense RVUs for advanced imaging studies or revising the equipment use rate and the time estimates is unlikely to affect the payments for many of these services in the short term. This is because the payment rates for many imaging codes would be reduced anyway by the outpatient cap.

Despite the presence of the outpatient cap, it may still be worthwhile for CMS to improve the accuracy of the physician fee schedule and to encourage efficient use of

expensive imaging machines. In addition, the impact of the outpatient cap will decline over time if outpatient rates increase faster than physician fee schedule rates for imaging services.

One final issue to keep in mind is that savings from the outpatient cap are returned to the trust fund rather than being shifted to other physician services. However, when CMS changes how it calculates practice expense RVUs, these changes are budget neutral. So, for example, if CMS were to increase the equipment use rate, dollars from imaging RVUs would be redistributed to other physician services. In this case, the outpatient cap would have less of an impact because fee schedule rates would already be lower. This would reduce savings for the trust fund, but it would expand the pool of dollars for physician fee schedule services.

I will finish up with some questions for you to consider. Should Medicare's equipment use rate for costly imaging machines be based on an efficiency standard? Should the time estimates for MRI and CT studies be updated? And, finally, are there other practice expenses used that we should consider?

MR. HACKBARTH: Okay. Let me see hands for clarifying questions. Nancy and then Jack.

DR. KANE: For the outpatient cap, what is the assumption in the outpatient rate about machine time, or is there one?

MR. WINTER: It's based on data on charges and costs from possible outpatient departments. So whatever their charges are reduced to their costs at the department level, that's the basis for the outpatient rates. So if they're using them efficiently -- whether they're using them efficiently or not, that's what the rates are based on.

DR. KANE: But they must have some volume that they divide that cost into? Or, you know, where do you get the rate? What's that? So there is some real volume standard built into the hospital rate because you're using the total cost into the real volume. So, in effect, that's at least some way to get it down to the level of -- okay. That was my question.

MR. WINTER: It could be that hospitals are using them very frequently or not very frequently. We don't know. Per machine. Per machine, sort of new overall.

MR. EBELER: Ariel, I'm sure that you've answered

this before. The assumption of 50 percent of the time that the practice is open, what's the assumption about the amount of time that the practice is open?

MR. WINTER: CMS assumes that the practice is open 50 hours per week, and that was based on data from the AMA and the MGMA. In our survey, we did ask --

MR. EBELER: That's including at an imaging center, that it would be open 50 hours per week?

MR. WINTER: Basing that across all practices and providers in the physician fee schedule. When we did our survey, we found that, on average imaging providers -- MRI and CT providers, at least, were open more hours than that per week.

DR. CHERNEW: I didn't catch -- and it's probably my fault -- why the percent time thing is actually budget neutral.

MR. WINTER: When CMS makes any changes to the practice expense RVUs or other RVUs -- work RVUs -- any savings or any money that's freed up from, let's say, reducing RVUs for some services are redistributed across other services. It's a statutory requirement that any changes be used for budget control.

DR. CHERNEW: If we found any of the ones with over -- if we found that any RVU was overpaid and said that should go down, by statute it would be redistributed across other things.

MR. WINTER: Correct.

MR. HACKBARTH: Ariel, in the physician fee schedule, generally what we're trying to do is work with empirical estimates of relative costs. Now, the data aren't always great for making those estimates, but it's empirically driven. At least that's been my understanding. Here what we're considering is using a normative standard, thus departing from what has been the practice in the past. That normative standard would be consistent with the idea of an efficient provider, and it's appealing in that regard. But could you address what the implications might be of departing from empirical estimates and starting to use normative estimates? We're changing the fundamental rules of the system.

MR. WINTER: That's a good point, and the idea behind the system is to estimate relative resource use for a typical service. This would be using the -- trying to encourage efficiency through the RVU process rather than

through the conversion factor or some other mechanism in the payment system. And you could think about extending this to other types of equipment perhaps or other types of services where you'd want to encourage more efficiency through setting the RVUs differently rather than through some other factor.

I'm sorry I can't go beyond that. We can try to go back and think about other implications, though.

DR. SCANLON: This is partly in response to what you just said, because it seems to me that the NORC data provide us an opportunity to make changes based upon empirical data or suggest that if we have more empirical data, we would want to be making changes that would move towards lower fees and potentially more efficiency.

Having an efficiency standard by itself I always find problematic because it's very hard to know what is truly efficient. So I guess I'd like the idea that we potentially can gain by having more data and paying attention to it.

Having said that, and earlier arguing for something on a national basis, let me now argue for something on a geographic basis, which is the fact that one

of the key criteria in setting payment rates and getting them right is to maintain access for Medicare beneficiaries. And in something like this with equipment, there's a real issue in terms of density and sort of then the market that you're talking about.

And so just to pick two states at random, providing MRIs in Montana and Iowa might be different than providing them in New York or Pennsylvania. You just have sort of lower density there, and the machines are not going to be operated to the same extent. And you could say, well, we'd like them to be operated -- you know, we'd like people to travel more. But we're talking about distances there that may be really problematic for people to swallow.

So we have a precedent here, which is ambulance payment in Medicare, where we take into account sort of the density of the community, and I think it's the kind of thing where we may want to think here, too, you know, we have a weight adjustment in the fee schedule; do we need to have a density adjustment if we're going to make some kind of aggressive adjustment of utilization?

DR. REISCHAUER: You know, that's true for high-level hospital care. It's true for specialist care. It's

true for everything in Medicare. You know, so why would you want to necessarily adjust imaging when we don't adjust all these other things?

DR. SCANLON: Well, we have already made some adjustments, but it's in the other direction. And I guess I'd rather do that in terms of this fee schedule than to start down the path which we have with the critical access hospitals and put everybody back on a cost basis. I don't want to do something that wipes out sort of MRIs in these areas and then have to backtrack and say, okay, here's going to be our new strategy for dealing with this. I'd rather have one system that brings in adjustments that are legitimate. Okay? It costs more to deliver that service in a sparsely populated area.

MR. BERTKO: I'm going to speak as one of those people who live in a corner of a sparsely populated state, a sparsely populated end of it. If you're going to go to that kind of geographic variation, I mean, it's normal for people in my end of Arizona to drive 70 miles to go to Wal-Mart. I don't think you need to have an MRI every 20 miles apart.

MR. GEORGE MILLER: If you happen to bleed and they need a CT, you don't want to drive an hour.

MR. BERTKO: We have helicopters for that.

MR. GEORGE MILLER: I just can't imagine the former President of the National Rural Health Association would be thrilled to hear that statement. I'm just sorry, it -- you wouldn't limit a fireman because there are small fires and say you can't get a fire truck, if that's a good analogy.

MR. BERTKO: It's not.

MR. GEORGE MILLER: Okay. Well, you don't pay a fireman by the fire then.

MR. BERTKO: If you had an accident in Arizona in the four corners, you wouldn't want to be treated by a facility there because they wouldn't see many of them. You'd want to be helicoptered into Flagstaff where they've got the big machine.

MR. GEORGE MILLER: Okay, but you at least would want the CT done at that facility so it would be already done --

MR. BERTKO: In Flagstaff, not in the four corners.

MR. GEORGE MILLER: Okay.

MR. BERTKO: There ain't nothing there.

MR. GEORGE MILLER: Well, I would be concerned about the statement we would discourage low-volume providers from purchasing costly equipment. That still could be a rural hospital that has the capability of providing diagnostic testing to determine whether that person needs to be flown to Flagstaff. We shouldn't make policy to determine --

MR. HACKBARTH: Yes. Important points are being made here about different geographic circumstances. To me, it's always -- you need to think carefully about where you want to make those adjustments. I always have sort of a negative reaction when, well, there's special circumstances, therefore, we shouldn't change it for anybody because it doesn't accommodate the special circumstances of a low-volume rural provider.

I think the appropriate policy response is you make a sensible change for everybody, and then if you need to make special adjustments for providers in particular circumstances, you do that.

So, for example, in a case of hospital payment, we've looked at low-volume adjustments. There are certain circumstances where providers are just not going to have

high volume. Their costs per unit are, therefore, going to be higher. And so we deal with it at that point.

I'd really be reluctant to --

DR. SCANLON: We're talking about just two paths to the same end, and, you know, the idea of -- I think we are. You know, it's the issue of sort of where are the parameters in this process. It's not the question of the structure. And it's not sort of trying to have an MRI every 20 miles. It's maybe having an MRI every 150 miles or something like that, because maybe 50-percent utilization is the right level for a sparsely populated area and 150-percent is the right level for a very dense area, because, you know, this assumption of 50 hours a week may be incredibly conservative in some areas. I've been in places where they run two shifts. That's 80 hours a week.

This is the issue of are we -- when we talk about right prices, how much do we want to invest in calibrating these prices to be truly right, because the low-volume adjustment is exactly the same idea. It's just using a different --

MR. HACKBARTH: Yes, well, let's get some other people involved. I agree that they are two different

approaches for getting to a similar end, but I think there may be some policy reasons to prefer one approach over the other.

DR. CHERNEW: The question I was going to ask -- maybe it's a little off base. It wasn't clear to me that full use is always efficient use. It might using the machine efficiently, but it doesn't mean that the actual use of the machine is always efficient. And so somehow one has to think through the issue of what the payment rate is in conjunction not just with what it costs to provide a particular care, but how we get the incentives to provide the right care. And I think that's really a challenge in some of these high-fixed-cost, low-marginal-cost services where the pricing, if you pick just one price and you try and get that price to get an average cost, by definition you're going to be overpricing the marginal use and encouraging inefficient care. And so I'm not sure what to do about that.

DR. MARK MILLER: [off mic] That's where we are now.

DR. CHERNEW: I understand. The challenge, though, if you lower is to be closer to the marginal cost,

then you think you've gotten it right at some level. But now you have a disincentive to invest in places where you think there might be a fixed cost. So there would be some other --

DR. MARK MILLER: [off mic] And then I think that gets back to should it be executed through a price or some other exception.

DR. CHERNEW: Exactly.

DR. CASTELLANOS: Let's get back to payment accuracy. I think we all want to get the payment closer to the cost. I don't think there's any question we want to do that. And I appreciate MedPAC's survey on six markets, but these are large communities. We all recognize that CMS went to AMA, and there's a national survey that's in progress right now involving every specialty all over the United States. And I would certainly be -- we talked about data. I would certainly like to get that data, which is going to be a better database than just six individual large communities. I'm not sure when that data is going to be available.

As far as cost per minute, I have a CT scan. It's one slice. I don't have a 64-slice, and I can't afford a

64-slice. So, you know, I think you have to be a little bit reasonable about cost per minute.

I think you need to see where we stand today, and if you look at the data, we saw a little bit of it last month on that last presentation where we did look at imaging, and imaging was flat as opposed to every other cost in the medical community. And the utilization rate for 2007 is still high, but it's down 5 percent from the year prior to that.

DR. CASTELLANOS: Yes, but it's down. Okay? And we can also see there's a site of service change and the high x-ray things -- the MRI and the CT scan -- they're going to back into the hospital. If you look at the data, there's a site of service change.

So health policy so far has worked, and I congratulate us for doing what we did, because we did the right thing. But let's get the data first before we jump at some assumptions.

MR. EBELER: I think your first question here in some ways is the policy framework we've been grappling with in other areas, whether we should be starting to norm payment not on averages but on some definition of efficiency

and effectiveness. Our problem has typically been, geez, how do you do that? It strikes me that this is an area where in the short term there may be a way to do that. It seems to me the suggestion you've come up with is a metric that lets us get an overpayment a little more accurate.

It strikes me as a valuable direction. You clearly need to adapt to communities in some ways that need access to a fixed capital item that don't have that type of volume. But I don't think we want to make national policy for other areas based on those exceptions. It seems to me you make the policy and then make sure you deal with those low-volume areas.

So it strikes me that the policy vector for the Commission is, as we head down this path, are we going to try to slowly norm where we can against a more efficient and effective provider? This is very appealing to me on that score, so I like this direction and would almost push harder. You flag it a little bit in the paper. Are there other areas in which one might consider such a direction? I think that's the hard discussion.

Again, I'm not saying that there's a magic here that this fixes everything in health care, but the bullet

point one is the long-term policy question for the Commission that I think is very valuable and worth pursuing in this area.

DR. KANE: Well, I guess one question I have is: Are we trying to talk about this in a generic way or just for CT and MRI? Because I have several colleagues in the radiation/oncology area who are very concerned about people rushing out and buying proton something that sound like they cost gazillions of dollars. And I guess my concern is, you know, I don't think there is a right price -- I mean, I think there is a point where it's really got to be on a different basis than the per unit use.

When I listen to us talking about what's the right rate, on the one hand, if you set it too high, people want to use it too much because it's more profitable. And if you set it too low, people want to use it too much because then they regain their -- I mean, there is no -- there's a volume incentive either way. And I think there's also an incentive to purchase equipment because you can leverage your time using ancillary equipment.

To me, the only way really to talk about efficiency in this whole realm is to really try to talk

about standards of care or -- I mean, the only way you can really get at it is bundling it for appropriate use within the episode, and all the other talk about it is really just -- I think we're spinning our wheels. I like it that using the hospital facility rate cut the rates on two-thirds of -- I don't know if it was the six sites or not. But, okay, so we have a standard. The hospitals are doing it. They're probably a little more incentivized because they have other ways to make money. Maybe we should just stick with the hospital payment rate for a while. But, really, I'm very worried about the incentive to go out and just buy those huge pieces of equipment, and then, no matter what, you've got an incentive to use it all you can because you've bought it.

So the volume incentive here is scary, and there's no way to stop it on a per unit price. The only way to stop it is to bundle it into an episode or a visit for an appropriate use, and maybe the best thing is the hospital because they have -- they're probably a little more likely to be using it the right amount of time only because they have other competing ways to make money.

I think this is really kind of a conversation that

can just go in circles for days and not really resolve the major problem, which is we're probably going to -- we probably have too much equipment out there, probably misallocated, too. And maybe we really need to go back and say should there be, God forbid, certificate of need or planning or some way to say, you know, let's have the right -- let's try to get at the right number of units of machinery out there and then we can talk about what the right amount to pay for that unit is. But as long as it's wide open to go buy as much equipment as you want and then have as much volume as you want, there is no efficient price.

DR. REISCHAUER: There, of course, is a huge problem with looking at what is because what is is the result of a flawed payment system that's wildly overpaid and paved the country with these machines. And I'm where Bill is, that I think you can say, you know, in metropolitan areas of a million or more people, we're going to assume 80 hours a week for these machines, and that's the way it's going to be. I think the hospitals probably -- you know, we're paying too much for them, too. But it would be a huge mistake to do surveys and look at what exists now, except

maybe in rural areas, you know, because it's the product of a flawed payment system.

DR. DEAN: I would just echo the concerns Nancy raised. It struck me when I read this chapter that there's just no way to figure this correctly for the reasons that Bill raised and the reasons that Nancy raised. We just put in a CT scan in an extremely small hospital where in a lot of ways it doesn't make sense, but in actual fact what we paid for it was a third of the amount that's listed here as the cost for a CT machine. And so the type of machine you buy, you know, how often you use it, there's just enough variables in there, I don't think there's any way to get an administered price that's going to fit all the situations.

So somehow I think that decision has got to be made on a broader level, and, you know, probably that means bundling. It doesn't make sense in this particular situation.

MR. HACKBARTH: Surely it's difficult, but it is being made, it's adherent in the payment system we've got. And so we can accept the one we have or we can modify it.

DR. DEAN: What you said a minute ago, you know, maybe is a good counter. The idea that you should set a

base rate that is an ideal rate in the most efficiently used piece of equipment, and then maybe make adjustments for some of these other things like low utilization. I don't know. But it's obviously very complicated because there's so many things that affect it.

MS. BEHROOZI: It struck me, listening to Nancy and going back to a comment that Mike made, we're using the word "efficiency" here, which is appealing when you're talking about a piece of the payment being based on paying back the cost of the machine. And you're right, we have to start with what is, and I'm learning more and more about what that is all the time.

But taking a step back from that, the word "efficiency" here is being used very narrowly, and I think that's what Mike said. How much you use the machine increases the efficiency of the use of the machine. But taking Nancy's comments, I thought we were supposed to be talking about efficient provision of patient care. And, you know, I just wanted to sort of incorporate that comment with Nancy's, that if we could think about efficiency in a patient-centered way rather than a machine-centered way, maybe that would help us.

MR. HACKBARTH: We do need to do that, and we need to look at other payment methods that might accomplish that. But remember what's at stake here is the relative payment for different types of services. And we've often talked about how primary care is underpaid and we've got problems there. This kind of adjustment goes to the distribution of dollars within the physician payment system and is one path -- not the only path, maybe not even the most important path, but it's one path to address some of those issues.

MS. BEHROOZI: I just feel like the word "efficiency" in the first question might be driving us in different directions.

DR. CHERNEW: I guess two things. The first thing is just a quick clarification question. How much use of these machines are in episodes that one would clearly think might be bundled, like coming back to follow up for cancer care, versus things that are harder to bundle, like acute head injury type thing, which you could conceivably bundle, but there's a lot of, you know, leeway around how you code that? So I wasn't sure how much that would work at the margin.

The other thing, I guess the broader thing I would

say is my sense of this discussion is that, given the presentation we had from Larry Casalino and Lawrence Baker -- and I forget the other gentleman who spoke to us -- I think we have a sense that there's been historically too much of a growth in imaging. So any mechanism one could -- in the efficiency. So any mechanism one could come out to do the redistribution is really a mechanism to get to where you think you want to be given what you think is going on with the services as opposed to having to justify it dramatically on what the cost is or should be, I think the economics would suggest some sort of two-part payment to try and get it right, because there is a price low enough to stop use. No. Zero. So I don't know how much above zero you have to go.

DR. KANE: Let me know when you want to set that price.

DR. CHERNEW: I don't want to set that price. There's some price above that, though, that -- I don't know how high it is. So the point is I don't think we're going to get there, so it strikes me that some of this discussion is sort of a convenience to adjust for a flaw that we know through use and other purposes exists in the system. And in

that sense, I think I'm supportive of the general tone of where we're going, much more so than I am addressing the broader philosophical issues that it raises, because I wouldn't want to be put into a transitive argument that you use just to justify and now you have to apply this somewhere else where I might not feel quite the same way.

MR. EBELER: I just wanted to sort of go back to something that you said, and a couple of other people. I don't have any disagreement that one wants to head towards more episodes in bundling. I think what is being laid out here is, given a currently flawed payment system that is being used today to pay for these things, is there a way to adjust this particular component to change that in a better way? And this strikes me as a good, short-term payment adjuster while we are simultaneously working on a lot of other episodes in bundled payment arrangements. It just strikes me that that is a way to think about this as we develop policy for this coming year.

MR. HACKBARTH: Well, that was thought-provoking. Thank you.

Okay. We're finished our presentations. We'll have a brief public comment period. Limit your comments,

please, to no more than two minutes. Begin with your name and organization. When you see this red light come back on, that means you're at the end of your two minutes.

MR. SCHUMACHER: Thank you very much. I will pay very close attention. My name is Don Schumacher and I'm the president and CEO of the National Hospice and Palliative Care Organization.

This afternoon we heard a presentation from staff and conversation with the Commissioners about hospice care and the issues associated with models of care. As we have in the past, we invite the staff and the Commissioners to also avail themselves of the hospice community's considerable data and information from multiple sources so that you can make fully informed decisions about the future of hospice care in the U.S.

On behalf of the 1.4 million patients and their families that received care last year and the hundreds of thousands of others who could have appropriately benefitted from hospice care, I'd like to make a couple of brief comments.

Recently, the leading membership organizations of the hospice industry -- these are folks that have an

interest in hospice care -- met and reaffirmed our common values about hospice provision. Included among our shared principles was recognition of the resounding success of the Medicare hospice benefit over the past 30 years. Millions of people have received care, and the need to preserve and enhance hospice care as the model of patient and family care focused at the end of life.

As has been discussed today, over the years the patient population definitely has changed. And just as our patient base has evolved, the benefit itself must be modernized to better meet patients needs and match payments in a cost-effective manner. We would urge MedPAC to consider this important dynamic to assure that your recommendations make a constructive contribution to the Medicare hospice benefit and to dying Americans in the United States.

I would make one personal comment that I think, looking at your recommendations, I would start with recommendation number four, which is data collection, because I think making wholesale rate changes without appropriate data collection will do a tremendous amount of damage to patients and families in this country.

Paramount in our beliefs is making sure that future patients and families can access in all service settings the high-quality care that hospice has come to symbolize. Eligibility for care should be based on an assessment of the patient to assure appropriate eligibility and receive support by evidence-based criteria.

Patients and families should know what to expect and receive consistent and measurable high-quality services delivered by a skilled interdisciplinary team within every hospice program in this country. At the same time, and importantly, the hospice community is committed to program integrity, transparency, accountability, and fiscal responsibility, working with this group in this room and others to ensure that.

One last comment from myself personally. You can still get a hospice license in this country and not be surveyed for 11 years. That's a significant problem. Just resolve these issues.

MR. INTROCASO: My name is David Introcaso. I'm from the Marwood Group. A few comments on the hospice discussion.

First, I think the comment of "candy store," as a

five-year hospice volunteer, I just find that basically insulting.

More substantively, though, relative to length of stay, I would have appreciated -- or maybe that was what was considered; I hope it was considered -- some discussion about the unpredictable nature of diagnosing death or disease etiology. I'd say also, too, that historically we all know, Jim, that hospice has been underutilized.

More substantively to Don's point, the data issue, fundamentally reforming health care reimbursement without, admittedly, little or no data I find actually truly remarkable.

Secondly, I didn't hear any discussion whatsoever, particularly on the Hill where we hear constant rhetoric about P4P and VBP, no discussion about quality and how you're going to tie improvement and quality at the end of life with reimbursement. It's just beyond my understanding.

Lastly, relative to the cut, the Marwood Group advises large institutional investors. They're already screaming about the BNAF cut. If you don't think there's going to be a capital flight, I think you really ought to consider what consequences that will have.

And, lastly, on the private sector, I've found the inherent bias towards the private sector in hospice somewhat also unbelievable. That there's large growth in the for-profit hospice, I don't understand why that's positive or negative. It's just, you know, hospitals grow, other industries grow. No one seems to make a complaint about that.

I appreciate your time. Thank you.

MS. MILLMAN: Hi, I'm Diane Millman with Powers Pyles Sutter & Verville, and I'd like to comment on the equipment utilization discussion and on imaging in general.

I think that there are a number of aspects of this discussion that I find troublesome. I think the first is that there's an awful lot of time that's been spent on this issue by the Commission that I'm aware of, and I think it's real important to emphasize that CT and MRI rates today and for the foreseeable future are not even based on the methodology that's being discussed. It's based on a DRA methodology which is a cap. That cap for MRI and CT is not what it used to be. If folks are thinking MRIs of $1,000 or $2,000, what we're talking about of MRIs is about $300 at the most, CTs at about maybe $200, something like that, and

going down.

I think it's really also very important to understand that the physician fee schedule methodology is a very carefully balanced system, and what is being talked about is one assumption among very many. There are indirect costs, for example, that are paid under the physician fee schedule -- that's lights, overhead, all of the rest of it -- that are allocated almost 75 percent based on physician work. Physician work has nothing to do with how much you pay for your lights. So, therefore, a surgeon who leaves his office and spends a lot of time doing a complex surgery in a hospital gets paid for the lights that are -- gets paid overhead that is far in excess of what an MRI facility gets.

So if you're going to look at the payment system, don't pick and choose your assumptions. You need to look at it holistically.

Finally, what I would say is with respect to the DRA rates for MRI, CT, PET, all those highly capital cost equipment, that's what's being paid right this minute. Fundamentally, the capital costs for those MRIs, for those CTs in hospitals are spread across the hospital. The rates that are paid, the rates that are paid today both in free-

standing and in hospital systems do not take into account appropriately the capital that is used for those. That's why they're so low.

So I would really caution against making precipitous judgments. You're going to have a 5-percent additional across-the-board cut for technical component services and, in fact, for all services because of the conversion factor that's just come out, which is going to hit disproportionately all technical component services. This is an industry that has taken a lot of cuts. It's continuing to take cuts, and I would caution against picking and choosing your assumptions and mucking with the methodology to get at a perceived overutilization problem rather than looking at a way to look at appropriate utilization and how to address that.

Thank you.

MR. HACKBARTH: Okay. We are finished for today. We will reconvene at 9:00 a.m.

[Whereupon, at 5:22 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, November 7, 2008.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, November 7, 2008
9:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair
JACK C. EBELER, M.P.A., Vice Chair
MITRA BEHROOZI, J.D.
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AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: Good morning. We start today with two sessions on Medicare Advantage, the first on the mandated report to Congress. Dan, are you leading -- Scott?

DR. HARRISON: Good morning. Today, Dan and I will present some preliminary analysis we have undertaken to start on the Medicare Advantage payment report that was mandated for us in MIPPA.

This is our mandate. We've been assigned three specific tasks. We must evaluate CMS's measurement of the fee-for-service county-level per capita spending. MIPPA also directs us to study the correlation between the fee-for-service spending measure and MA plan costs to deliver Part A and B benefits. Based on the findings from the first two tasks, we are to examine alternate approaches to MA payment other than the county fee-for-service approach and to make recommendations as appropriate.

In this session, I am first going to give some background on MedPAC's past positions and recommendation on Medicare Advantage payment. Then I'm going to present our preliminary analysis on the first two tasks and present a concept for one alternate payment approach. And then Dan

will finish by present analysis of an alternate approach using different payment areas.

MedPAC has a long history of supporting private plans in the Medicare program. The Commission strongly believes that beneficiaries should be given the choice of delivery systems that private plans can provide.

Private plans, through financial incentives, care coordination, and other management techniques have the potential to improve the efficiency and quality of health care services delivered to Medicare beneficiaries, and if the plans are paid appropriately, plans would also have the incentive to be efficient for the Medicare program and for the taxpayers that support Medicare. However, MedPAC has expressed concern that excessive payments to plans have been attracting inefficient plans to Medicare Advantage.

As a very quick reminder of how we pay, let me just reintroduce some terms to help new Commissioners follow the rest of the presentation. A bidding process is combined with administratively-set bidding targets, which are called benchmarks, to determine the capitated rates paid to plans. Plans submit a bid for the basic Medicare benefit and it is compared with the benchmark. If the bid is higher than the

benchmark, the plan is paid the benchmark and beneficiaries would pay the difference with a premium. However, if the bid is below the benchmark, the plan is paid its bid plus 75 percent of the difference between the bid and the benchmark and the remaining 25 percent of the difference is retained by the Medicare program. The plan must then use its share of the difference to provide extra benefits. The valuation of those benefits includes plan administration and profit.

Now let me come back to the point that we have attracted inefficient plans to the MA program. This system could be efficient for the Medicare program except that the benchmarks are now considerably above 100 percent of fee-for-service payments in many areas of the country. These high benchmarks have resulted in payments to plans of 113 percent of fee-for-service spending, well in excess of what it would cost the Medicare program to cover the same beneficiaries in fee-for-service.

Now, this slide comes from a table in our last March report. In the second column, we have the average bid as a percentage of the expected Medicare fee-for-service cost for the population the plan is bidding on. If a plan bids 100 percent of Medicare fee-for-service, Medicare would

consider that the plan is providing the Medicare benefit package as efficiently as the fee-for-service program.

We found that the average 2008 bid is 101 percent of fee-for-service spending. This means that beneficiaries on average are now enrolled in plans that are less efficient than fee-for-service Medicare. As you can see, the bids vary by plan type and not all plan types are inefficient. For example, HMOs bid an average of 99 percent of fee-for-service. Private fee-for-service plans, however, bid an average of eight percent more than fee-for-service spending.

These bids, combined with high benchmarks, produce payments to plans that are well above fee-for-service spending for all types of plans. However, some argue that the high benchmarks are okay because the beneficiaries are receiving extra benefits. However, those extra benefits, according to the plan bids, are worth 12 percent of fee-for-service payments and Medicare is paying 13 percent to get them, and the 12 percent includes plan administration and profit. Even for HMOs on average, only one percentage point of the extra benefits are funded by plan efficiencies and 12 percentage points are funded by the extra Medicare payments. Looking at private fee-for-service plans, Medicare pays 17

percent so that members may get nine percent in benefits.

MedPAC has argued that the original purpose of private plans in Medicare was to provide care more efficiently and thus allow beneficiaries to receive extra benefits funded by those efficiencies. But Medicare should not pay more so that beneficiaries who choose inefficient plans are able to get extra benefits. The Medicare program should be financially neutral in the beneficiaries' choice.

The Commission last made MA payment recommendations in our June 2005 report. I would like for you to keep in mind one of those recommendations regarding financial neutrality as we go through my part of the presentation today. We recommended the Congress should set the benchmarks that CMS uses to evaluate Medicare Advantage plan bids at 100 percent of the fee-for-service costs. CMS estimates fee-for-service costs as county-level estimates of fee-for-service spending and our mandate directs us to examine those estimates.

So now let's look at CMS's measurement of county-level spending. I'm going to present it at a highly simplified level, but I can give you more detail on question.

CMS uses a multi-step process to estimate expected county-level fee-for-service spending. Each year, the actuaries begin by tabulating spending from the fee-for-service claims files based on the county of residence of the beneficiary who received the Medicare covered service. The totals are then averaged and standardized for risk and a per capita spending figure for each county is calculated as a five-year average.

Generally, CMS is as accurate as one could reasonably expect, but there are a few issues we want to look at more closely. One issue is the timeliness and completeness of the claims data that CMS uses. On this issue, we need to do more investigation before we consider making a judgment. We have had some concern about the stability of the estimates, and Dan will address that issue later in the session.

And now I will discuss two issues that were specifically raised in the mandate, Veterans Affairs, or VA, spending on Medicare beneficiaries and administrative costs included in the fee-for-service estimates.

MIPPA specifically requires us to determine whether the fee-for-service measures fully incorporate

Department of VA spending on Medicare beneficiaries. Currently, the Medicare fee-for-service estimates do not include any spending by the VA for Medicare beneficiaries who are eligible to receive care under both Medicare and Veterans health programs. Plans are concerned that this lowers the per capita fee-for-service spending measures.

CMS has proposed to test the relationship of VA spending for Medicare beneficiaries and the MA benchmark and modify the calculations of fee-for-service spending, if there is a need. Essentially, they would remove any beneficiaries who are eligible for benefits from the VA when they calculate the per capita fee-for-service spending and see if there was a difference compared with when those beneficiaries were left in the calculation. This approach has promise and we encourage CMS to move ahead. CMS did not have all of the data it needed to implement the strategy for 2009, but the actuaries told us they expect to be able to implement it the next time.

On net, we don't know whether the proposal would raise or lower benchmarks because we don't know whether veterans use more Medicare services because they are sicker or use fewer Medicare services because they substitute

services from the VA.

MIPPA also requires us to determine whether the fee-for-service measures include all appropriate administrative costs. Using the HHS budget documents, we figure that the CMS administrative costs attributable to the Medicare program would be under $3 billion while total benefit spending is in the $400 billion range, meaning that the total administrative cost to administer the benefits is well under one percent of the benefit spending.

The fee-for-service spending estimates are adjusted upward to account for more than half of those administrative costs because those costs are for processing fee-for-service claims. CMS does not have to pay to process claims for MA members.

The rest of the costs are not included in the fee-for-service estimates because those costs include CMS funding to perform administrative functions for the Medicare program as a whole, for example, fraud and abuse monitoring. These functions are retained by CMS even for beneficiaries who have enrolled in MA plans. Further, some of the funding is actually used for the administration of the MA program.

Now, in summary here, the costs of claims

processing accrue solely to fee-for-service and are included in the fee-for-service spending estimates while other administrative costs are spread across the entire Medicare program and are thus not added to the fee-for-service estimates. We find this to be an appropriate allocation of costs, because even if there are some costs that could be attributed solely to fee-for-service, the amount of these costs would be so small, any adjustment would be negligible.

The mandate also asks us whether the fee-for-service measure is correlated with plan costs. While there are many possible ways to measure costs, the mandate instructs us to use the plan bids to determine costs.

To directly answer the mandate, we measured the correlation between plan bids and expected fee-for-service spending for an equivalent population. Correlation measures how two variables move in relation to each other. Correlation statistics range from minus 1 to plus 1. If the two have no linear relationship, the correlation would be zero. If one variable was always relatively high when the other was, then the correlation would be positive one. Correlations near one show high correlation and correlations near zero show low correlation, and negative correlation

values just means that the two variables tend to move in opposite directions.

We find there is a strong correlation between plan bids for 2009 and expected fee-for-service spending. Overall, the correlation was 0.88. This means that plans serving areas with high fee-for-service spending were likely to have high bids and plans serving areas with low fee-for-service spending were likely to have low bids.

We calculated the correlations separately for four plan types and found that there was high correlation within each plan type. HMOs had a correlation of 0.89, while PPOs and private fee-for-service had correlations of at least 0.93. The correlations were higher for plan types that tend not to have relatively tight networks of providers. This means that the bids of plans that are more likely to pay providers based on Medicare rates are more closely correlated to the level of fee-for-service spending in their service areas.

Although our mandate asks us to look at differences by geographic area, we are limited because CMS does not gather county-level bids. We were able, however, to explore differences between urban and rural plans. We

selected a group of 1,500 plans that drew their entire enrollment from urban counties and designated them as rural plans, and rural-only plans were rare, but we did find 125 plans who expect to get 90 percent or more of their enrollment from rural counties. We designated these 125 plans as rural plans.

We found that there was a high correlation of plan bids and fee-for-service spending within both urban and rural areas. However, the correlation was somewhat stronger in rural areas. As with the plan type differences, this finding suggests that plans that are more likely to have to pay providers based on fee-for-service Medicare rates, namely the rural plans, are more likely to have bids that are highly correlated with fee-for-service spending.

Incorporating the findings from the first two tasks, MIPPA asks us to examine alternate approaches to MA payment. Specifically, we are asked to examine approaches other than the approach using payments based purely on county-level fee-for-service spending. The mandate suggests that the Congress is interested in exploring payment approaches that would maintain broad plan availability. These approaches might involve paying rates closer to plan

costs rather than focusing only on local fee-for-service costs.

Today, I will discuss such an approach that uses a blend. Dan will discuss an approach with larger payment areas momentarily. And there are other benchmark-setting approaches that I mentioned at the last meeting that we will investigate more in future meetings.

We raised the possibility of using a blend of local and national fee-for-service costs in the past. The particular formulation of a blend could seek to incorporate fee-for-service spending in plan costs. We have shown earlier that plan costs are correlated with fee-for-service spending, but we don't know how closely plan costs track fee-for-service spending. We could use regression analysis of fee-for-service spending and plan costs to see how closely they track and to determine the blend.

Before we talk about using a blend to set benchmarks, let's see how the benchmarks look now. Along the bottom axis, we see counties arrayed from highest to lowest fee-for-service spending. The axis up the side shows the current benchmarks. Again, these are more theoretical than real. We have greatly simplified how the current

benchmarks are calculated really on this slide to make two points. First, benchmarks are not allowed to fall below a legislatively-set floor no matter how low fee-for-service spending is. We simplified the drawing to show one floor, although there are actually two.

The second point here is that for non-floor counties, benchmarks are a little over fee-for-service for some technical reasons and for some policies that are due to expire over the next few years. So the pink-purplish line there represents the general level of benchmarks, although in reality they are more scattered in relation to fee-for-service spending.

Now let's talk about a blend in general. This is an illustration of where benchmarks would be set using a local/national blend. The orange line represents a local/national blend where the benchmark is set incorporating local fee-for-service spending and the national level of fee-for-service spending. The two lines meet at the national average, represented by the thin blue line there. Benchmarks in areas with less than the national average fee-for-service spending, say rural Nebraska, would be higher than their local fee-for-service spending, and

areas with spending above the national average, Miami, for instance, would see benchmarks lower than local fee-for-service spending. The blend line would get steeper as we increased the local/national blend toward 100 percent local, which is the green line.

As I mentioned, the particular blend could be informed by the regression of plan costs on fee-for-service spending. We haven't finished running that yet, but as an example, if we found that plan costs rose, say, 60 cents for a dollar increase in fee-for-service spending, we could use a 60/40 blend to keep benchmarks resembling plan costs. At a future meeting, I will simulate the effects of a blend on 2009 plans, assuming they did not change their bidding behavior.

And now Dan will talk about payment areas.

DR. ZABINSKI: Currently, the county serves as a payment area for MA plans as each county has a benchmark against which plans must bid in order to serve that county. As a result of the process for setting county benchmarks, some counties have their benchmarks set equal to its per capita fee-for-service spending.

But using fee-for-service spending at the county

level does present some problems. First, some counties have low populations which can make their fee-for-service spending unstable over time because unusually high or low health care use among a few beneficiaries can cause substantial year-to-year changes in their fee-for-service spending in these low-population counties. Therefore, it's possible that a county can have a measure of fee-for-service spending that differs from its typical level. This can be carried forward into an erroneously high benchmark and can remain too high indefinitely through the mechanism for updating the benchmarks.

A second problem that is caused by using fee-for-service spending at the county level is that adjacent counties often have very different fee-for-service spending and consequently can have very different benchmarks. If adjacent counties have very different benchmarks, plans may offer less comprehensive benefits in the county with the lower benchmark or they may avoid that low-cost county altogether, creating appearances of inequity between those adjacent counties.

In previous work on payment areas, the Commission evaluated alternatives to the county definition that address

the problems presented by counties. From this analysis, in the June 2005 report to the Congress, the Commission made a recommendation that said, among urban counties, payment areas should be collections of counties that are in the same metropolitan statistical area and in the same State, and among rural counties, payment areas should be collections of counties that are in the same State and that are reflections of health care market areas, such as health service areas, or HSAs. The idea of an HSA is a group of counties whose Medicare beneficiaries receive most of their short-term hospital care at hospitals that are in the same group of counties, and we refer to this combined MSA/HSA as MSA/HSA definition of payment areas.

One point I would like to make is that this is not the HSA definition developed by researchers at Dartmouth University. Instead, it was developed by researchers at the National Center for Health Statistics.

Now, replacing the county definition of payment areas with this MSA/HSA definition would address the problems presented by counties that we discussed earlier. First, it would increase the stability of fee-for-service spending at the county level. For example, we found that

from 2007 to 2009, the average change in fee-for-service spending would be about 2.6 percent under the county definition, with changes in some counties exceeding 15 percent. In contrast, we found that the average change would be only 2.0 percent under the MSA/HSA definition with no county having a change of more than 15 percent. And this greater stability under the MSA/HSA definition would reduce the chance that a county would have an estimate of its fee-for-service spending that exceeds its typical level, reducing the chance that a county has an erroneously high benchmark.

Secondly, the MSA/HSA definition would reduce the prevalence of large differences in fee-for-service spending between adjacent counties. This would result in more similar benefits being offered in adjacent counties.

Now, the MSA/HSA definition would also have other important effects, including, first, it would effectively approximate market areas that plans serve. This is important because if payment areas do not accurately reflect plan market areas, you run the risk of having payments above plan costs in some parts of a payment area and below plan costs in other parts. This potential for losses in some

parts of a payment area could cause plans to avoid the payment area altogether, even if they are profitable in other parts of the payment area.

Also, using the MSA/HSA payment areas would have some redistribution effects. In particular, MA spending would be redistributed among urban counties and among rural counties, but the MSA/HSA definition would not redistribute spending from urban counties to rural counties or the other way around. This is because this definition of payment areas never combines urban counties with rural counties into the same payment area. Also, spending would not be redistributed from one State to another, and this is because this definition of payment area never combines counties in different States into the same payment area.

To close, our next steps for this report are twofold. First, based on Commissioners' input, we will develop alternative payment approaches to the MA program. The one that Scott already discussed is a blend of national and local fee-for-service spending. Also, we will examine a national benchmark that is adjusted for geographic variations in prices and other factors. We will then simulate the effects of these approaches under the county

definition as well as the MSA/HSA definition of payment areas. In particular, we will look at the frequency and magnitude of payment changes that plans would face and how many beneficiaries would be affected by payment changes. In these simulations, we will assume static behavior so that there will be no changes in plan participation, plan bidding, or beneficiary enrollment.

That concludes, and we turn it over for your discussion.

MR. HACKBARTH: Thank you. Good job. So let's do first our round of clarifying questions.

MR. EBELER: Thank you very much. Scott, if you could go to slide five. This is always very helpful data. Just two things. One, the policy question here, of course, is whether there should be extra payments at all, even if they do generate extra benefits, and so let's -- but the clarifying question is this extra benefits column. I'm very proud to have worked in the health plan community in Minnesota and nationally for a number of years. I never could figure out how to explain to an employer, a budget person, or my mom how my administrative costs and margin counted as an extra benefit.

[Laughter.]

MR. EBELER: And so my question -- especially my mom. She's not big on that.

So my question is, will we be able to split out of that column the administrative costs and margins and the extra benefits accruing to beneficiaries at some point in this analysis?

DR. HARRISON: We would have data on the bid as a whole that would show the medical portion, the administrative portion, and the margin, I believe they call it.

MR. EBELER: So that will be --

DR. HARRISON: We could do that, yes.

MR. EBELER: Thank you.

MR. BERTKO: Scott, just a quick clarification on the VA change. DOD costs are also one of those things. Is that included in the VA or is it VA alone?

DR. HARRISON: Let's see. CMS was going to do DOD as well, yes. It's just that our mandate didn't mention it.

MR. BERTKO: Okay. Thank you.

DR. CROSSON: Scott, on slide 15, the one that shows the blend, you may have said this and I may have

missed it. I think you said the blend you modeled here on this was 60/40.

DR. HARRISON: It wasn't.

DR. CROSSON: It wasn't?

DR. HARRISON: Frankly, this is a randomly drawn line.

DR. CROSSON: The question is, then, maybe you did say it or didn't, the goal here in recommending a blend would be what? In other words, what would be the criteria you use to determine the ideal slope of that orange line?

DR. HARRISON: Okay. So let's say we do a regression and it comes out that the plan bid is equal to some constant plus -- and we've been getting numbers, and we're not ready to do it yet, but we've been getting numbers in the 70 to 80 percent range. So let's just say it's 75. So if plan costs seem to go up by 75 cents for every dollar of fee-for-service spending in an area, then I think the idea would be to set the blend at 75 percent local and 25 percent national. This isn't necessarily our idea, but this has come from outside.

MR. HACKBARTH: The goal, as I understand it, is to lift the line at the bottom end of the distribution and

lower it at the top. And as for there being an analytic test of how to determine the slope of the line, I don't think that there is, at least in --

DR. HARRISON: Well, I think the idea is that if you use that line, you would be getting closer to approximating plan costs, and so there are some people out there, I think, that want to pick plans closer to their costs.

DR. CHERNEW: [off mic] Are you proposing initially to get rid of the floor?

DR. HARRISON: You would get rid of the floor if you were doing a blend, yes.

DR. CHERNEW: So this would just be the line?

DR. HARRISON: Right.

DR. MARK MILLER: And let's just be clear on the language here. The mandate has asked us to look at these types of ideas. I don't think there's a proposal. We're just trying to work through how people think through these kinds of ideas. I just want to be clear in the public about the vocabulary.

MR. GEORGE MILLER: Good report, and just a clarifying question. I think, Dan, when you were mentioning

about rural counties and urban counties that you would make sure that you would not blend -- did you say you would make sure they would not be blended together?

DR. ZABINSKI: Yes. I mean, well, just in that particular payment area, we keep the urban counties with the urban counties and the rural with the rural counties.

MR. GEORGE MILLER: But like in West Texas, for example, there are some urban counties that are surrounded by rural counties --

DR. ZABINSKI: Right.

MR. GEORGE MILLER: -- and you would make sure that that urban county and the rural counties would not be blended together?

DR. ZABINSKI: Yes. The idea is that -- defining urban in this case is a county within an MSA. That's the demarcation.

MR. GEORGE MILLER: Okay. Thank you.

DR. REISCHAUER: A couple of things. When you're talking about the VA folks, you said it could be that they are sicker and therefore use more services. But in a sense, that would be picked up if you had a good risk adjustment, so --

DR. HARRISON: Yes. The actuaries are actually going to look at the risk-adjusted spending differences by putting them in, yes.

DR. REISCHAUER: Right, so that doesn't really -- then when you were talking about administrative costs being excluded --

DR. HARRISON: But Bob, right now, we don't know the risk scores of some of the VA people because the diagnoses related to their treatment may be held by the VA and Medicare doesn't see them, some of them.

MR. BERTKO: I will come back later, but I have a little difference of opinion with Scott on that particular comment.

DR. REISCHAUER: With respect to the administrative costs, I don't know if I got this right, but I thought I heard you say that for some of the ones that are appropriately focused on fee-for-service, like the payment by the intermediaries and all that, that's in there, and then everything else is sort of taken out and isn't included, and it struck me that some of the most expensive administrative things are rightly associated with Medicare Advantage, I mean, risk adjustment, the whole bidding

process. I mean, these are very complicated things and if we're going to slice and dice this in an appropriate way, they should really be loaded onto Medicare Advantage.

DR. HARRISON: I think we decided not to slice and dice because as a percentage of the estimates, they really would be very small. So we --

DR. REISCHAUER: Okay.

DR. HARRISON: -- not getting deeply into the budget, we decided to say that that was okay.

DR. MARK MILLER: I also think the general tack here is what we are saying is whether a beneficiary is in managed care or fee-for-service, the program, Medicare, has to engage in a bunch of activities -- eligibility determination, fraud and abuse, making policy. And you're saying that there might be a level of effort associated to MA that's higher. But even sometimes when you think about fee-for-service, if you think about like competitive bidding for DME, there's levels of effort that really you could imagine situations where it's quite intense on the fee-for-service side. And given that and the small number, we kind of --

MR. HACKBARTH: My recollection from the paper,

Scott, was that we're talking about four-tenths of one percent of total spending, something like that that we would be divvying up.

DR. HARRISON: Right. You'd be divvying up, right, four-tenths of a percent.

DR. REISCHAUER: You mean just $3 or $4 billion?

DR. HARRISON: Right.

[Laughter.]

DR. KANE: When will we know what the actual costs are? Right now, all of your analysis is based on plan bids. At what point are we going to know what the actual spending on Part A and B benefits is, because I know there is some effort to collect at least some kind of encounter data about that. And will that, in fact, affect this notion of creating or driving the benchmark closer to actual spending?

DR. HARRISON: The encounter data is still a couple of years away, at least. But then you would have to have some modeling of what the costs of those encounters are and that would be yet another step. So it would be a while.

DR. KANE: So you're not collecting anything to do with their actual costs on Part A and B? It's just their plan bid costs?

DR. HARRISON: Right.

DR. KANE: There's never going to be a data set on what it actually cost them for A and B?

DR. HARRISON: The plans are supposed to submit with their bid -- they go back a couple of years and they say what their A and B costs were. In fact, it might even be at the contract level.

DR. KANE: So you can't get it at the county level.

DR. HARRISON: No.

DR. KANE: But if you made larger service areas the way we're recommending, maybe they could do that, or is that out of the question, too?

DR. HARRISON: Hopefully, you'd approximate the service areas that they're using, so it might get closer.

MR. HACKBARTH: We're still on round one.

DR. STUART: I'd like to go back to slide 11. I'm trying to interpret what that top row really means, because the row on HMOs is the only one in which you have estimates for urban and rural areas separately. So why would the urban and rural area overall be any different than the subset for that particular -- for the subset of HMOs if you

don't have non-HMOs in rural areas?

DR. HARRISON: There are a few, but just not enough for me to put a number up there. Yes, you see they're very close to the HMO numbers.

DR. STUART: I guess I think it gives you the impression of something that it really isn't. So it's really an interpretive issue. I mean, if it's really the HMOs that are driving this, then to say that it's all MA plans is not particularly informative, let's put it that way.

DR. HARRISON: Well, the mandate asked us to do it like that.

DR. STUART: Okay. And the second issue is, and it gets back to the VA spending and it's an interpretive question, and that is have you looked at the distribution of VA spending geographically?

DR. HARRISON: We don't have any such thing, no.

DR. STUART: I'm sure VA does.

DR. HARRISON: Well, CMS has been talking with them for years about it and hopefully they will get it.

DR. DEAN: On slide five, I'm still confused about the relationship between the bids and the payments. In the

middle column, we have the bids, but either the left or the right-hand column, why are the payments higher than the bids if the payments are supposed to be based on the bids?

DR. HARRISON: The payments are based on the benchmark.

DR. DEAN: But isn't the benchmark set in relationship to the fee-for-service spending?

DR. HARRISON: No.

DR. DEAN: Oh, okay. I guess that's what I'm confused about.

DR. HARRISON: Right. For 2008, the benchmarks actually average about 118 percent.

DR. DEAN: Oh really? Okay. I guess that was the part I didn't understand. And that's fee-for-service spending plus what?

DR. HARRISON: It's sort of historical artifacts of how they got that way. You had the floors. You had IME spending. You had this budget neutrality adjustor that went in.

DR. DEAN: I see.

DR. HARRISON: And then you can have sort of random mistakes or randomness on the fee-for-service numbers

that Dan had talked about, where one year it's high and you stay on that high road.

DR. MARK MILLER: But I want to give just a different answer, okay? All that's correct --

DR. DEAN: You're going to make me more confused.

DR. MARK MILLER: No, no, no, hopefully less confused.

DR. DEAN: Okay.

DR. MARK MILLER: All of that is correct, okay, but fundamentally, what's happening is that the Congress set the payment rates administratively in certain areas of the country above fee-for-service.

DR. DEAN: I see.

DR. MARK MILLER: And Scott?

DR. HARRISON: Right. The floors were set, and that's where a lot of it comes from.

DR. CHERNEW: I think, and I'm not 100 percent sure that this is important, but I actually think it is to answer this question and subsequently. There is, I think Dan was alluding to, this ratchet effect, which if you -- the floor gets updated, I believe, according to a minimum update percent. So if you are high at one point in time and

then your next year you are low, you can't drop back down to low for any statistical variance. And so over time, you see this ratcheting up of the level that is going to give you this gap because of the way the floor is moved, because I think there's a ratchet in it.

MR. HACKBARTH: [off mic] It contributes to this.

DR. CHERNEW: Yes, that's what I mean.

DR. MARK MILLER: But the point is, that's all set in law.

DR. CHERNEW: Right. There's a legal ratchet about how the updates work.

MR. BUTLER: Slide five seems to be a favorite. It's mine, too, but I have two clarifying questions. Let's look at the 101 percent at the top. What that says is that the Part A and Part B spending is one percent more than would have been. That's the first --

DR. HARRISON: Yes. The plans have said that --

MR. BUTLER: Right, and that --

MR. HACKBARTH: This is the plan bid.

MR. BUTLER: This is their cost --

MR. HACKBARTH: The bid -- the bid --

MR. BUTLER: This is their bid, which would cost

them more -- I'm sorry, not the payment, the bid compared to the fee-for-service --

DR. HARRISON: Right. Now, the bid also would include administrative costs and profit for the plan. That would be in their bid.

MR. BUTLER: No, that's on the right-hand column.

MR. HACKBARTH: Well, no --

DR. MARK MILLER: Let me just take a shot here.

MR. BUTLER: I thought I had it.

DR. MARK MILLER: The way to look at this number is the plans are saying to deliver A/B benefits, it's 101 percent of what fee-for-service is.

MR. BUTLER: Okay. So the 12 percent is in the 101?

DR. HARRISON: No. The 12 percent is for benefits above the A and B benefits.

DR. CHERNEW: [off mic] They get paid 13 percent and they lower the Part D premium and other things.

DR. REISCHAUER: But they're able to provide A and B benefits probably for 92 percent or something like that of fee-for-service. And then there's profits and extra administrative costs which they add on which gets up to 101.

Then we pay them 113 and they have to do something with the extra money by law, and they provide extra benefits or rebates.

MR. BUTLER: Okay. I think what was -- I understand the payments, that it's got the 12 percent in it. I mean, I can add the numbers across there. I'm still a little -- because the footnote says extra benefits. That footnote gets to be a little bit confusing.

DR. HARRISON: It's the administration and profit that's allocated to the extra benefits as opposed to the whole --

MR. BUTLER: Yes, because you said the administration is in the bid itself --

DR. HARRISON: Right.

MR. BUTLER: -- and now the footnote kind of says it's in the extra benefits and fee-for-service. So that's what confuses me.

DR. HARRISON: It's in both places, yes.

MR. BUTLER: So is there any way we get at -- get back to the 0.4 percent, the cost of running the Medicare program -- if you were to put it in the fee-for-service, it's 0.4 percent. What a bargain. And even then, it's

overstated because we said part of the cost is --

MR. BERTKO: The administration that's in there is the claims administration for fee-for-service, which is, what, about two percent or so, Scott?

DR. HARRISON: No, it's gotten really low.

MR. BERTKO: Smaller? Okay.

DR. HARRISON: Smaller.

MR. BUTLER: Let me finish. In the document itself, it says that if you took the cost of running the Medicare program, and it's not just the claims part, that's part of the point. There are other costs in the 0.4 percent besides just running claims, and it sort of why you said even that is maybe a little bit overstated. But if you were to take the costs, you would add 0.4 percent to the fee-for-service and you're saying it's not worth it and it's a little bit less than that, right?

So I guess my question and clarification, is there anywhere in this we will understand what the cost of administering this apparatus is versus the 0.4 percent? Is there anything in our data that --

DR. HARRISON: You mean administering the MA plans or --

MR. BUTLER: Not Medicare's cost of administering the MA program, but there's a lot of costs of setting up the networks and running the thing and so forth --

DR. HARRISON: Okay. We will come -- probably next month, we will sort of do our regular MA stuff and we'll try to have the medical costs, the admin, and the profit separated out for you.

MR. BUTLER: But that's what you should be getting as part of the medical loss ratio typically. It's part of what you get the value out of setting the thing up for. I'm just curious what that piece of the cost is. Okay. Now that we're all straight on this one, I think I understand it pretty well.

The second is that the legislative mandate here really, as I read it, it looks like they're really focusing mostly on the definition of the geographic -- what unit of payment. Do you go from county? Do you do service? Do you do a blend with -- they're asking us to advise on really the geographic boundaries as much as anything. In the short run, are they also looking at, you know, broader kinds of recommendations beyond just that, or how should we view our short-term charge with respect to modifying these payments?

MR. HACKBARTH: They are asking us for a couple of different things. One is to look at the unit of payment, county and whether some other unit ought to be substituted for county, and that was the piece that Dan talked about. We made recommendations on that in the past to go to larger units.

The second piece has to do less with the unit of payment than the distribution of payments across geography, and that's what the blend is about. Is there an alternative way to distribute the payments across geography that takes into account how plan costs vary geographically, not just how Medicare fee-for-service costs vary geographically? And the idea there is potentially a blend, and then if you put up the graph, that leads to a very different distribution of payments at the low end and the high end.

MR. BUTLER: Right, all geography related. But we're not looking in the short term at this, for example, the benefit issues and how to lump that or not lump it into our thinking long-term about how Medicare Advantage is paid for.

MR. HACKBARTH: Yes. You know, there are a bunch of Medicare Advantage issues that are important and

interesting to look at --

MR. BUTLER: But beyond the --

MR. HACKBARTH: The strategy that we're adopting right now is to try to do an early report to Congress by focusing very specifically on the questions that they asked, the mandate --

MR. BUTLER: Okay. I think I understand.

MR. HACKBARTH: And then we can go back later on. In fact, a number of Commissioners have said they would like to go back and look at the broader issues in Medicare Advantage. But to get an early report out, we really have to zero in on the three specific questions that they asked.

On the table -- I wonder whether it would be good whenever we have a table to always include benchmark information. There's sort of an instinctive effort to add and subtract these columns and figure out how you get one from the other and you really need the benchmark information there for people to sort of see the relationships.

Okay. We're on to round two now.

DR. CHERNEW: My question is if a plan has to give back by law 75 percent to the beneficiary if they are under the benchmark and 25 percent gets held by Medicare, what

incentive do they have to actually be more efficient?

DR. HARRISON: Well, they still want to attract beneficiaries, so they want to bid so that they have something to give back to them.

DR. CHERNEW: But what sort of the troubles me in the blend, if you were to show the graph, the blend one -- under a blend like this, if a plan to the right were above the blend but below the fee-for-service, in other words, above the red, if that is red, and below the green, if that is green, they would be potentially saving money relative to all the fee-for-service program in their area, but according to the blend, they wouldn't get paid for doing that, and I think that's the challenge in the spin that you're doing.

On the other side, I think the key issue with the floor, I have a real problem with the floors because I'm very concerned about this legislative ratcheting effect of how the floors work and so I think an advantage on the left side of the graph is you get rid of a lot of -- I believe, I don't know how much -- you get rid of a lot of the sort of overpayment, because historically over time, through both legislation and other legislative aspects of the program, payments have gone up higher than you would have expected in

the fee-for-service system in those areas.

DR. REISCHAUER: It's not just the benchmarks. That affects the -- I mean, the floor. It affects the benchmarks everywhere.

DR. CHERNEW: No, I agree. So I agree. There are a lot of those types of problems, but I think it's particularly relevant from the left side of this.

DR. MARK MILLER: And Scott, if you would track this, you said it would get rid of the overpayments? I think that all depends on what you set the payment at before you blend it. You could set the payments at 150 percent of fee-for-service, then do the blend, and, of course, your --

DR. CHERNEW: [off mic] You could ratchet it up or down but it does--it does affect the incentives of plans to go in to places that are high cost versus low cost and generally become more efficient. I personally think, actually, the incentives -- I know they want to get more. I actually think that's a relatively weak incentive compared to if you were six percent cheaper at a relatively -- you don't get to capture a lot of that savings the way that it is legislatively set up, if you could do that.

MR. HACKBARTH: It also, at the high end, if you

have the blend line as opposed to the green line, it affects the incentives of beneficiaries to move because it reduces the additional benefits that are their reward for perhaps opting into a more closed, confining delivery system.

MR. BERTKO: A number of comments. I'm actually going to start with this slide and say that while I think this is a perfectly good way to think about a blend, another way, and I'm going back to my recollection of our report probably from June 2005, another glide path to getting there might be to blend using market areas and market costs that is a bid-oriented one. Mike, it would have some of the same effect, I think, that you're headed towards, which is the highest payment areas tend to be the ones where HMOS, in particular, can be most cost effective. And so the bids actually -- and I think, Scott, you'd probably -- I know mostly about Florida, where the bids are actually quite a bit under the fee-for-service benchmarks and I believe that's true in other very high payment areas across the country.

DR. HARRISON: It might be. We're not sure.

MR. BERTKO: It might be. Yes. So that would have the advantage, though, of not being arbitrary as this

one is. I think several people asked that question, and it would be more oriented. And, as I'm guessing, in the low-payment areas, there's a certain cost for dealing with CAH hospitals and other kinds of things that would tend to bring the bids up.

MR. HACKBARTH: Are you saying, John, calculate the new system without any reference to fee-for-service costs --

MR. BERTKO: No.

MR. HACKBARTH: -- just base it solely on bids in an area?

MR. BERTKO: Well, perhaps ultimately, but in a glide path towards that, it would be a blend between, say, whatever the benchmarks are today or what they might become and the market costs of the bids in those areas.

MR. HACKBARTH: Well, as I understand the orange line, it is a blend of bids and fee-for-service costs, right?

DR. HARRISON: No. The orange line is just bidding local fee-for-service costs and national fee-for-service costs.

MR. BERTKO: That's the issue, and we already

tried that with BBA.

MR. HACKBARTH: But the mandate, they said that they wanted us to look at a blend that included plan costs.

DR. HARRISON: I didn't notice that, but I'm sure they'd be interested, but I don't think it's specifically in the mandate.

MR. BERTKO: No. And so whether you do it in the short answer but at least for the longer-term answer, I would suggest putting that into our thinking.

MR. HACKBARTH: I guess I was inferring that from the fact that they wanted us to look at the relationship between plan costs and fee-for-service costs as one element of the mandate.

DR. HARRISON: Yes. I guess that I thought that's what they wanted to do with the blend.

MR. HACKBARTH: Yes, and so I was just inferring from that that one of the options that they wanted us to look at is using the plan costs and -

MR. BERTKO: Again, as I recall, in I think that 2005 report, we actually had that as one of our four options in there.

Second comment, and this goes to the VA/DOD stuff.

I think I'm okay with everything Scott had in the slides, but partly to somebody else's question here, I don't have VA experience, but we've got some DOD experience from my former employer who was a big TriCare contractor and it's our experience that people use both systems. We, in fact, had a funny term for people who would emerge unexpectedly, calling them ghosts, because they'd come out of the woodwork in certain circumstances. And so I quite like the idea of removing both claims and people from the denominator, because right now, people are in the denominator, thus lowering the fee-for-service rate book by that amount.

On the risk adjustment side, I agree with your statement there, Scott. We can't tell whether it's up or down, but there's an implied risk adjustment already in there and the way that the HCC works, hierarchical condition categories, if a person is served by both the VA and the fee-for-service system, it's likely that their risk score is already captured because it's not additive for the same condition. It's, in fact, nested under it. So it's likely that -- well, I'm guessing that the risk scores wouldn't change all that much.

That is, you've captured some element of the risk

scores already, the net effect being that, A, I think there would be, on average across the country, a modest bump up by doing this, but secondly, and somebody asked about this, the distribution of VA/DOD people is quite concentrated in certain counties. Out of the 3,000 counties, I'm guessing 500 of them probably have most of the VA/DOD personnel because that's where the facilities are, or that's where the big facilities are.

So we're likely to see some bump when it's done, but to someone who asked why hasn't this been done before, several of us have been pounding on that door, and to the credit of OACT, it's very, very difficult and they are making some progress finally after a bunch of years.

MR. GEORGE MILLER: This may be more of a clarifying question. Where would payments for DSH and sole community providers be calculated, and how is that accounted for?

DR. HARRISON: I believe that they are in the fee-for-service measurement.

MR. GEORGE MILLER: How?

DR. HARRISON: They're included in the fee-for-service numbers.

MR. GEORGE MILLER: Is that administrative costs?

DR. HARRISON: No, there's a DSH adjustment that's paid for hospitals.

MR. GEORGE MILLER: Right.

DR. HARRISON: I believe that's captured when they look at the claims.

MR. GEORGE MILLER: Okay. And one second question. What about critical access hospitals? Is that also calculated?

DR. HARRISON: It should be, yes. Now, one of the problems is that when they measure the spending in a county, they take -- they start January 1 and then they let the -- and they go through December and then they wait six more months for all the claims to come in. Some claims aren't cleared by even six months, and so we're going to look and see if there's sort of a predictable distribution of late claims. But we've gotten some sense that maybe some hospitals tend to get tougher cases that are more likely to last more than six months out, and so it might be every year that they have a slightly higher payout than is captured and so we'll look at that. That's one of the outstanding issues.

DR. MARK MILLER: But Scott, I want to make sure I followed all of this exchange. The fee-for-service benchmarks, if services are provided in a county by a fee-for-service provider, they get counted in building up the fee-for-service expenditures which turn into the benchmarks. On this last point about the claims delay, that's sort of a current year problem and the benchmarks are based on five-year averages.

DR. HARRISON: But they do not go back to the previous years and update them --

DR. MARK MILLER: I see.

DR. HARRISON: -- and that might be something we would say something about.

DR. MARK MILLER: And that's something that we're going to look at for a future meeting. But to your direct question, those providers should be represented and built up in the benchmarks.

DR. HARRISON: I'm guessing that the CAHs, for instance, are paid all year on their claims, and yes, there's probably a settlement at the end of the year, but hopefully that's a small settlement and it could go either way.

DR. CHERNEW: And I think it's a lagged five-year.

MR. GEORGE MILLER: But it's a year behind, so how do you calculate that? That settlement would be in the next year.

DR. HARRISON: The settlement wouldn't get in. So yes, if the settlements were always up, that would be a problem and so that's something we're going to try to look at.

DR. CHERNEW: I thought the benchmarks were a five-year lagged, so it was in fact from year eight to -- fee-for-service are T-minus-eight to T-minus-three for --

DR. HARRISON: Right. For 2009, they're using 2002 to 2006.

DR. CHERNEW: Right.

DR. HARRISON: But, I mean, you've got to remember that the 2009 rates are put out early in 2008, so the 2007 wouldn't have spun out by then.

DR. CHERNEW: Right, but I was just saying that they have time to get -- I don't know if they do, but they certainly have time to get some of that done because --

DR. HARRISON: Some of the back years done, yes.

DR. CHERNEW: Yes, because they're doing a five-

year average, but they're not doing a five-year average right up until the day where they're doing it. They're doing a five-year average. They've already lagged it so they could get at least a complete financial picture.

DR. HARRISON: Right.

DR. KANE: I think it would be helpful in thinking about this and in considering what we would like to recommend to have an idea of what the impact on the Part B premium of the non-MA enrollees is in any of these benchmarks. I think part of the reason we are concerned about the benchmarks is that the Part B premiums are paid by everybody and this comes out of that, and so sort of what is the impact on the Part B premium of paying 112 percent of fee-for-service costs? So that's just something I'd like to see --

DR. HARRISON: Right, and we've had that in our past reports.

DR. KANE: But I think people don't always read back, because some people don't even know where to look to read back. So I would just like to keep that as a highlight, because I think in considering the interests of the beneficiaries, this is really a very important

consideration.

DR. MARK MILLER: Can I just back in behind that? Scott, in December, when we go through and do the MA landscape, what we call it, we usually report the premium effect and then we also have at least sometimes reported the HI trust fund effect.

DR. HARRISON: Yes, once in a while we've done that, but --

MR. HACKBARTH: The premium effect last time we looked at it, about $2 per month?

DR. HARRISON: Yes, $2 to $3, I think.

DR. KANE: I just think it's something that we should keep in mind and have that in front of us all the time.

MR. BUTLER: One general comment. Whether you're a big believer in Medicare Advantage or not, the more we understand these kinds of data, this is at the heart of the opportunity in improving the performance and expenditures under Medicare. So the more we understand this and the more we research it, I think the better off we're going to be.

Now, this may be a dumb suggestion or question, but I know the floor was set at one point in time because in

certain markets, I believe, if I remember right, people weren't participating. They said, I can't do it in Minneapolis or New Mexico or whatever because the numbers don't work, suggesting there must have been some flaw in the data in some ways because I think people took a close look at it and really believed they couldn't. So we set a floor.

Has anybody considered the other end of the spectrum and said, why not a ceiling? If the numbers are kind of flawed in some way, you could see a ceiling at the top and achieving some of the same things that a floor is to narrow the -- it's a very simplistic thing, but I suspect there are some comparable areas where it just doesn't make sense to accept the data as it comes through and I could see how you could maybe do it that way, too. Simplistic, but --

MR. HACKBARTH: Peter, you referred to it as a flaw in the data and that was the reason for the floors. I don't think it was necessarily due to a flaw in the data as much as a difference in market dynamics. In many but not all, in many of the low-end cost areas, it's difficult for private plans to compete with Medicare because the providers have a lot of market power and plans find it difficult to negotiate and get rates that are comparable to Medicare's,

whereas in many, although not all, of the high-end areas, there's a lot of providers and it's a rich environment for plans that can play providers against one another and negotiate and get favorable rates. So it's not a flaw in the data and how the calculations are done as much as different market dynamics at the different ends of the continuum. Some areas are better for private plans than others just in terms of market structure.

DR. SCANLON: There was also a scale issue, which is that some of the lowest APCC counties were very rural counties and there were situations where you could have very high penetration of a managed care plan, but you'd have very few enrollees. And so the cost of setting up a network was prohibitive in terms of going into that kind of a county.

DR. STUART: And just to clarify further, the ability of plans to reduce the cost is a function of the cost and that we really need to keep in mind. I mean, it's not just markets. It's difference in the underlying predilection to spend money. And in that light, I think it might be useful if we had an empirical version of this chart which showed for areas as you go up that green line what the bids were in those counties so that we would see what you're

likely to change when you do these blends.

And my guess is that we're going to find that the bids look somewhat like that blend line. In other words, they're going to be above fee-for-service at the very low spending areas, if they bid at all, but they're going to be below the bid in those very high-cost areas. And John was saying in some high-cost areas, I'll bet overall it's going to be below that average.

MR. BUTLER: Then just one follow-up, Glenn. That would suggest to me, though, then maybe Medicare shouldn't go into those markets with a floor. If we're going to be a prudent purchaser and get -- as we talked about yesterday, why enter the market? You get a better deal now. Why accept a higher price?

MR. HACKBARTH: [off mic] That's the point I've been making.

MR. BUTLER: Suckered in.

[Laughter.]

DR. BORMAN: If we could go to page 11 for a minute, and this may be an incredibly simplistic question because, of course, Peter's simple question was not simple, but mine will be. The correlation here is ballpark 0.8,

0.9, okay. Now, that means, then, that roughly 80 percent of the variation -- 0.9 times 0.9, 0.81 -- is accounted for by this relationship, or whatever this relationship is a proxy for, right? So that says that there is somewhere around 20 percent that's not accounted for here. Do we have any reason to know, believe, would we speculate, is there a major dominating factor in that other 20 percent or is it a myriad of small factors that are not worth considering or easily manipulable or worthy of our time?

DR. HARRISON: I think a lot of it is going to be market dynamics. But the other thing is, this can only measure linear relationships. Maybe linear is not exactly the right model. Maybe you should be having logs or square roots or all kinds of things. So there's all kinds of possibilities that maybe it's not a straight line anyway.

DR. CHERNEW: [off mic] You can still measure that.

DR. HARRISON: Oh, yes, we could. I think market dynamics would be some of it.

DR. MILSTEIN: At the same time we're considering this somewhat narrow question under MIPPA, the Medicare Advantage plan is being obviously actively discussed as a

source of Federal budget relief. I think many of us kind of chafe at the narrowness of this request and I wonder if we might, in the process of staying within the boundaries of the request, surface information that might inform a very active and very important debate going on concurrently.

And among the pieces of information that I would commend that we pursue, and this actually came up at our retreat last summer, is information that the plans have on what within their networks, subject to the managed care incentives that these MA plans use, efficient providers are actually able to deliver the benefit for, because the relationship between that number and the number that we have been looking at on slide five is breathtaking. There are provider systems, at least in the discovery process that I've been embarked on with some grant support funding, that are delivering this benefit for 60 percent of the premium.

And even if you grant that we need to add onto that the plan administrative costs, in the context of an overall Congressional statement that Congress wants to begin figuring out how to pay what efficient health care delivery actually costs, I think mobilizing that information and embedding it in our deliberations might -- in addition to

potentially giving us some ideas within the narrow mandate that we've been asked to address -- might also serve as information that might be quite useful in current deliberations on Capitol Hill.

DR. REISCHAUER: This is just a question, Scott, that was raised really by Nancy's remarks. How are Part A only folks handled? We have an increasing fraction of the population that's working past the age of 65. They become automatically eligible for Part A. They don't sign up for Part B because they're in employment situations which provide them with health insurance. This probably varies very significantly by geographic area, the fraction of the total population, and will become increasingly more important. I'm wondering, do they back all those people out?

DR. HARRISON: They actually do Part A and Part B separately.

DR. REISCHAUER: Separately?

DR. HARRISON: Right, and so you'd have only the Part A eligibles in one pot that you're looking at the average for and you'd only have the people buying Part B in the other pot, and then they put them together.

DR. REISCHAUER: But even that is wrong. I mean, I've been a Part A beneficiary for some time and have never obviously taken advantage of it. That must skew the data.

DR. HARRISON: There is also working aged adjustments, though, in the risk model, too. So you'd be in the denominator, but you'd have a working aged designation. Sorry.

[Laughter.]

DR. REISCHAUER: Hey, be careful, young guy.

MR. HACKBARTH: That affects the distribution of the dollars as opposed to the level of the dollars, the working aged adjustment.

DR. HARRISON: Well, it goes into the risk scores. So you wouldn't show any dollars, but you'd also show a very low risk.

MR. EBELER: Bob, I think of you as working experienced, not working aged.

Nancy asked the question in the first round that I think is an appropriate question for a very large purchaser here, which was what -- and I'm sort of phrasing it more in terms of moving towards a recommendation at some point in this process, which is shouldn't we be getting data from

health plans about what they're spending on a lot more of a real-time basis? It's not going to help us make the judgment that we're having to make here, but folks sitting here five or six years from now will really benefit from that. It just struck me. I think you gave the right answer under current policy. It sure is worth thinking about as a large buyer how to do that.

The second large buyer thing that I would put on the table, I don't know for this part of the report, because it may be outside the boundary, but for longer term, is most large purchasers don't dump off 100 percent of the risk to health insurers. They engage in various types of risk sharing and different types of corridors. The government is doing that in Part D in different ways. It is worth thinking about. I just sort of put it out there as a placeholder. Again, I don't know that it fits into the confines of this first request, but at some point it just seems worth talking about.

MR. HACKBARTH: Yes, I agree, those are both important issues. I think we would be hard pressed to handle those, effectively address them in the short term, in this cycle, but they're among the many Medicare Advantage

issues to come back to.

Okay. Thank you. Good job. We're done on this for today.

Our next Medicare Advantage presentation is on quality information. You'll recall that we have another mandated report asking us to develop an approach for comparing quality in Medicare Advantage to quality in the fee-for-service system and this presentation is part of that.

MR. RICHARDSON: Good morning. Today, we will be giving you an update on recently released information on quality of care that Medicare beneficiaries receive in private health plans. The presentation includes results from our analysis of publicly available data on the performance of individual Medicare Advantage plans and a review of a report on this topic released last month by the National Committee for Quality Assurance. We also will review the major sources of data on quality in Medicare Advantage plans and discuss how the performance results from different types of MA plans may be affected by characteristics of the data sources.

Please note that the findings we discuss today

only pertain to Medicare Advantage plans and their coverage of Medicare Part A and B benefits, not the quality of stand-alone Part D drug plans or of the drug coverage provided by Medicare Advantage plans.

The primary source of data on the quality of care for enrollees in health plans, whether those are Medicare, Medicaid, or commercial plans, is the Healthcare Effectiveness Data and Information Set, or HEDIS. HEDIS was developed and is maintained by the National Committee for Quality Assurance, or NCQA. HEDIS measures include clinical process and intermediate outcome measures and they address a broad range of clinical activity, such as diabetes care, treatments for cardiovascular disease, medication management, and screening for certain types of cancers.

Most types of managed care organizations have been required to report HEDIS measures as a condition of contracting with Medicare since 1997. Currently, some special HEDIS reporting rules apply to PPOs, which we will discuss in more detail later. Private fee-for-service plans are not required to report HEDIS results now, although some private fee-for-service plans are reporting some HEDIS measures on a voluntary basis, and we'll talk about that in

a moment. For all MA plan types, mandatory HEDIS reporting will begin for services provided on or after January 1, 2010, under a provision of the recently enacted Medicare Improvements for Patients and Providers Act, or MIPPA.

The second source of health plan quality we examine is the Health Outcomes Survey, or HOS. The HOS is a longitudinal survey of a continuously enrolled cohort of Medicare plan enrollees that provides information about the two-year changes in their physical and mental health status. Not all MA plans currently participate in the HOS survey, but as with HEDIS, MIPPA requires that all of the plans will participate in the HOS starting in 2010.

For the HEDIS analysis, we used two sources of data, the Annual State of Health Care Quality Report from NCQA, which NCQA released on September 4 of this year, and the Medicare public use files with HEDIS scores for MA plans, which are reported to CMS. Our reporting on HOS survey is based on information posted on the HOS website and some discussions with CMS staff who are responsible for administering the survey.

In brief, our analysis of the 2008 HEDIS data show that MA plans overall made marginal improvements on their

average scores compared to the previous year's report. This year, the average scores across all plans improved over the prior year's averages for about half of the HEDIS measures, while in last year's report we found that only about one-third of the scores showed any improvement from the preceding year.

As in our 2007 report, we found again this year that there would have been more year-over-year improvement but for the generally lower scores of newer MA plans, which brought down the overall average scores on a number of measures. Carlos will explain this finding and our other key HEDIS results in more detail in a moment.

Looking at HEDIS performance across the different types of MA plans, our analysis indicates that Medicare PPO plans performed relatively well in comparison to HMO plans. And in a new development this year, we also had HEDIS data for the first time from a set of private fee-for-service plans that comprise a significant portion of total private fee-for-service enrollment. HEDIS scores for these plans were generally the lowest among all MA plan types.

In the case of the Health Outcomes Survey, the most recent results are better than those reported in the

private period, but there continue to be a number of plans whose enrollees report worse than expected physical and mental health outcomes. I will provide more detail about the HOS results at the end of the presentation. First, though, we want to drill down into the HEDIS results.

This slide summarizes the findings of the NCQA's 2008 State of Health Care Quality Report, which published HEDIS scores for services provided in 2007 by Medicare, commercial, and Medicaid plans. In releasing this year's report, the NCQA stated that in comparison to commercial HMO plans, this year's data marks the second year in a row of relatively flat performance by Medicare health plans.

Specifically, commercial HMO plans improved on 44 out of 54, or 81 percent, of the HEDIS measures that were applicable to a commercial health plan population. Sixteen of these measures showed statistically significant increases over the previous year's scores. Medicare HMO plans, on the other hand, improved on just over half of the 45 measures applicable to that population, with statistically significant increases on only six measures. NCQA also noted what they called unsettling declines in the rates of screening for breast and colon cancer reported by Medicare

HMO plans.

For PPO plans, the 2008 report indicated that Medicare PPOs posted HEDIS rates that were higher on most measures than commercial HMOs. In fact, they were about the same as those for Medicare HMOs, while commercial PPOs generally had lower scores than the HMO plans in that sector.

Carlos will now go over the findings from our analysis of the latest HEDIS data reported by plans to CMS.

MR. ZARABOZO: Based on our analysis of CMS public use files with HEDIS data, we found a situation that was similar to what we reported last year. We compared newer plans with older plans, that is, plans that had been in the Medicare program since 2003 or earlier are compared to plans that started their Medicare contracts in 2004 or later. We found that older plans tended to have better HEDIS scores than newer plans. Consequently, the overall averages are lower because of the number of new plans that have entered the Medicare program over the past few years.

Because much of what we'll talk about concerns the differences between older plans and newer plans, here we show you the distribution of older and newer plans. This

table shows that in terms of number of plans, older plans are in the minority in the count of plans that are reporting HEDIS data. That is, the majority of plans that are in the HEDIS data, 56 percent, are plans that started contracting with Medicare in 2004 or later, after the Medicare Modernization Act of 2003 made a number of significant changes in the program.

However, among plans reporting HEDIS data, the large majority of enrollees are in the older plans, not the newer plans. Seventy percent of the enrollees in the data set are in older plans.

Here we show the make-up of the newer plans. Again, we are defining newer plans as plans that began their Medicare contracts in 2004 or later. The newer plans are mostly HMOs, 52 percent. However, a large number of the newer plans are PPOs, 40 percent.

Looking at the enrollment distribution, almost half of the enrollees of what we are calling the newer plans are in private fee-for-service plans. The remaining enrollment is divided almost equally between PPOs and HMOs. PPOs and HMOs each have about 28 percent of the enrollment among newer plans.

As was mentioned, older plans generally have better HEDIS scores than newer plans. If we confined our analysis to only those plans that have been operating in Medicare since 2003 or earlier, that is the older plans, we would find that these kinds of plans showed improvement in three-quarters of the HEDIS measures between last year and this year. However, for some measures, newer plans outperformed older plans, as in the case of monitoring of participant use of certain medications, and older plans showed declining performance in the measures tracking the avoidance of harmful drug disease interactions.

The next slide shows that there can be striking differences between newer plans and older plans in HEDIS scores. Some of the HEDIS measures track intermediate outcomes. Here, we show one of those measures for comprehensive diabetes care. This graph shows that there is a 13 percentage point difference between older HMOs and newer HMOs in the percent of patients with diabetes who have low cholesterol levels. And I want to point out about this measure, this is a so-called hybrid measure which I'll talk a little bit more about in a minute.

To return to a point that NCQA made, Medicare PPOs

perform relatively well. Here, we show that average HEDIS scores for PPOs are about equal to or better than average HMO scores in more than half the cases. For this table, we are only looking at measures reported on by at least half of the PPOs in the data set.

Private fee-for-service plans will not be required to participate in HEDIS until 2010 under recent changes in the law. However, CMS encouraged plans to voluntarily participate in HEDIS. This year, we have data from 14 plans representing about half of the current private fee-for-service enrollment. Sixty-three private fee-for-service plans have yet to report HEDIS data. As we previously mentioned, in general, private fee-for-service plan scores are lower than the scores of other plan types.

Using two of the measures for screening in HEDIS, this graph illustrates the points in the preceding two slides. One point is the private fee-for-service plans have scores that are lower than HMOs and PPOs. Looking at the second set of bars, as shown by the red bars, rather -- the red bars are the private fee-for-service scores -- this graph also shows one of the cases in which average PPO scores are higher than average HMO scores. Looking at the

second set of bars for the measure of glaucoma screening in older adults, the PPO score shown in the middle cross-hatched bar is better than the average HMO score, shown in the light blue bar.

Continuing with the example of glaucoma screening in older adults, this graph again shows that PPOs perform well and it also illustrates the better performance of older HMOs compared to newer HMOs. In this graph, we are comparing new plans and old plans but making differentiations based on the structure of the plan. Here, you see that if you separate newer HMOs and older HMOs, the older HMOs have much higher average scores on the glaucoma screening measure. The columns are shown in descending score older. The older HMOs in the first column have the highest average scores. You also see that PPO average scores, the second column, are much higher than scores for newer HMOs on this measure and that private fee-for-service plans have the lowest score in this grouping.

In an earlier slide, we looked at one of the HEDIS measures for comprehensive diabetes care, showing the striking difference in the percentage of patients with diabetes who had controlled their cholesterol. We compared

older HMOs with newer HMOs. We limited our comparison to HMOs and did not include the other plan types, PPOs and private fee-for-service.

By contrast, in looking at the glaucoma screening scores, we examined all plan types, not just HMOs. The reason for making a distinction when we compare certain scores across plans is for some measures, differences in scores between plans reflect different rules regarding how to measure and report for HEDIS. For most measures, all plans are on an equal footing in reporting their HEDIS scores. For most measures, all plans base their scores on administrative data, such as claims.

However, for 13 measures, including the comprehensive diabetes care measures, HMOs can use a scoring method that allows them to increase the score. HMOs can bring medical records to supplement the data collected through administrative records. This method of potentially increasing a HEDIS score is not available to PPOs or private fee-for-service plans for these 13 measures. The method is also optional for HMOs. That is, an HMO can choose to report solely on the basis of administrative data. So it may affect the finding regarding the cholesterol management

among HMOs.

In its HEDIS guidelines, NCQA has noted that this issue will be resolved by reporting year 2011, when all plans will have a uniform reporting structure when reporting on the care provided in 2010, and PPOs will be able to report on the so-called hybrid measures.

Another factor that could explain the variation in HEDIS scores we have seen between older plans and newer plans is that newer plans may have lower scores precisely because they are new to the HEDIS measurement and reporting process. The argument would be that as the newer plans gain expertise in using HEDIS, their scores should improve over time. One test of the validity of this argument is to look at newer plan scores to see if the newest plans have lower scores than plans that have some experience in reporting HEDIS scores.

Here, we show the results for six intermediate outcome measures comparing brand-new HMOs, so to speak, against plans that are also newer plans but which reported HEDIS data both this year and last year. That is, we are comparing the newest HMOs against relatively more experienced HMOs. For these six measures, the newest plans

are better than the more experienced plans on four out of the six measures.

Another point to mention on the subject is that what we are defining as new plans, those that started their Medicare contracts in 2004 or later, may not be new to HEDIS. Many newer plans are sponsored by organizations such as national chains that are not new to HEDIS reporting and the Medicare or Medicaid or commercial sector. For example, 12 out of the 14 private fee-for-service plans that are reporting HEDIS data this year are parts of larger organizations that have longstanding Medicare HMO contracts.

We would also note that among the newer plans, we have the 76 PPOs reporting HEDIS results that we classify as newer plans because of the start date of their Medicare contract. These newer plans often have average HEDIS scores that are above the averages of older HMOs.

As a final note on this issue, in your mailing material, we discuss the issue of plans reporting HEDIS scores of zero on some measures or very low scores. We found that in many cases, the low scores were reported by older plans that had been Medicare contractors for many years. So being new to the Medicare Advantage program does

not always explain a particular plan's low HEDIS scores.

We plan to continue looking at this question to examine other plan characteristics or other factors that contribute to the wide variation in HEDIS scores, such as plan size, plan experience in the commercial sector, or perhaps regional variation in plan scores.

We will now turn to the final section of our presentation with John giving you an update of the recent results from the Health Outcomes Survey.

MR. RICHARDSON: Just to briefly remind everyone what the HOS is, the HOS assesses a plan's ability over time to maintain or improve the physical and mental health of its Medicare members. The survey is administered to a random sample of members from each MA plan at the beginning and end of a two-year period. For each member who participates at both ends of the survey, a two-year change score is calculated, taking risk adjustment factors into account, and the member's physical and health status is categorized as better, worse, or the same as expected. Plan level results are calculated based on aggregated individual outcomes.

The most recent HOS results were released in August of this year and report on the physical and mental

health status changes for a sample of MA enrollees who were enrolled in the same plan in 2005 and 2007. The latest results are similar to those covering the preceding two-year period of 2004 to 2006. About 90 percent of the plans showed health outcomes within the expected range, and about ten percent had outcomes that were either better than expected or worse than expected. We refer to these plans as outliers. What is different in the most recent time period is that although a number of plans still show worse than expected outcomes, a higher number than last year show better than expected outcomes. I'll explain that in a minute.

Looking specifically at the separate physical and mental health outcomes captured by the HOS, we see that for physical health, there were more plans whose enrollees reported better than expected physical health changes in the most recent time period compared to the previous cohort. But looking across the most recent group, there were still more plans whose enrollees reported worse than expected outcomes compared to those with better.

For mental health outcomes, the results were uniformly positive in the latest results in that there were

more plans with better than expected mental health outcomes compared to the previous cohort, and within the current group, the majority of outlier plans are outliers because their enrollees' mental health outcomes were better than expected.

These points are shown quantitatively on this slide, where you can see on the physical health measure, which is the first two lines, there was an increase from two to seven in the number of plans with better than expected outcomes and a slight decrease in the worse than expected physical health category. On the other hand, looking just at the 2005 to 2007 cohort, there are still more plans with worse than expected physical health outcomes rather than better than expected, by eleven to seven.

In the case of mental health HOS measure, there were more cases of better than expected results and fewer worse than expected compared to the preceding time period. And just looking at 2005 to 2007, there were more plans that had better than expected outcomes rather than worse.

That concludes our presentation. We look forward to your questions and discussion. Thank you.

MR. HACKBARTH: Okay, let me see the hands of

people who have clarifying questions.

DR. DEAN: A couple of things. First of all, as I understand it, none of these changes were really tested for statistical significance, is that true?

MR. ZARABOZO: That's right, except our -

DR. DEAN: A lot of them are really fairly small changes. I think it may be a stretch to say that it is better or worse.

And secondly, especially the last data that just presented, or in general, do we have any indication about how these performances relate to the fee-for-service population? I mean, I'm sure you don't on any HEDIS data because I don't think any of that gets reported. Does the Health Outcomes Survey follow fee-for-service people?

MR. ZARABOZO: We are looking at attempting to get a comparison based on the questions in the Health Outcomes Survey that have been posed to fee-for-service beneficiaries to do the comparison between Medicare Advantage and the fee-for-service program, and Arnie is well aware of this issue. CMS has the ability to do that comparison, so we're trying to work on getting that comparison.

DR. DEAN: And finally, you talked about some

HEDIS data that -- all of that for like the private fee-for-service plans would have to come from claims data, right? I mean, there is no --

MR. ZARABOZO: Correct.

DR. DEAN: And yet, some of that data, like cholesterol control and so forth, that can only come from chart review.

MR. ZARABOZO: Well, the so-called hybrid measures are both administrative claims data -- they specify, for example, CPT codes that would indicate meeting certain things. But this is why the PPOs are not expected to report the hybrid measures. They are not -- in the CMS data, you see a lot of reporting of the hybrid measures by the PPOs. These are the measures that can include the medical chart review, and as I mentioned, can improve the score for an HMO that chooses to look at medical records.

DR. DEAN: I didn't understand that. PPOs, why are they not -- it said they are not allowed to use that. Why are they not allowed to use that?

MR. ZARABOZO: I think it's because it's assumed they don't have full access to the medical records to give them the contracting structures. In other words -- and

therefore, it would not make it a comparable comparison between PPOs and HMOs and across PPOs.

MR. HACKBARTH: Anybody else on this? Ron?

DR. CASTELLANOS: Just a clarifying question. Do you know if any of the MA plans get bonuses based on their HEDIS score?

MR. RICHARDSON: Not under Medicare.

MR. ZARABOZO: Within the plan, you mean, that they are --

DR. CASTELLANOS: Within the plan, yes.

MR. ZARABOZO: Potentially. I don't know if HEDIS is the basis of scores, but, I mean, there is the practice of better quality. For example, in California, HealthNet has a list of better performing medical groups and so on. I assume that HEDIS may be a factor there.

DR. CASTELLANOS: I think it does happen in the real world.

MR. RICHARDSON: Yes.

MR. HACKBARTH: So your question, Ron, is whether plans within their internal payments --

DR. CASTELLANOS: Within the internal plan use bonuses to increase --

MR. HACKBARTH: Yes, they do

DR. CASTELLANOS: It's a reverse on pay-for-performance --

MR. HACKBARTH: Yes, they do.

DR. CASTELLANOS: -- but it does happen. That's what I'm trying to say.

MR. HACKBARTH: Yes.

DR. KANE: Just linking back to our discussion yesterday about medication therapy management programs, is there a collection of questions around that? They seem to be disease-specific rather than if you have more chronic conditions and you're managing ten medications. Is there a question in HEDIS that addresses that issue and would help us understand better whether there's medication therapy management?

MR. ZARABOZO: It is only the specific measures for specific drugs.

DR. KANE: Okay.

DR. CHERNEW: So you reported the sample size, which is good, but some of them seem small, so I was wondering how many of the differences were statistically significant and how comfortable are you with any risk

adjustments that are done or benefit design effects. A lot of these things have to do with use of medications and other things and many of these things have to do with the enrollees doing something, like getting screened. So benefit design could be important. And, of course, there's obviously selection effects as the people who join the different plans. So I'm just curious as to how you feel about the statistical significance and the general adjustments to these things.

MR. ZARABOZO: We have not done analysis based on statistical significance. Also, on the risk adjustment, the measures are supposed to be not needed -- you don't need risk adjustment. But as you point out, a lot of these are adherence issues and so you have an issue of what kind of -- you need to recognize there are differences in the populations and how do you recognize those differences is an issue.

MR. BERTKO: Two questions. Carlos, I think I heard you say some of the HEDIS measures came from administrative data, and so you nodded then, and the question is can you then go to fee-for-service and get the comparable measure calculated from fee-for-service?

MR. ZARABOZO: Yes, you could do that. As Nancy mentioned I think last session, the Dartmouth, those people have done this. Now, the measures that they used are actually -- several, I think, are hybrid measures, so they're not directly comparable. But if you look at the averages in fee-for-service across, for example, the hospital referral regions, what you see is that at the very high end, you have HMO scores, but also at the very low end, below the fee-for-service averages are plan scores. So this sort of is related to the question of we have plans reporting zero, we have plans reporting low scores. So on that comparison, you have both extremes coming from the health plans as opposed to coming from fee-for-service.

MR. BERTKO: Okay. Good. I know I've worked with Beth McGlynn on the RAND administrative measures of quality, also, whether that would go in.

The second question was whether, and this is an Arnie kind of question, do you have the ability to display the best of the plans in either HMO or PPO mode to see what we might be striving for?

MR. ZARABOZO: In terms of just their scores? Well, yes, in terms of like a composite? Yes, which is what

NCQA does when they do their U.S. News kind of thing.

MR. BERTKO: I would be interested in seeing that.

DR. MILSTEIN: This question pertains to slide 21. I'm not sure whether I tracked the prior question and answer a few minutes ago, but I'll reframe it and give you a chance to potentially re-answer the same question. The outcomes better or worse than expected, isn't that based on a statistical definition of expected?

MR. ZARABOZO: It's case-mix adjusted expected, yes.

DR. MILSTEIN: So that would be -- these differences are -- and I also, just to make sure I --

MR. ZARABOZO: Yes, but in terms of the HEDIS scores, yes.

DR. MILSTEIN: Thank you. And the second question is, am I right that the norms here, where we see better or worse than expected, it's normed to just like an average population. It's not subject to any special management.

MR. ZARABOZO: It's the average within the MA sector.

DR. MILSTEIN: Within the MA sector?

MR. ZARABOZO: Right.

DR. MILSTEIN: Okay. Thank you.

DR. CHERNEW: I'm confused. You said on 21 these are statistically significant, better or worse than expected, but there are these multiple comparisons, so I am not sure I can explain the asymmetry. But if you have 100 plans and you have a statistical threshold for what is better or worse than expected, you are going to have a certain number that are better than expected or worse than expected in the outlier tails just by pure chance. It's constructed so that would have to be the case, I think.

MR. ZARABOZO: I don't think so because you have years in which there is zero, zero worse and zero better than expected.

DR. CHERNEW: So then would the better than expected bars have to be constructed in a way that's different than the statistical -- there has to be some other measure of expectation there --

MR. ZARABOZO: Right, and I'm not sure --

MR. RICHARDSON: We could follow up on that specific question.

MR. HACKBARTH: Any other clarifying questions? Hearing none, let's go to round two.

MR. EBELER: Thank you very much. This is very interesting. Two sort of requests for whether there's additional data that would be helpful. One relates to our push on the fee-for-service side for delivery reform and whether it's possible to look at -- both HMOs and PPOs have different degrees of relationship with the delivery system and whether it's possible to make some distinctions about that. I actually think John's question will implicitly get to some of this answer, but an HMO isn't an HMO and a PPO isn't a PPO. So if it's possible to produce those data.

The second is related to what you flagged about the definition of new plans and the fact that a lot of new plans are, in fact, presumably part of Humana or United or Wellpoint. Would it be possible to aggregate these data in effect at the corporate level? I mean, Rachel's data yesterday showed that we can put a half-dozen plans in the room and have 50 percent of the MA beneficiaries covered. There's advantages and disadvantages to that type of scale. The advantage would be for CMS to be able to sit down with those folks, look at their quality data, look at the variation among their various sectors, and challenge these major players to do the improvements. So could we aggregate

the data at the corporate level would be the second question.

MR. ZARABOZO: Yes, we can do the aggregation at the corporate level, and yes, as you say, an HMO and a PPO, sometimes the distinction is not clear. As I mentioned, in some cases, we have plans that are new PPOs that are operated by an HMO in a particular service area that have an exactly matching service area. Presumably, the network is very similar. So we are looking at a comparison of those kinds of plans.

MR. EBELER: Again, the one break point, if we're right on what we're talking about in the fee-for-service Medicare is the degree to which they're connected to delivery and whether that distinction is possible.

MR. ZARABOZO: For example, you could find out the -- well, if we could, I don't know that we can -- the degree to which out-of-plan utilization occurs, that is non-network providers are used within a PPO, but I'm not sure that we could find that out when we have encounter data. Everything is going to rely on encounter data.

MR. HACKBARTH: This point about the variation within these categories, statutory categories, HMO, PPO, et

cetera, I think is critically important, and I vaguely recall that Harvard Pilgrim Health Care now participates in Medicare as a private fee-for-service plan.

MR. ZARABOZO: Yes.

MR. HACKBARTH: Just as an illustration of these legal categories are not really representative of what happens on the ground in the real world.

MR. ZARABOZO: As a matter of fact, because Harvard Pilgrim dropped off of the HEDIS scoring between the previous period, their absence affected the averages such that there was one measure that would have improved had Harvard Pilgrim been in the measure in the sets, but they were not.

DR. CROSSON: Could I just respond to the first part of Jack's question, because that was going to be my question, also, and it has to do with the question of what are some of the factors influencing the difference between newer and older plans. It is, I believe, the nature of the delivery system, because I suspect that there are many more older plans that have organized delivery systems with whom they've worked for a long time than in the newer plans. That would be something to show, but I believe that's the

case.

There actually has been work done by Steve Shortell's group to break down -- with NCQA to break down the NCQA HEDIS data by delivery system type. It was published about a year and a half ago or so. So I thought it might be useful to actually take a look at that, if we could do that.

MS. HANSEN: Mine is probably more of almost going back to the practice level, delivery system. On page nine, the slide nine, the whole point of medications comes up with some of the performance of newer plans vis-a-vis older plans. The theme that's highlighted here, the example is the medication aspect.

I wonder -- there are two questions. One is related to yesterday's MTM component of it, whether or not there is any way to also get some information as to the utilization of any MTM practices in any of these plans. So I don't know whether it's something that can be overlaid as looking at this, because medications does seem to be a theme on this and there is a monitoring aspect of the newer plans that's noted and the older plans also are watching some harmful drug disease interactions. So I just want to

sometimes tie whether or not these practices are making use of this particular tool that's there.

The other one is more something that I would ask some help on, whether or not the HOS that have better performance over time also is reflected somehow in the HEDIS measures so that there's an overlay, so that they're not looked at in discrete bodies but we can begin to do kind of an overlay matrix of some of these factors. So that would be just of interest, to see basically what does the plan do on an actual delivery side.

MR. ZARABOZO: We can talk to Joan about the MTM relationship. The HOS data, we can get the information. We have the last version. We have to do a data use agreement with CMS to get the HOS information, but we can do a comparison.

MS. BEHROOZI: Thanks. Can you go back to slide five? We were talking about old and new plans, new plans often being subsidiaries or whatever, related to existing MA plans, but they're also related to existing commercial plans, so it's not just about being experienced at reporting HEDIS data or collecting it or whatever but they actually know how to do it better. So why is it that Medicare is not

getting what commercial purchasers of HMO and -- well, HMO plans, at least, are getting? Do we know anything about what's behind that? Is there not adequate risk adjustment or something?

MR. ZARABOZO: Well, I think it might reflect stability in the market. That is, the commercial market is more -- I mean, if it is the new issue, the set of commercial plans has probably not changed very much in the last couple of years.

MS. BEHROOZI: But aren't they run by the same, I mean, you have the corporate-level data looking across commercial --

MR. ZARABOZO: Yes. That's why looking in more detail about are these chain organizations, are these not chain organizations, do they have a commercial presence or not in an area, I mean, the area might be the issue, for example, if they're -- it could be a large national chain newly enters a market solely for Medicare, so that may not be quite the same situation as a large chain in a current market is adding Medicare. So that may be a difference, also.

MS. BEHROOZI: I just wonder if there's data that

we could dig into to see whether, side by side, we're just getting a worse product from the same producers of the HMO products. Are the expectations not as high or what's the problem?

MR. ZARABOZO: We could do some types of comparisons of commercial to Medicare. For example, the U.S. News, the NCQA U.S. News rankings, they have the commercial rankings and they have the Medicare best plan rankings and sometimes there's overlap, not necessarily always. Minnesota, for example, posts all of the HEDIS reports from all of its health plans on the web and there you can do the comparison of commercial to Medicare within the same plan, actually. I mean, we also would like to look at that to see how they're doing.

MR. HACKBARTH: Could one explanation be that it's the same company, but you're talking about different patient populations with different distributions of illness and they may be strong in an area where you have a smaller number of Medicare beneficiaries and weak in an area where you have more Medicare beneficiaries?

MR. ZARABOZO: Yes. I think looking at the Minnesota numbers might show that, that it's the same plan

but a different population, really.

MR. RICHARDSON: An example of that would be the commercial plans rely a lot on pediatric measures and those obviously are not applied in the Medicare measure set. So when you're looking just at these numbers of measures and how many improved or not, you need to --

DR. CHERNEW: A plan would share some amount of its processes across -- if you were one plan that had both commercial and not, you wouldn't do things necessarily differently. You might have certain different initiatives in one population, but you'd do much the same thing. The differences are likely to be because of the network where the patients are actually going to or the nature of the patients, they're different patients --

MR. ZARABOZO: Yes.

DR. CHERNEW: -- as opposed to the plan deciding, we're not going to focus our diabetes management in the over-65, because most of the time, they'll try and do the same things within those --

MR. ZARABOZO: Yes, and sometimes the Medicare networks are different from the commercial networks for a given plan in a given geographic area.

DR. CHERNEW: People may just live differently, because the commercial plans are going to have employers.

MR. ZARABOZO: Yes.

DR. CHERNEW: They're going to live in a certain place --

MR. ZARABOZO: Many differences.

MR. BUTLER: A comment and a question. The comment is when I read through this, it's just a reminder again of how fundamentally different the health plan agenda is on these things versus the provider community that's not involved in risk. It's just shocking. And Ron mentioned incentive compensation. All the way up our silos, we're working on totally different things that don't come together, and neither one is a bad agenda, but they're not connected in a partnership in a way that's going to improve things. Somehow, we have to bridge those gaps wherever we can to make a difference, because believe me, there's a lot of intellectual energy going into quality improvement and the more it could be sync-ed up, the better. So that's just a comment.

The question is, some of the HEDIS measures, my experience with them and so forth, in the employer-insured

market, one of the issues was constant turnover, high turnover enrollees. You know, you never had longitudinally a way to look at whether you're making a difference. I don't know, but my question would be if you turn 65 today, you're likely to live to 85. I'm not sure what the number is, but you're going to live a while. As the baby boomers emerge, are we going to be able to have a much better opportunity to look longitudinally in how we are doing across the years and really make a difference in this population that might be a little different from the under-65 population? Another very specific question, how long are people staying in the same plan would be a more direct way of answering.

MR. ZARABOZO: Medicare beneficiaries generally stay in the same plan and there is very little turnover, really, as a percent of the enrollment.

In terms of longitudinal results, the Health Outcomes Survey is what we currently have for longitudinal results.

MR. BUTLER: Does it leave you with some optimism we'll get better and better data then to see how we're really doing?

MR. ZARABOZO: I'm trying to think whether at the plan level we could -- one issue currently is maybe the growth in enrollment explains some of these changes, just that large enrollment growth, you have to handle it. You have to manage it. So it's not quite stable at the moment. But over time, I think we could do a comparison of how is a specific plan doing with a relatively stable population over time. So yes, potentially, you can compare based on HEDIS data.

DR. CHERNEW: I was just going to pick up on the point earlier about the heterogeneity in quality within plan types and add that I think it's important that we don't in interpretation condemn the program or malign it for those plans that do poorly or view it as simply the average, but instead -- this is probably an Arnie comment -- strive to figure out how to make those that might not be performing as well perform better, because I do think that it's possible that the MA program can, in the best cases, show us how well we could do and I think that's important to recognize instead of just looking at the averages.

MR. HACKBARTH: Arnie, you're having a real impact.

DR. MILSTEIN: I realize this has not come up before and the feasibility of doing this within the time that we need to deliver the report, I'll leave it to you to judge. But one of the things that is emerging in a number of efforts to measure and improve performance is the danger of an overly narrow dashboard of measures. I'll just give you a frame of reference. I think in HEDIS there are, what, 40 or 50 quality measures, and if you were to ask about how many things would you want to track if you wanted to optimize care for seniors, one window on that is the so-called ACO measure set that RAND developed, which I think has 450, so it's --

And the reason I think this might be important to at least footnote in our report is that there is emerging evidence that one of the unintended consequences of focusing on that which is easier to measure, or easier for all parties to agree on, let's call it, the HEDIS measure set, there's actually emerging evidence that one of the consequences of focusing on a narrow set of measures is that the aspects of performance that are not being measured are often declining due to lack of attention. At least in our report, we could pull some of those published results in.

I guess my only comment is that it would be, I think, useful given these emerging findings if we could address in our report the feasibility of a bigger measure set. I mean, the beauty of a bigger measure set is it really then makes so-called teaching to the test infeasible. In other words, if you're being tracked on 150 things, it's very tough to not begin to think about systematic quality improvement across the board, whereas if you're being tracked on a narrower set, it enables saying, well, let's just hire a bunch of QA nurses and just focus on this narrow, on tracking and dogging these narrow measures rather than focusing on what I think we would all like to see, which is kind of a step back and sort of asking, what is a systems approach to optimizing quality across all 450 things we'd like to see done perfectly for seniors.

DR. REISCHAUER: This is interesting, but I sort of have the feeling it's not getting at the real questions that we should be asking, and others, I think, have brought this up. The fundamental question is how does Medicare Advantage compare to fee-for-service, and once we have the answer to that question, then we have to ask ourselves, should there be a minimal threshold above which after, say,

three years of participation a Medicare Advantage plan has to meet because we're, in a sense, stimulating an alternative delivery system that might make people worse off in some cases.

I think, like Mike, believe the potential is actually in the other direction, but one never knows with all of the alphabet soup of types of organizations we have and we should therefore be maybe looking at the top ten percent in each of these categories of types and saying, well, what is the pay-for-performance system or the other set of incentives that we need to develop to get everybody up there who is in this game?

While we're looking at sort of one aspect of the variation here, which seems to be the characteristics of plans -- are they new, are they old -- what we need to also look at if we're trying to explain how this changes over time is the characteristics of beneficiaries, you know, education, income, age, length in plan, et cetera, and the characteristics of the market areas they're in. Does geography matter? Is it hugely difficult in rural areas to get these kinds of measures up to levels that would exceed fee-for-service? And so we should really try and

restructure what it is we're after in the long run when we go through these analyses each year.

MR. HACKBARTH: Okay. Thank you very much.

We are on to our final session, which is principles for measuring physician resource use.

Whenever you're ready, Jennifer.

MS. PODULKA: Thanks, Glenn.

Good morning. Today I want to sort of switch tracks. We are continuing to conduct our data analysis of physician resources use measurement, and I promise I'm going to come back to you at future Commission meetings with more than enough results to make everyone's palms sweat. But today I want to take a qualitative, more broad perspective and get your input on some issues related to that.

First, I need to remind everyone that in the March 2005 report to the Congress, the Commission recommended that Medicare measure physician resource use and share the analysis results with physicians in a confidential manner. In its most recent March report, the Commission recommended that Congress require the Secretary, following two years of this confidential feedback, to make data on physician resource use public and be prepared to use those data

analysis results to adjust physician payments.

At the time we noted that this recommendation was motivated by a sense of urgency over how the distribution of Medicare physician payments is distorted by incentives that encourage the overuse of some services and the underuse of others. Secondly, we were concerned that Medicare's physician fee-for-service payment system does not systematically reward physicians who provide higher-quality care or care coordination; and, third, that it offers higher revenues to physicians who furnish the most services, regardless of the value of those services.

This summer the Congress enacted our first recommendation on confidential feedback in the Medicare Improvements for Patients and Providers Act of 2008, or MIPPA. And as we discussed at the September Commission meeting, CMS has already begun work that they refer to as the Resource Use Report pilot that will implement physician confidential feedback, and note that MIPPA granted the Secretary a great deal of flexibility in how to design that program.

So today this is an opportune time for the Commission to discuss how they envision that Medicare's

physician resource use measurement program should work, and I want to note that CMS is explicitly seeking our input and that of others on this program.

We have already addressed some fundamental questions, but others remain. For what we've addressed, fundamentally we would like Medicare's program to measure physician resource use and provide feedback to encourage efficiency, which is defined both by resource use and quality, and discourage inefficiency. Payment adjustments could directly reward efficiency and penalize inefficiency and, thus, may help to abate Medicare's growing spending for physician services. Also, the program should encourage thoughtful reflection and discussion among physicians about how their practice patterns drive resource use.

So that's understood, but that brings us to several open questions, the first of which is: Should the program measure physician resource use in multiple ways? Most of our analysis has focused on using episode groupers as one way to measure resource use. Episodes are important, but they probably should not be the sole measure of physician resource use. Additional measures such as per capita utilization, quality, rate of generic drug

prescribing, and others could be included to produce a more complete picture. Also, we've already discussed how the program should provide physicians with both summarized data and more detailed information, such as breakouts by type of service.

A second question here is: Should the program provide feedback to most physicians or focus only on outlier physicians? Focusing only on outliers would be more administratively feasible for CMS and less costly, while it would still offer the opportunity for some positive impact by altering the practice patterns of the most inefficient physicians.

Alternatively, there would be advantages to providing feedback to most Medicare physicians. Note that it would be unrealistic to expect the program to provide feedback to all Medicare physicians. Physicians' resource use should only be measured and compared to their peers if they provide enough of a beneficiary's care to be considered responsible for that individual or the episode and if they treat enough beneficiaries and episodes to warrant comparison. Giving detailed feedback to physicians across the entire efficiency distribution would allow even non-

outliers to recognize any efficiencies they may have, such as overuse of advanced imaging, and work towards improving them.

A third question here is: Should the program measure and provide feedback to individual physicians, groups, or both? Some argue that when physicians are organized into group practices, they should be measured and receive confidential feedback or public reporting as an average for the group practice. However, about 40 percent of U.S. physicians practice solo, and comparing group practices can be problematic in communities where these groups are so large and command so much market share that there are too few peers for comparison. So if you think of it in this way, when one measures physician resource use, you need to balance the need for sufficient experience for each physician versus a sufficient number of peers for comparison.

And, finally, MIPPA requires that Medicare conduct education and outreach activities as part of the physician feedback program; but given CMS's limited resources and numerous responsibilities, these new efforts will be challenging. CMS could partner with other entities, such as

physician organizations and specialty societies, to support physicians in interpreting feedback reports and using them to improve practice patterns. Another possible approach would be to work through the quality improvement organizations, or QIOs, or redirect their current efforts.

Next, the Commission may want to discuss and embrace a set of principles to guide Medicare's physician resource use measurement and feedback program. Numerous other groups, such as the Consumer-Purchaser Disclosure Project, National Quality Forum, and many others, have begun to outline their own principles. Furthermore, we may want to know which principles should be adhered to from day one of the program versus those that should be considered future goals. Some possible principles are listed here. I'm going to discuss these now using statements rather than questions, but I want to note that these are straw proposals, and all are on the table for discussion.

First, for transparency, Medicare's measurement methodology and a description of the data used should be made publicly available. Currently, CMS's RUR pilot relies upon commercially available episode grouper software packages. This allows Medicare to evaluate features in

these software packages that could be included in a Medicare-specific software package. I want to stress, we have never expected Medicare to purchase off-the-shelf software. In its history, the program regularly contracts with vendors to develop tailored programs, such as diagnostic related groups, or DRGs. The final program used for physician resource use should also use a Medicare-specific transparent method.

Second, the principle -- sorry these aren't quite parallel, but actionable. Feedback should include detailed breakout, such as by type of service, provider, and condition, in addition to overall scores.

Third, on risk adjustment, MIPPA gives the Secretary discretion to choose to adjust data for beneficiaries' health status and other characteristics. We feel that the program must do so to measure resource use as appropriately as possible. The good news is that existing episode grouper software packages do include different forms of risk adjustment, and other measures of resource use if they were used, such as per capita utilization, should also be risk-adjusted.

Next, multiple measures. The program should

analyze physicians' resource use using multiple measures, such as per episode, per capita, quality, and rate of generic drug prescribing. However, the program should not be delayed until all of these measures are ready. Instead, the program should begin with as many measures as are appropriate and transition to full implementation over time. Even once it's fully implemented, the program should be flexible enough to weight or even exclude any of these measures where appropriate, such as excluding rate of generic drug prescribing for physician specialties that do not regularly prescribe drugs.

Next, opportunity for physician input. The program will need to balance Medicare's need to make methodology decisions necessary to begin implementation and a physician's right to be fairly measured. There are at least three mechanisms that currently exist to ensure that physicians' collective and individual concerns are addressed:

First, CMS's RUR pilot is specifically designed to garner physician input.

Second, the resource use measurement and feedback program should be included as part of the physician proposed

rule published each year. It's included this year, and this gives physicians and others an opportunity to comment.

And, third, physicians' individual payment concerns can already be appealed through an established system that includes carriers, administrative appeals boards, and administrative law judges.

And, finally, the principle that measurement will improve over time. Ideally, changes in physicians' year-to-year resource use measurement results should be due to changes in their practice patterns alone rather than changes in our measurement methods. However, this program will be an entirely new endeavor for Medicare. It is unrealistic to expect that the measurement methodology that they use in the first year will remain unchanged in the future.

One way to help deal with this would be to pilot test any future refinement to measures by including them, highlighted as such, in the detailed feedback for a year or two before including them into overall scores.

Now I'm going to move away from discussing Medicare's physician resource use feedback program and address a separate issue that the Commission may wish to address. There is interest in releasing Medicare claims

data so that entities such as private plans can aggregate Medicare data with their own to measure physician resource use. Data aggregation could address the small "n" problem where private plans, because of their low market share, have too few physicians or too few claims from physicians to appropriately measure their resource use. This would work, first, by adding Medicare data to the private plan's data to increase the number of claims and patients so that the plan's contracted physicians would each have more experience to measure. It would also add more measurable physicians for peer comparison.

For example, if a private plan contracts with only two pediatric cardiac surgeons, it would have an insufficient peer group for comparison. Aggregated data for Medicare would allow the plan to compare its two pediatric cardiac surgeons to many others of the same specialty.

One should understand that releasing Medicare claims data could assist private plans in their measurement of their physicians, but without reciprocal data sharing from these plans, Medicare would not benefit from the data aggregation. And data aggregation may not be as necessary for Medicare, which, as the largest U.S. health care payer,

has many physicians with sufficient n's for analysis.

Data aggregation is also suggested as a way to address the problem of physicians receiving contradictory efficiency scores from different entities. However, releasing Medicare claims data for aggregation would not result in consistent physician scores without some mechanism for standardizing the measurement methodology. Remember that there are at least three major episode grouper software packages that entities can choose from, and that measurement using episode groupers requires numerous methodology decisions which we've discussed here, such as grouping claims into episodes, attributing to physicians, selecting comparison peer groups, selecting minimum number of episodes, and many others. Entities can make perfectly legitimate but different methodology decisions on each of these that will lead to different results using the same claims data.

The issue becomes even more complex once other measures besides episodes, such as per capita utilization, are added. There is no standardized method for aggregating these with episodes into a single overall score for physicians. The question then is: Could or should

measurement methodology be standardized? If the answer is yes, Medicare or another entity could develop and disseminated detailed specifications for physician resource use measurement methodology, including which episode grouper software package to use, which methodology decisions to make, and how to aggregate measurement results into single physician scores. However, to cover all methodology decisions, I want to note these specifications would need to be fairly detailed.

In addition, it is unclear if there could ever be a mechanism to enforce compliance with these standards. Alternatively, claims data from Medicare and other payers could be pooled within a single entity, such as CMS, AHRQ, or an as-yet-to-be-formed public-private partnership. That entity could use these aggregated claims to measure physician resource use and release the results. If the output provided detailed results by type of service, provider, condition, and so forth, along with overall scores, private plans and other entities could merge these results with their own and apply the results in unique ways to suit their needs.

So before I finish, I want to leave you with two

broad questions to help shape the discussion.

First, would the Commission like to discuss, and possibly embrace, a statement of principles for Medicare's physician resource use measurement and feedback program?

Secondly, would the Commission like to discuss the question of whether Medicare should release claims data in addition to the analysis results that will be released separately from the resource use program for data aggregation?

That concludes my presentation. I look forward to your discussion.

MR. HACKBARTH: Thank you, Jennifer.

Clarifying questions for Jennifer?

MR. EBELER: One on this data aggregation issue. The way it's phrased is Medicare releasing it so that a private entity can combine Medicare and the entity and look at it. Can it also work the other way where both Medicare and the private entity get to look at the aggregated data?

MS. PODULKA: You hit on something. I addressed this in a somewhat purposely vague way because there's competing and numerous recommendations. In general, we've heard that there are several entities that would be eager to

see Medicare claims data to be able to aggregate it. And so in that sense, it would be releasing Medicare claims data, presumably through a public use file or something else.

There are also numerous competing and not always detailed proposals for aggregating other data from other entities, and so what I'm saying is if we go the first step and release Medicare claims without the mechanism for the second step of releasing other claims and pooling them, Medicare wouldn't be the one to benefit.

MR. BUTLER: Just a quick -- so I can focus my comments in round two. These are two specific questions. They're not all the questions that you asked. On page 5, you had the principles. Is that what you mean in -- because that's a much narrower question than some of the other things like episode versus per capita and so forth?

MS. PODULKA: Absolutely. I think of this as two stages. First is do you want to talk about principles, and a valid answer is, no, we'd like to wait and see what happens, or no for some reason. If the answer is yes, then absolutely, we could go back to the slide with the five detailed principles and discuss those individually or however you guys choose.

MR. BUTLER: I'd put it this way: Most of my comments were on should you focus on episode or per capita or some of the other questions in there, I assume you want feedback on that. It didn't look like that included that. If it does, that's fine.

MR. GEORGE MILLER: Mine is a process question, also. I don't know if I should wait until round two, because it has to do with the opportunity for physician input and the appeal process as being one of those opportunities. I'm not sure that -- I'm not a physician, nor do I play one on TV, but I'm not sure a physician would think that that's an appropriate input to say at the end of the process they get to appeal. But I'll until round two.

MR. HACKBARTH: [off mic] Why don't we come back to that.

DR. CHERNEW: I was confused, in part, by Jack's question about the release of the data, and I've lost track now of what's meant by releasing the data, because I guess I was -- surely you don't mean just releasing Medicare claims data broadly so people could just get the claims data, because there'd be all the HIPAA and other -- but in order for this to work, you would need to have the provider ID

numbers and a whole series of other things.

So I'm just confused now about what's meant by releasing claims data, what that actually means.

MS. PODULKA: There actually is a specific court case going on right now where an organization did seek to gain access to Medicare claims with provider identifiers and use these for analysis. Again, there are competing proposals and multiple parties are interested, and some of those proposals include Medicare should make claims available.

MR. HACKBARTH: With encrypted information on beneficiaries, but provider IDs, presumably subject to data use agreements of the sort that we discussed. That's a question. Feel free to --

MS. PODULKA: Yes. I don't want to get bogged down in details because I'm not a lawyer, nor do I play one on TV. But the current court case actually is a dispute between -- beneficiary privacy aside -- provider privacy. And right now there are district courts that interpret it that way.

MR. HACKBARTH: Just to be clear, what I was referring to is the policy issue. Congress can write a

statute that renders the court case moot. And so what I think we ought to be talking about is not the litigation, but what are the policy principles that should guide this if we think it's a good idea.

DR. MILSTEIN: On this point, because there have been a number of congressional legislative proposals directly on this over the years, and nobody is conceptualizing releasing information that would remotely allow identification of individual beneficiaries. Every proposal that's put out there would, for example, using intermediary organizations, kind of the brothers or sisters of QIOs. But the idea is always to do it in a way that would never jeopardize beneficiary identifiability.

DR. CHERNEW: But for research purposes, they assume things are identifiable. If you knew the person's doctor and a date of service, it would be considered identifiable. And so you couldn't do what we're talking about here.

The only thing I'm saying, this is -- I'll save it for round two.

DR. MARK MILLER: I just want to make sure that the question that drove Michael's first question is clear to

everybody at the table -- and not at the table. There's two questions on the table. The first one refers to Medicare's release of analyzed data on the performance of the physician. The second question is should raw claims level data be released to other actors to use in their process of measuring physicians. And I know you get it. I just wanted to make sure everybody does, in case that was unclear.

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

DR. CROSSON: In answer to the general question about principles, I guess my answer would be yes. I think we stimulated this direction, and, therefore, we have presumably some long-term responsibility for it and I think also some interest in seeing how it plays out.

I had a different thought about, you know, what some of the principles might be. It seemed to me that there's a question of focus, first of all, and a lot of these have to do with, you know, how this is going to be received by the physician community and whether it's going to turn out to be, in the end anyway, appreciated and valuable or it's going to be rejected.

So it seems to me that one principle ought to have something to do with the relative importance of what's being

measured and reported on. And the more important that is -- and there are a number of ways of describing that, but certainly the total cost to the Medicare program and the health impact of the particular issue on beneficiaries, are at least two ways of thinking about that. The more obviously important the issue is that's being measured and reported on, I think the greater respect the physician community and others are going to have for that.

In terms of the question of whether it should be directed at just physician outliers or more broadly report to physicians, my bias would be that it should be information received by the majority of physician, because the thought that we had when we started talking about this was that this sort of feedback -- that is, where I as a physician stand in the spectrum of performance relative to other physicians -- would have potentially a broad, salutary effect as opposed to trying to simply identify bad actors. So I would have that bias as a principle.

And then the third one has to do with, again, I think the relative resistance that this type of thing may create, and that we ought to try to pick things that at least initially are the most bulletproof, you know, where

the information is as solid as it can possibly be, where there is a minimum number of vulnerabilities so that people can look at it because of some issue around risk adjustment or some issue around the accuracy of data, point out something that's wrong with it, and then dismiss the entire effort. And I know that some of those things may have some inherent conflicts within them, but I do think that each one of those things has a certain importance.

MR. GEORGE MILLER: Thank you. In a follow-up to my question, I would say, first, yes, I think we should move forward with this. But my question primarily is on the content of the opportunity for physician input and the best way to design that input. Again, I would submit that saying the appeal process as a part of that I don't think is appropriate, although that mechanism still could be in there, but I don't think that is physician input. That happens at the wrong side of the table from my standpoint. And I would agree that physician outliers, looking at a small subset -- and I would favor input from physicians to help design this in a broad base, and using some form of evidence-based measurement program to get the broader input would be appropriate from my point of view.

DR. MILSTEIN: I would suggest that the best answer would be yes to both questions. I'd say that being involved in a number of these programs in the private sector, it's fair to say that most physicians who are not part of managed care medical groups really don't know, you know, how they compare to their peers on total resource use. Many are very interested to know and want to know and would be interested -- especially if the target is total resource use, not just focusing on their services alone -- in playing a proactive role in helping solve the affordability crisis of health insurance in the U.S., including the Medicare program.

I agree with Jay that, you know, the risks of doing this wrong are high, but the benefits of doing it right are very high. There is really a very -- you know, there's often a focus in these programs on the risks, but there's also some fantastic benefits. I think it's very well illustrated. Tom Lee, a physician in Boston, you can still click on a New England Journal of Medicine website and get his sort of personal account of how useful he found it for the first time get resource use measures from plans.

Last, but not least, I think the second question

is very important because part of doing this right and making it be maximally useful to physicians is to minimize the amount of statistical noise in the reports they get. You know, what you don't want is for a doctor to be told you're terrible or you're terrific or you're mediocre when, in effect, that determination was due as much to the small sample size on which they were judged by a particular insurer. And so I think there's tremendous benefit in us engaging on this second question and, per Mike's comment, making sure that it's done in a way that is absolutely bulletproof with respect to beneficiary confidentiality, because if you don't nail that, then all is lost. And, fortunately, if you look at some of the more enlightened congressional proposals on this issue, for example, the bipartisan legislative proposal that Hillary Clinton and Judd Gregg put forward last year, they've done a very nice job of thinking through how you could blend Medicare data or make Medicare data blendable with commercial data so you address the problem of adequate cell size and giving the doctors an accurate score, but in a way that is absolutely bulletproof with respect to protecting beneficiary confidentiality.

MR. BERTKO: I'll start by saying I've got to agree with Arnie and Jay strongly and then add a couple things to that.

The first is having MedPAC say something about the principles I think is a Good Housekeeping Seal. This will be controversial no matter what, and if we can get to those bulletproof measures that we can reach consensus on, I think that's extremely valuable.

The second is to kind of address this second question. I think there is a strong reason to have reciprocal data exchanges for a couple of reasons. The first one is Medicare has got the gold standard data set. It's extremely useful. But even in my experience in a couple of states, that wasn't big enough. And so getting the back and forth would be somewhat useful to Medicare and extremely useful to the private sector on this.

The second part of this data exchange that is useful is that there could be a spillover effect. If you can clean up the private insurance sector, it's likely -- and I think proven by Lawrence Baker, and, Mike, I think you even did some work on this -- that if it works in the private sector, it's likely to have a positive, beneficial

effect on the other side.

The last part is just to, again, say what Arnie said in different words. There's a lot of inappropriate care, as shown by the Fisher-Wennberg analysis. And to the extent that this can be used to explain some of that inappropriate care, I think there is tremendous room for savings. Report cards could be issued. I've had some experience with that. I think the effort is on the big side because it's probably best done on the county medical society level or MSA level. We have in my past life had the experience of going out there and explaining it. I won't say it's well received, but it's appropriately received by the physicians in the area, and it needs a fair amount of explanation. This is new and different, so getting it out there, perhaps having a joint Medicare-private sector presentation type of thing, could be extremely useful. So let's go for it.

DR. MARK MILLER: Can I get you to say something else, John? Because your very last point about the unit of analysis was a little bit -- I hadn't quite heard you say that before. Do you think that if information is conveyed at that level, the individual physician feels like they have

enough information to do something about their practice? Or maybe I misunderstood the last --

MR. BERTKO: No, no, you said that -- my experience limited to a couple of markets is that you can show these things. In one particular market, in fact, at the medical group level, small practices of between five and ten physicians in a particular specialty, when compared to specialty performance in that market, would show there are one or two outliers, and they can help fix themselves.

DR. MARK MILLER: I see. So you would show the individual physician, but just relative to their market? That's what you --

MR. BERTKO: I would start with that, but I'm not going to end with it because I think as -- I think Arnie would agree with me on this. Our overall would be to say fix it in this market and then fix it -- move on to try to have more uniform results across the country.

DR. CHERNEW: I'll make two comments. The first one is I can think of a lot of reasons why we would want more access to Medicare claims data. Physician profiling I think is but one, and so anything we could do to open up the floodgates of allowing access to Medicare claims data I

think is incredibly important. And I think the privacy issues are also very important, and I think historically they have been interpreted too stringently. Under the current privacy -- I think it could change the current views of privacy in order to get this done, because right now the stuff you would need to do this would require a violation of the current, very stringent views of privacy. You would be able to -- you know. So that's one.

But I think we should strongly encourage more access to claims data, including Part D. Strongly I think that. It's important.

I'm thinking of not even saying anything else and just singing. Thank you.

The second point, though, that I'd like to make is I think there's an underappreciation of the statistical issues that arise when trying to release aggregate data even if you had large sample sizes. And there's a great paper I would encourage you to look at by Tim Hofer and Rod Hayward looking at this. It was hospitals, not physicians. But the problem is largely that even if you perfectly risk-adjust and have reasonably large sample sizes -- and I'm not sure I know what "reasonably large" is. Because you have these

incredible multiple comparisons, you don't appreciate that there's a thousand physicians and they're all the same. You're going to find some subset of physicians just by chance -- even if your statistics are working great for statistical significance and all other kinds of things, you will find some by chance that are outliers, by definition, almost always. There are ways of getting around that, but I think those statistical issues aren't appreciated, and I think until we think through what is essentially a multiple-comparison/heteroskedasticity problem --

MR. HACKBARTH: Maybe you should have stopped.

[Laughter.]

DR. CHERNEW: -- we should be really careful in advocating release of the information broadly.

MR. HACKBARTH: Will you make a presentation on that next time?

MS. PODULKA: I plan to work "heteroskedasticity" into my next presentation.

Can I ask one clarifying thing? Release of information, are you referring to raw or analysis results?

DR. CHERNEW: I was using Mark's dichotomy, so the first thing, I think, it's very important on raw data that

we release more of it and worry about privacy in a more rational way. But what I was referring to when I was talking gibberish was the release of aggregate data, these sort of report card things. I think the individual physician level report card, even if you had all the physicians' claims data, you might do a good job if your hypothesis was Tom is average or better than average or whatever it is. But if you had a thousand Toms or a hundred thousand Toms, there's always going to be someone who per chance is in that outlier group. And the work that Tim and Rod suggested was, in fact, under reasonable assumptions most of the people you identify as bad would not be. They would just be randomly identified. And then --

DR. MARK MILLER: But, Mike, if you're making the dichotomy, does the release of the raw data out into an environment that is not going to necessarily be sensitive to those issues going to -- so you're going to see that problem multiply throughout.

DR. CHERNEW: I agree with that, but I think there's other real advantages to having the raw data available. This is what I asked in my first clarifying question. We haven't had the DUA-HIPAA discussion to allow

researchers to try and use the raw -- you can't even get the raw data now to do things that are so much more basic than this that I think that anything we could do to allow access to the raw data would be useful, but we have to deal with all the --

DR. MARK MILLER: Let me take you to what I'm starting to hear, and I'm really sorry to interrupt because I know I'm not supposed to take so much time. But I just want people to think about this because -- do I hear you saying to release the data out into the wild and let people begin to analyze it, and Medicare should not be doing this until it gets all of its statistical ducks in a row? And then you would have this occurring throughout, you know --

DR. CHERNEW: What I was saying was we should encourage Medicare to move forward to a more sensible release of data. I'm not sure how to do that in this privacy useful way. So I think that's a useful discussion as to how to improve access to Medicare claims data, and I think that transcends the issue of physician profiling stuff. I would probably be hesitant to just have Medicare claims data up on a website somewhere. I wouldn't want to do that. That I don't think would be a particularly good

idea. But I do think more use of Medicare data in a bunch of -- I think we could do a much better job than that. That's the first issue.

The second issue is I would not release out into the world aggregated data on physician performance until I was comfortable with the statistical issues that those physicians that get the two lower bars or, you know, the big black -- the circle with the black all filled in, the Consumer Report one, that I was convinced that those were not statistical artifacts. So I think doing the aggregation, giving it back to the physicians, beginning to move in this way is good. But my understanding of the program in general is the cost of having some really erroneous people identified is really big.

MR. HACKBARTH: Are you saying, Mike, that you would advocate confidential feedback to physicians?

DR. CHERNEW: Yes.

DR. STUART: I don't agree with that. I think we could learn a lot from what happened when CMS started publishing the mortality rates from hospitals, because essentially it's really the same issue, a statistical issue here.

Mike is right that, you know, if you use 95-percent confidence intervals, that means that 5 percent is going to be outside those confidence intervals. That's just the way it's described.

However, this is not going to be a static program. This is going to be a dynamic program. And here the statistics work for you rather than against you, because the odds of somebody by chance being in the tail two or three times in a row is really, really tiny. And so if you're thinking about it dynamically, then I think you come up with a different set of triggers in terms of whether you'd like to have this private or public.

MR. HACKBARTH: Bruce, the statistics are way beyond me. To me that sort of sounds like, well, maybe what you want to do is do confidential feedback for a period of time until you can get to the point where you can so, oh, this person has been out there, you know, three times in a row or -- that's a risk adjustment question.

DR. STUART: I think that we all agree that we want to go through this process and learn about it confidentially before, you know, you hit the big times.

DR. KANE: I guess I'll start with trying to

follow on that conversation. I'm also hoping it's not just statistics that determines outliers, but some sort of normative -- whenever possible to have normative standards of here's what we're looking for, and here's the people who get to that. You know, there are some positives that can come out of this, not just focusing on negatives, but that there be a normative standard for some types of episodes. That's what we're looking for, not the average, the 50th percentile, the 95th percentile, or the outlier -- I mean, outlier isn't really what you're looking for, often. You're just trying to push people towards a normative standard.

I'd also hope that there would be both quality and cost considerations, and that relates again back to this idea that it should be a normative standard, not just some statistical creation that creates outliers.

I guess my frivolous concern was that this physician resource use measurement program not be -- the acronym not be RUMP, because I don't want to read that over and over again for the next ten years.

The other piece, I think, is that there should be -- as a principle, I think we should try to put at least as much resource effort into the educational purpose as to the

payment and punitive purpose or cost efficient -- whatever. I mean, I think people don't think hard about how adults learn enough in these things, and coming out with something that gives you a report that kind of insinuates that you're not doing it right automatically keeps people from wanting to learn to adapt.

So I think we really need to get some people in here who help us understand how, when you give people this kind of information, how they can turn it into an educational event and not into something that they have to defend and protect the reputation and worry about, you know, this is an attack on their clinical autonomy, for instance. There's a lot of reasons why physicians would resist this information that I think if we think hard about how it's communicated and how it's used -- and, again, if it it's more normative than statistical, for instance, and has quality as well as cost, for instance -- these are the kinds of things that physicians will be motivated to improve. And I know the VA has had a very successful experience in learning how to communicate these kind of clinical standards to physicians who dramatically change their performance because of it.

So I would just like us to educate ourselves, at least, on how do you do this in a way that encourages, you know, active embracing of this rather than a resistant, defense response.

And then my final concern about a principle is that not only do we protect beneficiary confidentiality but that there be some concern about beneficiary access in this. I know when the surgical program, the cardiac surgery results in New York were released, I think there was a lot of concern that physicians would just start avoiding high-risk people who might have a bad outcome that would be hard to explain. So we do need, I think, to also consider what might happen to beneficiaries who are likely to make somebody look bad and think about how do we try to deal with that. It's really not just statistics. It's how do we define good performance, how do we communicate it, and how do we protect the beneficiaries in the process. So I think we do need to discuss these principles, but mine would be a slightly different list than the ones here.

Then, finally, yes, I think we should discuss -- we already are -- whether we should release claims data. But, I don't know, my sense again, along the same idea that

how you do it is so important, I am fearful that 50 different or 100 different players all releasing data in their own unique way could be detrimental to the goal of the program, of Medicare, of saying let's try to do this in a constructive way. I wish there was some big black box that everybody could put their data into and the reports all come out -- everybody can use them their own way, but they all come out kind of consistently formatted and that there's this process that's attached to that before anybody uses them for profiling or tiering or telling beneficiaries who they should and shouldn't -- so that's just my bias, but that's something I know we'll talk more about in the future.

MR. HACKBARTH: I just want to agree with what you said about how important it is to think through what this looks like from the physician perspective. I think both Karen and Ron have made this point in previous discussions. this is about how to get physicians to embrace the information to improve their practice.

Tom Lee has thought a lot about this and worked to use these data within the Partners Network to try to get physicians to improve. So I think that there are people out there who are very smart, agree with the objective, who may

be able to teach us some things about how to get it done.

DR. CASTELLANOS: Being a practicing physician, I'm going to have a lot to say on this issue. To answer this question, I don't think there's any question we need to make a statement of principle. There is a big disconnect between what we think is happening here in the medical community and the information the medical community has. Now, some of the specialty organizations and some of the organizations in medicine have this information, but it has not filtered down to where the tire hits the road. And we need to let the practicing physician who's out there every day understand what we're trying to accomplish. There's a big disconnect there. There really, really is.

We need to talk about the pathway of what we're trying to do, and I think we've outlined that so many, many times from private getting out the information to public disclosure, to perhaps impacting on reimbursement. But how we present this is really going to be extremely delicate because this could blow up in everybody's face. It really could.

There are a couple of questions that I have, and one is: Who do you present it to? Just what Arnie said.

Every physician wants to know how he or she is doing. You know, we're all competitive. We talked about this last year and the year before. We're all competitive. We wouldn't get where we were, we wouldn't have gotten into medical school, we wouldn't have done that. And I want to see how I do, and, gosh darn, if I'm not doing a good job, I want to make some corrections. So that's extremely important that we do that. Extremely.

Now, obviously, most of the money is going to be in the outliers, and that's where you're going to really perhaps focus. One of the very big concerns I have is this education and outreach, and there's been virtually no discussion on that. One of the questions I have is: Who is going to do that? Well, there's only one or two groups that can do it. My specialty of urology, there's nobody in CMS that knows much about that unless he's a urologist. So you're going to have to go to my specialty society. For Karen, you're going to have to go to her specialty society. And you have to embrace those specialty societies or medical organizations like the AMA, et cetera. And you're going to have to ask them to develop -- and most of them are developing clinical pathways. Most of them are developing

evidence-based medicine. We need outcome data. We need outcome data because we don't have clinical effectiveness. I can't tell you what's best because we don't have that data. We need to collect that data, and the only person that can collect that data is the specialty organization. It can be done, and I think most physicians want to do this. And I sincerely believe that this can happen.

One of the questions I have and it's drilling down probably more than anything else about one of the resource measurements of generic prescriptions, you may not know, but in Florida the pharmacy has to fill that prescription by generic. So you're going to have a disproportionate collection of data. And I'm not sure if that's one of the most appropriate measures to do with generic prescriptions.

You know, I could talk about a lot of other things, but I'd really like to hear what Tom and Karen and the rest of you have to say also.

MS. BEHROOZI: There's been a lot of discussion about how to invent the best wheel, but I really feel like the thing that we can do that would be most helpful to physicians -- having this be acceptable and embraceable by physicians and useful to physicians -- and to consumers is

to work on having there be one wheel and having it be the best wheel, rather than having us develop a wheel and having Blue Cross develop a wheel and having the State of New York develop a wheel. Because as Joan said yesterday about the pharmacists who have to be trained to comply with all these different MTM programs, doctors are going to have to hire, you know, at least one person, if not a whole staff, to figure out how to appeal the aggregation of data, the attribution of data, the correctness of the data that's used to judge them by, the judgments that are made based on those data. So I think aggregation of data and standardization of methodology is really important, you know, a black box with -- the appropriate black box, a really smart black box that can invent the right wheel. And obviously Michael, who speaks in a language I don't understand, has to be part of that, and people like him.

But I think that's so important. I'm thinking of my credit scores. I applied for an online bank account. We won't go into why. It has something to do with what's gone on the past couple of months and what the smartest investment would be, right? I get a notice back that I'm not eligible to open this account. You know, I'm doing

okay. I'm not wealthy, but I'm doing okay. I got to check -- there are three different credit reports. One has me with an alias that is my husband's last name, which I never use. One has me with one of my home addresses being my work address. There's all these other things. And then there's various bill payments that some say I've been late on and others say I'm on time on. I don't have time to go back and fix all of that.

So I'm like the physician who doesn't have time to fix all of that and challenge all of that. Meanwhile, a decision is being made about me that impacts my life. And the bank isn't getting accurate information about me. Maybe I'm a perfectly good depositor and they should be happy to have my money.

So it's really, really, really important, and I'm not going to sing, but I think that's the point I want to end with.

DR. DEAN: Probably most of what I have to say has already been said. Certainly what both Ron and Mitra just said is so important. This is a terribly important undertaking. I think it's potentially an extremely valuable undertaking, and it could certainly blow up in our face if

it's not done right. And it could set us back a long ways if it's not done carefully and properly. And it's very tricky for all the reasons Mitra just outlined so graphically. I mean, for a whole lot of reasons, this is technically difficult.

So I guess I would say, first of all, a strong yes to the first question, and that we really need to be proactive in terms of involving physician organizations and let them know what is in store and trying to educate the whole community that this is not just a cost-cutting thing; this is really intended to increase the value that the whole society gains from health care, because certainly especially the outliers are going to say, well, I'm doing the best I can and now they tell me I can't do all these things that I have to do to save my patients. Well, we know that's mostly overstated and mostly not true. But we've got to be up front and realize that those arguments are going to come.

The transparency is important. I think proactive involvement with the stakeholders is important, and the emphasis on education that Nancy and Glenn have both commented on, to try and emphasize, you know, why this is being done -- I mean, clearly cost saving is a big issue,

but presumably, if we can get the value proposition right, the cost saving will follow automatically.

So I would certainly say a strong yes to the first question. The second question I guess I would leave to people that know more about data than I do. But I would say that the list of principles that you've outlined are very well done and I think a great starting point. They obviously will have to be refined, but I think it's important that we be up front about stating what we're trying to do, how we're going to do it, and why it's important.

MR. BUTLER: So I think you're getting yes and yes on the questions. In terms of the focus on the principles, one side of me says we're headed towards more highly organized systems of care between particularly hospitals and doctors that need to be re-engaged in managing risk, and probably at a higher than an episode of care level, if we're going to make an impact. So I like per capita, but I don't think that's where we should start.

If we're serious about per episode, if that's where we're headed as getting the next level of risk on the table, from a very practical standpoint I think that ought

to be the focus of the release of the data. I think we learned from DRGs being introduced, when Thompson and Fetter were saying it's just for utilization management, and we were kind of getting used to seeing data, and so when it ultimately came about, people kind of already had an idea of what it was and where it was headed. I think episode of care is the same kind of concept, so that the more we can kind of get that data on the table, it will force some very interesting questions. You'll find it's not the individual doctor versus the group. You're going to find that the audience may be a PHO. You won't even know who to necessarily send it to in an episode. Who's the -- you've got multiple physicians in the same episode. It will force those issues on the table in a way that will really advance, I think, our own understanding of whether it can be successfully applied for payment purposes.

So that would be my focus and my suggestion of where we ought to focus our own efforts.

DR. BORMAN: Certainly the consensus of yes and yes with caveats to each has clearly emerged. I'd like to step back and say first I think when we discuss this issue, it's important to be very up front about context and support

it in the context and capturing on the -- you know, specifically acknowledging there's the background of sustainability, there's the focal point of the physician as the director of resource consumption or an agent for resource consumption. But I think there also has to be a clear acknowledgment of the vast majority of people behave very professionally and want the best outcomes, both on an individual patient and aggregate population level. And I think, as has been said very eloquently, this is the opportunity for engagement. It is also an opportunity for enormous disruption, but it certainly is an opportunity for engagement. And I think that whatever we put out about this, the opening piece has to be a very positive context, just as a general thing.

I think that the excitement here about this is palpable, and that's wonderful. And we have this enormous vision of what it can be, where it should go, and that will be great for formulating the principles. We have to remember, as I think Bruce said, it's going to be dynamic and that the principles we articulate we will have to keep revisiting, and that they will be -- some of them will shift in priority. The operationalization of them may change over

time. And I think we should, frankly, acknowledge that in whatever we write so that we're just very clear about that, that these are principles subject to re-examination, and that it is a dynamic process.

In addition, I think while we very much are excited about the long-term vision, that in order to be credible, as several other people have said, the initial steps have to be very focused and very thoughtful and have achievable targets. I think it was Jay who first articulated that in this current discussion. If we don't pick some things that are almost unassailable -- I'm not sure there's anything that's unassailable to a group, certainly, of physicians because we're trained to take things apart and to put them back together, and surgeons even more so about the "take it apart." And so you absolutely don't want this to get hung up in, I think Arnie called it, the statistical noise. And absolutely Mike raises things way over my head that are clearly valid issue, and this deal of multiple comparisons about multiple things generating, of course, some positive results, physicians are going to be all over that in a very quick manner, because we all understand that from studies in the medical literature.

So, again, a point of picking a set to start with, we are not going to achieve the entire visionary program in the first swing. So in order to allow the program to go forward, let's pick some things. It may not cover 90 percent of physicians; it may not cover all specialties. It will be an iterative process. Pick some things that can work, make those work, learn along the way, and expand it over time. I think those are pretty clean lessons about this.

In terms of some of the specifics that were raised, I'd just like to talk a little bit about the education and research piece. I think Nancy is absolutely correct that that effort is as important as the generation of the information, because if you generate it and do nothing with it, it has no impact. I think as has been mentioned, specialty societies are some obvious partners here. I would like to suggest that also probably the various boards, at least for allopathic physicians, the American Board of Medical Specialties and its 24 member boards because they're all in various stages down the road of a maintenance of certification process. And I know at our own American Board of Surgery, we're struggling with the

notion of how surgeons can provide us enough data about themselves for assessment of performance in practice. So there is enormous opportunity here for this to have a mechanism for outreach and, again, to be a two-fer for the practicing physician who's going to worry about what Mitra brought up, of what army of people do I have to bring into my office, at what expense, to make this work, when presumably most of the benefit or much of the benefit, at least monetarily, will accrue to the system, and it will be paid for, it seems like, from me as the individual.

So I think that, you know, we need to think about those partnerships and probably bring those people in early on in the discussion so that it goes forward in a way that's productive for both entities. And relative to the individual versus group data, I would say that if it's not usable by an individual, in the end it defeats the purpose to some degree. But it should be structured in a way that it is aggregable in a group so that if you report it to me and to each of my partners, it doesn't take -- I don't have to go hire Mike to put it together in a valid way to share with my group and also have a group actionable item come out of it, because some of the things will be actionable by the

individual physician, some will have to be actionable by either their partnership group, their medical staff group, whatever it may be. But we have to do it in a building block kind of way. It seems to me that should be the criterion by which we figure out how to do the data.

And just one comment about outliers and then I'm going to quit because I've been pretty vocal about outliers a couple of times at this Commission. Recognizing the statistical issue of you will identify outliers by definition, you know, even if you set the bar at P.01 instead of P.05, there's still going to be that, and with a large "n" it's going to be a significant number of people. I still think that the biggest impact and part of proving value to the program and value to the physician will be to make sure that we at least can confidently -- that we have a transparent rationale for identifying the outliers and providing that information.

Concomitant with that has to be what George brought up. There then has to be a mechanism, once you're labeled an outlier, for some sort of meaningful peer review that allows an analysis of whether your patient population, locale, support system, whatever it may be, is just so

unique that indeed you are the best of the best given the circumstances.

So I think that that process will need to happen, and in order to get physicians to do that, they're going to have to be offered some protection in that peer review process as well.

I'm going to stop.

MS. HANSEN: The last word is really putting it back in context in the lens that I oftentimes take. I'd like to underscore the point that Nancy made relative to the impact of beneficiaries, that as we look at this, I think we do know sometimes there will be the tendency not to want to take high-risk patients so that one doesn't look bad in these kinds of measures. So I would like to have that somewhere in the text that we have to think of the ecology of this. You know, we have approximately 750,000 physicians, but we've got 43-plus million beneficiaries. And I want to make sure that as we look at the performance and improving the normative practice, of course, but just thinking about the unintended consequences that could be mitigated relative to, you know, tough cases and complex cases, when you have a lot of multiple illnesses since

that's the growing population.

So I just want to put all of this in the context of the quality of care that we want at the end of the day for the beneficiaries for the value of the Medicare program.

Then the only other final comment I have is the impact of learning I think is really there. I've been reading this colloquial book, many of you know, and I don't know what you think of him, but Dr. Jerome Groopman, that speaks about what the impact of selection of how doctors change. And I was kind of impressed by just some of the work that many of you probably already know, but perhaps some way of understanding the educational side of it and the impact of that coming from the work of behavioral economists to be able to understand, you know, what are the levers that make it possible for people to do this in a way that is respectful but, frankly, where the outcomes should be going. So if we could, you know, take a look at that dimension because it's not just the information, it's really using it to make the difference.

Thank you.

MR. HACKBARTH: Thank you, Jennifer.

We'll now have our public comment period.

[No response.]

MR. HACKBARTH: Hearing none, we are adjourned.

[Whereupon, at 12:04 p.m., the meeting was adjourned.]