MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
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Wednesday, April 9, 2008
9:58 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair
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P R O C E E D I N G S

MR. HACKBARTH: I apologize for the late start. My fault completely.

Okay, without further ado, our first discussion today is about refining the SNF payment system. Carol?

DR. CARTER: Great. Should I introduce our guests?

MR. HACKBARTH: Please do.

DR. CARTER: This is Bowen Garrett and Doug Wissoker from the Urban Institute, who have been really wonderful colleagues and have done the lion's share of the work here that I'm presenting.

Over the past year we've talked about the need to revise the SNF PPS to improve the accuracy of payments for patients with high non-therapy ancillary care needs -- and these are patients who need IV medications, respiratory therapy, drugs, those kinds of services -- to base therapy payments on patient's care needs rather than on the amount of services that were provided, and to provide some financial protection to SNFs treating cases with exceptionally costly care.

We've come up with a revised PPS design which you

can see here on the right-hand side of the slide. This replaces the current therapy component with one that bases payments on patient and stay characteristics. It adds a new component to pay for NTA services. And it adds an outlier payment for stays with exceptionally high ancillary costs per stay.

Last month we went over our findings, so I'm only going to summarize them here this morning. Our design for a new NTA component would substantially improve our ability to predict NTA cost and would result in more accurate payments than the current design. You can see here on the side for every measure the new component is more accurate. Because NTA payments would be much more proportional to NTA costs -- and that's the last line, the NTA CMI coefficient -- there would be much less incentive to avoid cases with high NTA costs, unlike the current design which underpays facilities with above-average NTA costs and overpays facilities with below average NTA costs.

Turning to the therapy design, this component uses patient and stay characteristics. You can see that it would be essentially as accurate as the current design.

The big difference is on the last line, which

again is the one that's indicating whether payments are proportional to costs. In the redesign, we would result in payments that are much more proportional to costs than the current design. So there would be little incentive for providers to adjust their mix of cases for financial gain. This is unlike the current design, which overpays facilities with above average therapy costs and underpays facilities with below average therapy costs.

As in any PPS, we need to be mindful of the incentive to under furnish therapy services. Last month Bill mentioned proactively addressing the under provision of therapy services. We've explored the idea of a low utilization payment adjustment, or LUPA, that would pay a facility based on its actual therapy costs if its actual costs were considerably below predicted costs for the stay. This would be similar to the LUPA payment in the home health PPS that pays on a per visit basis for episodes with fewer than five visits.

We have not modeled a low utilization payment adjustment but plan to over the summer. We believe that a LUPA would be a good addition to the redesigned PPS, but that the key provisions should move forward without it.

CMS could also lower the risk of stinting by linking payments to performance using changes in functional status as one of the quality measures. CMS would need assessments conducted at discharge, which the Commission has repeatedly recommended.

With the best models predicting NTA and therapy costs and an ancillary cost per stay outlier policy targeting stays with exceptionally high ancillary costs, we estimated the impact the redesigned PPS would have on total payments.

As expected, we found that the redesigned PPS would redirect aggregate payments. Payments would decline to SNFs with high shares of patients in the rehabilitation only RUG stays and increase payments to SNFs with small shares of these patients. Payments would also increase to SNFs that treat large shares of patients in the extensive services and special care RUGs and payments would decline for SNFs that treat small shares of these patients.

Reflecting the mix of patients and treatment patterns, the revised PPS would increase aggregate payments to hospital-based SNFs and nonprofit SNFs, 20 and 7 percent respectively. Payments to freestanding SNFs and for-profit

SNFs would decline 2 to 3 percent. But not all SNFs within a group would experience the same changes in payments. For example, while over half of freestanding SNFs would see their payments decline, over a third of them would see their payments increase.

Last month Bruce and Glenn asked about the quality of care furnished by facilities that would experience large changes in payments. We know from our previous work that hospital-based facilities provided higher quality as measured by risk-adjusted rates of community discharge and potentially avoidable re-hospitalization compared to freestanding facilities. We also found that quality differences by ownership were a mixed picture. For-profit facilities have slightly higher community discharge rates, indicating better quality, but they also had higher re-hospitalization rates, indicating poor quality compared to nonprofit facilities.

We also looked at the relationship between changes in payments and SNF margins. We found that changes in payments were inversely related to their SNF margins. Most facilities that would have the largest declines in payments had Medicare margins that were at least 10 percent in 2003.

And the majority of SNFs that would see their payments increase by more than 10 percent had Medicare margins of negative 10 percent or lower. As a result of the shifts in payment, the widely divergent financial performance across SNFs would narrow under the revised PPS.

Our results provide strong evidence of the need to implement a revised PPS and that the proposed design would more accurately pay SNFs. In view of these findings, we have proposed the following recommendation: the Congress should require the Secretary to revise the SNF prospective payment system by adding a separate non-therapy ancillary component; replacing the therapy component with one that establishes payments based on predicted care needs; and adopting an outlier policy.

These revisions would be implemented to be budget neutral so there would be no impact on program spending. Payments would be more accurate and would increase to some SNFs and decrease to others. More accurate payments would also improve access for beneficiaries with high NTA care needs. To implement these revisions, CMS would need to make many changes that are consistent with those it makes when implementing or revising a PPS.

In doing this work, we identified several areas where better data would make payments more accurate and allow us to link payments and costs to patient outcomes. These included accurate diagnosis information and service dates recorded on SNF claims. SNF claims have poor diagnostic information and do not include when services were furnished.

We would like to see SNFs record the services that were provided in a hospital separate from the services that are provided during the SNF stay. Currently when the patient is first assessed, it is impossible to distinguish the services that were furnished by the SNF from the ones that were furnished during the prior hospital stay.

And last, the Medicare cost report does not require SNFs to separately report nursing costs.

This leads us to our second draft recommendation: the Secretary should direct skilled nursing facilities to report more accurate diagnostic and service information by requiring that claims include detailed diagnostic information and dates of service; services furnished since admission to the SNF be recorded separately in the patient assessment; and SNFs report their nursing costs in the

Medicare cost report.

This recommendation would not affect program spending relative to current law. Providers would incur modest expenses to report the data included in this recommendation. Most facilities' payroll systems can report their expenses by nursing category and many states Medicaid cost reports require providers to report this information. Under the revised PPS, which makes more extensive use of comorbidities, more accurate diagnosis coding could increase payments to some providers and decrease payments to others.

This recommendation would not directly affect beneficiaries but could improve access if the data resulted in more accurate payments.

With that, I will end my presentation.

MR. HACKBARTH: Thank you, Carol. This is a terrific piece of work. Thank you, Doug and Bowen, for your contribution to it.

Questions or comments about the draft recommendations?

MS. HANSEN: First of all, I agree. I think the greater accuracy and the method that you went about doing this has been fantastic. It makes great sense. I

appreciated the added piece that you did some follow up with Bill's question about possible indirect stinting as a possibility and going through that drill down a little bit more. And that would be very helpful.

One of my colleagues coined the phrase let's take a look at the lowliers in terms of perhaps that component.

The second one is more of a clarifying question. I noticed about the performance of the for-profit institutions, as in others, there are some mixed results. One of the results I thought I heard you say was that there was greater community discharge but slightly higher rehospitalization rates? Was that correct?

DR. CARTER: Yes.

MS. HANSEN: What was the period of time that was looked at for the rehospitalization rate?

DR. CARTER: I'm not sure of your question. We looked at that. We have had that result. The period was 2000 to 2005 but I think you're probably -- how quickly was somebody rehospitalized?

MS. HANSEN: Right.

DR. CARTER: It was within 100 days.

MS. HANSEN: And just as a question of using that

metric, what is the science behind using 100 days; do you know?

DR. CARTER: We also looked -- we've done both 30-day and hospital day. The 100-day parallels the SNF benefit and so there was some sense that we wanted to look at what happens when -- during that period of time. It also, I think, had more stable results, if I'm remembering that report correctly.

MS. HANSEN: Thank you. The only reason I bring that up is I think the period of greatest instability is -- just as in the hospital discharge -- that 30-day window. And so having it on a benefit period as compared to what really happens in terms of stability or instability is often so much in that immediate period. So that's just a clinical statement at this point. It's not based on any study.

Thank you.

MR. EBELER: Thank you, Carol. I also support the recommendations. I think this is really nice piece of work.

The question is on the chart, I think it's slide five, on countering the incentive to under furnish therapy services. You mentioned that we need further work in these areas. These wouldn't be formal recommendations but would

be included in the chapter as options to consider? Is that how this would be phrased?

DR. CARTER: There is a short paragraph in the chapter that just talks about this as more of an idea that we want to explore further. We think that this would be very global and is a good idea but we haven't modeled it yet. We plan to do that over the summer.

MR. EBELER: Thank you.

MR. HACKBARTH: Other questions or comments?

For those of you in the audience who have not been at previous discussions of this issue, I think the relatively few questions we have this time is testimony to the quality of the work that's been done here. It's a very effective adjustment, I think, and terrific work in developing it. So don't construe brief discussion as lack of interest or support.

DR. REISCHAUER: And the fact that we had a full discussion at the last meeting of this same material.

MR. HACKBARTH: So I think we're ready to move to the final vote. The vote is first on recommendation one, on the screen.

All opposed to recommendation one? All in favor?

Any abstentions?

Okay, move on to two. Opposed to recommendation two? In favor? Abstentions?

Okay. Thank you very much. Well done.

Next on the agenda is promoting use of primary care.

MS. BOCCUTI: Good morning.

Patient access to high quality primary care is essential for a well functioning health care delivery system. So today we're going to very quickly review the importance of primary care and its risk of under provision and then we'll talk about initiatives to promote the use of primary care services.

Under this goal, MedPAC is taking three approaches. The first we accomplish through work published in our March 2006 report and was service specific. As you recall, MedPAC recommend improvements to the five-year review process that would give adequate consideration to E&M work services and values.

The other two initiatives that are denoted by the arrows up there are the focus of our presentation today. The first is a fee schedule adjustment that focuses on

incentives for practitioners and services, and the second is a medical home program that encourage care coordination component of primary care.

So with these two initiatives you all have recommendations that are going to be up for a vote.

I'm going to go through these couple of slides very quickly because we've been through them in previous sessions but I think a quick review helps set the context for the recommendations.

In defining primary care, we know that the IOM has stressed the multidimensional nature of primary care. For the purposes of today's discussion, we consider primary care to be comprehensive health care provided by personal clinicians responsible for the overall ongoing health of their individual patients. It offers first contact care that encompasses preventive, acute, and chronic care. It means keeping track of appropriate patient referrals and requires teamwork.

Physicians who specialize in primary care are trained in family practice, internal medicine, geriatric medicine, and pediatrics. Nurse practitioners and physician assistants are additional, important professionals who

provide primary care. Some specialists also provide primary care to their patients, particularly those who specialize in specific chronic conditions.

Survey research repeatedly shows that Americans value having a primary care physician who knows about their medical problems. The Commission's SGR report stated that one way to improve value in Medicare is to increase the use of primary care services and reduce reliance on specialty care. This goal can improve the efficiency of health care delivery without compromising quality.

But despite these findings, primary care services have become undervalued over time and thus they risk being under provided.

Results for a large beneficiary survey, the MCBS, shows that most beneficiaries have a usual source of care that they want and value but the Commission has raised some concern regarding access to primary care. In our 2007 beneficiary survey, only a small share of beneficiaries are looking for a primary care provider but those who were experienced difficulty.

We also see a decline in the share of U.S. medical school graduates entering family practice and primary care

residency training programs. And internal medicine residents are increasingly going into subspecialties.

As several commissioners mentioned at the last meeting, the trend for medical students and residents to choose careers as specialists reflect a number of factors. These include income prospects, lifestyle preferences, hospital-based emphasis on training.

And additionally, as Tom described, medical students may find the practice of primary care daunting because of the perceived pressure to have vast knowledge about all health care problems. So policies to encourage medical training in primary care could improve primary care quality and access, and thus promote beneficiary use of primary care services.

Future Commission discussions could examine opportunities in Medicare's medical treating funding policies to promote primary care practice but we're not going to be discussing that today.

So with those issues before you about primary care, Kevin is going to take you through the first initiative we discussed.

DR. HAYES: For this part of our presentation, we

wish to go over further work since the March meeting on a payment adjustment for primary care as part of Medicare's physician fee schedule. In addition, we have a draft recommendation for your consideration on this.

At the outset, it is worth reiterating points Cristina made earlier. The Commission has made recommendations about improving the five-year review of relative value units and the fee schedule. The expectation is that such improvements could increase payments for evaluation and management services, including the primary care services I will list in a moment. With a fee schedule adjustment, however, we note that the focus is not just on payment for certain services but also for certain practitioners.

As listed here, the adjustment would be an upward adjustment in payments for selected services. We are starting with the statutory definition of primary care. We are then considering a subset of evaluation and management services within that definition. So this would be office visits, home visits, and visits to patients in non-acute facility settings.

The adjustment would be available to selected

practitioners. For that to occur, there are options to consider in structuring the policy and we hope that that's where you will spend some time today.

The adjustment would be budget neutral. As such, it would redistribute payments towards primary care practitioners and help reward a career in primary care. It could also support investment in information technology and other resources needed for the medical home programs that Cristina will discuss in a few minutes. Nonetheless, the adjustment is an increase in payments only with no requirements about how the funds are to be used.

At the outset, let me summarize three points discussed at the March meeting. First, the fee schedule adjustment could respond to concerns about the undervaluation of primary care. In the March 2006 report, the Commission made recommendations that addressed problems with the accuracy of fees in the fee schedule. These problems put primary care services at a disadvantage and make them undervalued.

A second point discussed was that a fee schedule adjustment for primary care would be a major departure from the structure of the fee schedule. Currently, the fee

schedule is intended only to account for differences in resource costs among services. Further, the statute prohibits differentials in payment based on physician specialty designation. Promoting primary care would be a very different goal for the payment system.

A third point from last month is that in setting the level of the adjustment there is no one formula or analytical approach to use. Instead, judgment would be required. There are two precedents: the current 10 percent bonus paid for services furnished in a health professional shortage area and the 5 percent bonus for services in a physician scarcity area. In making a judgment about an adjustment for primary care, the Congress could consider these precedents, at least as a starting point for its deliberations.

An issue we thought you would spend some more time on this meeting concerns targeting the adjustment toward practitioners who furnish primary care services. This table shows primary care services as a percent of total allowed charges for different practitioners and specialties. The primary care services considered here are the ones listed earlier: office visits, home visits, visits to patients and

non-acute facilities.

Of course, for any one practitioner, their percentage of allowed charges in primary care services could be higher or lower than the averages shown here.

Now looking at the different types of practitioners and specialties, we see that they tend to vary in how much they furnish primary care services. Among those typically thought of as primary care practitioners, the services they furnish are dominated by primary care services. On average about 50 percent of their allowed charges are for such services. By contrast, among specialists and others billing Medicare, allowed charges for primary care services average only about 13 percent of the total. To be efficient, the adjustment should distinguish primary care practitioners from others.

There are two options you may wish to consider for targeting the adjustment. Option one would be to consider both the physician's specialty designation and whether he or she has a practice focused on primary care services. The specialty designations would be those often considered to be primary care, namely specialties in geriatric medicine, family practice, internal medicine, or pediatric medicine.

The convention in Medicare is to also consider nurse practitioners and physician assistants as distinct specialties.

To identify a practitioner with a practice focused on primary care services, there would be a review of the pattern of claims submitted, say for the past year, to determine whether a pre-established threshold had been met, a threshold of allowed charges in primary care services. Thus, for this option there is a two-part test: specialty designation and meeting the primary care services threshold.

The second option is to target the adjustment but only with part two of the test. That is there would be a review of each practitioner's claims pattern to see if the primary care services threshold had been met. But there would be no consideration of specialty designation. In a minute I will list issues that arise with the two options for targeting the adjustment.

However it is done, requiring a focus on primary care services accomplishes several objectives. These are objectives that apply to both options for targeting the fee schedule adjustment. By using the pattern of claims submitted one objective, of course, is to target the

adjustment toward promoting primary care. A second objective is to address ambiguity in specialty designation. A physician may have a specialty designation of say internal medicine but actually practice as a cardiologist. A review of the claims pattern for that physician could be used to more accurately discern the nature of the physician's practice.

A third objective, the review of claims patterns could inhibit strategic behavior. As discussed last month, specialty designation is self-reported and is something that physicians have the option of changing. For a physician proposing to change his or her specialty to one of those eligible for the adjustment, a review of the claims could reveal whether the change is a fair representation of the physician's practice.

Looking at this first option for targeting the adjustment, namely a combination of specialty designation coupled with review of the claims pattern, there are issues to consider here. For one, it helps target the adjustment toward generalists. It would limit the adjustment to generalist physicians within one of the specialty designations I mentioned earlier and to nurse practitioners

and physician assistants. A review of claims would confirm a focus on primary care services.

Another issue is that specialty is self-designated. The concern here is that those billing Medicare may choose to change their specialty in response to availability of the fee schedule adjustment.

Our third issue is an implementation issue really. To address a self-designation of specialty, the Secretary would need to adopt criteria for using claims data to confirm that the specialty designated represents the physician's practice.

For instance, the threshold could represent a minimum level of primary care services. That would be among the criteria. Another criterion could clarify the rules on specialty designation and address topics such as the frequency with which a practitioner can change his or her specialty.

Turning now to the second option for targeting the fee schedule adjustment -- that is reviewing claims patterns without considering specialty designation -- there are issues to consider here also. With this option, all physicians who meet the pre-established primary care

threshold would be eligible to receive the adjustment. This would make the adjustment available to those physicians who are specialists to some extent but who also have concentrated their practices in primary care services.

This is what we mean by the blended practices listed on the slide. An example, might be a physician who first achieved board certification in internal medicine but then went on to gain certification in cardiology. For such a physician, the pattern of claims might meet the threshold for primary care services even though the physician furnishes a degree of specialty care also.

This option opens the eligibility for the fee schedule adjustment to more than just generalists. In turn, the reduction in payments required to make the fee schedule adjustment budget neutral would need to be larger or the minimum threshold of primary care services would need to be higher.

This brings us to the draft recommendation on the fee schedule adjustment. The recommendation applies regardless of how the adjustment is targeted. It makes no distinction between an adjustment that relies both on specialty designation and claims patterns versus an

adjustment that is based solely on claims patterns. It simply addresses whether the Congress should establish a fee schedule adjustment for primary care.

It reads as follows: the Congress should establish a budget neutral payment adjustment for primary care services billed under the physician fee schedule and furnished by primary care focused practitioners. Primary care focused practitioners are those whose specialty designation is defined as primary care and/or those whose pattern of claims meets a minimum threshold of furnishing primary care services. The Secretary would use rulemaking to establish criteria for determining a primary care focused practitioner.

The implications of the recommendation are as follows. For spending, as a budget neutral policy, it would not affect Federal benefit spending relative to current law. For beneficiaries, it would be intended to improve access to primary care services. For physicians and other providers, it would have redistributive effects, depending on the services they furnish.

That concludes the part of our presentation on the fee schedule adjustment. Cristina will now discuss medical

programs.

MS. BOCCUTI: Medical home initiatives are gaining attention of late. Some private payers are starting them and some state Medicaid agencies, frankly, have been working with them for many years.

Broadly speaking, a medical home is a clinical setting that serves as a central resource for patient ongoing care. Medical home initiatives have the potential to add value to the Medicare program. Ideally, through better care coordination, medical homes could enhance communication among providers and thereby eliminating redundancy and improving quality. They may also improve patients' understanding of their conditions and treatment and reduce the use of high-cost settings such as hospitals and emergency rooms.

Another important goal includes enhancing the viability of primary care practice and access, of course, to primary care services.

From our last two meetings you have discussed the specific capabilities essential for a medical home and I've listed them here. In the interest of time, I'm not going to run through each one but I do want to note some changes that

stem from your discussion at the previous meeting and make a few points for emphasis.

So first on the first bullet, we would require that the medical provide primary care. But I want to be clear that it doesn't mean that it's limited to providing primary care, but it must be some of the services that it provides. So multispecialty practices, primary care practices, geriatric medicine practices are natural candidates for medical homes.

But in some cases, patients may choose a specialty practice that would serve as their medical home, and the example that I've used before is the endocrinology practices for people with diabetes. But I want to be clear that these medical practices, if they're specialty practice and just mentioned, they would then be responsible for providing the primary care for the patient in most regards. And when needed, making referrals for other care.

So primary care will also include appropriate medication review, and that goes to something that you mentioned, Jennie. So we see that as falling within the primary care bullet. And that these medication reviews could even involve a pharmacist and can occur annually and

immediately after an event, like a hospitalization.

For the health IT criterion up there, note that we added the word active for active clinical decision support. I think Arnie brought that up at the last meeting.

Conducting care management criterion here, Jennie, you brought up to make sure we're saying care management and not case management. I think that brings in the care coordination component that we see falling within care management. We can discuss that more. But that's where we talk about coordinating care between appointments and among providers.

For the 24 hour patient communication bullet, we also added the word rapid, and that also goes to something that Arnie brought up.

And then the last two bullets are basically the same from the previous meeting.

A final note on these criteria, in designing a pilot project, Medicare could consider allowing a percentage of medical homes that participate in the project to have a little bit lower structural requirements, particularly in rural areas. These do speak typically to the health IT requirements and maybe setting aside a percentage -- say 25

percent -- to go towards that. So that may be something you want to discuss further after we're done talking.

Going on to beneficiary issues, a medical program in Medicare should start with beneficiaries with multiple conditions because they are the population most in need of care coordination. As the number of medical conditions increase, encounters with different health care professionals and settings also increases, as does Medicare spending. Also, a program that targets this population will in turn target the professionals that use the resources to treat them.

Regarding designation, as discussed, participating beneficiaries would select a single medical home. Medical homes would need to obtain a signed document from each participating Medicare patient indicating his or her medical home designation. This document should include principles for encouraging beneficiaries to seek care from their medical home first when appropriate and discuss the medical home's role in coordinating patient care.

So we see this as really an opportunity for a conversation between the medical home and the patient about what we're going to get out of this program. But to be

clear, I do want to say that patients would still able to continue seeing specialists without a referral from the medical home. So this pilot is not requiring authorization from the medical home to see a specialist.

In conjunction with launching a medical home program Medicare should engage in a public education campaign to inform beneficiaries about the potential benefits of primary care. And to give you just a teaser for tomorrow, in Joan's presentation, she's going to discuss public education campaigns and how they can be effective tools for health initiatives when they're tailored to the topic. So we look forward to that tomorrow.

Other implementation details that would also need to be worked through, of course, are selecting the qualifying medical conditions and determining eligibility under certain circumstances that I've listed on the slide.

In the last meeting, we discussed the payment mechanism for a medical home in Medicare, which was a modest monthly payment per beneficiary for medical home infrastructure and activities. No beneficiary cost-sharing, we've said, for medical home fees. And the medical home can continue to bill for Part B services.

Now regarding the pay-for-performance component in a pilot medical home project. As you know, MedPAC has recommended that Medicare initiate physician pay for performance programs to improve performance and quality and efficiency. The medical home pilot is an opportunity to implement and test such programs, and I'll mention just a few reasons here.

A disproportionate share of the quality measures that are widely accepted by experts are appropriate for primary care. In fact, commercial insurers that have implemented P4P have invested more heavily on primary care practices than specialists. These measures could focus on widespread high-cost conditions. And with respect to efficiency, because medical homes are designed to be the central resource for managing patient care, I think that they are well suited for efficiency measures and incentives.

Quality and efficiency payment incentives would be separate from the monthly fee. Rewards would be based on attainment or improvement. Bonuses for efficiency after a confidential feedback period would only be available to medical homes that have first met quality goals. As Arnie has suggested, a shared savings model could be available to

practices with sufficient size.

For comprehensive care management, medical homes need information on beneficiary service use outside of the medical home. As we've discussed, medical homes should actively follow up on results, treatment, and recommendations from specialists and they should also be encouraging their patients to communicate with them about their health care use outside the home. But in some cases, the medical home may not be aware of the patient's service use. Taken an acute hospitalization, for example. Although ideally hospitals should notify patients' medical homes upon admission and discharge, Medicare could also supply medical homes with some backup information on patient service use.

To this end, Medicare's claims processors could compile patient utilization reports monthly say and send them to Medicare or to the medical home directly. In fact, Medicare is transitioning to single contractors, called Medicare administrative contractors or MACs, for processing both Part A and Part B claims. So MACs could be key partners in this information exchange.

However, I can't disregard the last bullet which has to do with patient privacy protections. They will need

to be addressed before a MAC or Medicare can provide individual patient information to the medical homes. This can be part of the initial agreement that I talked about before in talking about the principles of the medical home both for providers and for patients.

So that brings us to the draft recommendation before you. I'm told I need to read this all word for word so bear with me.

The Congress should initiate a medical home pilot project in Medicare. Eligible medical homes must meet stringent criteria, including at least the following capabilities: furnish primary care, including coordinating appropriate preventive, maintenance, and acute health services; use health information technology for active clinical decision support; conduct care management; maintain 24 hour patient communication and rapid access; keep up-to-date records of patients' advanced directives; be accredited or certified from an external accrediting body.

Additionally, the pilot should it require a physician pay for performance program.

MedPAC envisions that this pilot would be larger than the medical home demonstration project already under

development through the Tax Relief and Health Care Act of 2006, TRHCA. An expanded pilot would achieve more definitive results and allow quicker implementation nationwide if the results are promising.

The pilot would require upfront costs, primarily in the form of monthly fees to medical homes. In the first year, these costs will be in the range of $50 million to $250 million. I will note that this range is one of several ranges that we use with CBO to assess spending implications of MedPAC recommendations.

In general the medical home pilot as we laid out is about four times larger than the demo I just mentioned with TRHCA. So in general, we're talking about sizing the pilot to have up front costs in the ballpark of around $400 million over the three years. Savings are not included in the assessment.

Medical home initiatives will help sustain the relationship beneficiaries have with their personal physician because they will support ongoing comprehensive care. With increased resources going to medical home, this recommendation is also designed to enhance access to primary care and also improve care coordination.

Pilot participants -- these are the providers I'm talking about now -- who specialize in primary care and in certain chronic conditions will receive additional Medicare resources for providing beneficiaries with comprehensive ongoing care.

I just want to mention a couple of additional comments that I hope captured some of your other discussions during the last meeting. These two policies that Kevin and I have been talking about are not meant to be mutually exclusive. The first initiative, the fee schedule adjustment, focuses on primary care services provided by clinicians who predominately provide primary care. The second initiative, the medical pilot, focuses on certain other activities like care coordination.

And finally, the pilot must have clear and explicit thresholds for determining if it can be expanded into the full Medicare program or discontinued entirely.

Thank you.

MR. HACKBARTH: Well done. Thank you.

Since I'm a splitter, John, I'm going to propose that we discuss these separately. Are you okay with that this time?

MR. BERTKO: I'm fine.

MR. HACKBARTH: So rather than combine the conversation of the medical home and the primary care modifier, what I'd like to do is separate that. Why don't we begin with the primary care modifier and take questions and comments on that.

MR. BERTKO: First of all, thank you for the very good work. I wanted to first say I support the fee schedule modifier and make two comments about that.

I think maybe in last month's you showed that there was some evidence that regions that had higher percentage of primary care physicians had lower costs, if I'm recalling correctly. And this supports my own experience in that there is not a huge but a measurable reduction in costs per person when more primary care office visits are the source of regular care. So I think there's some cost savings here that haven't been recognized in what we're talking about.

Secondly, I think this sends a message, and it's not only a Medicare message. But in the private sector many, many insurance companies link payments to the RBRVS. And to the extent that we made a change in Medicare, we

would be making a similar change implicitly in the private sector. And I think that is very appreciated. If anything, I think there is even sometimes more difficulty in access to primary care these days in the private sector than there is in the Medicare.

MR. HACKBARTH: Karen, can I just leap in front of you for just a second? I forgot to raise one question that I think might help set the context for the ensuing discussion.

Kevin, in your presentation on the modifier, you were very clear to say that this was not in lieu of but in addition to our recommendations on improving the RUC process. It might be helpful to remind us what other factors are in play here that affect the relative payment for primary care services.

The RUC recently did the five-year review and E&M services got an increase through that process. There is a process underway for changing the practice expense allocation. My recollection is that that also will increase payments for primary care practices? That's a question.

DR. HAYES: That's correct. We're in the midst of a transition now toward different practice expense relative

value units in the fee schedule. That transition will end in 2010. But overall we are looking at some increases in payments for E&M services during that transition.

MR. HACKBARTH: I just wanted to remind people that there are several processes in motion, each of which can contribute something to increasing payment for primary care services. And this would be an add-on, not in lieu of that.

DR. BORMAN: First, I would just say remember, I'm a plain Jane general surgeon and probably what I'm going to see is going to disagree to some degree with a lot of very smart people in the room, particularly the staff. So please put it in that context.

And I thank Glenn for making --

MR. HACKBARTH: Are you saying the staff are the only smart people?

[Laughter.]

DR. BORMAN: You can choose to interpret that however you like. If the shoe fits. No, I didn't say that. We all look smarter at the end of every day with the staff. How about that?

I thank you for making a couple of the points that

I was going to make and I won't dwell on those too much.

I have some philosophical problem here and I have a philosophic problem on a number of areas. Number one, I do believe there is conceptually an important difference in talking about the Medicare program, primary care services and delivery, and primary care physicians or primary care practitioners. And while there certainly is some linkage there, I think we have to be very careful about that.

For example, when I have a female patient with breast disease and we talk about screening mammography or activities going forward, to some degree I'm delivering some primary care. And we just need to be a little bit careful about having an inextricable linkage. I don't know if most of you may be old enough to remember the math things with the overlapping circles. I think they were Venn diagrams. I think we have to be very careful of being respectful that it's not a 100 percent overlap in that regard. So that would be one point here.

A second one is, as you said, there are already a number of processes in place. And I would remind you that the five-year review actually moved into E&M services more money than the total allowed charges for five surgical

specialties combined. That includes things like vascular surgery that are significantly utilized by the Medicare population.

So I just want you to remember the magnitude of what has gone on here and is still playing out. I think we have to be a little bit sensitive to we don't know all the consequences of that.

I would remind all of you that in what some of you found to be a painful review, as Mark and I talked about, of the practice expense methodology and potential models for it, virtually every model had the potential as the one in place to increase payment to E&M services. And the biggest loser in each of those methodologies is major procedures. And there's variability about the shifts up and down to imaging, laboratory, and minor procedures.

I would point out to you that while it's always good to think about rewarding what you want to do, you've got to be careful about whom you hurt. And if fairness conceptually dictates that we want to restrict volume growth, then this doesn't lead us toward that goal because it continues to penalize a group that has had quite low growth; i.e., major procedures. And it allows reward of

some areas that have explosive growth and for whom we have great question about some of the propriety. So I just throw that out as just a philosophic reason that I have some difficulty about this.

In terms of the thinking about chronic conditions and managing that and that that's sort of an implied criterion of how all of this works, I would point out if I recollect properly -- and I welcome staff or whomever correcting me -- the number of chronic conditions per beneficiary is on the rise. And the percentage of people who have three and four and five is going up.

And yet self-assessment of health status has actually been surprisingly good for these people with three and four and five. So I think we have to be a little bit careful about just the number of diagnostic codes that I can put on a claim form doesn't necessarily say something about my patient's status that's clinically significant. And you need to be a little bit careful, it's a limitation of administrative data, which lots of people in this room understand better than I do. So that's important.

Just a couple of comments to link this to the implication of relationship to manpower or person power or

whatever the politically correct term is today in medical care. I'm just going to address the physician piece and not mid-level providers and others who I think are hugely important parts of this whole thing. And I support their appropriate use.

Medical education is an extremely long pipeline. In that sense, it is a bit like a battleship, almost as big in its own way as the Medicare program. Battleships are hard to turn. It takes 50 miles of ocean, my Navy friends tell me, to turn a battleship. And as you start turning it, it's not something you can do on a six month or an annual basis and have the battleship have stability. I think we have to be very careful about allowing what we call visceral feelings -- it's kind of your gut emotions; right -- to drive decision-making and urgency of decision-making at times.

And I would point out that in the recent residency match selection the three top specialties of the competition were dermatology, plastic surgery, and otolaryngology, which has a very large and increasing component of its education and practice as facial plastic surgery.

So the common theme here is actually image and

sort of our self assessment and attention thereto. And I would submit to you that that's a societal driver, not so much a medical health care exactly driver. It you may also reflect everybody is going to tanning booths and they're going to need to have their skin cancers addressed, but regardless it does reflect things other than the Medicare program.

So I would just urge you to be a bit cautious about that piece.

And as we discussed in executive session, there's a two-part process here that's picking your primary certification. And increasingly, graduates are picking a secondary certification. And that's true in family medicine, where there are a number of fellowships. It's enormously true in the other two very large generalist certificates, which are general internal medicine and general surgery. And huge numbers of that.

So I think that again this is a complicated area that I'm concerned this is a broad brush to the solution.

One last comment, I absolutely acknowledge that the RUC process is not a perfect one. I would like to point out to folks that the RUC does operate under a charge from

CMS. And I think the RUC's charge is to establish a relative value scale, not to say what the top point and the bottom point value are. That difference between the absolute values and addressing the relativity, I think maybe we lose sight of a little bit in the conversation.

And if there are societal policy pieces, then I would support some of the thinking that the Commission has already articulated about that may need to come in at a level parallel to or whatever the RUC. And whether that's CMDs or a broad-based private sector representation on a group as well as CMDs, I'm not sure. But I do want to acknowledge that there is a pretty thoughtful work, particularly at the research subcommittee. And so I wouldn't want us to be perceived as entirely RUC bashing.

MR. HACKBARTH: Let me just pick up on that. Nick and I were talking about that during the break, and I absolutely agree that we should not be perceived as RUC bashing. When we made our recommendations on improving the RUC process a year or two ago, to me the real significance of that was we were saying that CMS needs to do a better job in its piece of the valuation. And our recommended advisory body was for CMS and the Secretary to help them identify

potentially overvalued services to be fed into the RUC process for analysis and put in context there.

I think it is inevitable, as we said a year or two ago, that a process that is run by specialty representatives, it's only natural that there's going to be a greater inclination to look at undervalued things as opposed to do overvalued things. And CMS and the Department, therefore, have a role in making sure that it's a balanced review of both increasing values and reducing values.

I think that's a different message than oh, the RUC process is awful. Thank you for raising that.

On this issue of the other things happening that affect the relative values of E&M codes, the five-year review and practice expense reallocation, could you just quantify those a little bit, Kevin? Or is that asking too much?

DR. HAYES: I'm reluctant to give numbers on the practice expense because I just don't recall.

MR. HACKBARTH: Let me ask about the work on the five-year review. My recollection was that the RUC process recommended fairly large increases in the relative values.

Once you did the budget neutrality adjustment and some other adjustments, what comes through at the end of that pipeline to practicing clinicians was significantly smaller.

Can you just refresh our recollection on that?

DR. HAYES: Sure. What you have is an increase in RVUs that occurred with the five-year review. But the law says that the review must be budget neutral. So we now have in place a budget neutrality adjustment applied to the work RVUs for all services in the fee schedule, which works out to be minus 12 percent.

So we have say an increase in RVUs, the one set of numbers that I recall is the increase in RVUs for a mid-level office visit was pretty dramatic. It went from 0.6 to 0.9, somewhere in that area. But then you applied the budget neutrality adjustment and it kind of clips off a substantial portion of the increase.

The other figure that I recall is that on average for E&M services the increase in payments worked out to be about 6 percent when you look at across all the services and the effect of the five-year review for those services.

MR. HACKBARTH: That percent is after the adjustments, the budget neutrality?

DR. HAYES: Yes.

MR. HACKBARTH: Thank you.

DR. REISCHAUER: But the game is a relative game. It's not an absolute game. And the incentive to do A rather than B depends on the relative payment for both A and B, not the level. So I think we shouldn't get too hung up on the fact that everything was lowered down because of the budget neutrality adjustment.

DR. BORMAN: Can I just say one thing to that? And Bob, I absolutely respect that position.

DR. REISCHAUER: I don't think it will make you happy. I'm not suggesting that. You should be upset.

DR. BORMAN: No, no, no. I think that we need to recognize that there is a price being paid already that's fairly substantial. My concern, albeit as a surgical practitioner, is obvious but I'm even more concerned as a Commissioner that the bigger brunt of this is being foisted upon the piece of the system that is growing at a relatively slower rate.

And it really is not doing anything to address the high volume pieces. And I, for one, would be very ecstatic to see something, for example, that resulted in an imaging

report that came to me without a recommendation for what the next imaging test is. And not to unfairly pick on radiologists but I think Tom or Ron can see that in patients who read their own report that this is the finding, could be better clarify by something else.

And I would also point out, the other piece in the fee schedule is professional liability. And that does hit certain people extremely hard. So my practitioner friends in Florida in general surgery start out January 1st of every year with $100,000 professional liability premium to work off before they get anything else.

So I just throw those things out.

DR. STUART: I want to say that I support this recommendation. Part of it seems to hinge on a technical issue of how we identify physician specialty. So Kevin, it's really a question about where that information came from.

Several years ago I did some work with the CMS UPIN file, which I don't even know whether it's still called that. But it had a self-designation for every physician who participated in Medicare.

My recollection is that it was a rare physician

that just had one specialty designation. And it was very common for doctors have five, six, or seven specialties.

So where does this information come from? And how does it affect the technical part of this recommendation?

DR. HAYES: The specialty designation comes from the applications that physicians submit to Medicare to establish their eligibility to receive payment. That information then, depending upon the location where they bill from, that specialty code gets combined to the claim form that is submitted by the physician. All that information is compiled into CMS's information systems and aggregated up to a level that we use whenever we conduct an analysis like this.

So the specialty that's identified is the one that gets combined with the individual claim form, depending upon the application that the physician is submitting.

DR. STUART: So you're suggesting that physicians have just one specialty, not multiple specialties?

DR. HAYES: Not necessarily. It's the specialty that goes with the claim form.

DR. STUART: That's what I'm a little concerned about here because I think if you do it at the claim level

what you're going to find is that you're going to find that physicians are this or that or something else. But when you aggregate all of their claims over a year's period, you're going to find, I think, that you have multiple designations and that that probably needs to be addressed here.

MR. HACKBARTH: Kevin, did you have a response?

DR. HAYES: That the discussion in here, the business about establishing criteria in drafting this was viewed as a mechanism for sorting out issues like this. There is some limit on how much detail we would want to go into perhaps in the report in specifying exactly how the administrative details of this would work. But we felt like this concept of establishing criteria and using rulemaking to explain how the process would work, that that would be a way to allow for multiple input and review and comment on the part of the physician community and other stakeholders.

But there is a recognition that there are some issues to sort out here. No question about that.

DR. DEAN: Just briefly, I wanted to make it clear that I certainly wholeheartedly support this recommendation. There was some question, last time I had raised questions about the appropriateness of this or how well it really does

what we want to do. And I still have some of those concerns. But I think that this is certainly an appropriate first step and something that we need to do and that we can do relatively quickly hopefully.

Having said that, I still think that it's a less than perfect structure. But given the structures that we have to work with, it may well be the best thing. And so I think that I certainly do not want the perfect to be the enemy of the good. And I think this fits into the good category and it's something that we need to move forward with.

DR. CASTELLANOS: Tom, I had the exact same feelings you do. I wholeheartedly support this. It's long overdue. Yes, it will help perhaps getting some people into the work force. But it may more importantly help people like yourself to stay in the work force.

Today we see a lot of things about concierge medicine and why are physicians going into that? Well, they're going to get higher pay, they're going to work less, and they're going to do things which they were trained to do. Not to see 50 or 60 patients but the five or 10 or 15 a day.

So hopefully, this will help in that direction.

I have a couple of questions. Could you put on slide number six? The one I have is the pay for E&M services. As a specialist, and I'm a specialist, I depend on primary care doctors, the internists, et cetera, for help in the hospital, in the emergency room, in hospital visits and consults. Now you're not precluding that but I have a question why you did not include it in E&M charges?

DR. HAYES: The focus here really was with primary care services, the combination of primary care services and primary care practitioners. And some of the other categories of services that you mentioned tend to be furnished mostly by what we might think of as specialists as opposed to primary care practitioners. That's kind of where we came down on this.

DR. CASTELLANOS: I think you're right, in some cases. But in rural America I can tell you it's the primary care doctor that's the person in hospital.

The third question, and Bruce, you asked how we can identify the specialists. I think a better question really is how does the patient identify them? This is supposed to be patient centered care. A lot of patients,

like Karen informed, a lot of her breast cancer patients consider her the primary care physician. And I can tell you the same with myself, my cancer patients in urology. I have a much closer active relationship with that patient. And a lot of specialists are doing primary care. I think we need to not limit it just to the first definition but perhaps the second definition.

The fourth point I'd like to make is again Karen's point about we're still not dealing with the volume issues that we have. We're still not dealing with the increase in costs. And we're still not dealing with how we can get a better grip on the cost of medical care.

DR. SCANLON: I think I started in a position somewhat similar to where Karen was. If you go to the slide three the issue is that primary care, the first part, is something that I think we absolutely want to promote to the greatest extent possible. But the second half of that slide, I mean we're talking about primary care providers which are a necessary but not sufficient condition for getting to the primary care that we're really interested in.

I'm concerned that, again in thinking about Venn diagrams, that even if you limit yourself to people that are

"primary care physicians" and to their E&M services, there are a set of those E&M services that fit the primary care sort of definition and then there's another set that don't. We are proposing to use a very sort of broad brush definition of what we're going to reward. It's not what we necessarily want to reward but we're willing to accept this definition in terms of trying to reward the behavior that we are looking for.

There is a concern that we're simply going to promote more E&M services without necessarily the coordination that we're really striving for. And think of this as a kind of relatively inefficient way of trying to achieve what we want. And when we start every March report with this sense of how much Medicare is under fiscal pressure, the idea that we can overspend to try and move in the right direction, for me, is somewhat inconsistent.

The other thing that concerns me about this recommendation is the fact that we don't have as much in the way of an analytic underpinning that we do for a lot of the things that we do. We've talked at various times about the role of MedPAC judgment in things. But I think at this point we're kind of going too far in making a judgment

without information. The fact that the RUC changes are still underway, I think if we had more information about what their impact has been.

And then also I'd like to know more about -- we talk about what does the RUC capture in the work values. It's supposed to capture the amount of time that is devoted to a service, as well as the intensity.

I'd like to know how the compensation or the relative values for those different things actually varies and varies by specialty so that we could make sort of a more informed decision as to how much we really might want to adjust fees or relative values outside of the RUC process.

But without those I feel like we're setting a precedent that we're willing to move in a very, very significant way without the solid analysis that we really should have before we can make that kind of a move.

MR. EBELER: It's interesting, because I sort of come from -- at least earlier in my career -- some of the same sort of policy analytic background as Bill, although certainly not at the depth that he has -- and reach a different conclusion to leads me to support the recommendation in part because I think the analysis is

pretty clear that this segment of health care is critically important and undervalued and action is needed. I think Tom said it better than I could in some ways, so that there is a claim for action and this is a good proposal.

One of the things, if you flip back to the recommendation, Kevin, you were trying to stimulate a discussion and question among the Commissioners on, in effect, the second sentence, whether one leans towards the two-part test, name the practitioner and find out if they are disproportionate share primary care, or simply use the second half of that test.

As I understand the recommendation, we are laying those out as options but the Secretary would be asked to pick. We are deferring to the Secretary on that.

It strikes me that in the course of the discussion we've fleshed that out a little bit. My personal bias is leaning to the second half of that test and not the first, for some of the reasons that have been flagged. But it just strikes me that that's part of the discussion we're having here that you've elicited.

Again, I think the call for action here is clear enough that you want to move. As I say, I lean to option

two there. But that's, I think, part of what we're flagging here that the report would reflect. Again, you'd want the Secretary to then set those criteria.

It could lean that way. It could go that way under this recommendation.

DR. HAYES: We just tried to develop those two options and some of the issues that one would want to consider in pursuing them. But I thank you. That's good.

MS. HANSEN: This is more of probably an editorial comment, is I appreciate the component of the primary care providers and the fact that it would be left to the Secretary to define the selection. I notice, of course, the use of nurse practitioners which is the nomenclature here.

I just would appreciate more in the text, just some background. Because I think one of the evolutions that I've been noticing more in the field of nursing itself for people who are now geriatric nurse specialists or other categories that fall into a larger rubric called advance nurse practice nurses. And so if that could be embodied in there so that it's not NP only, per se, but it is still about primary care. So it's just a backdrop comment.

DR. WOLTER: This is really nice work, and I do

think it's fairly critical that we have a robust primary care workforce, physicians and nonphysicians. And so I'm very supportive of this.

I did want to get on the record, and Glenn and I have discussed it, I personally would prefer that we not do this recommendation as budget neutral to Part B. I know that's a minority opinion, but I believe that if investing in the right places both improves care and has a high likelihood of reducing cost, that should be thoughtful. We're stuck in a budget neutrality mindset that sometimes keeps us from making wise investments.

And so philosophically, I'm in that place.

Also, I'm afraid that the divisiveness created by doing this in a budget neutral way is going to have other effects that we should be thinking about. And one should also remember that there are some very significant specialty issues out there, including critical care, general surgery where we have significant shortages. Much has been made about the Michigan work on ventilator acquired pneumonias. But many, many communities cannot recruit the kinds of intensivists that will improve quality and reduce costs.

In the five-year review there certainly was an

important improvement in payment to cognitive services. Although I agree everything is relative, Bob, much of that was removed when the budget neutrality adjustment was made by CMS. And some specialties actually are now seeing 10-plus reductions after the combination of all of that in addition to an unresolved SGR which is creating a lot of divisiveness out there already. And so although 1.2 percent doesn't sound like a big number, it's just another thing.

So I worry about all those issues and how they will all play out, although I'm very, very supportive of the recommendation in a general sense.

I guess the other thing that's out there is there is so much -- I mean, we're going to have as many CAT scans in Las Vegas as we do casinos in terms of the response that's out there to deal with all this. So there's so many moving parts to all of this that it really worries me.

I also agree with Bill Scanlon, there's some analysis around all of this that ideally would be much better done. Having said that, we have a real problem in primary care. I'm certainly not going to vote against the recommendation but I'm really worried about the budget neutrality.

Also John, I wanted to comment, one of the problems with the way CMS handled the budget neutrality after the five-year review is they made their adjustment to the RVUs, not to the conversion factor. So for those of us in the field, we now have two RVU systems. And that's not a good thing. It's really a bad thing in a lot of different ways, which would require more time to discuss.

But thank you guys, really nice work.

DR. REISCHAUER: I think Nick has put on the table the first practical idea we've heard here in a long time, which is to limit the number of CAT scan and MRI machines to the number of casinos in the Metropolitan area.

DR. WOLTER: [Inaudible.]

[Laughter.]

DR. REISCHAUER: I was just going to say that practically I think there is very little probability that the Secretary, if given the flexibility in recommendation one, would ever choose option one, as opposed to option two for the reasons that Bruce and Karen and others have expressed. And Ron, too. The concern that specialists will have about the amount of primary care they provide and the complexity of identifying who falls into one of these

preferred categories. So if people feel strongly that option one is better, we should -- it's a little late in the game -- but we should come out and say that. I'm actually leaning towards option two anyway, so this doesn't really upset me.

I think it also should give Bill a little satisfaction because this suggests that the pool will be larger. And so the amount of the adjustment will be probably less radical. So while we might be making some assumptions, their impacts I think are going to be less.

DR. SCANLON: The budget neutral world isn't -- the pool is larger. The amount of the adjustments on the others is going to be greater.

DR. REISCHAUER: But we won't tolerate a huge reduction in everything else. I'm just talking about the politics of how this would work out.

DR. SCANLON: You mean we're going to adjust the parameter.

DR. MILLER: So the criteria would have to be set higher in order to make the budget neutrality adjustment lower or tolerable.

DR. SCANLON: I think we're trying to work here

with too few levers. We're basically trying to say that we're going to make is on the basis of E&M codes and you're now taking out this issue of specialty. But the question is what about good coordination by people who are below whatever threshold that we take? We're not doing anything to encourage that. And that's where we should be.

Glenn made us separate the medical home discussion from this discussion but that's what the medical home is about. The medical home is about trying to change the delivery system. This is about trying to change the workforce. They're different.

And we're assuming that if we change the workforce, we're going to get something. Yes, we'll get something. But we maybe can do better by actually directly focusing on changing the delivery system through something like a medical home.

MR. HACKBARTH: And to the medical home we must go in just a minute.

What I'd like to do is vote on recommendation one and then proceed to the discussion of medical home. Recommendation one is up there. All opposed to recommendation one? All in favor? Abstentions?

Okay. Now let's turn to the discussion of the medical home recommendation. Actually, it's just one in this iteration.

DR. DEAN: Obviously, I think that this is clearly an important direction that we need to go. And I think the ideal structure for medical home is still a little bit unclear in my mind. I guess one of the things that I'm concerned about, especially coming from an isolated area where we have a lot of very small practices, that meeting the criteria that are up there may, in fact, be very difficult and would eliminate a large portion of the practices in this country that are small, one, two, three provider facilities.

And yet, at the same time those facilities may well be able to deliver all of the important services. In other words, the coordination of care services are easier when you have a small facility and a small group of patients and a small community where you really can more easily keep track of what's going on.

And so I guess I'm a little troubled that in setting this up we would mandate a structure rather than an outcome. And I understand that determining if these

services actually get delivered is a difficult thing to do. But to me, that's where the focus needs to be. And if a practice can show that they are providing the coordination and providing the ongoing monitoring of these things and the health maintenance and the various other things that we know are important, do they really need to have all these other things in place?

Because I think if we mandate those, we're going to eliminate a lot of practices and really limit this to larger organizations.

Now as I understand it, the North Carolina model allowed small practices to use a community sort of central bank of services. And that's a neat idea. I don't know that much about it, but they've apparently been doing it for a while and have made it work. And maybe that's a way to do it.

I don't whether they would qualify under this particular structure or not.

The one that worries me the most on there is the accreditation piece because my experience with accreditation and certification is usually that they look at structure and staffing and a lot of easily measurable things that -- like

I say -- I think in our case we would probably not be able to provide even though I believe we're doing most of those services right now.

MR. HACKBARTH: A couple of reactions, Tom. I think you need some combination of structure and performance. So I don't see that as an either/or. I do think that there are some potential models whereby small practices can share infrastructure support. And I think that's an interesting angle on this to pursue.

I also think, and I think the text reflects this, Cristina mentioned it in her presentation, that what I would envision is some portion of the resources devoted to this pilot would be set aside to test somewhat different models in sparsely populated areas. That may include trying to develop a shared services sort of structure for small practices or still other models.

So it's maybe not a totally satisfying answer to you but I think we need some combination of structure and performance and some accommodation to unusual circumstances like sparse population.

DR. DEAN: And maybe some caution in the wording to whatever the certifying agency is that they need to be

sensitive to these kinds of issues in terms of setting up their criteria or their requirements.

MR. HACKBARTH: I think the certification process would come into full bloom after you had the results of the pilot. And if, in fact, you tested different models in rural areas and they were shown to be equally effective, that would be information for the accreditation agency to say oh, there are different models that can work in these areas and we have a different set of rules.

DR. DEAN: In setting up the pilot, it might well be that it would be appropriate to set up different tiers or paths or whatever you want to call them so that we really can test different approaches to this. Because we know where we want to get to but I think we're not entirely clear, we don't want to be too restrictive in the path that we mandate about how we get there.

MR. HACKBARTH: Yes, I agree with that. I don't think our distinctive competence as a body is in pilot design, research design. So what I propose that we do is recognize that there may be some areas with special circumstances and some portion of the money be set aside to explore how the model might work there.

The risk always is if you subdivide into too many cells, then your ability to get meaningful results is compromised. And so there's a trade-off to be made. I don't think we're the best body to try to structure exactly how that is done.

MS. BOCCUTI: Excuse me, you just said something, Glenn, about maybe after the pilot having the certifying organization -- so I just want to be clear in the recommendation before we have this in print, where you see that last bullet fitting into the pilot itself? Or is this something we want to be handling in the text?

MR. HACKBARTH: Personally, I have no problem with it being there. What I was referring to is okay, tomorrow you're the Secretary and setting up this pilot, a piece of which is going to be dedicated to rural areas and sparsely populated areas. We're going to try some different models. So what you might say is we're not going to have the same accreditation requirement for those. By design, they're testing different models.

MS. BOCCUTI: Oh, you were just referring to those ones when you said after the --

MR. HACKBARTH: Yes.

MS. BOCCUTI: Okay. I understand.

MR. HACKBARTH: And then if, in fact, it works as well or better in these different models, that would fit back into the accreditation.

DR. REISCHAUER: But in the pilot, there is no accreditation to get into the pilot. The Secretary is choosing the entities that are going to do that; right?

MS. BOCCUTI: That's my question.

DR. REISCHAUER: That's your question. That's what I thought. There is no entity now, there are no standards now.

MR. HACKBARTH: Actually, there are entities in the process of being created and set up for the specific purpose, as I understand it, of accrediting practices for private demonstrations of the idea.

DR. REISCHAUER: But presumably CMS would want to do this, give some thought to it, define exactly what it wants. And that would delay this, I think, necessarily. And also, in a sense, you usually accredit something after it's had the chance to show its stuff.

MR. HACKBARTH: So would your preference, Bob, be to remove the last bullet from the recommendation and

discuss the idea of accreditation in the text?

DR. REISCHAUER: I think what we're saying here is when this thing is going, this is what we expect. I wouldn't include the accreditation right up front. You want care management, you want 24 hour patient communication. These are the expectations in this pilot.

MR. HACKBARTH: So you would leave it in? I'm just trying to understand, would you leave it in or take it out of the recommendation? This is a recommendation about a pilot.

DR. REISCHAUER: I think for the pilot I would leave it out but say that when we go full bore, this is what you'd want.

MS. BOCCUTI: The intent always around this, whether it be an accrediting agency and/or CMS, is to verify essentially that these requirements are met. So there needs -- we need to have some discussion of that, whether it be in the chapter or the recommendation.

DR. MILLER: This is the way I've been thinking about it -- and I'm not sure this means in or out but it may mean just some clarification in on text. We expect, as a product of the pilot, a clear statement about these are the

criteria and the hope that there is a body that can actually litigate that when it goes live. And so but you would expect during the analysis that CMS is doing on just the medical home itself is also developing this criteria.

I realize now by putting it in the recommendation it's a little bit ambivalent about before you do the pilot or while you do the pilot. But one thing we could do is take it out of the actual words here and discuss this directly in the text, this is what we're contemplating here.

MR. HACKBARTH: I propose that we do that. I think that makes sense.

DR. DEAN: Just one other comment, and it has to do with the issue of patients seeing specialists or making their own referrals, which I understand is a sensitive issue and one that's created a lot of concerns.

But from a practitioner's point of view that's trying to do coordination of care, unless we have some way of knowing that those things are happening -- and I think it relates a little bit to some of Jay's comments -- we really are not going to be able to be successful in this service. We have to know that these things are happening.

Now we don't necessarily, from my point of view,

if my patients will come and tell me that they really feel they need a referral, we almost never refuse those. And that's all they need to do, if they just would at least inform us.

The thing that really drives me crazy is I find out that the fellow went to see a specialist, and that specialist referred him to another specialist, and pretty soon there's three or four other people involved and I don't only think about it. And yet I'm supposed to be coordinating the care.

And somehow we have to have a way to do that. And like I say, we're not trying to block those services. But we have to know about them somehow.

I think there certainly are some patients that really do not want this structure, that really wanted to run their own show. And so there's some people that will select this approach and there are certainly some that won't. And we probably need to respect that. So for whatever it's worth.

MR. HACKBARTH: I certainly agree on the importance of the practice serving as the medical home having access to the information. Cristina, in her

presentation, talked about how part of the designation is the beneficiary authorizes CMS to provide directly to the medical home information about their use of services. Now that's easy to say, harder to do given the operational issues involved. But that is certainly what we ought to be aspiring to.

So when the physician or nurse practitioner or whoever sits down with the patient, they can say though, oh, I see you referred yourself to Dr. so and so the cardiologist, what's that about? Let's talk about it. I agree wholeheartedly, it's important information.

DR. STUART: I agree with that as well in the notes that I gave to Glenn.

If you go to slide 21 you will see, I think, the critical issue here. The word that bothers me here is that Medicare could provide relevant information. I'd like to see that in the text and maybe in the recommendation too, but should. This is what Tom is saying, it's should. You can handle the privacy concerns, it seems to me, with respect to the sign up, there would be patient consent to make this available. And then the others are really technical.

Not this isn't to say that Medicare must. There's a process by which this information is going to get there. But I think we all agree that without this information you can't coordinate care. It's an absolute critical central factor that is going to make either medical homes work or not.

For some medical homes, my guess is that some are probably going to be big enough that they will work because everything will, in fact, be in-house or close to in-house. But others, particularly rural areas, this might be even a greater issue.

And so I'd like to see kind of a proactive -- more proactive language in there.

DR. DEAN: There is a timeliness issue, too. And if we only get the information after the fact frequently, especially the second and third consultant that has seen that patient usually does not know that I'm even involved. They also don't have the historical information that we have. So frequently a lot of things have already been duplicated and redone or things have been started that we've already shown don't work or whatever.

And so while getting the information from CMS is

certainly better then nothing, it's going to come after the fact when a lot of the opportunities that we are trying to take advantage of have already been lost.

MR. BERTKO: There are some mechanisms potentially in place for this. The first one is being used by Med Advantage plans now and is a notification announcement say on a card. And so it's not a requirement, so there's nothing to keep you from self-referring. But in fact, the notification requirement has been remarkably effective, to 80 or 90 percent level.

The second mechanism is CMS is in the process of beginning a PHR, personal health record, experiment in South Carolina where this information -- not on a perfect timely basis -- would be available and loaded into a PHR and presumably on the sign up in a medical home you would give permission to the medical home to actually access this. So on a regular basis, monthly perhaps or even more frequently, any visit or stuff could be seen by the medical home physician on a pretty good basis.

So you'd miss some taking duplicate tests out ahead of time, but at least that could be seen at the right moment there.

DR. CROSSON: Thank you, Glenn.

I strongly support the recommendation. I think it is exactly the right thing to do. I think it's worthwhile to make the point that there actually is -- despite the fact we've discussed them separately -- there is synergy between the two recommendation. Because if we're going to have a movement towards this thing we call medical home, we're going to have to have physicians who are capable of doing it.

And I think what we see, if we step back from I think some of the discussions that we've had, if we step back I think what we clearly see right now is that the payment system as it currently is -- and I'm talking about the entire payment system, because as was noted in earlier discussions the commercial payment system now very often spins off of the Medicare payment system.

The payment system that we have is giving a very clear message to the best and brightest coming out of our medical schools that primary care is not the place to be, that specialty care is the place to be for lifestyle and for economic reasons. And if we're going to have the baby boomers now soon hitting the Medicare program, we have to

reverse that.

It is, in fact, a slow process -- a battleship or ocean liner or whatever metaphor we want to use. But if we don't start soon, by the time this burden hits the Medicare program there simply won't be any people to do the Medicare home piece that we're talking about.

I think the medical home that we have described here is a significant evolution from the medical home idea I heard described about a year ago in the paper from the American College of Physicians. And I think it's a good evolution. I think a lot of people, a lot of organizations, have lent their mind to it. And I see it very much in synchrony with the discussions we've had over the last few years that have basically said we think -- MedPAC thinks that the structure of the delivery system in the United States needs to evolve. We're not exactly sure how. There are issues around whether it's a functional evolution or a structural evolution or both. But I think this medical home idea as it is evolving is moving in that direction. I think we have other pieces we're going to discuss today called accountable care organizations and bundled payments which are part of the same set of issues.

I do want to make a couple of points here about the criteria or the following capabilities as listed in the draft recommendations, because I think it's possible it could be strengthened a bit.

The one I see primarily as being absent is any reference to quality improvement. And I would suggest that we add one.

I don't think -- this is at the risk of Tom's concern that this becomes a straitjacket. But I do think that some statement about quality improvement would help. And I would propose language relatively simple like a formal process for quality improvement be one of the capabilities that CMS would look at in certifying a medical home.

The second idea that I discussed earlier, I think has been dealt with. And it has to do with the fact that care coordination or calling it care management here really does require not only coordination within the practice of an individual physician or a small practice but coordination of the care that's delivered by other physicians who are caring for the patient for the same process or other processes.

And I think that my sense -- I looked back at the text under care management and it talks a bit about

referrals. My sense is if we strengthen that care management section in the text and we make it clear that it's not just referrals we're talking about but care that the patient receives on their own from other physicians -- as was just discussed -- and the fact that there's a requirement here for CMS to be helpful in that way -- that we could probably include this function under the care management bullet point that we've already got in the recommendations.

But I do feel that we need to make some statement about quality improvement.

MS. BEHROOZI: It is actually on the same point that Tom raised, and so I'll be brief. I had raised it with you on the phone, Glenn. And I remain concerned that we were taking a tool away from practitioners that we're looking to to be able to do that kind of coordination that Jay just talked about.

And the language in the text says the medical home pilot does not restrict beneficiaries from seeing specialists of their choice at any time. That's pretty expansive. Maybe we could tighten that up a little bit. And that its patients would not be required to obtain an

authorization for specialty care.

Cristina, you foreshadowed what I was going to say about Joan talking about public education campaigns tomorrow, except I think I'm going to steal a little of her thunder and say a little of the opposite, that she points out that there are difficulties and challenges with overcoming cultural -- ingrained cultural norms. I'm from one of those areas of the country where care is a little less organized than it is in some other places. And people would be more inclined to take that permission to see anybody they wanted to see at any time to the max. So maybe if we could jigger the language a little bit.

This is wonderful work. I'm sorry I'm picking on one sentence. But maybe if we could jigger that language a little bit. And then maybe include something about surveying the participants in the pilot, the physicians themselves, to see what are the tools that they feel like right now under fee-for-service rules they are restricted from utilizing.

And frankly MA plans, whether they're formally allowed to do it or not, they can be HMOs and limit the group of physicians that beneficiaries can see. So we're

expecting a lot from them so maybe we should ask them what they need to be able to deliver that kind of coordination.

MR. HACKBARTH: The language in the text that says the Medicare beneficiary can self-refer at any time to anybody is basically describing the rules of fee-for-service Medicare. So this is conceived of as a payment reform added onto the structure of fee-for-service Medicare, basically retaining the Medicare beneficiaries' current rights but then trying to steer them to other mechanisms to better coordinated care.

Just changing those words a little is a fundamental change in design and concept.

MS. BOCCUTI: I think saying retaining the rights will be a more effective way of saying it. And in fact, just for the flow and for the room here, it follows the passage about the conversation that I said in the agreement about the principles, which would also talk about -- the principles of a medical home.

So it was meant in contrast to but be clear that this agreement on paper about the principles isn't changing the fee-for-service status. And I think that would be a better way to get the point across.

Thank you.

DR. BORMAN: Just a couple of thoughts. One is, somewhat related to comments at the prior discussion, maybe there's room here to think about the better versus good argument.

Second, I would definitely view this as a much more appropriate and potentially successful way to get to the delivery system that I think is what we're talking about getting to. So I have some support for this recommendation.

I would, however, like very much to see -- it's on your last slide, the very last thing about the clear and explicit thresholds. I personally think that needs to be somehow incorporated in the recommendation.

I think that's absolutely fundamental here, particularly when we're talking new money. And I think looking at fiscal prudence in terms of where you invest new dollars, this is absolutely key to make this be the right thing.

I vacillate and continue to have concerns about the real practical feasibility of CMS, the Secretary walking away from this pilot at some point. I think that will be very difficult to do. And so a pilot versus demo or

whatever.

I personally would like us to get to we're going to create a robust trial of this, and get on with it and do it and get an answer and accept the answer, whether it's the answer that we entered with a bias to get or not. Because I think that's what we owe Medicare beneficiaries is an honest statement of the problem, an honest attempt to evaluate the problem, and honest acceptance of the results, whatever they may be. And I think this particular bullet helps us to get there in a big measure and I absolutely would like this that folded into the recommendation.

DR. REISCHAUER: I think that that's a principle for all pilots that we should do that, simply because what we're doing is we're giving the Secretary and the President immense authority. And it's not as if political pressures on any pilot won't be very strong to either go forward or not to go forward. If the thresholds are explicit then, in a sense, he can say well the underlying law made me terminate this or go forward.

And so at some future point maybe just as a recommendation in pilots in general, we should make a statement.

MR. EBELER: I think this is a very exciting recommendation. I think in part because of what Jay said, you have to see it in context of the other one. But this is certainly the one that lends itself more to reform of delivery.

I think there's always a balancing act when you're trying to pursue a new initiative like this, that is trying to change the underlying structure of what happens and having enough criteria that you have some sense that you're going to get the change that you want to get without so overburdening it with long lists that people look at it and go, oh there they go again, I can't do that.

I think Tom's point about certain sparsely populated areas, you have to be very clear that the list is smaller, that I think that has some merit.

I think the combination of the criteria we've talked about -- plus we haven't talked about it as much, the pay for performance piece of your recommendation really does look to these places and say we're going to have explicit measures and you need to have quality improvement as well as efficiency to get that money. It seems to me that puts in place a mechanism that works well there. So I think that's

very helpful.

I think Karen's last point really is quite helpful, the idea that Bob picked up on, real clarity on this pilot approach. Because what we're trying to do here is structurally change how people think about Medicare innovation. You do want clarity in how that happens. So I think that's a real good suggestion, to move that bullet point.

DR. KANE: Thanks. I'm very supportive of the idea, in general.

I guess I felt that the list on the recommendation was very one-sided and I felt very much the same way Tom did, was that there's a lot of structural characteristics here. Even saying you've got to get a lab connection in your electronic medical record, I know it took us a year with our software vendor to get that to work.

It's nice to say these things should be there and we'd like to see them there. But I don't think it's just the physicians or the primary care doctors. It's not even in their core expertise sometimes to have some of these things happen.

So you need multiple parties for this to work, not

just the practice. And I think that needs to be recognized more in our recommendation. Right now I feel like we've got a list of what the practices have to achieve but nothing about the level of the payment needs to be set and about how information needs to get to the physician to be able to manage care.

I would say the patient, even though they can go anywhere they want, should be required to notify the practice regardless. You can't stop them but they should notify the practice as a requirement on the beneficiary side.

I think in terms of coming up with a capitation amount, that it should reflect the real costs of doing these tasks, not just some number we'd like to pick out of the air. I know we don't but others have been known to. So I would like to see a real analysis of what are the costs of running an effective medical home with an electronic medical record, patients notifying you, social worker, caseworker, all those parts. We need to know what those costs are before we set this capitation level, I think. It's got to be realistic.

My other concern is we keep talking about rural

practices as though that's the only place that there are small practices. There are small practices in urban places as well. There's shortages of primary care doctors everywhere. So I don't want to restrict the infrastructure support to just the rural practices. I think we need to be much more open-minded about where there's only a couple of primary care doctors working together, who might be quite good but they just happen to be in the city.

And then finally, and I am a broken record here, but I'm trying to imagine how a practice manages chronic lung disease, diabetes, congestive heart failure, depression, and they don't know a thing about the drugs. There's no feed here for Part D.

Again, this has got to be a group effort. Let's not put all the burden on the practice to achieve all these wonderful things without recognizing that it's really a team effort. I would like to see in the recommendation, not just Part A/Part B feeds but Part D feeds and preferably some kind of -- when the patient signs up, they notify their Part D that they have to feed and even advance notify the practice of what's going on. Because you just can't manage these patients without that information on a timely and a

current way, not retrospective way.

I don't want to set things up for failure. We've got all these things structurally we'd like to see. But really, it's a team effort. We've got to say that up front or they're not going to pass that criteria for going forward or not. And then we'll just be back in the dark ages with people saying oh, it didn't work.

So I would like to see more of the obligations we'd like to put on the other parties that play a role here.

MR. HACKBARTH: Because we've had several issues come up about the requirements that we're imposing, let's just spend a second focusing on the language of the recommendation. So bullet one is furnish primary care. This isn't a burdensome structural requirement. This is simply an explanation of what it's about.

Use health information technology. Yes, that's a significant requirement.

Conduct care management. Well, that's more descriptive about the basic purpose of this. And Tom says that small practices are doing this anyhow.

24-hour patient communication and rapid access, again that's really core as to what this is about. If

you're going to be their medical home, you've got to be available when they need you, not just when it fits your schedule. So that's a definitional. That's pretty central.

Keep up-to-date records of patient's advanced directives. Well, I don't know where that fits on the burden scale. I would think that's basic good medical practice, myself, but...

And then finally, accreditation, which has been proposed we take out of the recommendation and have some discussion of that in the text. I don't see, other than the HIT requirement, huge new structural barriers here.

DR. KANE: I think the health technology one -- I think the interpretation of what conduct care management is, when you get down to it, might become a structural barrier. A structural barrier is --

MR. HACKBARTH: But if we can't say they're required --

DR. KANE: Let me just finish, Glenn.

I think the structural barrier is the HIT and the accreditation.

But my other point is we didn't put anything in the recommendation about what we expect of other parties.

And I think that's the piece that's missing. I'm not so much trying to remove everything.

MR. HACKBARTH: And I agree with that. I think that's a good point. And one piece of that is the data feeds on A and B and a proposal has been made to strengthen that language. As opposed to nice to have, this is really pretty central to the well functioning concept.

And I agree with your point about Part D. And our chronic problem there is a whole different set of actors are providing the data and providing any claims information to anybody is a really hot topic in Part D.

But having said all of that, I'm certainly sympathetic with your stated goal.

DR. CROSSON: Just one point. I had suggested an additional bullet point that is a good formal process for quality improvement, which I think is also integral to this idea.

MR. HACKBARTH: Yes, and I agree with that. But I do think that for small practices that might sound burdensome, although I would note that I know the American Board of Internal Medicine -- as part of their maintenance and certification process -- has such a requirement. I

believe the surgeons do also, Karen?

DR. BORMAN: [Nodding Affirmatively].

MR. HACKBARTH: And so it may be that even that one is not all that burdensome these days.

What I was planning to do is when we get back to the actual voting on the recommendation was to go through three changes that are on the table: Jay's for adding QI; the one for deleting and moving to the text accreditation; and then Karen's for moving the language about the specific targets and objectives for the pilot. Those are three things that we may want to try to modify in the language, Cristina.

MS. BOCCUTI: So from that summary, I'm not hearing about adding about the data feeds into the recommendation? Or you are?

DR. MILLER: That's what I wanted to raise is I think we could actually say here to put a burden on the Medicare program to feed the data to the medical home, and then in the text discuss what we think we're talking there, A, B, and D.

MR. HACKBARTH: So that would give us four candidates.

DR. KANE: And then maybe strengthening the notification obligation on the beneficiary, even though it will -- at least make a principle that they should be expected to notify rather than just let the provider find out retrospectively. Develop systems for the patient to notify of use of outside the home.

MR. HACKBARTH: In the text, we talk about the beneficiary signing a designation agreement and renewing it. To me that would be an item for including there.

So what I would propose this, as opposed to going into a lot of detail about the content of the designation agreement, maybe we ought to have a bullet that says that there should be a designation agreement from the beneficiary and then discuss that in the text. Does that make sense?

MS. BOCCUTI: So that would be a fifth change to the requirement that talks about this agreement?

MR. HACKBARTH: Yes.

MS. BOCCUTI: I do think that that agreement is important to focus on because I think having the requirements on the beneficiary about notification, I think you set yourself up for some problems where the beneficiary is unable to notify the home. And I think we want to

encourage this but I don't want to get into some challenges there.

DR. KANE: I mean, I've been in an HMO since I was 21 and I've been required to notify. Now they have exemptions when you can't notify. And that's okay. But still, you know in the back of your head, even if you've already been admitted for a condition, within two weeks someone should tell my doctor that I'm here.

I think we've adapted to that in the managed care world and it's okay to have it as an expectation. People won't always be able to -- they're not going to get kicked out of the medical home. But I think making a strong message that that's important would be part of the deal.

MR. HACKBARTH: I'm really worried about time right now. Very quickly, Tom.

DR. DEAN: I think the statement or the requirement that the patient sort of sign this intent is really important. Because if the individual buys this model, then a lot of this other stuff happens automatically. And so I think just making some emphasis on that is important. And that may solve a lot of these problems.

MR. HACKBARTH: What I'd like to do is get back to

our queue. We are already at 12:00 so we're a good half hour plus behind. So I'd ask each of you to keep your comments very brief.

DR. WOLTER: Well, some of the subtleties of this just keep rolling around in my head and I'm a little bit where Jay is and Bill, too, in some of the comments he made in the last section about starting with the patient and what it is we're trying to accomplish and what kind of care coordination activities are we really trying to incent. I think the quality improvement is key. I think things like registries are key.

Also, although this is in a primary care chapter, in my organization we manage the primary and secondary prevention care of congestive heart failure through a cardiac clinic where patients can come from multiple places. And I would like to be sure that as this recommendation unfolds, group practices can participate as medical homes because they may have mechanisms to manage populations of patients that are unique to just assigning the medical home to one individual physician.

I think that's really critical because we are talking about primary care here, but also secondary

prevention.

Like Jennie, I think the importance of visits between the doctor visits and care provided by nurses and other practitioners is probably the major thing that goes on in care coordination. I would think we would want to emphasize that in this chapter. It isn't just 24 hour access. It's active management between visits.

You almost wonder if there might be different types of medical homes, depending on the definition of the patients that we're trying to enroll in medical homes. This is also a great opportunity to think about high-volume/high-cost disorders as this is put together.

And so I hope that some of those nuances will be available in this program as it goes forward.

DR. CASTELLANOS: For the brevity of time, I'd like to say one, I support this and most of the comments that have been made.

My point, and I'm going to sound like a broken record, is that again on the executive we have the last paragraph talking about education. We're talking about a change in the care delivery system. And that has to be implemented right from the get-go in the medical school, in

medical school education. Not just in residency training.

I would hope that we could have it as an editorial point in the text, Cristina, talking about how important it is to start this educational process, the electronic medical record, the structure of care, comparative analysis, evidence-based medicine. This is a cultural change.

And the only way we're going to change this is right from the get-go, starting in the medical school. So I would strongly recommend something in the text talking about the educational aspects of furthering this plan.

DR. MILSTEIN: I also strongly support this proposal. I have a concern in the opposite direction from many of the comments made so far. My concern is that the payments are not tied to sufficiently stringent criteria. As a general rule in life, low expectations are met. And I am particularly concerned in this program that we might risk handicapping the medical home's chances of demonstrating some real gains if we are too permissive in the list of criteria.

There are a number of possibilities with respect to proposed remedies and I've have been actively processing this with great input from staff in the last several hours.

But I think maybe one way of approaching it that I would maybe put forward for consideration is elaborating a little bit on that last feature, additionally the pilot should require a physician pay for performance program. There are ways of designing that pay for performance program that could begin to send a signal for those who would be medical homes that don't bother to apply unless you think you can really deliver. And I personally lean in favor of sending that signal.

For example, we could make this recommendation, this is a proposal, that the pay for performance program be bidirectional, meaning the providers participating in this program can gain or they can have their supplemental fee wiped out or offset if they are unable to meet a relatively high standard for either quality improvement or along the lives of what Bob has periodically brought up, baseline high levels of performance. We don't really care whether somebody sustains a high level of baseline performance or they substantially move scores northward as a result of these medical home services.

But I do worry about loosening it too much and thereby dooming the experiment.

In my work I have a chance to see a lot of proposals from companies that want to find the next way to participate in the health care money stream. Listening to this, I can already see the nature of the business plans that will begin to filter forward, saying here's the medical package. We can get you just over the minimum threshold and therefore enable you -- you mean the primary care practitioners -- to participate in this new money stream. I would like to do what we can to only draw into this pilot those practices that are relatively confident they can move at least the quality numbers northward.

MR. HACKBARTH: So Arnie, do you have specific language?

DR. MILLER: Maybe I can help you out. Arnie and I were talking a little bit. And I think your fundamental concern comes down to this, and just so each of the commissioners understand what some tension here is.

If you can PM/PM running, Arnie's notion is if you're a really bad performer you should take that back. This is a pilot and some of the concern is do you get people to step up to the plate if they even lose their basic PM/PM. Those are both legitimate points, so trying to thread the

needle here.

One thing you could say is add a sentence at the end of this that says medical homes failing to meet minimal quality requirements would be removed from the pilot. So you're not clawing back what PM/PM they got, but you're booting them if they're not doing it. And it's a pretty strong signal, don't get into this if you don't want to play.

And then to his point on the reward and penalty of the pay for performance, which we are contemplating here, which is not on the PM but on the general services that are provided, be clear that text this is a plus and minus game. You can get a reward but you can also get penalized there.

I think that's the half or three-quarters of a loaf of what you're looking for.

MS. DePARLE: Thanks. I had two points. One is I want to underscore something that Mitra said and, to some extent, I think Nancy said. I was somewhat chagrined that with the provision that we will continue to allow unrestricted right to see other specialists, or words to that other effect, just in terms of what we're trying to accomplish here. I understand why and we had a discussion

in response to Mitra's point about why that's in there.

But I would hope we could at least keep track of when they do, somehow. Maybe that goes to Nancy's point. So that we can see what kind of savings might have been incurred or whether they're seeing other specialists because they're not getting what they need out of the medical home. To me that's part of answering the question of whether this really advances the care that they're receiving.

And that goes to Karen's point which I thought she made very eloquently about our obligation here in doing a pilot versus a demo. I think having very explicit criteria for a threshold of whether this goes forward or not is really critical. And it was an insight I had while you were talking that if we had this more frequently, whether it's a demo or a pilot, it would really help the Agency a lot because there's just a lot of cycling through of demos that continue whether or not they've answered the question, continued to spend taxpayer dollars towards ideas that maybe seemed like a good idea but it didn't work. It's very hard for the Agency to ever quit doing them because they do provide something, usually, additional do some subset of either providers or beneficiaries.

So that's really a key point and I hope that we go even further to spell it out as much as we can.

MS. HANSEN: Just picking up on that last comment, I come from the school of the demo world, so I was in a demo for 18 years from start to -- no, it did end because it actually amounted into legislation, and so it worked.

So I think there's something to be learned about the difference between our culture shift of a programmatic pilot versus demo in terms of what's to be proved and some of the rigor. It almost sounds like it's more beta testing of a directionality that we're going in, what Microsoft does. It puts it out there and it keeps improving.

The other thing was I just wanted to affirm Arnie's point about what actually started out with Tom, saying that a lot of this is structural pieces. But what's the outcome? And I think it gets picked up, Arnie, in your point about the results of performance. I really like the idea of yanking out when people don't perform so that there are consequences. This is not just new found money in which to basically build some new business plans.

Again, I come from this demo world but a program world where it's like the 12 days of Christmas. It's not

just A and B. It's actually A, B, and D, and it's A, B, and D with dual eligible with the Title 19 monies as well, that ultimately having that paragraph in there that I think is being included just to put the context until you have it all, which then incorporates the specialists that you see, the medications that people have, other kinds of things that really make a difference in terms of outcomes is there.

So I know we can't force this issue but I think we need to keep sticking in that language.

A technical piece, just to Tom. Part of our demo has now been extended even further. We now have a rural demo for PACE. And so the small group kind of thing. There may be some opportunities to segue into that when you have an actual program and what happens when you have a more rural environment.

And the final one is just something on the table. I know this is not to be included but it's something that when we're talking about the medical home, I think as we have talked about it -- and this is a personal outlier comment that I'm going to make -- that in many ways it's really about a health care home, to really incorporate the result on the part of the beneficiary. And so it's not

always the medical services, per se, especially if you're talking about following up quickly after a hospital discharge of how people do.

But I know that battle is not going there. I just wanted to make this as a conceptual point, that if we're really focusing on the beneficiary, it's their health care home that is there, not just a medical home. But I know it's not going to change, but I just want to have it said for the record.

Thank you.

DR. SCANLON: I am, as I said earlier, very supportive of the medical home concept as a targeted intervention to try and change delivery. I have actually had a number of conversations outside of our meetings with people about medical homes. And they would very much mirror what we've heard today about this idea that gee, there's maybe a variety of different houses that might constitute a home, and raised real concerns about being too specific about what it is we're testing.

I think ultimately, and this is partly to respond to Arnie, it's not a question that we're going to get ambiguous results if we create sort of a multitrack trial

where we can identify what happens with each one of those tracks. And that, I think, is sort of a key to this is that we understand what the intervention has been. We get enough quantity in each type of intervention that we actually can test whether or not we've had success.

My second comment relates to the whole issue of a pilot and goes to Bob's suggestion that we make it a policy to put into recommendations about pilots that there be a threshold saying that if you don't succeed by this level that it's going to end. Bob mentioned political pressures. I think political pressures are too great to make sure that those thresholds are going to be observed when the results actually come in.

I have my own threshold which is when should MedPAC recommend pilots? To me it's when the intervention is rather precisely defined and has a pretty reasonable probability of success. On this one I think we're not satisfying that first condition, pretty precisely defined. The discussion today, for me, mirrors that greatly. It's saying that we really need flexibility in this idea. We need to find out what's going to work and what's going to work on a broad scale because we want this to work on a

broad scale. And then we want to potentially move forward.

To say to the Congress you should give us the authority now to do this, I think is asking potentially for too much, given that uncertainty, particularly with respect to what is the role of the beneficiary in success in this area. Because it may be that we actually put some obligations on the part of beneficiaries. But I think doing that, having the Congress give a blank check to CMS saying okay, you figure out what these obligations are going to be is not something that a lot of members of Congress are going to be comfortable with.

We've talked before about a reason for a pilot is so we can move faster. In this case, I'm not sure we can't move pretty fast anyway. There's a question of how much we could potentially accomplish through the definition of new codes, say a management code. We already have global codes for surgery. Why can't we have a global code for management of chronic conditions? Through a combination of co-definitions and coverage policy how much of this medical can we accomplish under current statute? That would be a question that I would put on the table.

The last thing I'd raise is unrelated to this, but

it's this whole issue of data. As I said in earlier meetings, I don't think we should be shy about asking people for data, and that includes providers of services that are being paid for by Medicare. So that if a Medicare beneficiary has a medical home and goes to another provider, I don't think it's unreasonable to say that other providers should ask do you have a medical home? Where is it? We'll send notification of the service.

Because the reality of having Medicare do this, we're going to rely upon this lag of a claim going to Medicare and then a claim coming out of Medicare and getting to the medical home. Just from a crude perspective, I don't think clinically information that's 30 to 45 to 60 days old is necessary that good.

So I think that we shouldn't be embarrassed about putting data requirements on different entities. And I don't think the privacy issue is really an issue here. I'm on the National Committee on Vital Health Statistics, which is responsible for advising the Department on HIPAA. And treatment and operations are exempted categories. And it seems to me that the kinds of information we're talking about transferring here falls under both of those

categories.

So therefore, there doesn't seem to be an issue that we should really be concerned about privacy anymore than there's a privacy issue with respect to medical records.

MR. HACKBARTH: I think we need to use a two-step process to get to closure. I've got on my list six specific suggestions for modification of the language.

What I'd like to do is go through those one by one and get a sense of whether there is broad support for those changes. If there is broad support for a given change or changes, what we'll do is go off-line and try to redraft the recommendation and then bring something back at the end of the day, as opposed to trying to do this all in one giant gulp. Does that make sense to people?

Cristina, you were nodding your head that you have six. Do you want to walk us through your six?

MS. BOCCUTI: Sure. The first one I have is to strike the last bullet. These aren't in order.

MR. HACKBARTH: Let's do them one by one. So the last bullet is to take the bullet about accreditation out of the boldface recommendation and simply have some discussion

of it in the text. That's the proposal I think Tom initially -- let me see a show of hands, people who would like to make that change in the recommendation. Okay, looks like we've got a substantial majority to do that.

Okay, the second one.

MS. BOCCUTI: The second, again not in order, but I have Karen's suggestion to put that bullet about having clear and explicit thresholds within the body of the recommendation.

MR. HACKBARTH: So this is the language about the pilot, that to go forward and implement it needs to have attained specific clear thresholds. Let me see a show of hands who would like to see such language in the boldface text. Okay.

MS. BOCCUTI: I also have to put in the recommendation -- and it will probably involve -- it's not just going to be a bullet -- but somehow allude to the agreement that the beneficiary and the medical home will have regarding the principles of a medical home, the rights and responsibilities of each party.

MR. HACKBARTH: And so what I would envision here is a few words that refers to such an agreement with the

discussion of the content of that agreement really left for the text itself.

I'm worried about the length and complexity of this recommendation. And I think the longer they get, the more difficult they become, because there's a temptation to just add a little bit more and a little bit more. And so what we're talking about is a reference to the beneficiary designation with a real discussion in the body of the text.

Let me see a show of hands who would like to include a reference to beneficiary designation in the boldface? Twelve. So we will include that in the redraft.

MS. BOCCUTI: A fourth is about the data feeds. So there will be something in the recommendation about Medicare should provide information about the participating patient's service use -- this is obviously Medicare covered service use -- to the medical home. And it would include then not just -- we could just say Medicare or CMS. But with the Part D, we would have to see whether it would have to go to Medicare first and then to the patients or --

DR. REISCHAUER: Medicare is responsible and you can incorporate within that Bill's suggestion that it can say to other providers you have to provide it.

MS. BOCCUTI: So it would be up to Medicare to determine.

DR. REISCHAUER: How to effectuate it.

DR. MILLER: I think the language is just Medicare shall provide this information -- and there was a timely element to it, too -- to the medical home. And then in the text we're saying A, B, and D. And then there is an in a perfect union it would also include a reference to -- for dual eligibles -- Medicaid, although we understand we won't be able to do that.

And we can make the point about calling on the other providers to indicate when services are provided. But you know, as well, in making that point, of course, we can't enforce if someone fails to do that, that happens. But we can make that reference there.

But the line in the recommendation would be fairly straightforward, Medicare providing data, medical home, timely manner. And in the text we'll flesh all of this out. Everybody square there?

MR. HACKBARTH: Next item. I'm sorry, a show of hands who supports such an inclusion? Okay.

MS. BOCCUTI: Then the quality improvement, the

formal quality improvement program that Jay brought up. That would be a bullet. It would be a part of this list in a bullet.

MR. HACKBARTH: Let me see a show of hands who would like to see that included?

Clearly, at the outset there should have been a limited number of votes that each person has, a limited number of yes votes. Let me see those hands again. We've got habitual hand raisers here.

[Laughter.]

MR. HACKBARTH: Okay, that's enough.

All right. And where are we?

MS. BOCCUTI: And then Arnie, the sixth one I have here is the addition at the last sentence related to the pay for performance program, mention that consistent low performers not be eligible to participate.

Mark has wording.

DR. MILLER: Medical homes not meeting minimal quality standards would be removed from the pilot, or some language like that. And then remembering that the text also includes the plus/minus on the pay for performance quality piece of this.

MR. EBELER: Does that language need to be in the recommendation or in the text? The fact that you're thrown out if you don't meet standards, you clearly want to say it. It's a valuable policy. I just don't know if it's in the recommendation or the text.

DR. STUART: It should be in the text. If you look at this, these are eligibility criteria for being in there.

MR. HACKBARTH: Right. So Arnie's proposal is that it be in the text. So let me see a show of hands on --

MS. BOCCUTI: He's saying text of recommendation or text of chapter?

MR. HACKBARTH: I'm sorry, what I said was ambiguous. Arnie's proposal about they're being dropped if they don't perform on quality was a proposal for the boldface recommendation.

So let me see a show of hands on that, who would like to have that in the boldface recommendation. I scared everybody off. Sorry, Arnie.

DR. MILLER: Don't misinterpret this. Jack is saying, and I think this is shared widely by everybody unless I misunderstand, these statements will be made about

people who do not meet minimum requirements are removed, and then the plus and minus nature of the pay for performance on quality would, at a minimum, been made in the text of the chapter. But it doesn't sound like the first thought is clearing the threshold to get into the recommendation.

MR. HACKBARTH: That's the way I interpret it. Thanks, Mark.

So that's the list, we did all six. We talked about six, only five were included.

And so we will work to redraft the recommendation, which we will bring back at the end of today for a final vote.

Thank you very much.

We have one last session before the public comment period and lunch and that's on employer group Medicare Advantage plans.

DR. REISCHAUER: Why don't we get underway, Scott.

DR. HARRISON: While most Medicare Advantage plans are available to any Medicare beneficiary, certain plans can limit their enrollment to a subset of Medicare beneficiaries.

Today I'm focusing on MA plans that are available

only to retirees whose Medicare coverage is supplemented by their former employer or union. For this presentation I will refer to these plans as employer group plans. Such plans are usually offered through insurers and are marketed to groups formed by employers or unions.

The plans that you are more familiar with, the ones marketed to individual beneficiaries, I will refer to as individual MA plans.

For this work we spoke with insurers and employers and we analyzed plan bid and enrollment data.

The Medicare Advantage employer group market can be an attractive market for insurers and health plans because large blocks of Medicare beneficiaries can be enrolled without the need to conduct retail marketing to individual beneficiaries on a one by one basis. Generally the marketing costs are much lower for group plans than individual plans.

The MA market can be attractive to employer groups, as well. If MA plans can collect payments for Medicare that are higher than their cost of providing the basic Medicare benefit, they can pass on or share these savings with employer groups. Thus, insurers may be able to

offer MA plans to employer groups for less than they could offer traditional retiree coverage that wraps around fee-for-service Medicare.

Besides the advantage of lower marketing costs, employer group MA plans are designed in other ways that make it easier for insurers to offer products that are desirable to groups. As long as the benefits are at least as good as in fee-for-service Medicare, the benefit package is completely customizable. One particular advantage of the customization is that when retirees become eligible for Medicare, they can continue to be covered by the same health plan with the same benefit package that they had as active workers.

CMS also allows employer group plans to have expanded service areas with looser provider network requirements in HMOs and PPOs than for individual MA plans. This allows retirees to move somewhat outside the employer's local area and continue their coverage. Currently, about 17 percent of all enrollees in MA plans are employer group enrollees.

Our concerns with employer group plans stem with our concerns that we are paying too much to MA plans in

general. Employer groups are recognizing that the high Medicare payments allow insurers to offer them a better deal than they can now get from traditional retiree wraparound coverage. As a result, there has been rapid growth in employer group MA employment, and most of that group has been in private fee-for-service plans.

We have examined plan bidding behavior and found that employer group plans tend to bid higher than plans for individuals relative to Medicare fee-for-service spending, indicating they are less efficient for the Medicare program. One reason for the less efficient bidding may be the incentives in the bidding process. We are concerned that the bidding incentives create an opportunity for insurers to cost shift from employers onto the Medicare program.

Now let's get into a little more detail on these.

Private fee-for-service plans are especially attractive for employer groups. After employees retire, they often move out of the employer's area and the employer's plan for active workers may not have network providers outside the area. Therefore, local HMOs and PPOs may not be practical for many employers to offer.

Private fee-for-service plans, however, have no

network requirements, so all retirees throughout the country could conceivably enroll in an employer group private fee-for-service plan. In the last couple of years, employer group private fee-for-service plans have become more widely available and enrollment has grown rapidly.

In the last two years, enrollment in employer group plans has grown about 70 percent while overall MA enrollment grew by about 20 percent. As of February, there were about 1.5 million enrollees in employer group plans compared with about 7.5 million enrollees in individual MA plans.

As in the individual MA market, the growth has been concentrated in private fee-for-service plans. Over 80 percent of the growth in employer group enrollment over the last two years, and virtually all of the growth over the last year has come from private fee-for-service enrollment. There are now more than half a million enrollees in employer group private fee-for-service plans. Private fee-for-service plans now have about one-third of the enrollment in the MA group market.

At the same time, employer groups have become an important part of the private fee-for-service market.

Employer group enrollment is now about a quarter of all private fee-for-service enrollment.

Our analysis of MA bid data shows that employer group plans on average have bits that are far higher relative to fee-for-service spending than individual plans. This means that group plans appear to be less efficient than individual market MA plans. Employer group plans bid an average of 109 percent of fee-for-service compared with an average bid of 99 percent for individual plans. This finding held when looking within plan type. For HMOs, employer group plans bid an average of 108 percent of fee-for-service Medicare spending while individual plans bid an average of 97 percent. Employer group private fee-for-service plans bid an average of 112 percent and individual plans in private fee-for-service bid 108 percent.

While induced demand for more generous coverage in group plans may explain some of the higher bidding, we think there are other reasons why this is occurring, and I will go into that shortly. But I can take questions on induced demand at the end if there is interest.

As for Medicare payment, we estimate that Medicare pays employer group plans 116 percent of average fee-for-

service Medicare spending compared with an average of 113 percent for the individual market plans.

While the high benchmarks are, in general, responsible for high Medicare payments we believe that the bidding process may allow group plans to be paid even more than individual market plans. Let's look at the bidding process a little.

For MA plans marketed to individuals, the plan bid lays out the benefits that are offered and the plan's cost to provide these benefits. The bid, along with the benchmark, also determines the payments that the plan will receive from the Medicare program and any premium that would be collected from beneficiaries.

The bids submitted by employer group plans, however, only determine the payments that the plans receive from Medicare. The bids usually do not reflect the benefits that employer group members actually receive, or the plan costs to the members or to the employers.

The insurer typically submits a single bid for all its employer group plans, even though there may be hundreds of groups covered by the single bid. After the bidding process, the insurer will negotiate with each employer group

over the actual benefits that will be offered through each group. Each group could end up with different benefits and premiums.

Because plans negotiate with groups outside the bidding process, there is not the same competitive pressure on the bids as there is on the individual plan bids. In the individual market, a plan's ability to attract enrollment is highly dependent on its ability to bid below the benchmark and earn rebate dollars with which it can offer extra benefits. In the group market the extra benefits are negotiated with each group so the plan's bid relative to the benchmark is less important in determining the extra benefits it can offer.

And in fact, the data suggests that group plans bid fairly high relative to the benchmarks. The median bid for group plans is 95 percent of the benchmark, compared with 85 percent for the individual plans. On the extreme, 14 percent of group plan enrollees are in plans that bid at or over the benchmark, compared with only 1 percent of enrollees in individual plans.

CMS does review the employer group plan bid that is submitted and presumably the fact that there is a review

may help keep most bids below the benchmark. However, CMS does not collect data for each group and does not even know the exact benefits that are provided to each group. Thus, it is unlikely that the data submitted is solid enough to support a rigorous actuarial analysis and CMS's ability to promote lower bids may be limited.

Just a couple of final thoughts, just quick. I've just mentioned that we are not sure what downward pressure there would be on group plan bids other than CMS's review of those bids, so that review is very important.

I would like to conclude by saying the Commission has long held that benchmarks for MA plans have been set too high. MA plans are able to use the high Medicare program payments to finance the cost of extra benefits for both individual members and for employer groups. These extra benefits have attracted additional enrollment. Employer groups are benefitting in the same way as individual plan members.

One difference, however, is that high Medicare payments translate to extra benefits for individual beneficiaries in the individual market but translate into benefits that would otherwise be paid for by an employer or

union in the group market.

In other words, Medicare funding may be crowding out employer or union spending.

MR. HACKBARTH: What I hear you saying, Scott, is that in the bidding process for an employer group plan -- I'm going to put this little bit more starkly than you did -- really the incentive is to bid as high as you can and get by the CMS review. In contrast to the dynamic in the individual market, where lower bids help you get more rebate dollars and added benefits to attract enrollees?

DR. HARRISON: Yes.

MR. BERTKO: First of all, I will agree with much of what Scott has said, but disagree with some of his adjectives or other words.

To put this in the right perspective, I had a lot of experience with retiree medical groups back in the early '90s as FAS 106 came into play and took it upon myself to make sure that this one certain company didn't lose money on its group Medicare bids, as opposed to its sales staff who wished to lose money and have huge enrollment.

The first part, Glenn, I will challenge the statement that you just made. I think it was an inference.

There is a considerable difference between the populations that enroll in individual type of plans versus those in employer group plans. The amount of induced demand is considerable.

To the extent that in -- I won't say rare, but some cases, the implicit subsidy in fee-for-service Medicare is gigantic. The extreme example that I actually did is when we underwrote these kinds of groups, we would call for their fee-for-service A/B experience. And the implicit subsidy, in one example of a smokestack industry company, was 200 percent of the rate book. So they were paying carve out, so a supplemental premium as such, which was still considerable. But they were basically getting $20,000 worth of benefit in an area that would have a $10,000 rate book per person per year. So the amounts on these could be substantially different.

MR. HACKBARTH: For the sake of argument, let's just stipulate that that's true. What I was trying to get at, John, is the dynamics of the bidding process. You are providing another explanation for why bids might be high and let's just say okay and set that aside.

MR. BERTKO: Yes.

MR. HACKBARTH: I'm trying to understand why, all other things being equal, a plan bidding for employer business would bid low?

MR. BERTKO: The plans wouldn't bid low or high. They would bid to be marginally profitable on the part that is the Medicare payment. That would, though, lead you to have a different bid than you have for individual plans, and a higher bid.

MR. HACKBARTH: But ordinarily in the marketplace, we don't just rely on the inclination of firms to bid relative to their costs. You want competitive pressure to drive the bids down.

What I'm searching for is where that pressure is in the employer group market. Why bid low?

MR. BERTKO: So there's a twofold pressure. The first pressure is to keep the supplemental premium as low as possible. And you're correct there in assuming that that pressure then says get as much revenue from CMS as possible, and so you bid up towards the benchmark.

If you bid above the benchmark, as Scott has said happens in some cases, you actually then have to require the employer to pay that, which would be on top of the otherwise

supplemental benefits for additional premiums. So you do have a natural ceiling there at the benchmark itself.

The second part, though, is you still get rebates back if you bid below. You're balancing out where you get that. I'm saying that the governing mechanism is to have a margin on it that overall is positive. So there's a different kind of competition. You're competing basically against similar companies, company H versus company C versus company U, to have a supplemental premium that is lower than your competitors while inside a certain group.

MR. HACKBARTH: I'm really not trying to be dense, John. But it seems to me that the way that the plan has the best opportunity to lower the employer's supplemental premium is to maximize the revenue that it receives from Medicare. And it does that by having the bid as high as possible that can pass CMS muster.

MR. BERTKO: True, but then the flip side is also on the margin to be bid below so that you get bid back some rebate dollars to reduce your supplemental premium for supplemental benefits.

You're correct in saying you'll move up closer to the benchmark. And I'm saying, among other things, the

induced demand forces that in a natural way.

DR. MILLER: I just want to again try to take a pass at parsing some of this. The statement about the induced demand might drive higher premiums in the employer market. Just one thing I want to parse for everybody here is whether we're talking about an inherently more expensive population or whether we're talking about a more generous package which drives the utilization. To the extent that you'd buy down cost sharing, you're going to have a more expensive benefit.

MR. BERTKO: Correct.

DR. MILLER: And this is very much the conversation we were having last meeting on what assumptions we were making from -- so I just want to be clear that it's not necessarily that inherently they're less healthy and more expensive. They're more generous benefit packages so the induced demand is from the benefit package.

I always like to make that clear because in a lot of circles I travel in people say well, you know they're just more expensive. Well, they're more expensive because the benefit is more generous. So just one clarification.

But to move that aside, I think the question in

our mind on this bidding process, to the process, what Glenn is driving at is we don't see, other than CMS's review, any reason that you would go low. Because the more money you have, the more you can buy down a supplemental premium in this instance. That's the question that we have.

Scott, am I stating this --

DR. HARRISON: I think John may be just assuming that CMS's review is good and they're going to hold you to the proper supplemental.

MR. BERTKO: The CMS review, in my own personal experience, is thorough.

DR. MILLER: The concern here is the reference point, you don't have a benefit package that you're looking at when you're doing this review. And until recently -- and Scott, I want to be really careful here -- in terms of setting your bid relative to say your commercial market and how much more it could be than that, that requirement has only recently been introduced.

DR. HARRISON: Right. And the other thing is that now you could look at the bids for the individual market versus the group. But now private fee-for-service plans don't even have to offer individual. And so the CMS

reviewers have to try to find some commercial data to compare it with.

DR. MILLER: Maybe that's the distinction, that you've been operating in a world other than private --

MS. DePARLE: Can I just, on this point -- and this is to your point, John. Is the review totally different here? Because I agree with John. In my experience, it's very thorough and very much granular on what the benefits are and if you're offering them. So for these particular plans, do they not have to show their benefit package?

MR. BERTKO: Yes.

DR. HARRISON: They do not show their actual benefit package.

MS. DePARLE: Then that's a problem.

DR. HARRISON: The bid is a placeholder bid.

MR. BERTKO: Yes.

MS. DePARLE: That was going to be my argument to Glenn, is that at least on the ones I've been familiar with, the review is very thorough.

DR. MILLER: And now I think I understand better where John is coming from. I mean, the explosion of growth

in the last year or year-and-a-half is private fee-for-service, where you don't have that individual market reference point, which would also be a way to check in the review process on whether this premium is reasonable.

MR. BERTKO: And my company might be an exception because we were virtually everywhere. So there was an individual market.

But the point I want to make yet again is the comparison of the bid in the individual market and a bid in the group market, they are two different entities. They're both fruit, but we are talking apples and oranges here because of the induced demand from the much, much richer benefit packages.

DR. STUART: This is just an observation and we've raised it before. Regardless of what the incentives are for the plans and what this does to private fee-for-service enrollment, it also eliminates all those data from the main Medicare program. So to the extent that MedPAC and others are deriving policy from evaluation of Part A and Part B data, that's gone. So I'm worried twofold.

I'll take John's point that these people are really different than the typical enrollees in the

individual MA plans. Which tells me that if I take those people out of A and B, then I have even less confidence in what I am actually generalizing my conclusions, my analytic conclusions about.

I will just end by saying this is a case where there would be virtually no added cost to the plans to make those data available to CMS and to MedPAC because they are truly claims data.

MR. EBELER: The bidding dynamics are obviously complicated here. But in some way if you start with the reference point that MedPAC has analyzed and said we're generally overpaying by 13, 14, 15 percentage points, you generally have to then be worried about how the market plays out. In this case, you've got an extremely informed purchaser, the employer, looking to do as well as it can on its supplemental benefits. As I understand the dynamic, from that point on if you're selling to that plan then obviously the more it can get from the automatic payer, CMS, the more competitive it can be in selling the supplemental benefits. That's basically the analysis you laid out.

In particular, the surprising thing to me was the blanket A/B bid without supplemental benefits as the

reference point, which does take you out of the comparison with your competition in the individual market. It strikes me that there is a logical problem here and the proof of it is the growth. The growth here is an indication that something is happening, it strikes me.

MR. BERTKO: Can I only insert here that I agreed with Scott's comment completely. The growth comes because the payment rates set, particularly in private fee-for-service, are well above the benchmarks. And companies selling these and employers buying these clearly recognize it is that.

The bidding mechanism is just different enough that I don't think you're ever going to get to what you want to do, which would be transparent bids which you can compare to individual plans.

MS. DePARLE: I tried it to see if this was in the text and I don't see it. But I wonder if there's also another benefit to the employer separate from the one you've talked about with respect to the retiree population, which is that to the extent they had their retirees in a broader pool before this, would removal of them lower their rates in their active employer health market in some way? I should

be looking at our actuary here.

MR. BERTKO: The answer is if the company is well run, no. But you're correct --

MS. DePARLE: And if it isn't?

MR. BERTKO: You're correct in saying there are cross subsidies between retiree and active populations for some employers that are not explicitly recognized -- and I'll try to say this carefully -- to minimize FAS 106 accounting sometimes those are done purposefully.

MR. DURENBERGER: Scott, talk to me just a little bit about cost sharing. I didn't fully understand the paragraph in the material relative to the cost sharing in the bid versus the cost sharing in the final product, and a little bit of an understanding in the context of what is the value to us of cost sharing and the value to the employer of cost sharing.

DR. HARRISON: What the employer typically does is they're going to submit a bid for a very lean package. And sometimes the package is basic Medicare with the full implied level of Medicare cost sharing. So they're filing a bid for nothing other than regular Medicare.

Now when they go to the employers, they are

probably going to buy down some of that cost-sharing. But we don't know that by looking at the bid.

MR. DURENBERGER: Thank you.

DR. CROSSON: Just that, as I think some of the other Commissioners have noted to me, this is all news. This is an aspect that I wasn't aware of, nor were some of the folks in my organization. I would just like to urge that we continue this. We are not looking at it as an opportunity.

[Laughter.]

DR. CROSSON: Rather, I would like to suggest that we pursue this issue as a matter of good public policy.

Thank you.

[Laughter.]

MR. HACKBARTH: On that note, thank you, Scott.

We will now have a brief public comment period before lunch. Please introduce yourself and your organization and keep your comment to no more than two minutes.

DR. MARTINELLI: Thank you. My name is Larry Martinelli. I'm an infectious disease physician in private practice in Lubbock, Texas. I'm here to represent the

Infectious Disease Society of America.

I'd like to address the bundled payment that you're going to be talking about this afternoon.

MR. HACKBARTH: Can I ask you to address that after we've discussed it?

DR. MARTINELLI: Thank you.

MR. HACKBARTH: We will have a public comment period at the end of the afternoon session. Thanks.

Any others?

MS. STINCHCOMB: I'm Stephanie Stinchcomb. I represent the American Urological Association.

In reference to the use of primary care, I do support the comments that have come before, that there are other specialties that do provide primary care, and urologists are one of them. Men who have prostate cancer will come in. And that urologist will basically take care of them in primary care issues also.

So I just wanted to make that comment in support.

MR. HACKBARTH: Okay, we will adjourn for lunch and reconvene at five minutes to 2:00.

[Whereupon, at 12:56 p.m., the meeting was recessed, to reconvene at 1:55 p.m., this same day.]

AFTERNOON SESSION [1:53 p.m.]

MR. HACKBARTH: First up this afternoon is public reporting of physician financial relationships with manufacturers, hospitals, ASCs and others.

MR. WINTER: Thank you. Good afternoon.

In March we discussed physicians' financial relationships with drug and device manufacturers, hospitals, and ASCs, and there seemed to be significant interest in possibly requiring that these entities publicly report information about their ties to physicians.

Today I will review the chapter on this issue for the June report, highlight new material we have added in response to your comments, and lay out key design issues for a public reporting system.

Based on your discussion in March, we expect to return to this issue in the fall.

Before I start, I want to first thank Hannah Neprash and Jeff Stensland for their important contributions to this work.

As we discussed last time, there are extensive financial relationships between physicians and drug and device manufacturers. A survey of physicians

conducted in 2003 and 2004 found that most physicians have some type of interaction with drug manufacturers. We've added material to the chapter describing how these relationships begin during medical school and residency.

The Association of American Medical Colleges has observed that medical schools have become increasingly dependent on industry support of medical education in the form of free meals for students and residents at conferences, sponsorship of seminars, and unrestricted grants to faculty and departments. The AAMC has convened a task force to develop principles for medical schools to manage industry support of educational activities.

In addition, there is evidence of strong financial relationships between device manufacturers and physicians.

According to an article in the New England Journal of Medicine, pharmaceutical industry spending on promotion and the retail value of free samples provided by companies totaled $30 billion in 2005. To put this amount in perspective, $30 billion is 18 percent of total sales. In 1996, promotion and the value of free samples equaled 14 percent of total sales.

Spending on detailing, which refers to visits by

sales representatives to physicians, was almost $7 billion in 2005. This amount does not include spending on meals, gifts, and educational events.

Direct to consumer advertising was over $4 billion and this category has grown much more rapidly than detailing over the last decade. We've added a text box to the chapter describing DTC advertising.

As you can see, the retail value of free samples is far greater than spending on detailing and advertising combined.

Another dimension of physician-industry relationships involves industry support for continuing medical education activities. According to data collected by the CME accreditation organization, commercial support for CME activities quadrupled from 1998 to 2006, from $300 million to $1.2 billion, and now accounts for half of total CME revenue.

This money is paid to groups that run CME events such as physician organizations and medical education companies rather than being paid directly to physicians. However, physicians benefit through free or subsidized CME activities.

According to guidelines issued by the CME accreditation group, industry associations, and the Office of Inspector General, CME events must be independent of industry influence. However, a Senate Finance Committee investigation last year found that some CME events were properly influenced by commercial sponsors. In one case, for example, an industry sponsor was involved in selecting the faculty at an event.

Moreover, significant industry support for CME may lead to an overemphasis on activities that focus on medications and medical devices rather than other ways to improve care.

As we discussed in March, relationships between physicians and manufacturers have both benefits and risks. Physicians play an important role in developing new drugs and devices by running clinical trials and providing expert advice. In addition, marketing efforts directed at physicians may lead to greater use of beneficial treatments. But physician-industry ties may also undermine physicians' independence and objectivity. According to studies in this area, industry interactions are associated with rapid prescribing of newer, more expensive drugs, lower use of

generics, and requests to add drugs to hospital formularies.

The private sector and government have made efforts in recent years to curb inappropriate relationships between the industry and physicians. In response to legal and public scrutiny, industry and physician groups have developed voluntary guidelines for relationships with physicians. The OIG has also issued guidance to help manufacturers comply with the anti-kickback law.

There is some evidence that companies have changed their promotional practices but there's no mechanism to measure and enforce compliance with these guidelines. There is also evidence that some inappropriate practices may still occur. For example, a recent physician survey found that some physicians are still receiving tickets to cultural and sporting events from drug manufacturers, which is a violation of industry and physician guidelines.

Four states and D.C. require drug manufacturers to report payments they make to physicians, and several other states have introduced similar bills in the last year. However, the existing laws have significant weaknesses. They do not cover device manufacturers. The data are often incomplete and not easily accessible. And payment

categories are vaguely defined, which makes it difficult to analyze the data.

One option we discussed in March is to have the Federal government collect national data on physician-industry relationships. Here we describe the potential benefits of public reporting. It could encourage physicians to reflect on the propriety of their relationships with the industry, perhaps discouraging inappropriate arrangements. The media and researchers could use data to shed light on these relationships and potential conflicts of interest. For example, physicians who receive significant payments from manufacturers who serve on formulary committees or develop clinical guidelines.

Payers and plans could use the data to examine whether physicians' practice patterns are influenced by their financial arrangements with the industry. Finally, hospitals could check on whether physicians who request the purchase of specific drugs and devices have financial ties to manufacturers.

Public reporting also has potential limitations and costs. First, it's unclear if the data would be useful to patients. Second, greater transparency will not

eliminate conflicts of interest. A third issue is that manufacturers will incur costs to comply with a reporting law. But it might be easier for companies to comply with a national uniform law rather than state laws with varying rules. And finally, there will be administrative costs for the government to collect data and enforce a law.

Two states with reporting laws indicate that they incur minimal cost to collect information and to post it on their website. However, these states do not allow users to search for data electronically. We don't have estimates of the cost of monitoring and enforcing compliance with the reporting law.

There are three key design questions for a potential public reporting law which we will flesh out in the following slides. How comprehensive should the reporting system be? What size and types of payment should be reported? And how can data be made readily accessible to the public?

We'll start with the question of how comprehensive the system should be. For the sake of argument, we will assume that it would include both drug and device companies and apply to small as well as large manufacturers. So the

first question we ask here is whether a reporting system should include payments to recipients other than physicians. Several types of organizations receive significant funding from the industry and it may be worth collecting this information. For example, medical schools and teaching hospitals receive support for education and research. CME organizations received funding as I mentioned earlier. And professional societies, which receive funding for training and educational activities.

I want to emphasize that it would be the manufacturers, rather than physicians or other recipients, who would be reporting the information.

Next, should companies be allowed to withhold information that they deem to be proprietary? On the one hand, companies may wish to shield details of their marketing and educational efforts from competitors. On the other hand, the public may have a legitimate interest in learning about the industry's financial relationships. The Vermont law permits companies to designate information is trade secrets that is not publicly released, but this policy has resulted in 72 percent of payments being withheld from disclosure in 2006.

Under the next design question, the first issue is where to set the dollar threshold for payments that should be reported. State laws have thresholds ranging from $25 to $100 per payment.

Second, with types of payments or transfers of value should be reported? There is a long list of potential items, ranging from small gifts such as tickets to sporting events to large consulting agreements and royalties.

The third design question is how to make the data easily accessible to the public. This is a significant issue, given the difficulties of accessing information collected under state laws. It would be important to create an online database that is easy to search and download. It would also be important to allow users to search for payments by type, amount, physician or entity, and manufacturer.

Some other issues to consider include which agency should administer a reporting law? And should a Federal reporting law preempt state laws? An argument in favor of preemption is that it would reduce compliance costs for manufacturers because they would only have to comply with one Federal law rather than state multiple laws. An

argument against it is based on respect for state autonomy.

A potential compromise can be allowing state laws that are stronger but not weaker than a Federal law. In other words, a Federal law could be a minimum floor. For example, if a Federal law excluded reporting of free samples, state laws could require such reporting.

Now we will turn our attention to reporting of physician relationships with hospitals and ASCs. In March, we talked about the growth of physician-owned specialty hospitals, as well as ASCs, and an increase in joint ventures and other financial arrangements between hospitals and physicians.

We also noted that information on financial relationships between physicians and ASCs and hospitals is generally not available to payers, the media, and researchers.

If there were public reporting of physician ownership and other relationships, payers, reporters, and researchers could use this information to study the influence of financial incentives on physicians' referral patterns and overall volume.

In addition, public reporting may encourage

hospitals to examine whether their relationships with physicians are appropriate and serve legitimate purpose.

An option we discuss in the chapter is for hospitals and ASCs to report to CMS information on physician ownership and certain other relationships, such as joint ventures and equipment and space leases. CMS could make this data publicly available on its website.

To reduce the compliance burden, CMS could limit the amount of data that hospitals and ASCs would report. For example, they could avoid requiring that hospitals submit copies of contracts with physicians, which is something that CMS is planning to collect through a survey of a sample of hospitals. CMS could also limit the types of relationships that would be public reporting.

To conclude, we want to make sure that we've incorporated your comments into the chapter and to ask whether you have additional comments. We'd like to get your feedback on the key design questions for reporting of physician-industry relationships. I would also like to ask for your guidance on next steps to pursue.

Thank you.

MR. DURENBERGER: Thank you very much. Ariel,

thank you very much for not only last time but the advance from the comments of last time. And I imagine this is sort of like the beginning of an ongoing process.

I want to make just a couple of observations, one of them is from experience and the other is from some current involvement.

First, I asked myself the question why MedPAC? Why are we doing it? I think the answer to that, at least for me, is not that this leads us to some specific recommendation necessarily, but the very fact that an organization with this reputation and this impact on public policy sees this as an issue affecting what the Medicare beneficiaries receive and what the Medicare payment system is rewarding, is really critically important.

So I think that's -- and that, in and of itself, encourages change. And most of this is going to have to occur voluntarily, not because somebody passes some legislation.

Why? Because basically ethics in the doctor-patient relationship is like ethics in congressmen and constituents. It turns out basically to be appearance ethics. It's not do I know that you've committed a sin?

It's did your activities, particularly as they relate to money, give the appearance that your judgment can be affected by the gifts of special interests? And that's because we, as a patient, have no way of determining what it is that needs to be prescribed in our particular situation, any more than my constituents had any way of knowing exactly how they would vote on a given subject. So I think the whole business about appearance rather than being able to prove it is very important.

And every one of us asking any doctor who takes money from drug, device, whatever it is for any purpose, the doctor always say it never affects my judgment. The fact of the matter is even if that were true -- which I don't think it is -- but even if it were true, it's still the appearance that is the problem.

So I think the next point is, and maybe I already made it, which is I just don't think this can be legislated. I really think it has to be the power of influence on the basic oath that every professional, particularly health professionals, take.

It's the responsibility of medical organizations, health care organizations, and professional associations to

take the leadership on this issue. And the question is who, how, under what circumstances? There's not a professional medical association in this country that should not be moving on this issue and going as far as they possibly can, other than the clear purchase of a service which can be quite transparent. I mean, I buy from you your expertise in urology, and that's very, very clearly specific. There's so many other illustrations that have been out there that don't directly relate the financing.

I know that Pharma and AdvaMed have clear codes of ethics and things like that. But we all know from the evidence that keeps getting reported to us that it's one thing to have a code, and it's quite another to see people implement it.

By the same token, professional associations should be doing the same sort of thing. And so should medical organizations.

The pioneer in this is Kaiser or Permanente or both, or whatever it is. The uniqueness of what they did there, of course, is they're such a dominant factor, I think, in the marketplace, under the leadership of Sharon Levine. But they're such a unique market out there that

they could probably make some of these decisions, we won't do this, we won't do this, you can't do this, you can't do that.

In every other medical market you can't just have one of a competitor say no more sales on the campus and no more walking into the OR and all the rest of that sort of thing, because the specialty associations -- whether it's orthopedics or cardio or whatever it is -- is so strong that they will threaten the hospital organization with taking their business elsewhere, if in fact the organization tries to put some curbs on it.

So it leads me to another conclusion just in terms of thinking about this, which is that in many communities getting to as close to zero as possible needs to be a collaborative effort, in which organizations work together and organizations and professions work together as well.

I just want to endorse, give that as a framework for endorsing this effort.

And then the final thing, and I went through this when we were in the majority of the early '80s about the ethics of financing and all that sort of thing. And I concluded at the time that about the only thing you have

available to you is transparency, and just the way this paper starts to work its way through. If you can get information that is actually understandable -- but it's only understandable by reporters, that's enough. But if you can get good transparent information clearly makes a connection. Too much of it today, even in Minnesota in that Minnesota Registry, you can't sort that one out between somebody who might be just used to getting $200,000 a year for whatever, and somebody who is rendering a specific service.

So making sure that that information is understandable, that it's accurate, that it's understandable, and that it is transparent is really very, very important.

On the last issue, which is which types of payments to include, again using the political analogy of everything that the Congress has been through, I come out in favor of wiping it all out unless you can demonstrate that there is a clear need for the salesman to be in the OR with the surgeon or you can demonstrate a clear connection like something more than consulting, I suppose. Maybe it would follow in the research category. I don't have a specific answer for how to get to it.

But short of a legitimate fee for a service that is demonstrably contributing to the value added not just to that individual but to whatever the technology may be, I would favor reporting as much as possible and encouraging people in professions and organizations to eliminate as much as possible of the financial conflict.

MR. HACKBARTH: Dave, what I hear you saying is that you support government required reporting but enforcement of standards as to what's appropriate and acceptable needs to be done by the relevant professional group? That's your basic distinction?

MR. DURENBERGER: Just a slight modification of that is that on sort of like the preemption issue, the danger of setting up a Federal reporting law --

MR. HACKBARTH: That was good to be my next question.

MR. DURENBERGER: -- is that you take away -- I mean, as soon as the next iteration of influence comes out and some state like mine wants to act on it they say well, the Feds are already doing that and that sort of thing.

So drawing that line between doing at the Federal level and encouraging it being done at the state level -- so

the way I come out on the preemption issue is you can do this at the Federal level but that should not prohibit state legislatures from taking it another step further.

MR. HACKBARTH: So you support Ariel's option of having the Federal reporting be the minimum standard. If a state wishes to adopt something more stringent, they would be free to do so.

DR. CASTELLANOS: David, I appreciate your comments, and especially from a person like you who emulates honestly and integrity to all of us, I really appreciate your comments.

The chapter really has emphasized more the industries responsibility and it really hasn't said much or even identified the physician responsibility. And this is a two-way street. I think the physicians do have a responsibility also, especially with ownership of hospitals and especially with ownership of the ASCs and perhaps print independent diagnostic labs.

I don't know where you draw the line but I do know the individual physician, the patient sees me or sees Karen or Tom for our knowledge and our abilities. But he also or she also trust us. She is where or he is putting their life

in our hands. And that's a sacred trust. And I think the physician has that -- not option but that physician has that responsibility to be as honest to that patient as possible. I think he or she does have that responsibility, too.

There's no question there are ethical guidelines by the American Medical Association, the ASC, the American College of Surgeons and a lot of the societies. But I think it also comes down to the physician himself level.

The other comment I'd like to is I appreciate, Ariel, your comments on the direct to consumer advertising. I think that is really important in the material that you sent out. I think we should try to make some kind of a statement that that should be just educational. I don't know how we can trim that up a little bit but I certainly appreciate you picking up on that and appreciate the discussion in the material that was sent.

MR. WINTER: Can I asked to clarify, Ron? Educational to that patients? And by educational do you mean balancing the risks and benefit in terms of the content? Or is there something else you were getting at?

DR. CASTELLANOS: The balance to the risk and benefits of the drug really -- I'm not sure how -- I think

it's necessary because the FDA requires that. But what I'm saying is the value of the ads should be educational to the patient and perhaps to the delivery system. But it shouldn't be ask your physician for the Viagra because it may work.

MS. BEHROOZI: Thank you. I liked it before. I like it even better now, Ariel. You added a lot of great stuff. I like Dave's question, why MedPAC?

I feel like so much of what we do when we talk about the methodology for paying physicians and some of our earlier discussions today recognizes the role of the physician as the decision-maker and the decision driver and the cost driver to Medicare. And when you've got evidence based on the little information that is disclosed out there that costs are driven inappropriately by these kinds of payments via the doctors, then that's why MedPAC, that's why Medicare.

I think also, and I'm sorry Joan, I'm going to foreshadow again. I loved your paper, too. We'll talk more about that tomorrow. But the difficulties of doing public education in a context where we don't have a free marketplace of ideas because we don't know to what interests

some of the drivers are beholden.

In other words, if the doctors are making decisions based on these payment and we, the payers and the patients, don't know about it then we're really swimming upstream in that marketplace of ideas, in the battle to persuade people that no, that thing that you're doctor -- that brand-name drug that you're doctor is prescribing is really not better than the generic. Did you notice the pad on his desk or whatever the things are? No, the stuff that you don't see, actually. It's not the pad on the desk. It's the things that you don't see that might have influenced the doctor to tell you that the brand-name drug was better when really it's clinically the same as the generic drug.

So we have an interest, that we'll talk more about tomorrow, in making sure that we free up the marketplace of ideas.

And I agree with Dave that since we're talking here about reporting and not prohibiting certain kinds of payments that makes it easier. I don't know that I'd agree that we shouldn't get into prohibiting. But let's wait and see. Let's see what the information shows us, whether there

are areas where there should be restrictions or prohibitions.

But again, since we're talking about reporting, I think the threshold should be very low. I think samples absolutely should be part of the reporting requirement. Because while it seems like a humanitarian thing for, for example pharmaceutical companies to give doctors free samples to hand out to their patients, evidence shows that that does not go to low-income patients in the main. It goes to higher income patients and is part of the whole system of driving prescribing behavior that is not about better outcomes or greater efficiencies.

In terms of recipients other than physicians, I'm thinking about recent news reports about a study about I guess the efficacy of CAT scans -- is that what it was -- in detecting lung disease early. That turned out to have been funded by tobacco companies. I would think that you could find those connections if you traced it back far enough and finely enough. But I would think that something like research entities, research foundations could be on the list, too, to make it all available in one place and easily accessible, as you said.

And I would also agree with your formulation on preemption, that a state can do more.

Thank you.

DR. CROSSON: Thanks. I support this direction. I think this is a significant issue. I think, if anything, the chapter may understate it a little bit.

I think, for example, the impact of pharmaceutical funding of medical research and the impact that has on the medical database that physicians and others use to make clinical decisions is very significant not only because of what is chosen to be studied and what's not chosen to be studied but, as we find out increasingly, what data is released and shared and what data is not released. And I think that is perhaps part of the iceberg that's not so evident.

The data shows, and I think we have believed for a long time, that these sorts of activities directed at individual physicians do influence prescribing and often not in the best direction, the direction that increases costs and may even induce inappropriate prescribing.

It's our sense -- and Ariel did take a look at our policy -- that physicians should not be accepting gifts or

financial rewards of any kind from pharmaceutical companies. So I think in terms of the questions we have in front of us, I'm trying to think of what examples from our experience would be helpful and what others are not applicable, I think as Dave said.

So for example, we prohibit all gifts. Does that mean that should be the threshold for public reporting? It might be that in order to create something that is administrative feasible there has to be some threshold set, for example. Zero tolerance might prove to be an administrative nightmare in that direction.

The issue of what types of gifts or provision of specie we're talking about I think is complicated by the sample problem. As Ariel pointed out, the total dollar cost of samples outweighs the rest of these things we're talking about.

We have found that a difficult one to deal with because there are arguments on the other side. There are occasions for our physicians to able to use samples for people who, for one reason or the other, can't afford their medication. That happens on occasion. And there are clinical situations in which samples -- particularly the

samples of small amounts of medication -- can be used relatively inexpensively for a situation in which you really can't figure out which one of five or six creams might actually help a patient -- yes, a patient of a dermatologist.

So there are some rationales there. Now I think those are outweighed by the impact of the provision of the brand-new high-cost medications and then the use of those and the influence that has on prescribing. We've been able to deal with that by simply allowing samples to be provided only for those drugs which are already accepted on the formulary and have been screened by the physicians for general use and not allow the provision of other samples. That would be very difficult, I think, to broaden.

In terms of whether to go beyond physicians and deal with issues around gifts and other sorts of values to professional societies and things like that, I think that adds another level of complexity. It's one step removed from the direct interests of the Medicare program, but not entirely. So I would think that we might want to spend some time analyzing that in detail before we made a decision about that. I hope next year we'll have the opportunity to

do that.

Those are my thoughts.

DR. WOLTER: Ariel, I also think just a fabulous chapter and it really lays out the context very well. I really am supportive of this movement to transparency in this area, as I've said before. In some ways there are analogies to the increasing requirements around transparency for hospitals, related maybe to the article you passed around, Dave, earlier today in terms of governance practices or charity care or executive compensation. But I think at least understanding what's going on in this area is very important and to have a reporting mechanism in these areas, to me, makes a lot of sense especially if we can do it in a way that's relatively efficient.

I probably would lean toward being in favor of having the institutional and professional society recipients be reported, as well. But I agree with Jay, that could certainly have more analysis. But that might not be much more onerous if we're already requiring reporting to individuals.

I like the categories we're looking at in terms of device manufacturers, pharmaceuticals, but also hospitals.

I think there's a lot of talk about physician ownership and physician-owned entities. But the myriad of hospital economic joint ventures which in many cases have as a primary motive looking at volume, I think, make good sense for reporting as well.

And I think in terms of future directions that continuing to look at utilization patterns and their relationship to these various financial arrangements will have value if that can be done somewhere, perhaps by us.

DR. DEAN: I just wanted to -- first of all, I totally agree. I think this is valuable stuff. It was really well put together.

I wanted to comment on the medical student aspect of it. As I was reading this chapter I stopped and called my son, who is a third-year medical student at the University of South Dakota. It was very interesting. This is a hot topic among medical students. He knew all about this. It was an active topic of discussion. The University of South Dakota, which I think is a very good school but it's not known as a trendsetter, has issued some very stringent guidelines in terms of what -- they're not requirements, and I talked to one of the faculty folks that

helped put this together. He said we debated whether we should put rules in place or just guidelines and chose the latter because they felt that it was better. These are budding professionals that are going to have to make their own decisions and we thought that they needed some guidelines put we should not dictate how they respond.

But I thought it was encouraging that at least in one small medical school this is a topic of active discussion. And my son went on for 15 minutes talking about the discussions they had had and his concerns and that he was upset with these arrangements and so forth.

So it's out there.

Now I will say that the discussion that he was talking about was very similar to the discussions that we had 30 years ago when I was in medical school. They haven't changed.

[Laughter.]

DR. DEAN: So maybe that's not so encouraging. I don't know.

On the topics that came up, I totally agree with what Dave said, that all physicians will say that this doesn't affect their decision making and I don't believe

that. I would lean, just for purely probably administrative reasons to not include the little stuff. I mean I think it's important but my inclination would be report the bigger things first. That should be -- take the low hanging fruit. I don't know if that's a logical analogy or not. But that should be somewhat easier and I think probably is more important. And then move gradually towards the little stuff, which the sample issue is complicated, as Jay said. I would be inclined to not include that to begin with, although hopefully we move to it eventually. Because some organizations are much more set up to do it. I know Nick said that they were able to move samples into their pharmacy and use a mechanism. Well, that's a good solution. It's not available in my situation.

I guess the other issue that Jay mentioned which hadn't gotten much discussion, which I agree is terribly important, is pharmaceutical industry support of research and the reporting of those results, which also there has been movement on. As the journals -- I guess there's a requirement of the Clinical Trial Registry. And at least we know there is a public source of information about trials that are run, and I presume the outcomes of those trials.

So at least some of that is available. I think that's important because we know there's a lot of research that has been selectively hidden because it didn't produce quite what people hoped it would.

Thank you.

MS. BEHROOZI: I just want to say one thing about the samples because obviously in clinicians know more about how the samples are used so I don't presume to know that. But I just want to reiterate that we're talking about reporting from the pharmaceutical company's side to whom they're giving free samples. And so then those clinicians who are able to use them in the most effective ways, to give them to people who otherwise can't afford them or really be able to say well, I used this and found this to be more effective than something else, they'd get to respond. They'd get to say this is what I did with the samples, as opposed to forbidding anybody from accepting samples.

So again because they play such an important part in the driving of prescribing behavior I would just make another plug or repeated plug to keep them on the list.

DR. DEAN: Just other quick thing I just realized I forgot to mention, the issue about direct to consumer

advertising really ties in -- it is a concern, obviously, we all struggle with it -- to the comparative effectiveness discussion we're going to have because so often, especially with new drugs people will come in requesting them. And we have no answer. We don't have any data as to whether this is any better than what's already out there. So we're sort of stuck with saying well, maybe it is as good as the company says it is. I kind of doubt it but it may be. But the patient wants it. I can't say it isn't better. I'll probably prescribe it.

MS. DePARLE: I support the Federal reporting system and I think Medicare has very direct interests in promoting transparency here. I just want to speak to the narrow issue of the types and sizes of manufacturers because there's a paragraph in the text about that.

I think that we should require this of all manufacturers of all sizes, both types and sizes. There is a suggestion that policymakers may wish to exclude very small companies. I know at least one of the bills that's being considered in Congress does that.

But I don't think we should have an interest in excluding small companies for this purpose. In fact, at

least from what I've seen, in some cases they can be among the worst offenders of the situation. So I would say that whatever we recommend should be broader and should include everybody, should be a level playing field.

DR. BORMAN: I certainly support absolutely the spirit here, and I agree with Nick about transparency and how that's really key to this discussion.

I do want to say that we need to be careful that there is a few circumstances that we don't throw out the baby with the bath water. I will point out a couple of places. There are times with variations on devices, prostheses, whatever, that have very nuanced individualistic things to their use and implementation. And to have somebody come to the operating room for that purpose to answer questions about that during the implementation I think is actually to the patient's benefit.

Maybe some day we'll get to where there's simulation to everything you do before you ever do it and it will resolve this problem. But I've got to tell you, we're not there yet.

And so I think it's absolutely unconscionable to think that somebody's going to come to the operating room

and do medical decision-making for me. But in terms of when I've got a new gadget and the screw didn't go in quite right and now I'm not picking up enough amplitude out of the current for the pacemaker or whatever, I mean it's to the patient's benefit to have a knowledgeable source about that particular thing.

And so as we kind of work through this I would like to see -- depending on whom we task to report the information -- that there be ways to be able to report when it was used for good purposes and not subject that to undo bureaucracy or whatever, that this becomes a reporting -- just yet another one of those reporting kinds of things that ultimately becomes a burr under the saddle to whoever it is that has to be doing the reporting.

So I would just make the pitch that there is a certain amount of time where some of this may be beneficial. The challenge is to be able to craft guidelines or language or whatever that says when that might be. We just need to be a little bit careful about that.

MR. HACKBARTH: Okay, thank you. Good work, Ariel. We look forward to hearing the next report.

Let's see, we are now on to bundled payment around

a hospitalization.

MS. MUTTI: The Commission has repeatedly noted that fee-for-service payment creates an incentive for providers to deliver more care rather than the right mix of care. We've pursued the notion of bundled payment around a hospitalization because it has the potential to temper those incentives, and importantly encourage providers to collaborate in coordinating beneficiaries' care.

However, bundling payment is a big change. And with such a big change in incentives for an industry as complex as health care comes the possibility of unintended consequences and design challenges.

In addition, the lack of systemness in health care delivery suggests that some hospitals and physicians may have a hard time agreeing on how to share that bundled payment and managing that care under that bundled payment.

Accordingly, we have been pursuing a glide path or incremental steps toward bundled payment for care around a hospitalization.

In this presentation, I won't be taking you through every design consideration and analysis that we've discussed in the numerous public meetings over the last year

and a half. Much of that is in the draft chapter that you have for your review.

What I will do here, though, is to first summarize the glide path we've discussed and present two possible modifications based on some of your comments during the last commission meeting. We've drafted new recommendation language that incorporates these modifications for you to review and discuss.

As you will recall, we discussed that the first step would be for CMS to confidentially disseminate to providers information on their resource use around hospitalizations. When we say around a hospitalization, we're thinking of something like the stay plus 30 days after discharge.

The idea here is that once equipped with this information about the service use patterns of their patients, providers may consider ways to adjust their practice styles and coordinate care to reduce their service use. But information alone is likely not enough to fully motivate change.

A second step, therefore, would be to change current payment to begin holding providers financially

accountable for spending across a hospitalization episode for select conditions. These select conditions are perhaps ones that are high-volume, high cost ones, and where we have some quality measures available.

This mandatory change in payment would apply to everyone except those participating in a bundling pilot, and I'll describe that pilot in a moment.

We call the payment change virtual bundling. Under this approach Medicare still makes regular fee-for-service payments but adjusts payment for both hospital and inpatient physician services based on all services used within the episode window. Again, the window here would be the stay plus some time after discharge, something like 30 days.

To be clear, under virtual bundling no one is receiving a bundled payment. They continue to receive fee-for-service payments. It's just that these fee-for-service payments would be reduced for hospitals and inpatient physicians with relatively high spending across hospitalization episodes. Fee-for-service payment amounts could also be increased for hospitals and inpatient physicians with relatively low average spending and good

quality scores.

In this way, virtual bundling creates incentives for both hospitals and inpatient physicians to be mindful of spending across an episode of care but it doesn't require providers to form a joint entity to accept the bundled payment and to divide it amongst themselves. That requirement we think may be unrealistic for some providers, at least in the short term.

A diagram might help explain virtually bundling a little bit more clearly, so I'll go through this quickly. First, we have the hospitalization episode, and I do have it animated. First, we have the hospitalization episode that starts with an admission, then the discharge, then 30 days after discharge. Those are noted on the bottom of the time continuum there.

And then we note here the types of providers delivering services during the admission. That's the hospital and inpatient physician services.

Here we have the services that are delivered after discharge, and those include post-acute care services, outpatient facility services, physician services, and readmissions.

The way we've structured this policy is to hold the providers involved in the admission accountable, that is that they are subject to a payment adjustment based on a performance measure. That performance measure is Medicare spending across the entire episode.

It seems reasonable to hold hospitals and inpatient physicians accountable because we know these providers have the ability to influence the care both during the admission and after discharge. Patients are less likely to need costly post-discharge care if, for example, providers avoid complications during the admission, they use a teach back method to explain to patients how best to take care of themselves after discharge. If they go through the process of reconciling all their medications, make sure that there is not contraindications. And if they communicate well with other outpatient providers -- SNFs, also -- but make sure that at an appointment is made with the primary care physician after discharge and make sure those discharge notes are transferred in a timely way. That can make a big difference, as research has told us.

So concurrent to steps one and two, which the first step again was information dissemination, the second

step was virtual bundling, CMS could conduct a voluntary pilot program on actual bundled payment for an episode of care that extends beyond discharge. There are a number of reasons for choosing a pilot as the vehicle to test bundled payment.

Bundling payment raises a range of implementation issues that virtual bundling does not. This is because under bundled payment the entity accepting the payment rather than Medicare has discretion in the amount it pays providers for the care provided, how it defines those services, and how it rewards providers for reducing costs and improving quality.

The advantage of this flexibility is that providers can decide for themselves the best way to structure payment to achieve efficient quality care. And as such, it's likely to be more effective. But it can also lead to some unintended consequences. For example, providers could respond by stinting on care or increasing the number of initial admissions or bundles.

A pilot allows CMS to consider policies to reduce the chance of these unintended consequences and determine how Medicare can best share in the savings. At the same

time it also gives providers who are ready the chance to start receiving the bundled payment.

In the course of your discussion at the last meeting, at least two ideas for modifying this policy path were raised. One was whether disclosure of information on resource use should first be made confidentially but then be publicly available.

The rationale for this is twofold. First, providers faced with public disclosure may be inclined to make needed changes to align their performance with other providers. Second, the public may be entitled to this information to use in making their own health care decisions. By allowing confidential disclosure first, measurement issues and possible inequities can be uncovered and addressed prior to public disclosure.

A second modification to the recommendations would inject the idea of focusing exclusively on readmissions as a possible alternative to virtual bundling. Given the merits of both ideas, perhaps the recommendation should be framed to allow both policy options to be considered.

Here I'll just take a moment to expand on the readmission policy idea. Reducing payment to hospitals with

excessive rates of readmissions has a strong rationale and could be a good starting place, as some of you have mentioned already. The variation in readmission rates drives much of the spending in that post-discharge window and is the prime outcome we'd like to encourage providers to work to avoid. Unnecessary readmissions are not good for patients and can be a signal of missed opportunities to better attend to their needs.

Focusing solely on readmissions is an extension of the sentiment behind recent Medicare payment changes for never events and hospital acquired complications. That is, Medicare should not be rewarding providers for delivering services that could have been avoided through the provision of better care.

A readmissions policy is also likely to be less complicated to administer than virtual bundling, mechanically but also because of the conceptual simplicity of the idea.

If shared accountability -- or we also call it sometimes gainsharing -- were permitted as the Commission has previously recommended, concurrent to a readmissions policy hospitals may be more effective in engaging

physicians in an effort to reduce avoidable readmissions.

Virtual bundling also has a strong rationale. It is a broader policy and as such has the advantage of encouraging providers to not only be aware of their readmission rates but also whether the use of other post-acute care services are appropriate.

Also, given how we've structured in here it can be a vehicle to hold not only hospitals accountable but also other providers as well, including inpatient physicians.

So on the chance that you might want to incorporate these modifications, we have a revised package of draft recommendations. The first recommendation states that Congress should require the Secretary to confidentially report readmission rates and resource use around hospitalization episodes to hospitals and physicians. Beginning in the third year providers' relative resource use should be publicly disclosed.

In terms of spending implications for this recommendation, we expect to have some administrative costs associated with disseminating information. We also note that there could small savings from reduced utilization but these are indeterminate.

To the extent providers do modify practice patterns as a result of having more information, coordination of care could improve. Similarly, to the extent that providers respond by reducing the number of services, the growth in aggregate payments to some providers may slow over time.

The second draft recommendation states that to encourage providers to collaborate and better coordinate care the Congress should either direct the Secretary to reduce payments to hospitals with relatively high readmission rates for select conditions or implement virtual bundling which reduces payments to hospitals and inpatient physicians with relatively high resource use around hospitalization episodes for select conditions. The payment penalties can be used to finance additional payments to high-quality providers with relatively low resource use.

Offering this choice allows Congress or the Secretary to determine which policy option is the better starting point. It reflects the fact that the Commission finds that both ideas have advantages and should be debated in a larger context.

I just want to note again here that enactment of

shared accountability with appropriate quality protections would strengthen and reinforce the intent of these policies by allowing providers greater flexibility in aligning financial incentives.

The spending implications are indeterminate, particularly because they may vary depending on the policy selected and how the policy is implemented. But the intent of either policy is to produce Medicare savings, or at a minimum be budget neutral.

With respect to beneficiary and provider implications, either of these policies should improve coordination of beneficiaries' care. Providers with high resource use or readmissions would receive lower payments. Efficient providers might receive higher payments, depending on the policy design.

The third draft recommendation is about the pilot and remains basically unchanged from the last meeting. It states that Congress should require the Secretary to create a voluntary pilot program to test the feasibility of actual bundled payments for services around hospitalization episodes. Again, this pilot would focus on select conditions, particularly those for which we have quality

measures and are high volume and high cost.

The spending obligations are indeterminate because the impact depends specifically on how the pilot is designed.

With respect to beneficiary implications, we expect the pilot to result in improved coordination of care. Also it should align provider incentives, allowing them to share in savings resulting from greater efficiency.

So with that, we look forward to your discussion of these recommendations and any comments you may have on the draft chapter.

MR. HACKBARTH: Think you, Anne, you've done a terrific job on this. Thank you, Craig, for the work you've done.

This is a very important recommendation in that it is an effort to begin making headway on a critical theme that we keep coming back to over and over and over again, and that is to increase collaboration among providers in the name of improving care for patients, which is sometimes difficult -- indeed very difficult -- when they're in siloed different payment systems creating not the right incentives. So this is an important goal.

As always, it's easier to say than to figure out exactly how to do.

For me, the ultimate goal here is a true bundled payment, what we talk about in recommendation three. Whether we can do that effectively and make it work is an open question, hence the recommendations cast as a pilot of the idea. But I think it's important to keep that ultimate goal in mind.

The other recommendations are directed to interim steps, steps on the glide path, as we phrased it last time, to get to a true bundled payment.

The context is important to me in thinking about the draft recommendation two, if you would put that up, Anne. I just want to get this on the table so when we have the open discussion people can be thinking about this as well.

We've talked about a couple alternative approaches to be applied to those hospital physician combinations not participating in the pilot of true bundling. One is the virtual bundling idea. The other is to have an adjustment for excess readmissions and couple that with gainsharing.

The more I think about this personally, the more I

keep coming back to the conclusion that if this is an interim step thinking about which we can do most quickly and economically in terms of the resources dedicated to it is a very important consideration. My instincts are -- and I don't have data. But my instincts are that the readmission policy combined with gainsharing is something that could be done much more quickly and efficiently.

Having said that, it doesn't have exactly the same impact as true bundling might if we could make the true bundling work. The incentives are admittedly a little bit different and apply not to all of the same parties, and there's no denying that difference.

But as I say, for an interim step I tend to -- my instinct is to favor that which is simpler and quicker to implement. So my inclination -- I want people to react to this -- would be to recast this recommendation and simply recommend to the Congress that the Secretary be directed to develop a readmissions policy coupled with gainsharing as the interim step.

Thanks for hearing me out on that, and let's open it up for discussion.

DR. WOLTER: On draft recommendation one, I think

it's implicit because of what's in the text, but I assume we would start with certain high-volume/high-cost hospitalization episodes? There might be a limited number in the beginning. I don't know if we want to reflect that in the recommendation.

And when we stay resource use around hospitalization episodes, we are talking about some period of time after discharge I assume? Because I think we want to be clear about that. And I think that reporting, in and of itself, is going to take a lot of motivation around how might people reorganize themselves to be able to deal with the information they're getting back if something else happens down the road.

And then on the points you made, Glenn, on draft recommendation two, personally I kind of like giving the option there, quite frankly. One issue is that if we go with the readmission policy the gainsharing regulatory relief has to happen, I think. I assume that's what you're suggesting by including gainsharing in it. Because there needs to be a way for physicians and hospitals to work together and in some ways share some of the financial approaches maybe that would be necessary to reduce

readmissions. And the regulatory barriers right now can be quite significant.

If we went to the virtual bundling approach and had legislative language that made it clear physicians and hospitals could work together on that, that might be a little more straightforward. I don't really know.

But one thing I like about offering both options is over two or three years if communities are seeing this information and they know that both options are on the table we might see some organizational efforts develop a bit sooner around the potential that they would see virtual bundling.

And so there's really advantages and disadvantages. I certainly understand maybe the simplification around the readmission.

But mostly this is great work. I thank you guys. I think that, as Glenn said, the real prize here is what might be unfolding over the next five and eight years around some redesign of the delivery system that can be more effective. So thank you.

DR. KANE: In our written work, page 14 table one, I want to ask a question. I'm just wondering if the way

we're designing this is capturing really where the best possible savings might be.

Do I understand for table one you've got the resource variability by different type of provider: hospital, physician, readmission and other post-acute. I notice that there's almost no variability in resource use at the hospital level which first of all is the largest chunk of the money. And I wondering if you're not using the DRG payment as the resource use rather than the actual cost to the hospital?

MR. LISK: In how this is designed, it's because it's based on a standardized payment. So we're looking at that from that context, because the current payment system already rewards hospitals that are more efficient within the DRG system. So in that context of how this was designed, it's based on what is the standard payment for each of the type of --

DR. KANE: That's what I thought and I'll tell you why I think that might be shortsighted of us. I think right now it is hard to achieve inpatient efficiencies within the DRG without having physician alignment. But if can align the physicians up allow gainsharing, I think we're kind of

avoiding capturing any measurement or even savings sharing of the inpatient. It's the biggest chunk. And I can tell you, even from the examples in what you wrote about how the different -- Virginia Mason and Intermountain Health, where their savings occurred was not on their read admission rate or their physician use. It was on cheaper devices and things that happened within that DRG payment.

So I just wanted to bring that out, but I feel like we might be -- by this design -- not capturing either the measurement of and/or the ultimate potential long-run shared savings around the inpatient.

I realize maybe we want to start with the smaller possible places but that's where the big money is. And so do we really want to start with savings on physician visits and post-acute alone? Or do we want to say let's look at the utilization inside and see the variability there and start rewarding places that can really reduce that variability and then trying to share some of that in the long run? That's point one and we can talk about that.

The other comment I had to make, of course, is that Part D is left out. You can rely on me to just keep saying that. Again, that's another huge area of

variability. I think we really have to address it. I don't think we can just keep ignoring the fact that the pharmaceutical piece of this pie is totally left out.

The final thing I was going to say is, going back to what we said earlier about pilots, that if our recommendation three is to have a pilot and to test feasibility, do we need to also say we need to set standards for when that's a go everywhere? I think I mentioned that to you in my e-mail to you, how long do we have this limbo going on of hospitals getting readmission plus or virtual? At what point do we say okay, it's kick in time or not? Do we need to specify that there should be some trigger, as we wanted to do with whatever it was, the medical home, I guess.

MR. HACKBARTH: Just on your first point, Nancy, I think you may well -- certainly you're right that table one probably understates the potential for cost shavings gains within the admission because it is based on the payment flow, as opposed to cost.

Whether that will prove bigger than the readmissions opportunity I don't know, but I suspect there's some real opportunity there.

And that's why I think that combining readmissions with gainsharing is very important. The gainsharing gives you that within admissions dynamic that you're seeking.

DR. KANE: I agree and I think that's -- but we won't know -- in other words, unless we are looking at cost variability, I think in the long run we want to know what that is and how it's coming down because really at some point we'd like to have some of that come back to the program.

MR. HACKBARTH: Yes.

DR. KANE: And I think we need to have best practice and celebrate when hospitals do achieve lower levels of inpatient utilization. Otherwise it's going to take a long time to get those back through the -- I don't know, the DRG recalibrations or whatever, long time. I'm not sure we have that long to wait.

I actually have one more question related to that. In the '91 to '96 period, when we did the coronary artery bypass graft demos -- and I know they went really well -- what happened to them?

DR. MILLER: This is the centers of excellence demonstration, I believe were the key words. People who

were not designated as centers of excellence were unhappy with that designation and basically there was -- I can't remember the specifics but I think --

DR. REISCHAUER: [Inaudible].

DR. MILLER: Yes, as Bob said, there were more of those than there were centers of excellence. I think actually legislation was brought wasn't it?

MS. DePARLE: It was in the president's proposal in the BBA and then it got -- at the very last minute -- taken out, to extend them. So they were ended as a result of that.

DR. KANE: And nobody said this is such a great thing, let's bring bundled rates back into the real program? They just dropped it as an idea altogether?

MR. HACKBARTH: What I hear you saying, Mark, is actually the context was a little different in that they were characterized as centers of excellence and these were places to which Medicare would try to steer patients, whereas the bundling as we're talking about it now isn't based on steering beneficiaries to particular institutions but altering the incentives for all physician-hospital combinations.

So it's a little bit different policy context but I think many of the lessons are still applicable.

DR. KANE: There was no political pushback on the feasibility of bundling elsewhere then? It was just really they didn't like the idea that somebody might get -- I think that's where we wanted to know --

MR. HACKBARTH: My take was that operationally things worked pretty worked pretty well and, in fact, providers were able to find efficiencies when paid differently. That was the part that was a real plus and it was the centers of excellence piece that was the controversial hang up.

MS. MUTTI: That's my understanding, too. I know that some providers got together in Virginia and wanted to try and launch their own -- maybe not calling it centers of excellence. And there was negotiations back and forth between the hospitals and physicians as they were trying to structure that deal. But I think that it was also hurt by the restriction on gainsharing, that they felt they were on shaky ground on being able to get the kind of efficiencies they wanted without explicit permission, without being allowed to gainshare.

MS. DePARLE: The resistance, I think, Mark was correct in saying this, was that some other providers didn't like the idea that Medicare might have a program where it would designate certain hospitals -- because they were kind of leading this -- as being superior to others. It wasn't so much you would be steered to it. But as I recalled, beneficiaries faced lower cost sharing if they chose that. So it was choice but you could argue that was steering.

DR. MILLER: There was a designation for the hospital, like it was...

MS. HANSEN: I just want to thank you for this chapter and the work that you've been doing because I really like the directionality in which it goes.

But I am struck with Nancy's comment earlier just now, but I have been thinking about the best practices that have come up from Virginia Mason and Intermountain Health and how we can capture that total episode. And even though I'm really seduced by the idea of the readmissions component and the gainsharing as the first level of this.

However, I just wonder if as we do kind of the glide path of all the programs, because I, too, Nancy, was struck that when we talked about the medical home earlier as

to what would be the patient experience earlier on, not just the hospital side but the prevention, the care management, that part on the front end, the hospitalization experience and the post period. Which then leads me to keeping the two options of both the rehospitalization and the virtual bundling just to see the total trajectory.

Because I fear that with the -- as pointed out in the rehospitalization thing, if it's after 30 days -- and I'm kind of stuck on this 30 days. I asked the question earlier, what happens is do you dump the issue to the next provider and not capture that? And I don't know whether the gainsharing just kind of focuses only on the hospital episode between the hospitals and the physicians. But then it's the nursing home component.

So I like the idea of the virtual bundling, because it's a longer period of time in which to take a look at that.

So I just wonder with all of the initiatives that we have, we have today medical home, we have this component, and we have even the more accurate payment of SNFs, is there a way to look at some of the best practice of say what Virginia Mason has done and just follow how they might

actually apply between if we were to actualize medical home, virtual bundling, and the SNF PPS just to see what the costs might be over these particular episodes?

It's almost like stringing together these components that we've been looking at MedPAC but taking it from a patient centric standpoint with all these levers that we're trying to get into place. And yet we have actual experience with places like Virginia Mason, when they were able to do great work -- or whatever these centers of excellence on the cardiac issue. And can we learn something from this a little bit more on an analytic level?

MS. MUTTI: The idea being almost to do a case study and walk-through and then quantify where each of the savings came from?

You know, we can look into that. We can reach to the evaluation of the CABG demo to yes, reaffirm that the hospitals and physicians achieved savings. Medicare did also, but that gainsharing ability that they had, people changed the way they practiced. They used less nursing. They used less lab services, less ICU days. They probably used less consults. So practice does change. And that's part of the whole gainsharing thing.

And there are estimates by particular participants, how much savings they got. So we can bring that a little bit to the fore. The exercise of going to one of these other facilities and asking them to factor in some of the SNF payment changes and everything else would take a little bit of work but we can think about that.

MS. HANSEN: I definitely am not asking that this be done, but perhaps an evaluation of just the merit of taking a look at this. Because as we are trying to devise different policy and payment levers, there is so much to be learned from things that worked well but for barriers like the issue of gainsharing. If we could identify the things that facilitate -- excuse me, the outcomes that were positive in terms of delivery change, outcomes, and costs. And then what were the barriers that were kind of stuck in the way? What barriers could be alleviated by some of these models? With the ultimate goal, I think Glenn, when you were saying at the end of it, how do we put the whole episode together to save money, have high quality, and take the benefit of efficient providers here and save money for the program?

So it's really looking at the whole epidemiology

of the delivery and payment system together with the structures that we're working on right now.

MS. MUTTI: I would also just note that the Institute for Health Care Improvement out of Boston, I've been looking at their website a lot lately. And they seem to be a very constructive forum for bringing in real practical experiences of facilities that have -- whether it's throughput, whether it's addressing readmissions -- is really bringing together best practices and trying to shed light on that.

MS. HANSEN: I just spent half a day of them on Monday.

MS. MUTTI: So you probably know better than I.

MS. HANSEN: So I think our ability to take that and put a lot of the lessons learned, as well as the quantification, together and have the story told and then where are the best levers to make a move?

DR. CASTELLANOS: Anne, first of all, this is great work. This is where we want to be. We're not going to get there tomorrow but the next five or 10 or 15 years we hope well get there. And I really appreciate what you've done.

I just have three questions. Nick brought it up on draft recommendation one. This is just for selected conditions; is that correct? And draft recommendation three would be the same, for selected conditions?

MS. MUTTI: I realized that in draft recommendation three maybe we should put it in the text. And on draft recommendation one, I could use your feedback on that. I wasn't sure whether for information purposes we were going to be more broad or if for information purposes we still wanted to stick with select conditions. So I could use your feedback on that one. And then your feedback as to whether we should put the language in on three, I can see doing that.

DR. CASTELLANOS: The second point again is the same theme. First of all, the physician community is not ready for this at all. We need an education process. There's just no question in the world.

Nancy, you need to teach and educate more leadership in the physician community. But we really don't have any experience with insurance risk. We don't have any experience with this. This again gets back to the basic education process in the medical schools. I really think

this is important. It's just not for medical homes. It's just not for bundling. It's the whole process of care that we're trying to change. We're trying to change the delivery system reform.

And the third point again is we talked about the regulatory changes, especially with gainsharing. There is another point. In the ideal world this is going to work but I don't live in the ideal world. I live in South Florida.

[Laughter.]

DR. CASTELLANOS: And South Florida is notorious for liability. We've already learned that there is some form of defensive medicine that's practiced and I think it's probably more evident in certain locations in the country.

This needs to be somehow discussed and worked out. I think if a physician does not order a test or does not send a patient to a specialist and there's a poor outcome, I think the jury is going to have a field day when the physician is asked how much of a financial benefit did he or she receive for not doing this, what was appropriate.

We're not going to discuss it at this meeting but that has to be discussed. That's a really pertinent problem by the physician, especially in South Florida.

MR. HACKBARTH: Ron's initial question about recommendation one is a good one that I think we may have some different thoughts in our heads.

What I had in my head was that the feedback of data would also be focused on certain high-cost/high clinical quality opportunities. And part of what we're trying to do -- and Nick has been a very strong voice on this -- is create focus and help people go where the real opportunities are. If that's how we're going to operationalize any payment change, focus it, it seems like you'd also want to have a similarly focused approach to the data disclosure at first.

Or at least that was my thought. If people disagree with that we ought to have some discussion about that issue.

MR. EBELER: Thank you, Anne and Craig. Let me join the list of people thanking you for the work.

On one, I think this makes sense. You had asked, I think in your discussion of particular comments, about whether this moves to public disclosure, which you flag in the second sentence here. And I really think that's an important step, first private but moving public at some

point.

Draft recommendation two, I think in some ways the terrific work that you've done on virtual bundling, for a while made that sound doable. We may be a victim of staff work that's too good.

Because I think as we sort of reflect on it, it's like wow, that's very, very hard to make that happen. And while we appreciate how far you went there, I worry that it's hard to do.

I would have a suggestion on two. I think, in my mind, we are directing the Secretary to reduce payments for hospitals with relatively high readmission rates for selected conditions. That's a go do that, as a policy change.

It seems to me the second piece of that, rather than specifying virtual bundling, we may want to step back a tad say develop other approaches for moving in this direction. In the text we could say that could include virtual bundling. There's a couple of other things one could try here.

But it just strikes me that in the case of the admissions, we're saying hit the do button. In the case of

what we're now describing, virtual bundling, we may want to step back and say that is part of a list of a couple of options that the Secretary could persist as we are thinking about this path. And just ask for some thoughts on that. It may be another way to parse this as we go forward.

MR. HACKBARTH: Jack, you have experience with Congress. Did you sign?

MR. EBELER: No, I did not moan.

[Laughter.]

MR. HACKBARTH: So recommendation two is a recommendation to the Congress that the Congress direct the Secretary to do one or the other. That's a sort of unusual formulation for legislation.

MR. EBELER: And again, what my formulation would be direct the Secretary to do the one thing.

MR. HACKBARTH: State the one broadly.

MR. EBELER: Do the readmission and develop recommendations for other approaches for heading down this glide path.

MR. HACKBARTH: Let me just play that back. I think I misunderstood the first time.

So it would be direct the Secretary to do the

readmissions thing and then explore other possibilities that may be better than that still.

MR. EBELER: Right. And we could include in text -- I know we're getting wordy in recommendations -- virtual bundling. There's other things we could signal there. But it just strikes me that there's conceptually two paths here.

MR. HACKBARTH: Thanks for the clarification.

DR. CROSSON: I think I'm actually close to Jack here, both intellectually as well as physically. I did hear a change in breathing coming from Jack.

But I just want to emphasize that the goal, as Glenn said, is to get to bundling, want to save costs, improve care coordination, and induce something called systemness or something like that.

So I wanted to go through what I think the evolution of our thinking has been. And here I may make many errors. But to take the answer to the question about whether to get rid of that or not.

What I remember is we first started talking about this in terms of mandatory bundling and we quickly came up with the notion -- and I think Ron said it -- not everything is ready for that. We really couldn't move that quickly on

something to all doctors and hospitals across the United States. So then we started talking about voluntary bundling. How about if we did it on a voluntary basis?

And then the concern was while that might work well, we might very well only get those institutions and physicians volunteering who expected their efficiency would lead them to have lower costs and Medicare might have a net increase in costs as a consequence of doing that.

I think that's what then took us to the virtual bundling. At least I thought part of that was that it would -- by having everyone in the game then, everybody would be in the bundling game, we might have a broader set of institutions and individuals interested in the voluntary bundling. I don't know how explicit that was, but it seems like I remembered something like that.

And then we came up with the notion we're discussing now which is although that might be true virtual bundling seems to be so administratively complex that it might never get implemented.

And so then we came up with the idea of substituting for that the readmission penalty, and with that the gainsharing -- and I still like the term shared savings

for that -- which I think we admit is probably a weaker stimulus for those three ends, but perhaps more feasible.

So it sounds like to me, though, and I know, Anne -- I think you're ready for this -- that to me anyway if what we're now thinking of voluntary bundling is put in the context of a pilot and therefore it has a certain set of rules associated with it, and if the pilot then could mitigate the risk of only attracting efficient providers -- and I think that sounds like that could be done by perhaps making it more attractive in some way than the alternative which is the readmission/gainsharing. So it would probably have to include at least the shared savings part of that.

But also construct the reward in such a way that it could reward both efficient providers who became more efficient and non-efficient providers who became more efficient, that we could get rid of the problem that we foresaw in the beginning and therefore might not ever have had to march down the path that took us to the current conundrum.

So what I would ask Anne to do is talk a little bit more about the thinking that's been going on about the pilot and could we indeed solve the problem by that

mechanism? In which case, I would probably fall on the side of getting rid of the virtual bundling.

MS. MUTTI: Yes. In the pilot we have made it voluntary and we have come up with a payment mechanism that we think doesn't subject us to this problem that only the low cost people will participate. So now we've got high cost less efficient people could participate, as well as more efficient. So right, we have addressed that problem.

You could still argue that though there's a need for some kind of policy for everybody who stays outside the pilot because, as we've gone through there is a big problem where nobody who's held accountable has a financial incentives to take care of these beneficiaries once they're discharged. And there's this sort of this lack of accountability. We can improve the accountability through a readmissions policy.

In a way they're sort of cousins of each other. You can also improve that accountability through virtual bundling.

You can argue, as we've talked about here that readmissions -- that's the biggest problem that we're really trying to solve here. So readmissions really does 99

percent of the job of solving the problem.

The advantage of virtual bundling is that -- aside from the fact that it's a little bit more administratively complex, but it does balance the incentives. You could argue that in a readmissions policy everyone will pay attention to their readmissions rate and perhaps use other types of services, discharge patients more often to post-acute care, in order to avoid the readmissions since the focus of the measure is on just readmissions.

The virtual bundling is more broad so it doesn't introduce that bias. But perhaps it comes at too great a cost. People don't understand it. It's difficult to administer. We really got a lot of the job done with readmissions, so let's do that.

Does that amplify what you were saying?

DR. CROSSON: It's helpful.

DR. REISCHAUER: Maybe it's just like a balloon and you push it into the post-acute care, because the other area where there's huge variation is post-acute care.

MS. MUTTI: Right, that's why virtual bundling gets at the broader thing. So maybe it's a stepping --

DR. REISCHAUER: But talking about the readmission

doesn't really --

DR. CROSSON: We're still left with the choice of between leaving the virtual bundling in and accepting the potential that it never works but leaving it in because it appears to be a more comprehensive solution.

It sounds to me like your answer said we can deal with part of that through the structure of the pilot program but not all of it. That's what I heard.

DR. MILLER: Can I take one pass it that? I thought the key to his question was in the pilot what's going on? And will that resolve his concerns? And are anyone's concerns enough to say okay, we can take this virtual bundling off?

And I'm speaking to you now and I don't want anyone else to listen until we get this straight so if you can keep this to yourself.

Okay, I think one thing we could say to Jay here is that if it takes a shared savings approach, which is built off of the baseline of the individual provider, then whether a low cost or a high cost person came in and savings were realized off that baseline, you've kind of dealt with the budget neutrality problem. Just hold that thought for a

second.

So it might be attractive to either a low cost or a high cost provider. You had a different way of saying people who are inefficient but could come down. And so that's how -- and this is where I'm really looking for your here, Anne, that's how we're envisioning this pilot to work.

The $64,000 question, as always in these pilots -- and John, you've made comments about this, many of you have -- is how well can you construct that baseline and actually hold the actor to that? But conceptually, the idea is that a low -- in fact, a high cost person might see the pilot as attractive in the sense of saying -- and you've made this argument internally, Anne -- this is an opportunity. Because if I can bring my costs down I can -- and then if it's a shared saving the program takes -- I'm making this up -- 50 percent of that and it leaves 50 percent with the provider. Then on net the program is still getting something out of it.

But the $64,000 question is how well can that baseline be set?

But it would allow high and low cost providers to come in. And then I would leave it to you as to whether

that would say okay, then maybe virtual could go in the meantime. That's what I think you were asking.

DR. REISCHAUER: But isn't one of the real questions here whether there are many entities that have relationships with physicians, post-acute care providers, et cetera, that could actually administer the transfer of resources? The beauty of virtual is you don't have to know each other's names. And this one you have to be dating pretty seriously.

[Laughter.]

DR. WOLTER: Just a few thoughts. I certainly have no idea how impossible virtual bundling would be. It may be impossible for various administrative reasons.

I wouldn't say the readmission approach is 99 percent of what we're trying to accomplish here. In fact, I would say it's a distant cousin, maybe at best.

The reason I say that is if you look at the accountable care organization conversation we're going to have upcoming, there's more to come. The more to come is admissions, not just readmissions. It's the ability to manage in that across time and across silos beyond just the DRG.

And so if we're looking ahead at the years in front of us where we really have to keep moving in terms of how we manage care more effectively, the virtual bundling has some advantages that are quite significant in terms of the incentive it might create for providers to form new organizational approaches to work together. If it really can't be designed or administered then so be it. But we shouldn't lose sight of that. I think it's real bundling, as Glenn said, but then it's something beyond that that we want to look ahead to as we design more incentives.

And I just wanted to say to Jay, you used a different phrase once before on gainsharing. I think it was shared accountability, which is even better than shared savings because it brings quality and savings together.

DR. MILSTEIN: Ease of measurement and ease of administration are valid considerations. That being said, they often substantially restrict the boldness and the probability of yield from a lot of what we consider and what Medicare does. So I support Nick's and Nancy's and several others view that we should preserve for the Secretary both options in recommendation two. If indeed it's completely impossible to administer then the fact that we've offered

both options gives the Secretary a chance to back away from virtual bundling.

The reason I'm very interested in preserving it is if you look at this first slew of attempts to improve efficiency and quality outside of mainstream care, referring to the demos, most of the demos and pilots, I pull away from those -- among other things -- the danger of relying on narrow signals for the total bundle that you're trying to influence.

A lot of those demos and pilots actually did meaningfully impact admission rates, emergency room rates. But they were more than offset by higher costs in other areas. That's one of the lessons I pull out.

In view of that, I feel strongly we should preserve both options for the Secretary.

Regarding option number one, I think here we are -- I would say why not give hospitals and their affiliated -- and organizations that deliver inpatient care and follow-up care in concert with them -- the full range of information across all of the categories of problems they take care of.

Yes, it's true that many of them are management challenged and can't focus on more than four or five. But

there are others that are much more capable -- Virginia Mason probably being an example -- that would be grateful to see how it works -- because they're not a payer, they're a provider -- across all of their treatment types. Because they and other organizations that are midway between them and mediocre in their management capability would be able to handle a lot more than four or five things.

So since it's purely informational, let's not drag it down to the lowest common denominator, hospital and physician management capability.

And last but not least, as long as we're going for when I'll call the whole bundle, Anne, can you remind me what our thinking was or wasn't with respect to including in the bundle for non-emergency admissions the preadmission work up?

MS. MUTTI: You know, we just haven't explored that very much. We focused mostly starting with the admission -- mostly for simplicity to focus us. We've heard others mention this and this is something we can look at.

Of course there's the 72 hour window already that exists for the DRG, so that anything that's done gets captured into the DRG.

DR. MILLER: It's sort of marking the beginning of the episode, the triggering event. If there's stuff that was going on beforehand, you'd have to go back and then associate it with the episode. Administratively it's easier to say here's the event, here's 15 or 30 days after the event.

DR. MILSTEIN: [off microphone] I think Anne's answer was great. We're already encompassing in the first 36 hours, not all but a lot of the [inaudible].

MR. BERTKO: I'm going to go back to Glenn and support your position on recommendation two, which is to have only one. I'm going to come off of Nick's comments in a way and say the most important thing we can do, I think, is to send a clear signal. Draft recommendation two, the first part there, is nice. It's a yes/no answer to did you have more readmissions than anyone else?

The second part of that is let's have a food fight. Are my patients more severe than everybody else's? I've been in the midst of those food fights and they're not fun and they don't get anywhere.

Because I think this is something to be done urgently, I think it would create more systemness, as we've

been talking about, and it can be done really quickly and avoid some of the mess that I know is likely on the virtual side just because it's difficult and complex.

DR. MILSTEIN: If I were running a hospital or a medical staff, I would argue that my readmission rates are related to the acuity and socioeconomic characteristics of my patient population. So I would still, if I felt I was going to lose, engage in a food fight even on this narrower measure, which carries all the disadvantages of suboptimization.

DR. DEAN: Most of the comments I think I have have probably already been made.

I like Jack's approach and the thinking, Glenn, my thinking sort of evolved like yours did. The readmission approach is something we know how to do, we can probably do reasonably quickly. It obviously isn't perfect, but it's something we can do reasonably quickly. But we need to be looking for other things. Because all of these are basically a means to an end, in other words to build the systemness or the collaboration that we're trying to get to.

At first when I thought about readmissions, in some ways those are outside the control of the hospital

because it really depends on what's available in the community in terms of follow-up care. At the same time -- and then I thought a little farther that there needs to be an incentive someplace if that capacity or those facilities are not there, there needs to be an incentive for somebody to develop them. And maybe that needs to be on the hospital.

I think back to the presentation at one of Dave's conferences where the fellow that's the CEO of Parkland talked about how they had reduced emergency room admissions by building primary care capacity within their own community and how that had really benefitted the overall stability of the system. The incentive was there and so they did the right thing and it paid off.

And so I think even though it's putting a burden on hospitals to some degree, maybe that's appropriate.

I would also just echo to some degree what Ron said about the concern about liability issues and defensive medicine. This is a real issue and certainly a lot of docs are very frightened by that. And to some degree that's going to continue. But I think there is also an awful lot of consults and so forth that take place simply for

convenience that really don't reach the level of where there's really a liability concern.

I think back, just a quick story of my son's experience. He was on obstetrics, which obviously is not really that involved with Medicare. But he was rounding with his attending. And one of the ladies said that she had a rash. And the attending ordered a dermatology consult without even looking at the rash. And my son was incensed. He said this is crazy.

But I think those kind of things happen. And we need some kinds of incentives to discourage that. But we can't push too far because Ron's concerns are very legitimate, that given the dysfunctional liability system that we have, we have to understand that we're not in a perfect world.

DR. STUART: I was really pleased to hear Jay's history of how we came up with this because I think what's happened is that we've got this one idea in our head and it's kind of morphed in a number of different ways. So when we try to pull it back together again it really is kind of Humpty Dumpty on the floor.

One of the things that I found particularly

interesting about the first proposal for virtual bundling or actual bundling is what happens within the hospitalization itself. I mean after all, it's not just the hospital payment, it's the physician payment within the hospitals.

If you can focus just on the readmission rate then that piece goes away. And frankly, I think that's the piece that's going to be the easiest to handle organizationally. So I would be very reluctant to give the Secretary the opportunity to avoid that particular issue.

So I think the virtual bundling, to me, has two advantages. One, it focuses on what happens with the hospital. It also focuses on readmission rates. It does get that, to the extent that that can be handled by better management, patient management, within the hospital.

Thirdly, and this is the point that Bob raised, is that it gets to post-acute care. We really haven't talked a lot about post-acute care and it may well be that this is one of those cases where the people that are getting the money are not the ones that are going to be making the decisions here. And that, I think, is potentially problematic.

But we also know that post-acute care is one of

those big, big issues. It's a cost issue, as Bill continues to tell us we don't know what we're buying in a lot of this area. And so I think this is probably an area where potentially the greatest savings could be obtained and to maintain better quality as well.

I find a real disconnect between the two pieces of recommendation two.

MR. HACKBARTH: Just one clarification, Bruce. Unquestionably virtual bundling, as we've discussed it, has impact on a broader range of services. I think that's beyond argument. From a conceptual level it's better, at least from my perspective.

The issues are operational. Now if you look at readmissions combined with gainsharing, the gainsharing piece would materially alter the dynamics of the within-admission care within the hospital. Would it alter it as dramatically as gainsharing? I think potentially. It really is an opportunity to fundamentally change how physicians and hospitals work together to improve care, reduce cost. But readmissions plus the gainsharing may not address the post-acute issues and a number of other things. I do think it would affect the dynamics within an admission.

Differently, a different mechanism, but it would affect it.

DR. STUART: I agree but since we haven't studied it, we don't know what part of the opportunity would not be addressed by this. I think that's one thing that concerns me.

MR. HACKBARTH: And I agree with that.

DR. BORMAN: Just a couple of observations. One would be that in all of these I can kind of already hear out there people telling me -- or probably attacking me more than telling me -- on the topic of risk adjustment. I think it applies to every single piece of these recommendations. And getting ready to crawl out on some extremely thin ice would be the notion that we not to try and fix all of that up front but to say we're going to put the data out there. And that will, I suspect, instigate some reaction and perhaps come up with better systems and better proposals and counterproposals on anything we could take a lot of valuable staff time to try and iterate.

So I think that that may be a piece behind all of these several things.

I think the question of the readmission rate

versus the virtual bundling to some degree touches on the discussion we had really about what's the function of the Commission and how can it be most effective? What's the best mix of judgment, data, all those kinds of things? All of you folks know that a whole pot load better than I do. I think maybe in the end that's what's got to drive the decision as to how to present this, as a single thing, a menu, or whatever, and whether we go with identify a single thing as Jack suggested and then sort of give the menu thereafter. I think that's the important part of that.

I do think that because reduction of readmission in a number of diseases states will hinge on differences in post-acute care, it will imperfectly, indirectly get at that a bit and it will start some thinking about that.

So I guess I'm less uncomfortable -- and that's a real academic away of saying something, isn't it? I guess I'm more comfortable with the notion that readmission starts to capture something meaningful and isn't just totally ineffective as a mechanism. And I'm going to trust my seat mate here that this is a whole bunch easier to implement maybe than the virtual bundling.

DR. CROSSON: As I've listened to the

conversation, I look back at the recommendation. The recommendation says that Congress should either direct the Secretary to do one to the other. Isn't there another option here? Which would be to ask Congress to direct the Secretary to do either of those two things.

And isn't it more likely that the kind of feasibility analysis that would have to go on could occur at CMS, rather than ask the Congress to do that? Is that another option for us?

MR. HACKBARTH: Actually, we talked about this the other day. The either was in the original draft, located where you propose, and Bob suggested moving it. The effect of moving it is to say -- this version says Congress should choose one or the other, whereas your version says the Secretary should choose one or the other.

DR. REISCHAUER: And Glenn is saying have only one.

MR. HACKBARTH: We've got several actions on the table on how to modify recommendation two and I want to go back through this in just a minute. But let me address what I hope is some lower hanging fruit.

Ron raised the issue about recommendation one and

are we going to disclose data on all types of Medicare admissions or only on a select number of high-volume high opportunity. I told you what I was carrying in my head but that doesn't mean it was right. Arnie made the argument why not do it on all?

So I would just like to nail down where we are on that so that we can write the accompanying material clearly.

Who would like to see it made clear, if not in the boldface language in the accompanying text, that we're talking in recommendation one on data disclosure about all types of Medicare admissions? Can I see a show of hands? Seven. There are 17 of us. So we'll stick with the narrower.

On recommendation two, I see three basic possibilities on the table. One is to leave it as is, and we can talk about crossing them and moving either around. But to keep it simple let's have leave as is with the choice.

A second is to go to readmissions plus gainsharing only.

A third would be what Jack proposed, which was to have a clearer simpler recommendation to the Congress and

say readmissions and gainsharing. But we did add to that that we think the Secretary ought to be directed to examine the feasibility of virtual bundling and report back on some date certain or other options.

And then, of course, the way we would write that in the accompanying text is say that we're eager to have something happen early and happen across a broad front. It seemed to us that this was a way to accomplish that. But if we could have a system that created broader impact and somewhat better incentives, that would be even better. But the issues there are operational and they're really beyond the expertise of MedPAC. We think the Department should, in a very timely way, report back to Congress on that issue. Is that a fair representation of your idea?

MR. EBELER: The goal is to put policymakers several years from now in a position where they've got the data from recommendation one, they've got some of the experience from recommendation three. You've got the readmission piece implemented and you now can be discussing with providers -- and you have some recommendations for other things to do. And you can now proceed to the clearly stated optimum goal of how do we get that. That's to try to

create that space.

DR. CROSSON: Glenn, could we consider all four? Because I think some of the Commissioners might feel different about this direction if given to the Secretary rather than given to the Congress.

MR. HACKBARTH: So your proposal would be to give the Secretary the choice. The recommendation as is is Congress makes the choice.

DR. STUART: If we were trying to do something easy another alternative would be to simply have a bundle that handles everything during the hospitalization itself. I'm not convinced that just looking at the readmission rate is going to make the hospital episode more efficient. I think it's going to have some effects for some admissions for certain kinds of conditions but not for others.

And so if the bundling idea is there, I mean bundling the physician payment, the other payment with the DRG I think goes to the -- it certainly goes to the same ultimate direction that we want to go and it gives another alternative.

MR. HACKBARTH: It does but then you need an entity to receive the payment and distribute the dollars.

DR. STUART: It would be virtually. It would have to be virtual because you don't have the mechanism to do it. But at least it's virtual within the context of a very defined event. It doesn't get into the problem about you're not controlling who is doing post-acute care.

DR. REISCHAUER: If you look at the numbers on page 14, there's almost no variation between hospital and physician across these. Now what that means is the way you'd have to operationalize this, I would think, would be to lower the DRG if you wanted to incent some kind of different activity. There are ways to do things more efficiently, but you have to change the payment structure, right, to get at them?

MR. HACKBARTH: I think a big part of the operational challenge with virtual bundling -- and it's true whether you do it for just what happens within the admission or the admission plus 30 days -- is that you need a mechanism like a withhold to operationalize it.

So we're envisioning a system under which CMS is managing withhold pools and paying out various amounts out of withhold pools based on an examination after the fact of performance with issues of time lags. I am absolutely not

an operational person, but that sounds hard to me.

And before I say that's where we ought to go, I'd like somebody who has operational experience really look this over and say yes, we can make this work.

And so I would be happy to go, for ,example to Jack's option and say we think something needs to happen quickly. We think the easiest path is readmissions plus gainsharing. A better path might be this, let's ask the Secretary to report back in a tight time frame and say I can do this or I can't do this.

DR. CROSSON: That's the same as I'm saying. That's virtually what I said, which is that we put the feasibility analysis between these two on the Secretary. You might want to then just broadened this thing.

[Simultaneous discussion.]

MR. HACKBARTH: There's a clear direction from the Congress, as opposed to a direction that the Secretary do something.

DR. CROSSON: So there's a fifth proposal.

MR. HACKBARTH: You're being really helpful. I really appreciate the support.

[Laughter.]

DR. REISCHAUER: If we can find a sixth, we can get up to the other recommendation.

MR. HACKBARTH: Again, let me just review the bidding here. Leave as is and I'm going to ignore Jay. So when he acts out, everybody else ignore him, too.

Leave as is, readmissions plus gainsharing only, or readmissions gainsharing with a very specific request that the Secretary examine the feasibility of virtual bundling. Those are the three options on the table.

It's a little complicated to know how to vote when you've got three options. It's strategic voting. But let's just do the simple thing in the first instance. How many would like to just leave it as is and move on?

DR. KANE: [off microphone] I have no idea what we're talking about.

MR. HACKBARTH: What's confusing you, Nancy?

DR. KANE: [off microphone] I'm not sure what we're talking about anymore.

MR. HACKBARTH: Recommendation two, leave it as it is is the question. How many people would like to just go with that?

DR. KANE: [off microphone] Do we want to leave

either over?

MR. HACKBARTH: No, leave it as it is.

DR. KANE: Is this the last vote or the draft?

[Laughter.]

MR. HACKBARTH: This is just to figure out which option we're going to vote on finally.

My goal here is to reflect your collective will. I'm sorry it's complicated. It is complicated. Life is sometimes that way.

I think we've got three reasonably approaches that people have articulated and I want to get your sense of where you stand.

So option one is to leave it as is. Option two is to go to a recommendation that simply says the Congress should direct the Secretary to develop a readmissions penalty for excess readmissions coupled with gainsharing. Option three would be to direct the Secretary to do that but also report back within time certain on the feasibility of virtual bundling as a substitute, a better substitute. Got it?

DR. KANE: Yes.

MR. HACKBARTH: So we have one on leave is, if I

saw the hands correctly.

How many would like to go to just a straight readmissions plus gainsharing as the recommendation?

How many would like to go --

DR. REISCHAUER: The Hackbarth plan.

[Laughter.]

MR. HACKBARTH: Yes. Right.

And how many would like to go with readmission plus gainsharing plus a direction? I thought that's where it might be.

That wasn't so painful, was it?

DR. KANE: [off microphone] Once you said what they where.

MR. HACKBARTH: I said what they were three times.

I think we're done on this unless I'm missing something.

So the next question in my sequence is do we want to actually rewrite the recommendations so when people do the final vote they can actually see this language? I think that would be a good thing to do, Anne, if you think you could do that quickly. And then at the end we'll do the vote on it, just to make sure we don't have any further

misunderstanding.

We can do the others right now. So why don't you put up recommendation one on the data disclosure.

DR. MILLER: We will be clear here that this is -- where did we end up.

MR. HACKBARTH: On all DRGs I think is where we ended up, didn't we, on this one.

ALL: No.

MR. HACKBARTH: I'm sorry.

DR. MILSTEIN: You're saying that hospitals should not be allowed to have this information from CMS? That's what we voted, that it would be harmful.

MR. HACKBARTH: So on recommendation number one, all opposed? All in favor? Abstentions?

Recommendation three. This would be on select. yes. Opposed to recommendation three?

DR. KANE: [off microphone] Are you going to add a trigger recommendation?

MR. HACKBARTH: On the pilot language, yes. Good point.

Just so everybody knows what we're talking about, in the earlier discussion about the pilot, the

recommendation had been made that we have the language that say that the Secretary would be authorized to move forward only if clear goals were met for the pilot. I don't have that language right in my head. So Nancy's saying since this is a pilot, we ought to have corresponding language here.

DR. REISCHAUER: I think actually it should be balanced. It should also be turning off the pilot as well as -- move forward but it has to end under other circumstances.

MR. HACKBARTH: In the interest of time and clarity what I'll ask is that let's just pull out that other language. And so we will vote on three when we've got that language worked out. Thanks for catching that, Nancy.

Anything else on bundling? Thank you, Anne and Craig. Good work.

Don't you love live television? Yes, a reality show. That's what we are.

MS. RAY: Now for something completely different.

Hannah and I are back to discuss issues about establishing an organization that would sponsor and disseminate comparative effectiveness research, both

retrospective research like systematic literature reviews and prospective research like head-to-head clinical trials in which researchers compare the effectiveness of service A to service B. We are building on last month's presentation.

Spending on health care is substantial and increasing rapidly. Nonetheless, the value of services furnished to patients is often unknown. Frequently new services disseminate quickly with little or no basis for knowing whether they outperform existing treatments and to what extent. Increasing the value of health care spending requires knowledge about the outcomes of services. More comparative effectiveness information, analyses that compare the benefits and risks of different treatments for the same condition could help payers, patients, and providers get greater value from their resources. By treatments, I mean drugs, biologics, medical devices, procedures, medical care, and no care.

The Commission has been looking at this issue for several years now. Our June 2007 report had a chapter that discussed the importance and the need for more comparative effectiveness research. This led the Commission to recommend that the Congress establish an independent entity

that sponsors comparative effectiveness research and that disseminates the information to patients, providers, and payers.

This slide lists the principles the Commission laid out in last year's report for establishing a comparative effectiveness entity.

Efforts to create a comparative effectiveness entity involve thinking about its structure and funding. Policymakers are looking for guidance on the pros and cons of different ways of setting up and funding such an entity. To be supportive of the process, we are planning a June 2008 chapter that weighs the tradeoffs of different ways to establish and fund an entity.

The goal of this session is to get your views on different approaches. You don't need to reach any decisions here. The chapter focuses on the governance of a comparative effectiveness entity and evaluates the pros and cons of different ways to set up a board of experts that oversees the activities of the entity, different ways to structure an entity, and alternative funding mechanisms.

I am going to talk about the design issues associated with setting up a board of experts which the

Commission called for in our June 2007 report. The first issue is the participation of experts from the public and private sector on the board. That is to say, the level of involvement of experts from the public and private sector.

On the one hand, board members could provide periodic guidance to staff and director. This type of design, a so-called part-time board, might promote greater participation of experts from the public sector like the head of the VA health group and DOD and the AHRQ, and the private sector, for example medical directors from private plans.

If the board's level of involvement is to provide day-to-day oversight, then board members would not be permitted to be employed elsewhere. This is a so-called full-time board. The Federal Reserve and the SEC are examples of such boards. Being a board member would be the occupation of the experts. Thus, outside experts from let's say the VA or AHRQ or DOD or experts from the private sector could not participate on the board unless they left their occupation to join the board full-time.

Recall last month the Commission discussed some of the trade-offs between the full-time and part-time board.

Regardless of the board's level of involvement, ensuring that the board members and staff are objective will be important for the comparative effectiveness research to be viewed as objective and credible. Ethics rules will help minimize bias and ensure the impartiality of the board and staff.

So here's an illustration of the structure of a full-time board. For example, the board could directly interact with outside researchers conducting work. Under this illustrative case, a number of advisory committees could provide direct input to the board. You could have one committee on setting priorities, another on methods, another on dissemination. Individuals knowledgeable in communications, for example, could serve on the dissemination committee. Stakeholders, like manufactures of drugs and devices, could be on the stakeholder committee. The role of the committees would be advisory only.

This figure illustrates the possible design of a part-time board. Under a part-time board model, the director could have day-to-day oversight of the entity's activities. The board could meet periodically and provide guidance to the director and staff. Note that the outside

researchers and advisory committees could have direct input to the director and staff, rather than the board of experts.

Here are some of the other issues that will need to be considered when setting up the board of experts. Concerning the appointment process, in general there are three ways individuals are appointed to a board of a Federal entity. Most boards and commissions, particularly in the executive branch, are appointed either by the president or by the president and confirmed by the Senate.

The second approach is for an independent person to appoint board members. The third approach is for heads of other Federal agencies to appoint board members. The appointment process partly depends on where the entity is located and the function of the entity. That is, does it carry out some type of function for the executive branch or the legislative branch?

Boards that are appointed either by the president or by the president and confirmed by the Senate may not offer the independence one might desire. Disagreements could occur, which could lead to gridlock, vacancies on the comparative effectiveness board. This could undermine the stability of the entity by affecting its ability to move

forward. This might be circumvented by having a neutral individual, such as the Comptroller General, appoint members to the board.

Two other issues to consider is concerning the duration of appointments. Appointments that are longer and overlapping may bring more stability to the entity than shorter appointments. And board meetings that are held in public on a regular basis will help ensure transparency.

There are various public-private options to consider for structuring a comparative effectiveness entity. They vary in their closeness to Federal policy makers on the one hand and the private sector on the other hand. All options would have some type of board of experts overseeing its activities.

A Federally Funded Research and Development Center, an FFRDC, might be the option that is closest to Federal policymakers. Even though FFRDCs are nonprofit private sector entities, they are under contract to an executive branch agency. The executive branch agency would have the responsibility of defining the FFRDC's scope of research. In the case of a comparative effectiveness FFRDC, possible agencies could be AHRQ or NIH within the Department

of Health and Human Services.

A second option is an executive branch independent Federal agency, the so-called Federal Reserve model. An independent agency is one that is in the executive branch but not in a specific department.

The third option is an independent legislative agency. Independent executive branch and legislative agencies generally operate independent of direct supervision from other executive or legislative branch agencies. The option farthest from policymakers is a Congressionally chartered nonprofit private organization. This would be a private sector organization established by the Congress. IOM and its parent, the National Academy of Sciences, is such an organization, and augmenting IOM has been mentioned by some policy experts as one alternative.

In terms of funding, some Congressionally chartered nonprofit organizations rely only on Federal funding.

Typically, what drives the placement of a Federal entity is its function. As an entity with broad private public-private mandate, each of these options has pros and cons and I would be happy to discuss them with you on

question.

Now Hannah will review two options for funding.

MS. NEPRASH: When the Commission last discussed how to fund a comparative effectiveness entity, there was agreement on the importance of a stable and secure funding source. You suggested that this could come from a public-private mechanism. This slide outlines two options for mandatory public-private financing to establish a comparative effectiveness trust fund.

One option for a comparative effectiveness trust fund would be to designate a small percentage of the Medicare Part A Trust Fund combined with a levy on private sector organizations such as private health plans and self-insured employers. This financing option has the benefit of mandating contributions from all payers. However, the incidence of this new levy would likely fall on consumers. Additionally, it's important to bear in mind the financial stress already placed on the Medicare Part A Trust Fund.

Alternatively, funding for the comparative effectiveness trust fund could come directly from general revenues. As a societal broad-based revenue source, a mandatory appropriation of general revenues is one way for

all payers -- public and private -- to contribute to a comparative effectiveness entity.

So Nancy and I have talked about various design issues for a comparative effectiveness entity. As you know, we're putting together a chapter in the June 2008 report to clarify and respond to policymakers' interest on the issues involved in establishing such an entity. Today's session is not intended to result in any decisions, but we're interested in your comments on the topics we've raised and any guidance you may have for future research directions.

Thank you.

MR. HACKBARTH: Thank you. Well done.

Questions? Comments on comparative effectiveness?

DR. REISCHAUER: There obviously is no right or wrong answer to these questions. It's sort of where your values and biases lie. And mine lie very strongly in the direction of having this as a chartered nonprofit organization, in large measure to remove it from the political pressures as much as possible and to allow the private sector to feel the most co-ownership of it.

A lot of this, oh the Medicare Trust Fund is under extreme pressure, general revenues is an alternative. I

don't know if that's like saying the Chinese will pay for it or else our children will pay for it or something. It's not like general revenues are in great supply right now either.

I would be much in favor of having a five-year or a seven-year renewable period and dedicating a chunk of A Trust Fund resources and some kind of per beneficiary surcharge on all providers of health insurance in the nation as the funding mechanism for something like this.

MR. HACKBARTH: So the Federal piece, Bob, would not be subject to annual appropriation but would be an automatic --

DR. REISCHAUER: But you could have the thing sunset after seven years or something, to have us reassess is this doing what we wanted? Is it the right scale? It's going to take a long time to get this up and running and feel what the worth of it is to our society.

MS. HANSEN: The funding mechanism you're saying was the health plans or the private sector paying per beneficiary. So it's not the beneficiary themselves; is that it?

DR. REISCHAUER: I mean, everything in the end comes out of the people's pockets. There is no tooth fairy

in our system.

MS. HANSEN: There's no question this is the public's dollar. But I think when it's on the burden --

DR. REISCHAUER: Some of it comes through public resources that are taken out of all of our pockets and some of it comes out of health plans, employers, whatever you want taking it out of our pocket. And we're not sure, in either case, exactly how much is taken out of our pockets for these kind of things. It would be a tiny amount. I'm in favor of billions of dollars in this, but billions of dollars are tiny amounts when divided among us all.

MS. HANSEN: I go for that. My antennae just go up when it's -- whether it's another direct tax to the individual beneficiary. That's my only concern.

MR. HACKBARTH: You can impose it on insurers but it's going to eventually make its way into the premiums paid? So at the end of the day it probably doesn't make any difference.

DR. REISCHAUER: The reason we're doing this is we hope it's going over the long run to have a salutary impact on the cost of health care.

MS. HANSEN: One of the usual aspects is just

knowing the copay and the deductibles for the direct beneficiaries these days are -- just relative to their income -- has just kept going. So I just want to put a little stake in the ground of knowing that ultimately it's about it comes back but I just don't want another immediate direct hit to the beneficiary.

MR. HACKBARTH: If I may, Bill, just one further clarification. You could set up an automatic withdrawal from general revenues as Part B does, so it's not subject to annual appropriation but the source is general revenues. As you say way, obviously we run in a deficit there. But who bears the tax in general revenues is different from -- the distribution of the tax burden is different in general revenues than it is on the payroll tax.

DR. REISCHAUER: In one sense, of course you're right. But since at the margin every dollar we spend is being borrowed, and most of it borrowed from abroad, in fact it's not affecting any of us. It's going to affect our children and our grandchildren and we don't know what the tax system will be like when we're forced to face the music. So I would just assume take it out --

MR. HACKBARTH: Does that lead you to indifference

between general revenues and HI tax funding? Or does that lead you to HI tax funding?

DR. REISCHAUER: I mean HI, at the margin you're right. But what it means is we'll run out of the trust fund sooner and we'll do something maybe -- I mean, this is a trivial amount of money even relative to the HI tax system. And if you want, I will raise the payroll tax by two basis points or something.

DR. SCANLON: I think one of the most important things in my mind is the idea that the board is as independent of conflicts of interest as possible. And for me, that leads me to favor a full-time board.

If it is going to be in an organization that's not governmental, I'd like it to still be subject to governmental ethics rules in terms of their holdings. I also think that the board should have long enough terms so that they span administrations because I think that I actually take more comfort in a very public process with the president and the Senate being involved here. I think it would help instill even more statue and confidence in this process.

And the idea that politics is going to play a role

plays less of a roll when you've got the long-term. So I would be thinking about that people are involved in this for at least a 10-year term. The Federal Reserve Model is a 14 year term now.

This is something that I've thought about but I don't know how you exactly address it. With respect to government employees today, we have rules on their lobbying activities for a period after they leave. We need to think about what happens when people leave these kinds of positions, but what kinds of strictures you should put on them, that's not clear. For this kind of a body, putting a restriction on lobbying may not be a very meaningful kind of action in terms of eliminating some type of potential conflict of interest towards the end of one's term.

But I think the idea that the board needs to be as independent as possible is a critical part of establishing the confidence in the organization.

MR. DURENBERGER: This is a minority of one on the subject, but for me it's sort of like the reality show question which is what we're talking about going into the next Congress or whatever it is, asking for a new agency or a new board plus a new tax, I try to listen to the debates

between the presidential candidates and see if I can hear anything like this coming out of it and it's very difficult. I know they all talk about effectiveness and they all pick that up.

So when you try to think about somebody has to make these decisions next year, the first question is always whose the constituency for this? I'm not sure that while I think it's a great idea, if you try to label a constituency from a politician's standpoint it's health service researchers, health economists, people like us sitting around a table. I'm not sure that's readily identifiable as a potent constituency -- with all due respect to my colleagues -- compared to all the other demands on time and dollars.

So the second one is who will benefit from it? It strikes me that in the immediate sense the people who should benefit the most from it would be hospitals, CMS as a payer, health plans, technology companies because for the first time they're going to have to think differently about research and development.

So I could identify a lot of people with a lot of money who would benefit from it but I can't find a way to

pass the hat among them and have them standing out there saying oh, I'd love to do that. I mean, if there were a line up in this room on the subject from the hospital association and the physicians association, as well as AdvaMed and Pharma and so forth, saying by god, you guys are on the right track, what can we contribute to this? I'd say well, it's a great idea, and then let them come up with a financing mechanism.

But it doesn't yet -- just judging from a well-written paper and a lot of good research -- it doesn't come through to me other than let's tax providers, let's tax insurance companies, let's tax -- as Russell Long would say -- the man behind the tree and all that sort of thing.

When I recount the efforts to try to do this sort of thing, the logical place for the 25 or 30 years I've been involved in this sort of thing is in the National Institutes of Health, where we do our spending on what is good for the people of this country in terms of research investments. So that's the logical place to put it.

I can't recall, except for so-called patient driven, what's the latest disease we've got to eradicate, I can't recall a situation in which trying to do health care

right and efficiently and make sure you get a better outcome and a better result has had much of a constituency inside that bunch of people. I mean, they are just interested in plowing money into academic medicine and into all of this research so we can do hearts and cancer and AIDS and you name it. And then the appropriations committees can sit there and try to parcel up the money.

And yet, if we think about this I think everybody in this room would agree the best place for this, so it has to compete for our dollars and recruit dollars at the same time from the legislature, should be in the National Institutes of Health. When we went for the first time to do whatever we called it before AHRQ, that was one of the reasons we did AHRQ was because we knew the guys at NIGH would be like this to this sort of thing. And that continues to be a problem.

But the closer we get to crisis and the closer you get to presidential candidates saying we're in crisis, we've got to do something about it, they talk about comparative effectiveness, I would suggest -- and I'm not going to be around here after today -- but I would suggest we not leave the NIH, if you will, off the list and try to persuade

others in the health service research community that it probably would be, hopefully would be, easier to make an argument that we need to build something like this into NIH and finance it through general revenue than that we try to pass a new tax or some other form of financing.

I'm deliberately staying away from the organization of it. Bob is right, the easiest of the alternatives would be this chartered nonprofit and things like that.

And yet, this is America and all of these seem to be difficult to get your hands around, for me at least, except for the National Institutes of Health where we ought to be doing this kind of research today but we can't only because there are some constituency groups carving up the available pool of money to do other kinds of research.

MR. HACKBARTH: That's an interesting point. I guess my thought about NIH would be that it's sort of countercultural for them. It's an institution built on innovation, research, finding new things is why they exist. And it's terrific. It's very important for society that we have an institution like this.

The spin here, though, is something different in

that we need to be looking for value in that innovation. I'm trying to imagine myself as the director of the NIH. It's a little bit schizophrenic to run an organization --

MR. DURENBERGER: All I say is I think everybody around this table and a lot of people in this room agree that the research that is most needed in this country today is not another device or another me too drug. It is value. It's the research around what is valuable and what is less valuable. And that is the key innovation. If we did that kind of research, I think it's another important key to more innovation in this country.

MR. HACKBARTH: Change the innovation, a different type of innovation.

Just real quickly, I'd be interested in hearing from John and Arnie on Dave's first point about the constituency for this. In the very preliminary discussion about comparative effectiveness and creating a new entity, at least the piece of it that I have heard, the most vocal and articulate people have been those expressing concerns about it. There have been research types, as Dave says, advocating it. But I haven't heard -- and maybe I just haven't been in the right places -- the private purchaser

community saying this is really important and counterbalancing.

Have I just missed that?

DR. MILSTEIN: I think that partly it's a very -- it's a very fragmented community. So it's hard to pick up any signal, even if a view is held by a majority of those in that constituency. But I think if you were to poll 100 private purchasers and ask would this be useful? Would it be useful enough that you would be happy to pay your pro rata share of this research, the vast majority would say yes.

MR. BERTKO: I would echo those comments. You would want to ask in health plan payers, the senior medical director, the chief medical officer, if he or she were interested in that. The answer would be overwhelmingly yes.

And then the two of us, the actuary in hand with that, would show the rates would go down eventually. And the CMO would go into the CEO's office -- or more likely the CFO -- and twist their arms and say pay up a little bit right now for big savings later. But you wouldn't necessarily get that on the straightforward request to the

people who usually speak out.

DR. REISCHAUER: Places like the BlueCross BlueShield plan and numerous of these plans, all of which have a paragraph saying something like this should be set up.

MR. HACKBARTH: You represent another part of the purchaser community?

MS. BEHROOZI: We're just constantly looking for information anywhere that we can, to make our claims to our members more credible about our formulary drug list or prior authorization requirements or that kind of thing. Yes, desperate for it.

DR. MILLER: I'm sorry to interrupt because I thought we were going to a different point.

The other thing, and this is with all due respect, I think the constituency issue has changed a little bit. It doesn't mean that there's a group out there lined up, but it has changed because CBO is now scoring long-term savings to this idea. And so actually, the interest in this idea on Congress's part has shifted. It used to be in the past like great information, eggheads, researchers, that type of stuff, thanks. I didn't mean that quite the way that came

out. It's been a long day.

But I think now with the scoring dynamic, I think some of this has shifted a bit on the Hill. Not quite a constituency but the hook for it is a little deeper, I think.

MR. HACKBARTH: Other questions comments on comparative effectiveness?

DR. STUART: I want to comment on what Bob had to say and I agree that it should be a chartered nonprofit. NIH just doesn't have the culture, I think, to handle this. We all remember the near death of AHCPR, then when it became AHRQ. They, frankly, haven't done a great job of this. I think it's not all of their fault because they've got a lot of different constituencies that they have to deal with. And they've got no money to do it.

This is just such a wonderful opportunity that I think we want to make sure that we've do it right. And starting fresh, I think, maximizes that opportunity. So I think it ought to be outside in a chartered nonprofit.

The second reason is that gives you a mechanism by which you can more easily grab the private money. The more broadly this is based, the less the bit is going to be. And

so if we were to take your point, Glenn, and tax not only part A but tax general revenues that go to Part B and Part D, even if the final incidence doesn't matter, at least it says that everybody's in the game and it spreads the costs around.

MR. HACKBARTH: Others?

DR. REISCHAUER: When we think about the board, I think you want to think about -- and you've mentioned this -- the size and functioning of the board. The way you were talking, Bill, and I agree with what you were saying and the thrust of your remarks, whether you're talking about a very small supervisory board, it's almost like three commissioners, one representing the government, one representing the stakeholder community, one representing people, which are permanent full-time jobs of the sort you were talking about. And then an awful lot of the responsibility and action is really the executive director and the staff under the guidance of let's say three, could be five, individuals.

The other is the 10-person board. And I'm not sure something like this works that way. Then these individuals would have to be into the management of sections

of it in a way that the Federal Reserve Board allocates its members to certain monetary policy and commission functions. I'm not sure you'd want that, quite frankly.

MR. HACKBARTH: Others? Okay, thank you very much.

Next is accountable care organizations.

MR. GLASS: Good afternoon. Today Jeff and I will talk about the concept of accountable care organizations. We hope today's discussion will give us some guidance as over the summer we think about how ACOs might fit into the broader picture of incentives you've talked about today. These are preliminary thoughts ACOs. They're not going to be in the chapter in the June report and there are no recommendations to vote on.

The motivation and the background for our interest on ACOs is, of course, the quest for volume control that's been discussed many times. Volume growth is unsustainable, leaving to exhaustion of the Part A Trust Fund by 2019 and Medicare making up an ever larger part of the Federal budget and GDP. Quality is uneven, not getting enough of the recommended care, getting too much of other care, and outcomes not outstanding. There's a lack of care

coordination, which can lead to extra costs in the system and decreased quality.

We need some sort of mechanism to counteract the incentive for volume growth in fee-for-service. The basic incentive in any fee-for-service system is to do more. Providers get paid for each service, hence more services, more pay.

There needs to be someone with an incentive to do less of the unnecessary things and that is where ACOs may be useful.

We also want to improve overall quality. So P4P may be part of the answer, but it's confined within the individual payment system so its scope is somewhat limited. ACOs might provide a broader measure of quality and allow us to consider overall outcomes.

As a reminder of where we are going, this is the big picture for outlining a long-term direction for payment delivery system reform that we discussed back in January. We are now in the first column under current fee-for-service payment systems. Each of the payment systems is independent of the others. Providers are paid within their own system, such as SNF or home health. There's no pay for coordination

of care across systems or encouragement of care coordination. This is a serious problem for patient care and Medicare costs because volume is encouraged by fee-for-service payment systems.

The Commission has recommended using the tools in the middle column to increase value within fee-for-service systems. You have just discussed comparative effectiveness. Reporting resource use begins to increase awareness of practice patterns. P4P within individual fee-for-service systems can make some inroads on improving quality. ESRD is an example of paying for a bundle of services within a payment system. And we've talked about shared accountability or gainsharing two discussions ago. And creating pressure for efficiency through updates we discussed in the March report.

However, there are two important limitations to these tools. First, the fee-for-service system still has a strong incentive for providers to drive up the service volumes, even if these tools are put in place. Second, the fee-for-service system lacks incentives for individual providers to coordinate care across the payment silos, and tools that operate within these systems cannot directly

solve that problem.

Therefore, we need to consider paying for care across settings over a period of time that encompasses multiple visits and procedures. We have considered three approaches: earlier today we talked about medical homes and bundling because of their potential to improve the coordination of care. A complementary policy option could be accountable care organizations.

First of all, what do we mean by an ACO? For purposes of today's discussion, we're thinking about an ACO being a group of physicians that is held responsible for the quality of care and the annual Medicare spending for their patients. Whether hospitals should be part of the ACO is an important design choice, as well. The distinguishing characteristic is that the ACO is responsible for quality and costs over a year, even if ACO members do not directly provide all of the care. This can be thought of as unfair, as some care provided may be outside of the ACO's control, or it can be looked upon as an opportunity for increased revenue if the ACOs can share in savings with Medicare.

That is why the payment design is important, and although we will discuss the payment design in more detail a

little bit later in the presentation, I will sketch it out briefly here so you can have some idea of what we're talking about.

Our potential payment design, physicians are paid fee-for-service rates less a withhold. Bonuses are possible if resource use and quality targets are met and those bonuses would be paid for from savings off of expected resource use over the year. Savings would be shared between the ACO and the Medicare program.

Being good stewards of the taxpayer dollar, we also contemplate penalties for failing to meet both targets. We'll get into the specifics later, but broadly speaking this is our working definition of an ACO.

Given that you have already looked at moving forward with medical homes and bundling, you may ask why do we also need accountable care organizations? ACOs would be responsible for all their patients. Medical homes may only have chronic care patients, bundling just deals with patients admitted to a hospital. So an ACO would be more inclusive in that respect.

In addition, ACOs create two key incentives. They have a financial incentive to keep patients healthy and out

of the hospital. The bundling design discourages readmissions but does not have an incentive to avoid initial admissions. In fact, as Anne has said in the past, there may even be an increased incentive to admit lower severity cases.

ACOs also have a long run incentive to restrain recruitment in health care capacity in the area. This is a little more speculative. There is some evidence that Medicare resource use is supply driven. If there are more specialists and hospital beds in an area, Medicare spending is higher than in areas where supply is less. Recruiting an additional cardiologist may look less attractive to an ACO that is responsible for overall resource use for its patients.

In this presentation we will discuss two possible ACO paths. First, the voluntary ACO. In this, existing multispecialty group practices would volunteer. They would want to be held accountable because they believe that they can improve quality while keeping resource use in check through better care coordination and treatment.

Physicians who do not volunteer to be in an ACO would remain in the current fee-for-service system and their

incentives would not change.

An alternative would be mandatory ACOs. These would be virtual organizations. That is, there would not necessarily be any contractual relationship between ACO members. This is akin to the virtual bundling you discussed earlier today. Physicians and beneficiaries would be assigned to ACOs based on claims. They wouldn't have to take any action to become part of a virtual ACO, but on the other hand they wouldn't have any say in their assignment. This is similar to previous work that Elliott Fisher discussed with us. In that work they showed that almost all physicians could be assigned to an ACO in this manner.

So I will briefly walk you through the voluntary approach and then Jeff will discuss the mandatory approach and the payment design.

In the first path, multispecialty groups would volunteer to be held accountable for quality and resource use. The payment design could be similar to the PGP demo whether the reward is shared savings between the program and the ACO. Savings would be considered relative to a group's own baseline. This would allow all groups to succeed and Medicare could break even or maybe even come out ahead. The

ACOs would be large enough so that it would be possible to judge if the improved quality and reduced resource use and distinguish whether that's real or whether that's a random change.

One concern is some areas do not have large multispecialty groups. As you can see on this slide, there are parts of the country that do not have a lot of multispecialty groups in them. We have defined it here as multispecialty groups with more than 25 physicians. The circles on the chart each denote a group. The area of the circle is proportional to the number of physicians in the group. This is not showing the percentage of physicians in an area that are within a group, just where the groups are and their size. You can see the usual suspects. There are large circles in Boston, Cleveland, the Mayo Clinic in Minnesota, Permanente North and South in California. But there are also many more across the country and there are over 300 in all.

So issues with voluntary ACOs. First, it's difficult to structure rewards and penalties that attract all ACOs. This is similar to this question that was just talked about in virtual bundling. High use ACOs will want

ACO-specific targets and low-use ACOs will want national targets. Jeff is going to explain how we're going to work that out.

The other issue is only those that expect bonuses would enroll, and that might create problems maintaining budget neutrality.

Jeff will now discuss mandatory ACOs and the potential payment design.

DR. STENSLAND: A second approach is to have a system of mandatory ACOs where patients and all physicians are assigned to an ACO based on claims data. An example of this is the extended hospital medical staff model that the Dartmouth researchers have talked to you about in the past. In that model, physicians you use a common hospital are assigned to a virtual ACO.

As is the case with voluntary ACOs, all physicians in the ACO are jointly responsible for every patient assigned to the ACO. However, only in the mandatory model will virtually all physicians and all patients be assigned to an ACO. What that means is every patient would then have a group of physicians that is responsible for that patient's quality of care and that patient's resource use.

The mandate could be viewed as either a negative or a positive. Some may argue that it is unfair for physicians to be held responsible for care provided by other physicians with whom they have no formal contractual relationship. Physicians may feel they have little influence over other physicians' practice styles.

However, some others may look at this same situation and see the mandatory ACO as a way to improve the level of communication and peer review among physicians. Under the mandatory ACO model physicians will have a direct financial incentive to improve communication, improve quality, and restrain health care capacity in the market.

So once physicians are assigned to ACOs the question is is there really that much variation in resource use among ACOs? Researchers at Dartmouth have shared some preliminary data with us and, as expected, we see wide variations. We see almost double the number of ambulatory physician visits in Miami or Los Angeles compared to Minneapolis or Portland.

However, what's interesting is there's also a significant amount of variation within markets. For example, the average patient in a low-use ACO in LA may

receive seven or eight physician visits in a year but the average patient in a high-use ACO in that same market may receive 12 visits per year.

So what this tells us is that there's a wide variation and that suggests room for improvement. But we may also have some room for a reduction in variation within markets, not only between markets.

So there is some potential for gain with ACOs, but are the potential problems? We already talked about one challenge, which is whether physicians will accept being assigned to a virtual organization. Second, even if they are assigned, will peer pressure be enough to really create improvements in the way care is delivered?

In addition to those concerns, there are some general challenges that affect both voluntary and mandatory ACO design. There will still be an incentive under both cases to refer patients to physicians outside of the ACO when those patients have expected costs that are not picked up in the risk adjustment models. For example, A doctor may know that one of their diabetic patients is thinking about getting a new hip next year. So this primary care physician may refer the patient onto an endocrinologist in an academic

medical center to manage their diabetes. The patient may then end up being assigned to that academic medical center and that hip replacement cost would be assigned to the ACO and not the primary care physician's ACO.

To reduce the incentive for physicians to avoid certain patients, I think we will need to continue to work on both the risk adjustment algorithms and maybe the timing of when patients are assigned to specific ACOs, the patient assignment algorithms.

A second challenge is determining how we would blend quality and resource use scores to determine bonuses? In addition, we're talking a lot about resource use target. But how do we set that target? And we are not trying to give you definitive answers today, but I do want to show you a couple of alternatives just to point out that there are some reasonable solutions to these difficult questions.

In this slide, we present one possibility for setting bonuses and penalties. Similar to the bundling approach you've heard before, physicians would continue to receive fee-for-service payments less a withhold. ACOs that do well both on the quality and the resource use measures would get a bonus. Those that fail to meet both the quality

and resource use targets would face a penalty and the penalty would be in the context of not receiving their withhold. All others would be held harmless.

A key point is that we expect that most providers will be able to improve their quality scores. In the PGP demo, all providers were able to meet the quality targets. Therefore, there will be few penalties and few penalty dollars to distribute as bonuses. The main action will be in sharing of savings. If physicians can save the Medicare system some money by keeping patients out of the hospital and constraining capacity growth in their market, they will be rewarded with a share of those savings.

The next question is how do we set those resource use targets that will determine whether they get their bonus or not?

Here we present one possible way to set resource use targets. Our goal is to set targets so that they could appear fair, make bonuses for improvement achievable in both high and low use markets, and to have the potential for generating some savings for the program.

In this example, the national level of spending in the first year was equal to $10,000 per beneficiary. The

expected increase after adjusting for wage index and risk adjustment, the expected increase in the average market would be $500. The target for an ACO with average spending in the second year would then be $10,500, a 5 percent increase over last year's spending. So that $500 would be kind of like the allowed increase in spending.

On this next slide, we add some data on a low-use ACO in the market. This ACO is still allocated a $500 increase in spending, of course adjusted for wage indexes and risk scores. Just assume that it's average wage index, average risk score for this model. But for this low-cost provider the $500 allowance is equivalent to 6.3 percent increase in spending.

But again, the objective is to set the target so that everyone can still gain a bonus for improving, but we realize that providers that are already providing care at a fairly efficient level may have a harder time reducing costs by the same percentage as some of the higher cost providers.

Now let's look at one of those higher cost providers. Finally on this slide, we present the option of requiring a high use provider in the market to bring their

resource use down to at least the average of the market before they receive a bonus. So in this example the high-cost provider with a historic risk-adjusted cost of $11,000 per Medicare beneficiary would have to reduce their cost down to the expected market average in order to qualify for a bonus for restraining resource use. The idea is that if you don't do better than the average of your market, you don't get a bonus.

Now just to recap here, the general idea behind the ACOs is that providers need more of an incentive to coordinate care and less of an incentive to drive up volume. Making physicians jointly responsible for quality metrics creates the incentive for cooperation, and making physicians jointly responsible for resource use will reduce the existing incentives to drive up volume.

As David said, this differs from the medical home and bundling or readmission concepts in that we're casting a much broader net and that the broad net would cover all A, B, D spending over the whole year.

So now we'd like to hear your thoughts on the direction we should take from here. Specifically, should the ACOs still be considered as a complement to the medical

home in an effort to control volume? And if we move forward, should the ACO be voluntary or mandatory? And finally, should the ACO include a hospital? We've not talked with that much but some may say they want a hospital in the ACO to create an incentive for physician/hospital operation. On the other hand, some of the savings that ACOs generate will come from reducing initial admissions and it may be harder to get buy-in on that goal if a hospital is part of the ACO.

So now we'd like to hear your thoughts.

DR. CROSSON: Thanks.

It probably comes as no surprise that I am interested in this notion. I think I view it though as part of a -- now anyway -- as part of a spectrum of activities helping us direct the country towards a different kind of delivery system some time in the future. I think we're making a number of steps in that direction with the actions that we took today, and I'm happy about that.

Just a couple of points. I think I'll bring this up at some risk, and that is withholds or rewards within one payment year is only one way of rewarding or penalizing. It was brought up some time ago that the update system, both

for physicians and hospitals, is another way of doing that in a cumulative way over time. I still think that is a viable idea.

Having said all that, I think that I would be quite adverse to the idea of a mandatory process that would try to involve all doctors and hospitals in the country. I think it would not work, and certainly not without a lot of pain and after a long period of time. I think the experience that we saw in the 1990s, when there was an apparent incentive for hospital/physician integration, was largely unsuccessful. Now we've seen some noted successes, and there are some across the country.

But I think the experience generally is viewed as being unsuccessful because it was kind of a forced throwing together of individuals and institutions who had very different cultures, who were suspicious of each other, who did not have the skills -- nor in that case the time to develop the skills in order to make this work.

So my sense is if this were done in a mandatory way, it would probably not be successful.

What I would rather see, and I think supportive of work that we've done here and thinking that we've done here,

is a progressive identification of incentives, different kinds of incentives, certainly payment incentives but perhaps other kinds of incentives also that would over time make it quite clear to institutions that a successful future lies in this direction.

And they could be incentives that accelerated over time or that were expressed as points in time at which changes would take place that would make it clear to institutions and to physicians that doing the work -- and it is work, and it's hard work -- doing the work of getting together, of learning, in the case of physicians to trust each other and to work together across specialties. And in the case of hospitals, to work with their medical staffs in ways that they don't like to work with now, is work that has to be done. And that, to my mind, would be the way to get there.

I think we've thought about some of the ways. I think bundling begins to do that. I think the notion of the medical home, at least with respect to physicians, is a beginning process, also. And I think we should spend more time on this. I think more about what that message would look like long term and how we could express that and how we

could imagine a set of increasing incentives over time that would bring this about.

MR. BERTKO: Just a couple of words, first off to give the disclosure that I've actually been working with Elliott Fisher and his team on this. So I've done a little thinking about it. I probably have a little biased, too.

Secondly, I agree with Jay, I think, in your point about saying it needs to be voluntary at the start of this. And Nick, I will look to you down the line somewhere, you had your hand up at least about comment, if you think of this as an expansion of some ways of the PGP demo and whether or not you'd be supportive of thinking along that?

Having said that, going back to the voluntary part, then you have selection issues. I think you guys have identified them. And I think, based on again Elliott Fisher's work, they're solvable but tricky. So in terms of budget setting targets and stuff, you have yet other issues that go well beyond what I'll call normal risk selection on those.

And lastly, the comment that Jay I think began to address this, except I will say that not only would I include the carrots that I think Jay was saying in terms of

incentives but inertia might provide a very big stick. In this case, the inertia I'm talking about is the SGR just never gets fixed. And yet, this ACO has become an escape hatch for any group that begins to come together, whether it's doctors only or doctors and hospitals, to eventually try it out. And as in the Karen amendment, if they fail then they get tossed back into SGR hell.

So with that, I will stop.

MR. HACKBARTH: I think that's, at least in general terms, what Jay was alluding to in terms of using the update as a potential mechanism.

MR. EBELER: I would just echo Jay's and John's points. I think they were made. Two additional things. At some place in here we may need to discuss that awful word capitation or partial capitation. If these things get up and going, it may well be that that is somewhere on the glide path. I know it gets controversial, but that might be worth thinking about.

The other thing is a little bit different frame for this. We're looking at this as how do we go from current fee-for-service to an accountable care organization. So to go back in history, in some ways this is what some of

us thought health plan participation in Medicare was about. It was about prepaid group practices gravitating into Medicare.

And there may be a policy direction here to sort of backward map from where we are in Medicare Advantage and create more accountable organizations through Medicare Advantage. I mean, heading in this same direction, if you presume we're going to have to do a stream of policy work in sort of trying to redesign Medicare Advantage, one set of steps would be to try to take some of those organizations and head this way as well.

In particular, as the market has shifted from 6 percent private health plan/94 percent fee-for-service when you had to figure out what to do in fee-for-service well, the market may now be more and more Medicare Advantage.

So just conceptually thinking about starting with a Medicare Advantage system as it appears as though it's going to look in a year or two and taking a stream of policy to turn those into what some of us thought they were supposed to be all along, may well be another direction here to try to push.

MR. HACKBARTH: Just say another sentence or two

about that and how you would take Medicare Advantage and move it?

MR. EBELER: The question, I think, would be if you presume, as I do, that part of that direction for bringing those organizations into Medicare was to produce accountable entities, accountable health plans and delivery systems, I think we're a far ways from that in how Medicare Advantage has evolved. I think one could sort of start with where we are now on Medicare Advantage and sort of rethink what standards and payment methodologies you might want to put in to place to try to nudge that part of Medicare to more accountable care, at the same time we try to move sort of the open-ended -- --

MR. GLASS: Jack, do you mean move away from full capitation in that scheme, towards --

MR. EBELER: It may well be moving away from full capitation, in some cases. It may well be setting a set of standards for what you have to look like in order to get that. And in my mind, does private fee-for-service fit at all in that model? It just strikes me that there's two ways to move to accountability here.

DR. STENSLAND: The defining difference, in my

mind, between the MA plan and the ACO is under ACO model the government maintains its pricing power. When you're envisioning this, do you still envision an ACO where the government is a price setter? Or do you think it would be like the MA model where the MA plan is a price negotiator?

MR. EBELER: I think if you move from the fee-for-service in this direction you have to do it the way you've talked about. I'm just saying there is another -- I'm not suggesting it as an alternative to what you're doing. I'm suggesting it as a complement to what you're doing, that there is another policy direction to drive to accountability and care that is modifications of the MA program.

Again, in some ways it's where we started. We used to be able -- I think I used to be able to say I sort of know what that looks like. And now I can't say that anymore because of the way MA has evolved.

DR. MILLER: One way to interpret what he's saying is -- and again I think a key point to take away from this, which I was getting immediately -- is we're pushing from fee-for-service. Is there anything we want to do on MA policy -- separate thought, end of sentence, separate thought -- to also drive, just for one second -- and I'm

completely making this up and I'm not suggesting it. But say private fee-for-service plans where they say okay, I'm covering these lives. But there is this express concern that many of you have said that they don't really act like managed-care organizations.

Well here we're saying some group of physicians might be rewarded or penalized based on how the underlying spend of their population does. What if we were to say that about private fee-for-service plans? Instead of just saying here's your capitated rate year for year after year if you change the spend your rate will differ different depending on that, go down if you don't control expenditures the point being. That begins to drive them to say I can't do this in an unmanaged unorganized way. I've got to get into an organized system or get out.

MR. HACKBARTH: One of the concerns that I've had about trying to graft accountable care organizations onto the fee-for-service system is whether you can ever get the incentives strong enough. Your basic flow of dollars is still fee-for-service with all the inherent incentives to do more stuff and more sophisticated stuff over time. And you're saying at the margin we're going to change that by

establishing a target and sharing savings if you come underneath of it.

I imagine if you're running one of these organizations -- and maybe, Nick, you can address this -- the model for sharing of savings is vitally important in what sort of decisions you make and whether you invest in things that have the potential to reduce long-term costs. If you're just getting a piece of the savings after Medicare takes X percent off the top, it may be that at the end of the day you're just better off going like hell in fee-for-service and generating as much revenue as you can. There's just not enough pressure in the opposite direction to make it worthwhile.

You need to model how that works out for particular institutions but that's a concern that I have.

MR. GLASS: That may be one reason why you'd go with the physician-only world of ACOs, because then they can steal everyone else's money.

MR. HACKBARTH: Which is a point that Arnie has made in various contexts, that you want entities that don't have mouths to feed, is the way I think Arnie put it.

DR. CROSSON: Does a couple of points. In terms

of the strength of that incentive, that was one of the notions why using the update system would be stronger, because it might only move a few percentage points but it would move them cumulatively over time.

I'm sorry, I'm forgot the second point I wanted to make.

DR. WOLTER: I wasn't going to mention the SGR today or tomorrow, but I can't help it now.

[Laughter.]

DR. WOLTER: Just to start off, I honestly do believe that the SGR remains a much bigger impediment to progress than it is a boon or some kind of a lever. I have said that many times. I think it is so much in the way of really focusing on these other topics that we're getting behind, because we're not finding enough time for the conversation we're having right now.

So next year when you guys vote to eliminate the SGR, I'm going to cheer.

The comments I want to make about this are starting where Jay was. I would agree mandatory and trying to move quickly to a payment model that goes right to the medical staffs or the hospital model. That really makes

virtual bundling look like a simple project, I think. And so I wouldn't see that happening.

But this is how I think about all this. Nancy said once earlier this year we always talk about how most communities aren't ready for this. But truly in the '90s, when capitation was looming, PHOs were formed overnight. And I think if we had a combination of things like bundled DRGs -- and it was pretty clear that was coming to everybody some day, and I wish we wouldn't be so timid about that.

And then I would connect this to pay for performance. If we could focus pay for performance on high volume high cost disorders at the physician/hospital intersection and really create incentives for docs and hospitals to be shared and accountable around the care that has pay for performance tied to it -- and gainsharing work would be required here, so that the measures around post-op infection, ventilator-acquired pneumonia, acute MI, CHF, COPD, et cetera, really require that docs and hospitals have some shared organizational approach to how they take care of those high volume, high cost diseases -- we would have a lot of new PHOs and we would have a lot of people looking at how can they start working more together to attack those kinds

of problems.

Obviously we saw a fabulous example of that with Middlesex, the organization in the group practice demo that's a virtual organization or a PHO. So this is very doable over a period of some reasonable period of time.

I did think the whole issue of mini-capitation and capitation comes back into play. I think the PGP demo is maybe setting up the stage where some organizations can become accountable for per beneficiary payment per year. And maybe it's mini-cap to start with around CHF or diabetes or COPD.

But there's lots of ways to start the process, I think, of accountable care organizations forming if we think about those mini-steps which will create an experience of people coming together to share accountability.

And once that happens, you can move to bigger steps like payment per beneficiary per year.

Maybe I'm an idealist. I think it's crazy to think that we should set up ACOs without hospitals. I mean, I think there are plenty of organizations right now that are trying to reduce readmissions, although they know that in some way that may take payment away from them.

But to use the idea that you would pit one set of providers against another so that we can have even another food fight about money, rather than be patient-centered and reward the care of patients over time and over silos -- which is really what the IOM is talking about, I think, in many of its reports -- those are the payment models we should put in place.

So the ideal ACO will have both, and then hopefully we can really focus on the patient.

DR. MILSTEIN: A few comments. First of all, I favor the voluntary option because I fear the compromises that would be needed to be made in order to move forward with the mandatory option; i.e. those compromises would dumb down the program and the goals, et cetera.

And I think the voluntary program, I think might work if we were to offer options on degree of exposure to risk and opportunity for gain. Some organizations that might want to step forward might not have the courage to take responsibility for some kind of quality adjusted capitation, but they might be willing to go with some of the more modest proposals we put here, we put up on the screen.

But I would hate to see organizations that were

fully capable of doing fabulously under a quality adjusted capitation be restrained from stepping forward and being able to assume that high degree of responsibility.

There are obviously all kinds of gradations between them that have come up in various suggestions, the withhold, the adjustment to the update, the shared savings. I think we could have sort of array that in ascending order of risk and responsibility and opportunity for reward and let these organizations -- some of which will be very embryonic -- step forward and reach for what they can reasonably handle and obviously have rules to essentially prevent an organization from assuming a huge level of risk and then crashing and burning with a lot of Medicare money in their pockets.

A second comment is I noticed in the first option we had up there that that first option would only be available to physician group practices. And while I have only the deepest respect for this country's best run group practices, and have actually been very impressed with what they've accomplished, I still think we need to be flexible regarding the minimum size and I'll call it the minimum specs for these organizations that might want to step

forward and become accountable care organizations A, because I think that's what the evidence-based, based on the Casalino and Burns presentation and the neutral review we had of the evidence which suggested that the larger physician practices have a huge advantage in terms of central mass, management resources. But the small organizations tend to have an edge with respect to agility and speed of shift.

And so the net judgment from those two researchers of the evidence suggested that it was, at this point, a tie with respect to up-management potential.

The second reason I would encourage us to be flexible is I've had my eyes opened over the last couple of years. I've had some foundation money to go out and try to find delivery systems that are exceptional with respect to what I'll refer to as low total health insurance fuel burn without evidence of any quality reduction. And while some of those organizations are bigger, more complex organizations, some of them bringing in rather stunning results are not that big. They are, in one case, a four doctor practice that has been able to reach for and fabulously manage quality adjusted capitation for a quarter

of their patients.

One of their observations was that they are making so much of a margin on those patients that they are able to take the excess and provide a much better care experience for all of the other patients who don't have equally enlightened payers backing them.

And last, I think that there obviously are limits to how small these groups can be relative to the insurance risk they're taking. I think in any rules we might conceptualize there would be reasonable ways of making sure that physician organizations like a single doctor practice don't reach for a level of accountability that's completely unrealistic from an actuarial perspective.

MR. DURENBERGER: Apropos of the point Arnie made about sometimes the obvious isn't so obvious, when we did the first community measurement project and announced some of the results on diabetes, I think, ranked all of the physician groups in Minnesota, the highest performer was six doctors up along Lake Superior someplace in the middle of what's called nowhere. And the Mayo, and that sort of thing was not anywhere near the top.

If you look the same way at the costs procedure by

procedure by procedure looking at health plans in our country or in our state, Mayo is somewhere near the top and all that sort of thing. And I'm not doing this about Mayo. I'm doing it largely about the incentives. Because whether it's the Mayos or the six docs or its Marshfield out here in the audience or wherever it is -- and I'm reminded of this by Jack's really cogent remarks -- for the 20-some years I've been involved in this, we've been changing the game so often on a good thing that it's pretty hard for these folks to follow. To the point about -- how does this relate to medical home and things like that.

I think what you need to do is decide what is the direction you think -- in terms of physician or physician groups, where should we be heading? And what are some of the elements to get there? And that might be bundling and other things like that. If I were you, I'd really fix on this accountable care organization as the way to go.

But apropos of what Jack said, in 1983, when we did the DRG and that sort of thing, thanks to Jack Heinz's amendment on the BBA or TEFRA or something like that in 1982, we started down the private course. And so we have this history of going down two tracks, the public and the

private. And it wasn't designed to put one in competition with the other. It was really designed -- at least Heinz and I and others who were kind of like believers -- that properly motivated, properly rewarded, properly incented, that the physician community, along with the hospitals that they either owned or had an interest in or they used and so forth, would show us how to improve the delivery of care.

And in select parts of the country in 1985, '86, '87 when it was first being implemented, it happened just like that. We went from at or above the national average in Minnesota, North Dakota, et cetera, probably Montana, we went to 17 points below because physicians changed their behaviors.

We've lost that over 20 years basically to the insurance industry as it has merged all of these good ideas that Jack was involved in when he was in Minnesota, they've merged them all into big national organizations and they've started to set the national policy for reimbursement.

And rather than attacking Medicare Advantage or doing all this sort of thing, it strikes me that there's an opportunity here with accountable care organizations and the way you structure that to start building the necessary

relationships with the health plan or the risk bearer or who bears risk and how they do it. And as you evolve this particular set of tools we've been talking about today, but with a focus on accountable care organizations, that you begin to show opportunities both in traditional Medicare and on the private side for linking performance and payment and let these various communities show you how to do it, wherever they may pick up on it.

It seems to like that's a better way to get at the issue of Medicare Advantage overpayment or however we might characterize it is to show the important linkage with performance that we believe exists, has existed, could existence and so forth. Because I think we all agree that if something isn't done at some point about setting the signals appropriately and correctly, there's going to be well, what's today's issue? It's the employer MA.

And my partner over here has a little sketch she's developed, and I won't tell you about it, but it's very funny about you toss it out there and all the fish come up and grab it. And that's the history of what we've been at.

And yet Jack made the point that in many places in this country we had it right at one point in time, but we

weren't rewarding it appropriately. So I simply want to make the argument that tying the financing and the performance stuff together in some way as a Commission as you go move into the future would be very, very helpful to policymakers in the future.

MR. HACKBARTH: Others?

DR. CROSSON: Just one quick point. In fact, what Dave is describing has started to happen. Just in the last year I've probably had three or four individuals from groups -- I know in the state of Washington in particular, but in other parts of the country -- looking at the payment differential between Medicare Advantage and what's happening on the physician update side -- have come and said gee, we got burned by this 10 years ago, or the other group that we know got burned by it. But gee, let's consider it again. And could you please point me towards a health plan that might help us become involved in this?

So there is already, and it may be a financial issue relative to why they're doing it, but there is already an appetite for this from organizations that very much could be doing what Jack is describing on the delivery side.

MR. HACKBARTH: Any others? I see a lot of tired

eyes.

Okay, thank you very much. Good work.

We have one last item -- actually two more items. We have Kevin's annual review of the CMS preliminary estimate of the physician update. You will recall this is something that we are required to do by Congress. I think it will be probably pretty brief. It has been in the past.

And then after that we will do the votes on the revised three recommendations.

DR. HAYES: All right, during this session we will review CMS's preliminary estimate of the physician update for 2009. Please note that this review is non-decisional. The Commission is required by law to include a review of such update estimates in its June report to the Congress.

The process is that every year by March 1st CMS sends MedPAC a letter with an estimate of the physician update for the following year. This is the update as calculated with the sustainable growth rate formula. The Commission then conducts a technical review of the calculation. Upon completion of the review, a summary appears as an appendix in the June report.

From our staff work, we see that in calculating

the update, CMS used the best available data, estimates consist with recent trends, and otherwise that the calculations are consistent with the formula in the statute.

We also know that the calculation may change somewhat between now and the fall, when CMS will finalize the update for next year.

Despite that, it is very unlikely that the result of the update calculation will change.

There is a target for spending, as you know, and that target has been exceeded by a wide margin. Indeed, the margin is so wide that it is highly unlikely that the update calculated with the formula will be anything other than the maximum negative update permitted under the SGR formula.

Recall that calculating the physician update is a two-step process. First, CMS estimates the target growth rate, the sustainable growth rate, then computes the update. For the first step, the SGR is the target growth rate for spending for physician services. It includes allowances for inflation, change in real GDP per capita, change in enrollment in fee-for-service Medicare, and changes in spending due to law and regulation.

Combining these allowance, CMS estimates a target

growth rate for 2008 of 0.7 percent.

The update calculation itself is shown here and I'll just go over a couple of details here just to make that point about the maximum negative update. That Medicare Economic Index is estimated at this point at 1.7 percent. This update adjustment factor plays, of course, a big role in this. We can see that when calculated with a formula, it's showing an adjustment of minus 26.5 percent.

The maximum permitted under law is minus 7 percent, and so you can see there that things would have to change by a very, very big amount between now and November in order to make this anything other than the maximum negative update of minus 5.4 percent.

What we have here is, of course, the reason for this minus 26.5 percent is since 2001 actual spending has exceeded the target. CMS estimates that the accumulated deficit between spending and the target will reach $57.8 billion by the end of 2008.

The large accumulated deficit, in turn, is due to a couple of things. Among the reasons here would be the fact that there have been legislative overrides of the update formula. Since 2002 the formula has called for

negative updates. All of them have been overridden except for the one in 2002. In addition, growth in the volume of services has exceeded the real GDP per capita allowance in the SGR.

From 2001 through 2006, the cumulative growth in volume and intensity of services has been 27 percent. Meanwhile, the growth in real GDP per capita factor cumulative has been 10.5 percent. As you know from previous work, the most rapid growth we've seen is growth in the volume of imaging and tests.

In the end, and I'll close with this, the estimate of the 2009 update serves as a reminder of the importance of a broader set of issues of concern to the Commission, CMS, the Congress and others, issues such as the growth in the volume of services, geographic variation in use of services, and the need to improve the quality of care. In turn, these consider are focusing the attention of policymakers on the value of Medicare.

For its part, the Commission has considered ways to improve value. I will not go through all of these. You are familiar with them. In general though, the Commission has said that a major investment must be made in Medicare's

capability to develop, implement, and refine payment systems to reward quality and efficient use of resources will improving payment equity. Examples of such reforms include pay for performance and bundling payments and all of the other things that you've been talking about.

Nonetheless, it's understood that the underlying incentives in fee-for-service payment systems and the structure of the delivery system will make significant gains in value difficult to realize.

That's all. I look forward to your comments.

[Laughter.]

DR. HAYES: Sorry. Was it that fast?

MR. HACKBARTH: Thank you. Any questions or comments? This was an inspiring presentation, Kevin.

[Laughter.]

DR. BORMAN: Can we nominate him for an Oscar?

MR. HACKBARTH: In all seriousness, any questions about this? This is, at this point in time, a fairly pro forma exercise.

Okay, thank you.

We've got three recommendations to vote on. The first is on the medical home pilot.

MS. BOCCUTI: I have two slides here. The first one is the one before you and this is a reworded recommendation from the five points that we discussed. And then I have another slide that talks about some of the things we're going to make changes in the chapter text.

So I will read this for the record: the Congress should initiate a medical home pilot project in Medicare. Eligible medical homes must meet stringent criteria, including at least the following: furnish primary care, including coordinating appropriate preventive maintenance and acute health services; use health information technology for active clinical decision support; conduct care management; maintain 24-hour patient communication and rapid access; keep up-to-date records of patient's advanced directives; have a formal quality improvement program; maintain a written understanding with beneficiary designating the provider as a medical home.

Medicare should provide medical homes with timely data on patient utilization. The pilot should require a physician pay for performance program. Finally, the pilot must have clear and explicit thresholds for determining if it can be expanded into the full Medicare program, or

discontinued entirely.

So here are four points that we want to make sure that we're going to capture the chapter text. The first, under quality performance. Medical homes not meeting minimum quality requirements would be ineligible to continue participation. A P4P component would involve rewards and penalties. So this gets both to the bi-directional component that Arnie brought up and the first point about not being able to participate when you're a low performer.

The second component, beneficiary/medical agreement. That did get into the recommendation but we would also say in the chapter text that there would be an encouragement for beneficiaries to notify medical homes of all relevant service use. That's from what Nancy Kane brought up.

We will also talk about the data support to medical homes and talk about Parts A, B and D data going to the medical homes from Medicare.

We also would mention that other providers should be encouraged to communicate with medical homes. So those providers would be other physicians and also Part D plans.

DR. MILLER: We will just make the point, Jennie,

you made the point that in a perfect world we would have also the Medicaid data for the dual eligibles. Obviously, we can't mandate that from the states. But that point will be made in the text.

MS. BOCCUTI: In the chapter text; right. Thank you.

And finally, we would stress that care management includes care coordination among providers, which is what I think Jay you were mentioning, too. So that we would stress that we see care management to include coordination among providers between visits.

How does that sound?

DR. KANE: Do we want to say in the text something about the information technology may be provided through some kind of -- maybe facilitated in some geographic way for small providers? We were trying to get at the fact that not all providers will have EMR and an active -- in their own office, they may have to rely on some more general service organization.

MR. HACKBARTH: We can mention that in the text.

MS. BOCCUTI: In the text. I think the bullet there is not so specific about HIT that there is some leeway

about how much would be required if there was any sort of a dual -- if there were some homes that wouldn't be required to have as many HIT functions. Are you comfortable with that?

MR. HACKBARTH: I am.

So we will include -- I think we'll have a passage in the text that talks about how some of the money might be allocated to medical homes in different circumstances and in that context we can make this point.

Other comments?

DR. BORMAN: Generally, this has really been good, considering all the disparate commentary.

I'm not sure, if you can flip to the next slide. I'm not sure I get quite the same sense of that in terms of strong language about getting the other data shared. Maybe that's what you mean by the Parts A, B, and D.

I think Bill Scanlon was exactly correct when he said we shouldn't be embarrassed about requiring data. Is that's what's going to go behind the bullet that says Parts A, B, and D? Because otherwise it just didn't come across that strongly to me on the screen.

DR. MILLER: I think there were two thoughts. One

is the program will take responsibility for delivering A, B, and D data. And then there was the conversation of we shouldn't be embarrassed about asking other people to produce data.

The second thought is other providers should be encouraged to produce data.

Now the reason we put it that way is there's no mechanism to force somebody to report back to the medical home, unless you change the law to that effect. That's why it's worded that particular way. So if the patient uses some provider outside of the medical home -- remember, this is a pilot. The notion of requiring somebody to report back, I think, is the issue.

DR. BORMAN: I guess I feel a little bit more strongly about it with regards to the beneficiary, who is getting a service here.

I have to say relative to the other providers, I share the notion, number one, you can't force it. And number two, I have some concern, being one of the other providers. The money's going to go to a group to coordinate the care and to some degree, in my view, the biggest burden of information gathering and coordinating rests with them,

which I think you expressing.

DR. MILLER: That's the point above, where the beneficiary is asked to --

DR. BORMAN: Maybe encourage is enough, Mark. It's appropriate to the circumstance. And I understand where you're coming from. I just got the sense that maybe we were at a little stronger but I could be wrong.

DR. REISCHAUER: I think you're right. I think we say should. Take out the encourage. Should. If there's no enforcement, it isn't must, it isn't we'll shoot you if you don't. But yes, I agree with you 100 percent.

DR. MILLER: I now see what you're driving at. I thought you were making a different point.

MS. BOCCUTI: I think that's what would be in the agreement that we talked about, too, is things that they're expected to do. One of the expectations would be, as what you were saying. How does that sound?

DR. DEAN: Just very briefly, the wording on the information technology, I guess -- although I don't know if it's really changed -- as I look at it I'm more comfortable with that because I think that does not mandate a full multifunction electronic record. There are a whole variety

of other types of decision support technology that are within the reach of small practices. And I think this wording would -- I mean, it would satisfy this wording and so I'm much more comfortable with. I think that's what Nancy was getting at.

MR. HACKBARTH: Others? Ready to vote?

All opposed to recommendation two? All in favor? Abstentions?

Okay, nice work.

Now let's turn to bundling. We have two revised recommendations.

MS. MUTTI: Here's the new recommendation two. It reads to encourage providers to collaborate and better coordinate care the Congress should direct the Secretary to reduce payments to hospitals with relatively high readmission rates for select conditions and also allow shared accountability between physicians and hospitals. The Congress should also direct the Secretary to report within two years on the feasibility of broader approaches such as virtual bundling for encouraging efficiency across hospitalization episodes.

It does change the spending implications a little

bit. We would be more inclined to say that there is potential savings, but the amount depends on a specific policy design. The beneficiary and provider implications remain the same as before, that it could improve coordination of beneficiaries' care and providers with high readmission rates would receive lower payments.

This is three, the Congress should require the Secretary to create a voluntary pilot program to test the feasibility of actual bundled payments for services around hospitalization episodes for select conditions. The pilot must have clear and explicit thresholds for determining if it can be expanded into the full Medicare program, or discontinued entirely.

The rest of the implications remain the same.

MR. HACKBARTH: Let's go back to two for second. Any questions or comments about...

DR. KANE: [off microphone] So shared accountability means L&R.

MS. MUTTI: Absolutely.

MR. HACKBARTH: I really don't have any objections to shared accountability or any other term. I'm not wedded to any of them. We have used gainsharing in previous

recommendations, as I recall.

MS. MUTTI: I think so.

MR. HACKBARTH: And so I just worry changing the language may create confusion.

DR. REISCHAUER: [off microphone] [inaudible] negative, as opposed to --

MS. MUTTI: In the text, we've made it a practice, since that point was brought up of the preferred terminology. We pair it usually, in the text.

MR. HACKBARTH: Pair gainsharing with --

MS. MUTTI: Pair gainsharing with shared accountability, so for some people who don't know what we're talking about.

MR. HACKBARTH: This is fine with me.

DR. BORMAN: I guess my only question is if I were reading this on the fly and read allow shared accountability, that's kind of like motherhood and apple pie, and how would I ever say that was a bad thing? And yes, let's go for it. And then when I sat down to say what does this mean in terms of implementation, legislation, anything, I think I might hit a dry well there. And maybe I'm just not imputing enough smarts to the people that will

read it. But I would hope that we have sort of a fairly clean description of what it is in the text. And if we do, that's great.

DR. MILLER: We would take them back not only in the text, we would refer them back to the recommendation we had made before which has a complete chapter built around it.

MR. HACKBARTH: I, for one, am happy to leave it this way. Any other questions or comments?

DR. STUART: This is really tiny, but tiny makes a difference. It's the word across hospitalization episodes. I think you really mean around. Across sounds like you're bringing in more than one hospitalization episode.

MS. MUTTI: I think you're right. I think around is the better word. We'll just change it to around.

MR. HACKBARTH: Yes.

Any others ready to vote? I am.

All opposed? All in favor? Abstentions?

Terrific, put up number three. Any questions about this?

DR. CASTELLANOS: Again the same question. I thought we talked about selective conditions.

MS. MUTTI: I did add that language. It's lost in the middle there in the end of the third line, for select conditions.

DR. CASTELLANOS: Okay.

DR. KANE: By discontinued entirely, does that mean it can't be adjusted to deal with -- the pilot must have clear and explicit thresholds or discontinued entirely or adjusted -- I mean, do we just want to say yes or no?

DR. REISCHAUER: You're having conditions for termination. You're having conditions for going forward. There could be anything in between.

DR. KANE: Okay.

MR. HACKBARTH: Ready to vote? All opposed to three? All in favor? Abstentions?

Well done, Anne. Thank you.

Okay, we will now have a very brief public comment period. Okay, that was just the right length.

Thank you very much, and we will reconvene tomorrow morning at nine o'clock.

[Whereupon, at 5:41 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Thursday, April 10, 2008.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, April 10, 2008
9:02 a.m.

COMMISSIONERS PRESENT:

ROBERT D. REISCHAUER, Ph.D., Vice Chair
MITRA BEHROOZI, J.D.
JOHN M. BERTKO, F.S.A., M.A.A.A.
KAREN R. BORMAN, M.D.
RONALD D. CASTELLANOS, M.D.
FRANCIS J. CROSSON, M.D.
THOMAS M. DEAN, M.D.
NANCY-ANN DePARLE, J.D.
DAVID F. DURENBERGER, J.D.
JACK M. EBELER, M.P.A.
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
NANCY M. KANE, D.B.A.
ARNOLD MILSTEIN, M.D., M.P.H.
WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, PH.D.
NICHOLAS J. WOLTER, M.D.

P R O C E E D I N G S

DR. REISCHAUER: Why don't we get underway. Glenn is under the weather and is unable to be here today. He apologizes but he's been quite sick over the evening.

We have a couple of sessions, the first of which is a continuation of the discussion that we have been having on consumer information. And it isn't related to a chapter, but really to an ongoing inquiry that Joan has been conducting for us.

And then we'll have a session on hospice.

Joan, why don't you take it away?

DR. SOKOLOVSKY: Good morning. Today, I'm going to talk to you about something very different from our usual work on how best to improve the Medicare program. Even the vocabulary of this presentation is different. I'm going to present our findings on a group of public health campaigns.

The question is why should the Commission care about this? We've explored many issues in the past few years aimed at increasing the availability of information on the cost, quality, and effectiveness of health care services. But information is only valuable if people use it.

We've also recommended initiatives to improve the delivery of services and these initiatives are far more likely to succeed if beneficiaries support them.

The public health community has much to tell us about how best to communicate with Medicare beneficiaries and staff would like the Commission to consider future work, including specific areas that might benefit from more beneficiary education.

The Commission has recommended many policies to improve Medicare and the health care system. We usually focus on providers and how to align financial incentives. But there are more than 40 million Medicare beneficiaries and their actions have a lot to do with whether any policy will be successful.

For example, yesterday we spoke about encouraging medical homes and accountable care organizations, developing comparative effectiveness information. We also touched on the role of direct to consumer advertising in driving medical costs.

To maximize the success of initiatives that are related to these subjects, Medicare needs to engage beneficiaries and gain their perspectives. Let me give you

an example from some of our previous work. Last summer we went on a site visit to Maine to talk to them about how they managed to increase beneficiary participation in the Part D low-income subsidy. CMS and the Social Security Agency have put lots of resources into developing a multimedia campaign aimed at informing beneficiaries about the program. In Maine they told us that this national campaign was not very effective in their state. The message of that campaign, as you might recall, was to tell people that they could be eligible for extra help based on their limited income. Local volunteers told us that this message was not in accord with the local culture of Maine. Seniors there were too independent to be attracted by the idea of extra help.

Drawing on their knowledge of the local community, a state group created a local campaign, telling beneficiaries that they could save money. Local seniors responded to this more culturally targeted approach.

For this project, we wanted some information on how best to communicate with beneficiaries on health care issues and the way they make decisions about their care. So as a first step, we contracted with researchers at Mathematica Health Policy Research to examine a range of

public health campaigns. Our goal was to explore what these programs could tell us about engaging consumers and informing their choices.

They studied a mix of 10 public health campaigns with their focus on those that received some independent evaluation and were recent enough so that information about the program design and implementation was available. All but one of the campaigns had a mass communication component.

We found that campaigns can result in changes in individual behavior. To use some very common examples outside of our study, we all know that smoking has dramatically declined and that people have to learn to use car seat belts. But the challenges are great. Successful public health campaigns aimed at consumers are typically part of a wider movement that also target providers, policy makers, and the political environment. Campaigns must be sustained over time and adapt to changes in the external policy world.

As for our study, we identified four types of behaviors typically targeted in public health campaigns. The first is individual risk behaviors. For example, here we looked at campaigns aimed at preventing skin cancer by

getting people to cover up in the sun and two campaigns meant to increase physical activity by encouraging people to walk.

Secondly, we looked at participation in mass screening or immunization. Here we looked at two campaigns to encourage people to get screening for cancer.

Thirdly, we looked at individual behaviors that have consequences for the larger community. Here we looked at two campaigns, one an anti-littering campaign and the other one a campaign to discourage inappropriate use of antibiotics.

Fourthly, we look at health care purchasing or decision-making. Here we looked at one care management company. This is the different one, without a mass communication component. They don't conduct public health education campaigns but they use an approach called shared decision making that provides personalized health coaching services to identified individuals to help them understand their medical issues and become more engaged in managing their health care. We included this organization because they represent an additional way to reach consumers and inform their choices and several of you asked us to look at

this approach during the summer.

For a campaign to be effective, policymakers must take into account the targeted population's beliefs and values, interpersonal relationships, the political environment, and social and cultural norms. The challenges posed by the wider social context are illustrated, I think, very well by the experiences of the Wisconsin Antibiotic Resistant Network or WARN. They tried to reduce inappropriate use of antibiotics to treat sick children. Organizers crafted very specific messages aimed at different audiences. They worked with physician opinion leaders. They worked with professional societies.

The evaluation said there was a small decline in the use of antibiotics but they didn't find a significant change compared to their control group. In part, educators were unable to overcome the messages contained in the social context in which the children lived. For example, daycare centers would not allow sick children to return unless they were on an active antibiotic regimen.

Successful campaigns take time and patience. Keep America Beautiful has been partnering with local volunteer groups for more than 50 years to reduce littering. To do

this, they have shifted emphasis, connecting their anti-littering message to concerns of the population at the time. In the 1950s, with the development of the interstate highway system, they stressed highway beautification. Some of you may remember the slogan "every litter bit hurts."

Then in the 1970s, following the first Earth Day, they emphasized environmentalism. And here I'm sure all of you remember the very famous public service announcement with the Native American with one tear coming out his eye, standing surrounded by litter.

Since the 1990s there has been more emphasis on recycling, but all of this without changing their core message about littering.

By linking their message to popular concerns of the day, they also stretched their resources by getting more local news coverage of their issues. And recently, to appeal to a younger generation, they have shifted a lot of resources to an interactive website.

The third thing that we learned is that messages must connect with individuals. Campaigns that target individual risk behaviors can derive messages stressing how, for example, the behavior that you're doing can increase

your chances of developing cancer. However, campaigns that target individual behaviors with social consequences have the more difficult challenge convincing consumers that they have a stake in the campaign's outcome.

Here again I want to talk about WARN. Sponsors of WARN found this a really significant problem. They observed that many physicians resisted changing their antibiotic prescribing patterns for fear of losing patients and they argued that it would have no effect on the overall antibiotic use because patients would simply go elsewhere for their prescriptions that they wanted. Campaign sponsors also found it very difficult to convince parents that they should avoid giving antibiotics to their sick little children with ear infections for the sake of the common good.

Campaigns also must reach people at a time when they can use the information. For example, here we talk about the Falmouth Safe Skin Project. The goal of this was to warn people about the dangers of overexposure to the sun. They found that -- this was again a wide campaign with all kinds of different community activities. But they found that the most successful part of their campaign took place

in hospital nurseries.

Here parents of newborns received ongoing education on how to bathe their children. They found that they could connect the sun protection to the lessons on bathing children and it had a much more effect at that when parents were much more geared to learn about how to take care of their children. They found that this was much more effective than the broad mass communication.

Our interviewees agreed that the most effective campaign messages are those that include specific follow-up actions for people to take. Canada on the Move is a good example here. That was a public-private partnership between the Canadian Institute of Health Research and Kellogg's Canada. They designed their campaign to increase individual physical activity. The campaign included a pedometer in designated Special K cereal boxes and they asked consumers to use the pedometers to add 2,000 steps to their everyday activities. Consumers found the message clear and the free pedometers made it a very doable action to take.

Now we come to some of the challenges. Behavioral change takes time but few campaigns have the resources to sustain a long-term effort or evaluate more than short-term

outcomes. In addition, researchers may not be able to distinguish the effects of the single campaign from the broader social and political trends affecting their community. For this reason, although the campaigns we chose ahead evaluations, the evaluations tended to focus on short-term effects of the campaign. For example, telephone surveys to find out did people see the campaign and did they remember the message.

Alternately, the evaluation may focus on short-term changes in attitude but rarely is there any follow-up to see if the attitude change reflected long-term behavioral changes. For example here, a government-funded evaluation of the Canada on the Move program that I just spoke about found that, in fact, a larger segment of the Canadian population was aware of their message. Pedometer ownership had widely increased. But they didn't have the resources to have a longer-term evaluation to find out if people, in fact, continued to increase their physical activity and whether there was any increase in fitness or weight loss because there simply was no budget for that evaluation.

Public health campaigns compete with other policy issues for media and political attention. While campaigns

may require continuing effort, they may not be able to maintain public interest for the time that is necessary. Campaigns also compete for funding with other equally important policy objectives.

To quickly sum up, beneficiary involvement is important to achieve many of the health system changes recommended by the Commission. Researchers suggest that campaigns can affect individual behavior. Again, we know that smoking, littering, and unprotected exposure to the sun have all declined over time. However, they emphasize that achieving behavioral change is difficult and that campaigns may require long-term efforts on multiple levels.

So the questions that I want to ask you are do you think we should address beneficiary education as it relates to specific Commission initiatives or more broadly? If you favor the first approach, looking at it in relation to specific initiatives of ours, do you have suggestions for areas in which the beneficiary perspective would be most important? For example, looking at the medical home discussion yesterday, we might want to find out what does a medical home mean to beneficiaries? What services would they want it to include? Would they want one? And what

obligations might they be willing to accept in order to have one?

So we're looking for your guidance on what direction future work on this issue should take. Also, of course, I'll be happy to answer any questions.

DR. REISCHAUER: Okay, thank you, Joan.

John?

MR. BERTKO: Joan, just a couple questions. Very nice report there and certainly interesting stuff, like Canada on the Move.

The research that -- now this is private development, commercial type of stuff for Med Advantage plans -- has shown that the senior population appears to be very heterogeneous. And so we found different types of people -- I will give you a couple, worried well, people budgets, and then there would be chronically ill people. So you might want to think about targeting a little bit better, as opposed to what I'm hearing, kind of a very broad single communication campaign. I would be personally interested in what would help drive medical home sign-ups and things like that.

Along those lines I can think of at least two

areas where you might do a little further investigation. PDP plans had a great interest in driving generic utilization, and the communications were fairly broad. In our case, it was sending out a tailored mailing but with very actional items, saying you're taking this drug. Do you know this other alternative is available to you? And perhaps some learning from when and how these things work.

The other, which is a little bit broader, and Arnie I think knew a little bit about this -- a remembered the name, Arnie.

The second part of this is some senior activity campaigns. This one in particular was Silver Sneakers, and you had a different name, Arnie, I think that you knew about. Perhaps, Jennie, that also corresponds to some of the PACE activities where the encouragement and the communication was to get seniors to sign up for these things and, much like the Canada on the Move, become more physically fit. So I think there might be some ways to learn from those, as well.

DR. SOKOLOVSKY: Can I just mention one thing? In the focus groups that I talked about briefly last week on Part D plans, one of the things I didn't mention but was

incredibly striking to me in terms of the difference between 2006 and 2007. In 2006 beneficiaries seemed somewhat nervous and not very excited about generic drugs. In 2007, we just asked how many drugs are you taking? And they would tell us in terms of I'm taking five generics and two brands. And that's because there were no generics available here. It was remarkably striking the difference.

MR. BERTKO: And learning how that was accomplished would seem to be good. I have a couple of thoughts but it would be better to do it across a broader segment.

MS. BEHROOZI: Thank you. Finally I get to talk about Joan's paper the context of Joan's presentation. Obviously, I really enjoyed the paper and hearing about the information that you had gathered.

Just starting from your last point -- and we talked about this a little bit yesterday -- I found in the work that we do, in communicating with our membership base of a few hundred thousand lives -- I know there are a few more in the Medicare program. But even, I think, the lessons are applicable across a very large group. We can't overstate the importance of focus groups in learning what

really works.

You talked about the challenges of trying to quantify, to analyze, whether these broad campaigns would had an impact. But in talking to individuals, it's kind of like letters to the editor. That newspapers assume that one letter represents the opinions of X thousands of people. I think it's true of focus groups, as well, and the kinds of things that people bring out when it's not just a yes or no answer to a survey question. The things that they choose to focus on and reveal in the course of conversation are really valuable.

So to turn to your questions, your first question about whether it should be targeted, what we address should be targeted toward specific initiatives or more broadly, that was really a thought that I had sort of carried through looking at the work that you had done. We've got limited resources. We want to try to make the things you we're spending so much time thinking about working on and the staff is doing so much work analyzing, we want to make them work.

That is again what we have really found in what we do, is that it's all about supporting or enhancing the

policy initiatives of the entity.

As you said, this is not like our usual vocabulary. The usual vocabulary here is about driving behavior with economic tools, copayments and things like that. We hear about induced demand because the economic pressure is too low on beneficiaries and things like that. But we also know that economic tools can cut both ways, depending on not only people's income levels but their perceptions of whether they can afford something or not.

So to talk to them about value, as John was saying and reflected in your work about the value of generic drugs can really -- as an example, can really enhance their acceptance of generic drugs and not just have it be okay, slap a copayment on it and vary the copayment and let's just hope it works out okay.

I think that as you pointed out the medical home initiative yesterday, we were talking about beneficiary responsibility and how do you drive that when the only lever you have in our control is payment policy. But we're talking about a provider group, not a payer entity that we're going through. That was, I think, the whole discussion where we brought up MA plans and how they can do

different things that maybe we can do through provider groups. So that would be a natural, as you say, for looking at ways to support the notion of care coordination and making appropriate choices.

We've talked before about the whole notion of value-based purchasing and the relationship to comparative effectiveness research.

Getting those messages out to people in a way that makes sense to them and appeals to their self interest -- and that goes to your pointing out that the broad-based social good kind of thing doesn't fare as well. Self-interest is the most reliable motivator. And if you can identify what it is, you can really get people to move. And talk to people through institutions that they trust. Again, referring to yesterday's conversations about payments to providers motivating what the providers do and then the beneficiaries do what the providers tell them to do because that's who they trust.

There are other institutions that they trust. The Medicare name, I think, is still pretty trustworthy to people. And also people whom they perceive to look like themselves or to be in their own circumstances. I think

that's something you brought out in the paper. Again, that will help them identify their self interest and feel like this is something relevant and meaningful to them.

And all of the other stuff is really great, too. Thank you, Joan.

DR. CROSSON: Thanks, Joan. I also enjoyed it and I particularly like the categorization, which is helpful to put things into mental pigeonholes. I had a couple of thoughts.

I think the notion of the teachable moment is an important idea. I think we've noticed over the years that all of a sudden people are very interested in generics when maybe five years ago, despite the fact that the drugs are the same chemical entity, that that notion was difficult for people to understand and there was a distrust of generics among some people. And all of a sudden I think the increase in the cost of pharmaceuticals and perhaps other changes in reimbursement patterns for drugs has changed that. So there is a certain time for messages and another time when they don't seem to work so well.

In terms of the Wisconsin antibiotic program, we've also had one in California for about the last five

years that's sponsored by the California Medical Association Foundation. And you might -- I do know that it has been putatively successful because I have seen the data. I can't remember now the statistical significance. But it might be interesting thing to look at just to contrast the processes that both have used. I can give you the contact for that.

The last thing is having to do with words. I started laughing when you mentioned the medical home demonstration as an issue for communication. I have been involved in a project for a number of years with the American Medical Association called the Council of Accountable Physician Practices, which is sponsored by large medical groups. In the last year one of the things that we have been doing is trying to take a look at some of the words that we use -- I mean in health policy circles but particularly in the delivery system community -- and understand how they sound to the average person, the average patient and the like.

We just finished five sets of focus groups, in New York, Boston, Minnesota, San Diego, and Billings, Montana, testing different words. Things like efficiency, care coordination, electronic medical record, and a bunch of

others. One of the ones we tested was medical home.

Much to our surprise, in every venue the term medical home came in on the bottom of the list and evoked images of aging and nursing homes and putting granny away.

So if we are going to --

MR. EBELER: Can we revote?

DR. KANE: How about health care home?

DR. REISCHAUER: Medical party.

DR. CROSSON: I'd be happy to give you the raw data because it's quite raw.

[Laughter.]

DR. CROSSON: So if we are going to advance this brilliant health policy direction -- and I believe that sincerely -- which we took yesterday -- and least in this area there is some work to be done.

MS. DePARLE: When were you going to tell us that, Jay?

[Laughter.]

DR. REISCHAUER: We should reconsider Glenn's interest in this. Thank you.

MS. HANSEN: Thank you. Gosh, that segues well to what I said yesterday, that perhaps it's a health care home.

But I will just pick up quickly on your point about the focus groups.

As you can imagine, AARP does a lot of that kind of testing, relative to how people receive information about health care reform, health care change, and so forth. We have not gotten to the part of really testing out the medical home. But since policywise AARP supports that, it is one of the areas we test. But my comment yesterday was a personal comment relative to using perhaps health care home. But we'll see.

What I wanted to respond to is the question, Joan, that you had. First of all, again, I thank you for this. I certainly appreciate this chapter. It's a chapter that I can well understand for a change.

The question you had was twofold. One, do we focus on specifics or do we do a general? I really agree that doing the general is tough. However, without doing at least some context background about how older people learn -- and I think with John's comment about how the private sector has divided up kind of the clusters of people of worried well and people on budgets and people dealing with chronic illness. One of the studies that AARP did back in

2000 was done by Judy Hibbard. And she really took a look at how people make decisions about health plans at that time. That was prior to the Part D complex decisions.

But the piece that's probably a little different that I contribute here is that the age factor and the cognitive factor of people -- especially once they hit 80 -- really drops off. Even with a fairly educated background of people. But when you hit 80, there are other elements that come into play. So the segmentation of understanding what happens -- and this was even, as I said, before Part D came in and the complexity. We heard some narrative in previous meetings that people oftentimes will rely on their children to make that decision.

So that as we think of these campaigns it is directly at the beneficiary. But so often when there are complicated issues to decide on, they will have a surrogate making those decisions. And more often than not their adult children. So it's a factor to consider with any kind of change. And if medical home is one of those components, it's an area of thinking because it's a bit of a shift here in the messaging, of asking people to be responsible, to report who they may have seen and so forth. So this is

another level.

There is a group in Boston called the Foundation for Informed Medical Decisionmaking. That group is actually connected to the Dartmouth folks about how to, when you're faced with decisions to make that are complex, how to really bring that to consumers. So that's their core competency in terms of doing that.

Third, there is actually existing in CMS a group that has been operating for years called the Advisory Panel on Medicare Education. That's group does both general medical education, but one of the subsets of areas they focus on was in your chapter -- and Mitra you brought up -- about cultural differences, let alone language differences, and how people frame their thinking is going to be really important. So the main example was a great general example of what language means. But there are probably different elements of cultural groups and linguistic groups that even have an added frame.

So as this model perhaps appeals to the broad Medicare beneficiary, and as this population historically has noted greater disparities, even though they are connected to the Medicare program, it may be merit worthy to

kind of have a particular focus on groups that typically are going to be harder to reach now with the whole contractual arrangement that's even a little different.

So that's what I just wanted to use, but emphasize the age factor and the cognitive factor of our population.

Thank you.

DR. MILSTEIN: Joan, I want to make sure that I'm on track in terms of understanding the problem that we're attempting to help with. I've been around long enough that I've heard probably, in my career, 10 different presentations on best practices in communicating health and health insurance related information to consumers. I would say though over time it's evolved, there certainly has been a consistency in terms of core thinking in the U.S. about best practices. Many of those best practices you mentioned in your presentation.

I guess as I think about this from the perspective of MedPAC, I would be interested in knowing what is our basis for believing that CMS's current communications to its beneficiaries is off the mark, either in CMS not understanding current best practices in communication or they understand the best practices but in the design of the

programs there are some flaws? Or is it the programs are well designed but in the execution we feel there's some opportunity for improvement?

In other words, what is the gap between what I'll call model communications and how we perceive CMS to be communicating with beneficiaries that we seek to help with?

DR. SOKOLOVSKY: I don't think that there's anything in what I've done so far -- although depending on where I took it I couldn't say that -- but I don't think there's anything that's saying okay, this is what CMS is doing wrong and this is what we should do. It's much more a sense of resources and targeting. They don't have the resources to target beneficiaries for all initiatives that either we recommend or they are interested in or in any way like that.

And I think that we could help make initiatives that we support more successful if we did some work going in to understand how these things would -- how beneficiaries feel about these things and how best to communicate with them.

DR. MILSTEIN: Thank you.

MR. EBELER: That was an interesting question.

A couple of things. It strikes me that, particularly listening to the comments, this is one of those chapters or presentations that we deal with as a specific thing but it, in fact, cuts across everything we're talking about. If you go back to the presentation on ACOs yesterday that David and Jeff did, they have a chart that lists the provider sectors on the left-hand column that we normally talk in those silos. The middle column is sort of tools and interventions that we use across those sectors. And in many ways, this is an example of one of those engagements that we need to think about all the time. It's a very powerful piece.

It strikes me in your questions what I hear the research saying and the folks here who are knowledgeable about this is that if really does need to be more specific than broad.

A question I would have in particular in thinking about what the Commission does is there evidence on who is the best communicator? And in particular, in a lot of these changes the role of the physician as the communicator to patients and sort of thinking about interventions -- whether it's this thing that somebody once called the medical home.

I categorically reject such a term.

[Laughter.]

MR. EBELER: Although, I might note that our expert on public communication is sitting here. The former leader of the largest and arguably one of the best medical groups in the United States of America and possibly the world is talking about public information campaigns eating Cinnamon Toast Crunch. So for the public health experts in the audience, there is work to do, obviously.

DR. REISCHAUER: The nutritional stuff is so small he can't read it.

[Laughter.]

MR. EBELER: If one thinks about a targeted campaign around an initiative like that, whether there is any evidence or experience in communicating with and/or through the physician community to their patients as well as other mechanisms. Do we know who's the most credible conveyor of information in this process?

DR. SOKOLOVSKY: I don't know if I can answer that specifically. We do have information on who are the most trusted intermediaries, and certainly physicians are on that list. They're not exclusive on that list. I think that the

issue here, in many ways, is that an appointment nowadays, the duration is so short that all of the messages that a physician might want to get across to their patient, it would be very unlikely that they would be able to do that in that time.

MR. EBELER: Thank you.

DR. SCANLON: I think we have a common thread here but many aspects to it. And John's discussion kind of set us in that direction, the common thread being the role of the consumer and our interest in trying to inform that consumer and potentially influence their behavior. John brought up the whole issue of marketing research. How should we design a policy intervention that's going to potentially either mesh well with consumers' natural inclinations? Or the second step would be how do we market something in a way that actually influences consumers and their choices.

There is both of those aspects.

But then I think the third example that John brought up which is important -- and it relates to Jay's teachable moment, which is this actual intervention with specific information about an individual. Not trying to

influence a population but trying to say to a person here's your circumstances and here's information that you should take into account in thinking about those circumstances.

I think that's a very important aspect for us to consider because potentially our future will involve different capacities and being able to do that with the whole idea of electronic health records and information that can flow more readily and in more real-time.

Because a teachable moment has got to be real time. It can't be 30 days after a decision is made somebody gets some information that might have influenced that decision.

The big issue I think that we also need to think about is this whole issue of trusted source and what role can the Medicare program play as a trusted source? John gave the example of drug plans sending out information saying you are on this drug and there is this alternative. There is a question of how people react to that some will calculate gee, this drug company is trying to save money on my premium. But then there's also a potential question about how do people react when the government sends you a letter saying we know that you have this condition or you

were on this drug or you should think about these things? How is that going to be perceived? This is potentially a real issue.

We had the experience of the '90s with managed care in the issue of prior authorization when a physician was saying you needed this and the managed care company was saying you don't, and we had a backlash related to that.

At the same time I think what the work of the people at Dartmouth suggests is that there is a role for education and education can have an effect at an individual level in terms of changing decisions. And how we can create the trusted source that's going to supply the information that is relevant and is helpful in terms of making better choices is the kind of challenge that we should be thinking about.

MR. DURENBERGER: Having spent something like $10 million on three campaigns -- and that was like 20 years ago or more -- I probably have 1,000 things I could share with you. I'm trying to think of something that would be most helpful.

It should be obvious to us that if you cut health policy in half and you take the easy side of it, that the

sellers of MSAs, HSAs, consumer driven health care, Botox, plastic surgery, LASIK surgery, retail clinics and stuff like that don't need a lot of advice on how to make a sale.

When you get into chronic illnesses and high cost surgeries and radiology and what imaging that's necessary and so forth, you in a whole another ball game.

So I guess what I could contribute from the experiences that I've had on the political side and applied to this is the importance of reinforcement. There just has to be reinforcement for whatever the message is.

The ideal reinforcement comes from the doctor. That's often the hardest one to get because if they don't like the message then you've got a different problem.

But other examples are Mike Huckabee in Arkansas. They had launched this public health campaign, take off weight and all that stuff, and Mike takes off 105 pounds. I was at an event last Saturday in Ripon, Wisconsin with the former Secretary of HHS and somebody introduced him as wearing a pedometer. And he says yes, I'm wearing it today. And I'm already up to... and you've already referred to that.

Another reinforcer is employment. And one of the

reasons that health management, health fitness, some of these sort of things are now beginning to catch on as part I think a public health movement and people willing to accept some responsibility if, in fact, it leads to some reduction in their health care is it's being reinforced at work.

All of the people out there who are providing health insurance but not making any effort to help their employees improve their health are making a big mistake. So they are a big market for reinforcement.

One of the biggest in this area, of course, I don't want to debate how well they do, it's just a real potential, in Jennie has already referred to it is AARP.

I'll just leave it there because AARP has a huge influence in the public policy arena and it could have a much larger influence on how people think about their own personal contributions not to the passage of a bill or something like that but to their health habits, the choices that they make, and so forth.

And then the flipside of reinforcement is how do you counter the information that in our experience in reform has largely come from doctors that don't want to change or somebody like that? How do you counter that most

trustworthy relationship and the information that flows from it? That doesn't lend itself to a media campaign but it suggests to you that if you can't counter that in some way you're not going to get very far.

Then a third observation I think relates to the words that are already out there that were good words, they work, but we assume they can't work in the future. I thought of that when you were laughing about medical home.

The health maintenance organization is, in my opinion, a very, very important institution for a variety of reasons. But because it's an HMO and because we had bad experiences with HMOs in the '90s, we can't say it anymore. The same thing is true of managed care. The same thing is true of capitation. We make assumptions. You can't say that kind of thing any more, you can't use it, and it deters us from making good policy. So we're going to think up another name or something like that.

We lost the Medicare Improvement Act, if you will, or the Medicare Catastrophic Act in 1988 over means testing or income testing. Well, no Republican was bothered in 2003 with income testing the Medicare program and there it went because it was tied to something else. I'm just suggesting

that as we think about policy there are some very good concepts that we might lose because of the way we characterized them at one time yet were discredited.

The last thing, relating to the doctor-patient relationship, and this comes from Wennberg and those people as well. One of the most important policy changes that relates to what we're talking about, education, is changing the legal standard for physician liability from patient consent to informed patient choice. The implications of informed patient choice is that the doctor has to be fully informed -- fully informed -- about all of the alternatives available to the patient. And then the patient has the responsibility for making the decision.

It's worthy of exploration as an important add-on to -- when you're in a part of the information realities and you haven't got anybody to rely on but your doctor, that doctor better have the obligation to bring to his interface with you all of the information. And then you take the responsibility of making the decision.

DR. REISCHAUER: Thank you.

A couple of reactions, Joan. One, it struck me that when you were going through the information education

campaigns that were successful, the successful ones were, in a sense, reinforced by sticks and bribes. And the unsuccessful ones, there were no incentives. You think of smoking and where we've raised the price and said you can't do it anywhere. Seatbelts, we arrest you, we fine you. Drinking and driving, we've raised the limit here. Generics, we bribed you with lower co-pays.

And so we should think about both sides of this, the positive and the sticks and bribes.

We also don't, for unhealthy behaviors, we are often reluctant as a society to portray the consequences. This is a difficult issue because it's not just the consequences of not adopting healthy behavior because for some it's inevitable, it's unavoidable, and you don't want to blame the victim. So I think there's sort of a problem there.

I think it would be interesting to look abroad and see what some other countries -- because my guess is that all lot of them are moving down this path of having the health insurer -- meaning the government -- communicate information much more broadly than we do. There is this difficulty here, do you trust the government? Can you find

it? I think all of us have been on the Medicare website dozens of times and, quite frankly, I am just amazed that it has everything but it's so difficult. If I were an 85-year-old beneficiary and I wanted to find something, I'd still be on it trying to find how to get there, as opposed to just some site for beneficiaries that then had big buckets which you could go to and find out information.

You wonder also how much of the -- how many areas of health care where we're talking about making people more informed of their choices and the consequences of their choices like the information on prostate cancer treatment there are? And how available that kind of information might be? And what impact, if it were widely available, it might have.

I think we also want to think about what are the goals here? Are they to improve health or save money? Or both? Then try and divide up the interventions, the movements in this direction in that way.

I think Bill raised an important issue, which is some of this is directed at the beneficiary, some at the broader population that's important for some of these things to have societal values change and to you to reach a tipping

point like you can be macho and wear a seatbelt, which of course wasn't true in the mid-1960s. But some of it is more directed at the individual, and Jennie's point of to what extent can old dogs learn new tricks.

With the Internet we have mechanisms of communication that just didn't exist and ability to individualize the direction that we go on. Some sort of analysis of where that might be useful when we're thinking about this for 20 years from now. It will be a very different population than the current Medicare beneficiaries with respect to technical expertise.

So I think there's a lot of material that we should keep pursuing in this.

Thank you, that was a good session.

Next we're going to have hospice, Jim, Zach.

I might mention to those of you who came in late, the chairman, Glenn Hackbarth, is ill today and unable to chair this session.

DR. MATHEWS: Good morning. I didn't realize from the turnout in the audience that so many people were interested in and consumer education.

[Laughter.]

DR. MATHEWS: I hope they will all bear with us for the next presentation?

Today what we will be talking about several disparate hospice issues. This will be the last installment of our series on hospice in this analytic cycle, culminating in the June report chapter.

As you know, there is significant interest in this topic from Congress, policymakers, and the hospice community. While we are not making recommendations, we do want to solicit your comments on the content of the draft chapter.

In developing this chapter, we've covered most of Medicare's hospice benefit. We began with issues related to the cap, but in the end covered most of the information presented on this slide.

Today, we will be presenting the results of our analysis of hospice visit information from a large for-profit chain. We will also present some information on measuring the quality of care in hospice. First, however, we'd like to follow-up with you on some of your outstanding requests for additional information.

Nancy-Ann, back in November you asked us to look

at access to hospice care by a measure other than the number of hospices per Medicare beneficiary. You had pointed out that such a measure doesn't account for the size of the hospice, that is a large number of small hospices might not accurately portray access.

We therefore measured access as the number of Medicare hospice users over the number of Medicare decedents in each state. Our results are in the last column of this table. In general, while there is some shuffling of the order, states identified as having good access by the measure in the last column here also had good access in terms of hospices per 10,000 beneficiaries. For example, hospices in Alabama, Mississippi, and Oklahoma, which together represent over 55 percent of hospices reaching the cap overall, have access rates substantially higher than the national average of 43 percent.

Mitra, in the fall you asked us about the impacts of geographically adjusting the cap. In general, geographically adjusting the cap benefits urban hospices by increasing their cap amount while it works against rural providers by lowering their cap. We modeled the impacts of a geographic adjustment using the FY 2008 hospice wage index

against the payment data that we used to estimate the number of hospices exceeding the cap in 2005.

Adjusting the cap amount by the local wage index would result in an increase of 21 percent in rural hospices exceeding the cap, would increase the number of nonprofits exceeding the cap by 26 percent, and would increase the number of provider-based hospices exceeding the cap by 24 percent. Keep in mind that relatively few of these providers currently reach the cap so the numbers are small.

The number of urban hospices exceeding the cap increases as well, which might come as a little bit of a surprise. Places like Los Angeles and Nashville benefit from geographically adjusting the cap. But urban areas that have a wage index of less than one, which are mostly smaller cities and larger towns in Alabama, Louisiana, and Oklahoma -- would see an increase in the number of hospices exceeding the cap. Overall, under this adjustment, 12 urban hospices would no longer exceed the cap under a geographic adjustment while 17 urban hospices would newly do so.

Mitra, also last month you asked for additional information on the distribution of cap overpayments. We ranked the cap hospices by their 2005 overpayments.

Hospices at the 25th percentile of the distribution are obliged to repay amounts of less than roughly $200,000. Hospices at the 75th percentile had repayment amounts of roughly $1 million and up.

In percentage terms, overpayments are roughly 20 percent of all cap hospice revenues in any given year. In 2005, one-quarter of cap hospices had repayment amounts that were less than 9 percent of their revenues, while the top quarter had repayment amounts that were more than 35 percent of their revenues.

In short, hospices are exceeding the cap either by a little or a lot. Since the cap is a function of length of stay, if a hospice's length of stay is double what would be permitted by the cap it is not surprising that such a high proportion of its revenues would we be represented by overpayments.

Bob, last month you asked about the variation in the post-payback margin for hospices that exceed the cap. In all years, when we include the overpayments, margins for cap hospices are generally positive. Subtracting the overpayments, the picture changes and the margins for hospices subject to the cap at the 25th percentile are

significantly negative. This calculation assumes that the hospice's costs are the same, that is the hospice would not have made a change in the way it operates. It is worth noting that even after the return of overpayments, a quarter of cap hospices still have margins of 26 percent or more.

We can go into additional detail in the Q&A session if you'd like but the bottom line is that the larger the percentage of copayments represented by overpayments, the greater impact on profitability.

Bob, you also previously asked for information on the number of patients dropping out of hospice. On the MBD file about 7.5 percent of beneficiaries had a code indicating that they had revoked hospice. Some of these patients reelect hospital -- that is they go back into the benefit -- so the actual number who decide they don't want the hospice benefit may be closer to 5 percent or 6 percent. We've not yet been able to cut this file to examine whether the percentage changes over time.

Ron, you asked about hospice patients who use more than one hospice and asked if quality of care was a potential reason for a patient to switch hospices. As you can see here, only about 3 percent of patients use more than

one hospice during the course of a terminal illness. We do not have data on why patients change hospices. Quality of care could be a reason. Others include patient moves and hospice mergers or closures. But again, we don't have that kind of detail.

Arnie, we have a quality of care item for you when we get to that section.

There are other requests from individual commissioners that I know are outstanding and we'll attempt to continue to run those down for you and follow up off-line.

At this point, however, I will turn the presentation over to Zach, who will report to our findings from an analysis of visit level hospice data.

MR. GAUMER: Good morning. At our March meeting we talked about our desire for visit level patient data and how this data could be used for hospice episode analyses. Since that meeting, we have had the opportunity to look at data such as these. That's because they've been voluntarily provided to us by one of the largest for-profit hospice chains in the U.S. This chain has over 40 hospice agencies and they serve approximately 5 percent of the hospice

Medicare population.

The data files that we have consist of all the visits that this chain has provided to patients from 2002 to 2007. Each visit record itself contains information on the patient's diagnosis, the location of the visit, the duration of the visit, the type of provider, and the service that is actually being provided at the visit.

Taking in aggregate, these data corroborate trends that we've already seen in the larger Medicare population. For example, average length of patient stay has increased in the last six years. This has been driven largely by neurological patients and patients with ill defined debilities.

Also, case-mix has changed in the last six years, such that the proportion of cancer patients is decreasing and the proportion of neurological patients is increasing.

The other thing that I would add here about these corroborating trends is that they also persist at the regional and state level. One of the first things that we did with this new data was to look at how many visits Medicare patients received per week and how these varied by diagnosis. Stratified solely by diagnosis, it appears that

while cancer patients had a stable number of visits per week in 2002 to 2007, traditionally longer stay diagnoses such as neurological, ill-defined debility patients experienced a decline in the number of visits per week they received.

However, further analysis revealed that the primary driver of changes in the number of visits per week is length of stay rather than diagnosis. More specifically, in the slide above you can see that in 2007 the average number of visits per week patients received was relatively consistent across the various diagnosis when grouped by length of episode. Cancer and neurological patients with episodes of 30 days or less had similar numbers of visits per week. The same is true when we look at cancer patients and neurological patients with episodes of 121 days or more area.

Instead significant changes appear in the number of visits per week patients received when this is viewed in the context of subcategories of outpatient length of stay. For example, patients of all diagnosis types with episodes of 30 days or less had significantly more visits per week than patients of all diagnosis types with episodes of 121 days or more.

To reinforce this finding, we believe that it is long stay patients more generally rather than diagnosis that are driving declining visit intensity. This finding is consistent with some of our earlier findings that longer stays are more likely than short stays to generate profitability.

These data also suggested that longer stay patients are served by a different mix of hospice staff. The ratio of nursing visits to home health aide visits charged on the slide above displays that from 2002 to 2007 cancer patients were served by a relatively consistent number of licensed nursing staff and home health aides, a balance actually that relied more heavily on licensed nurses.

In contrast, over the same time period the balance of staff visits changed for long stay patients. From 2000 to 2007 we see that home health aides slowly assumed responsibly for more and more of the visits than licensed nurses. That's for all three of the diagnosis types that you see above you, which are regarded as the long stay diagnoses.

This suggests that the needs of long stay patients

can be met with less intensive staff mix and that this mix can change over time. Further, both of these factors help explain that long stays are more profitable or can be more profitable for hospice agencies.

To summarize our observations, I will leave you with three key points. First, that the variation in the number of visits per week is a function of length of stay rather than diagnosis. Second, that patient diagnosis does appear to be driving changes that we've seen in the intensity of the provider service mix. Third, we believe that these visit level data enabled us to conduct in-depth episode trend analyses that could otherwise not be conducted with data that are currently available to the public.

Jim will now discuss quality of care.

DR. MATHEWS: Thanks, Zach.

Much of what we know about the quality of hospice care comes from the Family Evaluation of Hospice Care Survey, or FEHC, developed by the National Hospice and Palliative Care Organization and researchers at Brown University. NHPCO members voluntarily participate in the FEHC survey. Participants represent about one-third of all hospices nationwide. Participating hospices mail

questionnaires to the families of is decedents one to three months after the patient's death. NHPCO compiles the results and provides each hospice with its aggregated survey results for comparison with state and national benchmarks. Quality information for individual hospices is not public under this mechanism.

The survey identifies three general areas that have a bearing on quality of hospice care. These are pain and symptom management, attendance to the patients physical and psychological needs, and various dimensions of communication.

The surveys represent a potentially risk data source on hospice quality and the hospice level results can be useful for individual providers in identifying areas where they need to improve their performance. However, they may pose difficulties for potential use as a program management tool for several reasons. First, participation is voluntary. Not all hospices participate in the survey and there may be some self-selection at work.

Likewise, the response rate, while high relative to other surveys, is still less than 50 percent and again may reflect a bias in the respondent base.

Second, the questions in the surveys are somewhat subjective. This may be appropriate given the nature of hospice care but they are less satisfying than objectively measurable outcomes.

Third, most of the surveys to date have focused on the satisfaction with care as assessed by the patient's family members one to three months after the patient's death rather than the patient themselves during the course of care. Again, this may be appropriate given the amount of the hospice's interaction with the family but satisfaction with care may not adequately reflect the full scope of quality of care in hospice.

Lastly, the surveys may not adequately differentiate performance among hospices. As noted in your paper, aggregate scores under the FEHC are very high with relatively little variation. While there can be more variation on any given measure in some sense these scores suggest a very high level of satisfaction with hospice care in general, with only the really disastrous cases resulting in negative survey responses.

These data also underscore the need for additional information on quality in order to fully assess the range of

metrics of quality of hospice care.

Arnie, last month you asked for information about the relationship between quality of hospice care and length of stay. One recent published study compared satisfaction with care by the diagnoses -- in this case cancer, patients with which tend to have shorter stays -- and dementia, the stays of which tend to be longer. It used data from NHPCO's FEHC survey. It found that a slightly higher percentage of respondents rated care for cancer patients as excellent compared to dementia patients but the difference was not statistically significant.

We also asked NHPCO to analyze the FEHC data on satisfaction by length of stay. They provided results representing roughly 140,000 patients in 2006 that showed no significant difference in satisfaction by length of stay. We also analyzed data supplied by the large for-profit chain that Zach just spoke about, which similarly suggested no significant variation in respondent satisfaction by length of stay.

So with the limited data available on this point suggests that family satisfaction with care does not vary by length of stay. However, as we mentioned, this measure may

not reflect the full spectrum of quality of care in hospice.

There are a number of newer developments in measuring the quality of or satisfaction with hospice care. These generally try to assess the same dimensions of care that appear in the NHPCO FEHC survey, mitigation of pain and symptoms, meeting the patient's physical and psychological needs, and various dimensions of communication. In late last year the National Association of Home Care and Hospice began to field a much shorter survey that gets at these areas but no results are yet available from this effort. NAHC's effort also includes a one-page patient survey administered two weeks after hospice admission in addition to a family survey. This would fill a critical gap, but again keep in mind that the median hospice day is currently only about two weeks so fully half of hospice patients wouldn't be picked up in this survey.

CMS, in conjunction with the North Carolina QIO, is in the process of developing hospice quality measures. While they assess care in the same general domains as we've discussed already, this effort is intriguing in that it tries to more objectively quantify performance, for example by requiring documentation in patient charts rather than

relying on survey respondent recollections.

Lastly, the American Hospice Foundation is developing a public report card that would report hospice specific measures of family satisfaction and other administrative measures of quality.

You have more information on these in your draft chapter.

Lastly, there are potential administrative measures that could be investigated further. Such measures could include assessments of hospice admissions procedures, measures of visit intensity, or measures related to staffing, as we have discussed in the context of skilled nursing facilities.

For example, the American Hospice Foundation report card that I just mentioned includes measures of skilled nursing visits per week for each hospice, compared to regional and national totals.

These kinds of measures would need a lot more work by way of additional development and evaluation. They are generally less satisfactory than outcomes measures that can be more readily identified in other settings. But absent those kinds of outcomes measures they may have some utility

as high-level, relatively accessible proxies, and they could be used in conjunction with patient and family focused evaluations.

In the course of our analyses, discussions with various stakeholders, and your deliberations on hospice issues we've identified four general conceptual areas in which we believe there are opportunities to make specific changes. First, based on our quantitative analyses, we have identified a number of potential improvements to Medicare's hospice cost reporting process. Some of these can be made in light of CMS's pending visit data collection effort that we've discussed previously. Such improvements are necessary to better understand what CMS is paying for under the hospice benefit.

Certification of eligibility for hospice is another potential area that we could develop further. We think that this is a good candidate for soliciting input from the clinical community via an expert panel, as has been suggested earlier. As you will recall from the chapter on comparative effectiveness discussed yesterday, developing evidence on the appropriate use of hospice care is one of the 10 highest priorities of CMS's Medicare Evidence

Development and Coverage Advisory Committee.

It is also our understanding based on your discussion last month that you are interested in developing options for reforming Medicare's hospice payment system. Such reforms would reflect the requirement that Medicare spending for hospice users be less than spending for comparable decedents who do not use hospice, should you choose to maintain this requirement. These reforms would also include changes that would reverse the incentives in the current payment system. We could also develop specific proposals related to the cap in the context of larger payment system reforms.

We anticipate being able to provide detailed analyses to support potential recommendations for your consideration in the fall. That would follow the guidance you provide today. We would be happy to take any direction you may wish to provide now, however.

To summarize then, over the course of the last six months, we've covered most of the Medicare hospice benefit. We hope this information has given you a basis to begin discussing specific policy options to address some of the topics we've covered.

At this point, we'd like to solicit your discussion on the new material we've presented here today, the June report chapter, and the future policy areas that we anticipate developing further. While we will not be presenting recommendations in the June report, your guidance today will help shape those areas that we develop further for recommendations in the next analytic cycle.

Thank you.

DR. REISCHAUER: Thank you, Jim and Zach. I think we all appreciate your responsiveness, looking into the questions that we've raised in previous sessions. It is very interesting.

Nancy-Ann?

MS. DePARLE: Yes, thanks for following up on some of the questions I had. Your follow-up actually raised another question that I was pondering. If you will go back to that chart that you did, I don't remember what page it's on. That one.

You mentioned that a number of states that had large numbers of hospices exceeding the cap also were at an average level of hospice use or access -- I forget which word you used -- national average rate of hospice access --

that was higher than the average rate, which I think you said was 43 percent?

DR. MATHEWS: That's correct.

MS. DePARLE: I guess I'm wondering what we know about whether 43 percent is an optimal level of hospice access? One reason I ask that is in looking at the data -- it's on this chart -- you point out in the text that Utah and one other state -- Arizona, I think -- are considered to be by the industry at the highest possible level or some words like that. And they're at 70 percent or close to that.

DR. MATHEWS: That's correct.

MS. DePARLE: So what is considered to be the optimal level of hospice access? Do we have a measure of that?

DR. MATHEWS: I don't know that we have anything that I could safely call an optimal measure. But when you do talk to the hospice associations and researchers in the field, they do say that the highest potential level of access in a practical sense is probably 65 percent to 70 percent. And when we say practical level, there are certain patients who simply cannot qualify for hospice, those who

die as a result of accidents or very precipitous declines in health status --

MS. DePARLE: Sure.

DR. MATHEWS: -- where there is simply no time for a hospice intake.

MS. DePARLE: That percentage, Jim, just to be clear, means the percentage of hospice users per Medicare decedents? So 70 percent of Medicare decedents in Utah --

DR. MATHEWS: That's correct.

MS. DePARLE: -- use hospice for some length of time?

DR. MATHEWS: Right. And I wanted to clarify here that we have explicitly decided to use hospice users over Medicare decedents here as the measure of access rather than hospice decedents over Medicare decedents because if you are in hospice you have access. So we felt that was the better measure. That explains why we get a national average utilization rate that is higher than what I believe is the measure you get when you look at Medicare hospice decedents over total decedents, which is about 37 percent.

MS. DePARLE: Right. Part of the reason I ask this is it harks back to the Vice Chairman's line of

questioning at our last session about this, which is there was a point in the very recent past where it was thought, where I thought that not enough people did have access, not enough Medicare beneficiaries did have access nationwide to these services. And so growth in them, even dramatic levels of growth, is not necessarily a bad thing. So we're trying to tease out what does it mean.

On the quality question, you provided a lot more information there, too, and I just wanted to bring out something that was mentioned in the public comment period the last time.

I don't think you deal with this in the chapter but I'd like your views on, which is the importance of surveys to ensure that hospices are complying with the minimum conditions of participation in the Medicare program. You can argue whether that's a measure of quality but I at least would say it's a measure of some threshold of quality. It's my understanding, and I think someone said this at our comment period, that currently hospices can go to six to eight years between surveys?

DR. MATHEWS: Or longer.

MS. DePARLE: I'm looking at Bill Scanlon and I

think we can both agree -- and I'm sure it was that way when I was there too. I'm not criticizing anyone. But that's not adequate. So current is not adequate.

And my understanding is the president's budget proposes to increase the level of time that hospices go between surveys from 10 to 12 years. Again, what can they be thinking. That isn't appropriate for any provider group or any of us.

That's problematic.

DR. MATHEWS: This was something we did contemplate in an early draft of the chapter. We came to the conclusion that was this was a CMS resource issue at the moment. But if you wanted to does to develop that further, it is a line that we could pursue going forward.

MS. DePARLE: I do. I think that yes, it is a CMS resource issue. It certainly is. I'm sure if we looked at other provider groups, I know at least there were some a couple of years ago that were going every 13 years -- maybe dialysis. It isn't appropriate. And it's our job to highlight those things and get CMS, the administration, Congress, to pay attention to them. So I do think it should be noticed.

MR. EBELER: Thanks for the follow-up to all the questions.

I know we're not making formal recommendations, and this probably follows a little bit up on Nancy-Ann. But it strikes me that there were a couple of themes today and in our last meeting that as we go down the road on this are worth attention.

One is this issue of reporting of quality and service information. Again, it's sort of a cross cutting theme for the Commission of getting information on what's going on out there. I would hope the chapter, even if it can't formally recommend that, encourages those pushing in that direction because it clearly is something that is something that everybody needs. I think Nancy-Ann's comment about surveys, in some ways, fits into that. There's certain commonsense things that are really critically important here.

On future policy direction, Jim and Bob had a discussion about a short-term direction that I think you validated with your data today. We saw last time the declines in costs, the increase in margin by decile of length of stay. You've sort of teased that apart here and

shown that it's both the number of visits and the nature of the visit that is causing that, give us more granularity. It certainly implies a short-term payment policy direction where one would change an average payment level and sort of pay more at the beginning and less as you slide down that curve.

The third is there was a bit of a long-term discussion that I think Jay started, which is at the same time we sort of figure out how to make sense of the current benefit and payment policy, the changes in the nature of what's happening underneath hospice certainly called for a longer-term look at what we want in this area.

And again, I understood we're not making recommendations but they are certainly directions that I hope the report can begin to signal just as the community goes forward.

DR. CASTELLANOS: First of all, thank you. I think you did an excellent job and you brought out a lot of things.

As you know, Jim, I'm a practicing physician. So this is an important part of the medical community's ability to deal with death and dying. We really appreciate what

hospice does.

There are a couple of things that really strike me that I don't think we completely looked at. One was the single carrier that's responsible for the majority of the hospices reaching the cap. That just doesn't pass the smell test. I'm not quite sure why is that? Has that been looked at?

DR. MATHEWS: Yes, actually I did talk to the folks in each of the four HHIs very closely. I talked to both the applicable managers and their staffs, kind of going through the methods by which they calculate the caps. I also talked to them, including a couple of their medical directors, about the homogeneity or heterogeneity of the admissions guidance that they use.

With one small exception with respect to the way each RHHI handles the calculation of what are known as fractional beneficiaries -- these are beneficiaries who use more than one hospice -- they are all using the exact same method of calculating the cap.

So I do not believe that with the information that I have available that there is any difference in what the RHHIs are doing that accounts for the variation in the

number of hospice that are hitting the cap among the different regions.

DR. CASTELLANOS: As we've seen with the other Medicare issues that we've dealt with, profit versus nonprofit, it's pretty evident that that same pattern exists here. The ones with for profit have a higher margin of profitability. The for-profit ones are the ones that exceed the cap more commonly.

One of the things that we've used in medicine and on a state level is CONs. I noticed that at least in your paper, I know in Florida we have a CON for hospices, and I know in New York they do. That seems to have some control over the number of caps and it also has some control over the number of caps that don't exceed the cap. Do you have any comments on that?

DR. MATHEWS: No.

DR. CASTELLANOS: I think that's the safest answer. I think that really is the safest answer.

[Laughter.]

DR. MILLER: What Jim meant was when we go through the policy stuff there is payment areas that we're looking at. There's areas of accountability, how you make decisions

about whether a patient goes into a hospice. We can look at supply based policies, as you're suggesting. There is also the oversight enforcement quality types of areas. There's large blocks of areas that we have ideas -- the payment step down is one of the ideas. And we can consider ask the question about supply base policies, which is essentially what you're asking.

DR. CASTELLANOS: And that's true because supply base CONs do work in medicine, whether it's hospitals, whether it's MRIs, surgical centers. I know it is a tool that can be used.

I think the last thing really that I want to bring up is that as a physician we all recognize that it's very difficult to predict when a person is going to die or how many more months they have. But we need to develop better medical criteria for admissions to hospice. We need to be a little bit more specific than the current regulations. Is there any push to further trying to delineate or try to define or try to develop more or stricter Medicare criteria for admission?

DR. MATHEWS: There is an effort, as I mentioned, under way -- not an effort underway. CMS has identified a

pressing need to develop -- I don't want to use the word more strict, but better criteria for admission to hospice, especially given the change in the composition of the hospice user population over time.

The problem with using more or less strict criteria is that you can indeed tighten up the criteria. You can more focus the clinical indicators that identify a patient in such a way that will increase the percentage of your hospice user population who will die within the six month presumptive eligibility period.

But the side effect of tightening those eligibility criteria is that it also increases the percentage of patients with the same conditions who are also likely near death who do not meet the strict criteria who will die within that same six-month period.

So it's a little bit of a balancing act. Do you want to tighten the eligibility so much that others who could benefit from hospice are categorically excluded? Or do you want to have criteria that are a little bit looser and draw a larger near decedent population into the benefit? So that's the trade-off.

Again, we think that is an appropriate topic for

the clinical panel that, again, it's taken us six months to come to this point despite mention of a clinical panel on a number of different occasions during the last several months. But we think that's the place where we could generate the most beneficial input.

DR. CASTELLANOS: And finally, and lastly, I know Nancy-Ann brought up the question about the optimal percentage of patients participating in hospice. I really think we should almost strive for 100 present. I mean, we're all going to leave this world and it's an excellent program. It's a societal benefit. It's a family benefit. I don't think we should really try to get an optimal percentage but we should encourage that this program is available and for those who qualify and want it, it should be available.

DR. SCANLON: First of all, I want to say thanks to Jim and Zach. You've taken an area where there isn't a huge amount of information but over the last six months you've done an incredible job of educating us about what is the status of this area.

In terms of thinking about the future, I think today the editions of the chapter in terms of quality is a

very important piece. As I've talked about before, I have a concern that with the patient that's deteriorating or dying that we really don't have good quality measures. We tend to focus on outcomes where people get better, and what constitutes good care for that deteriorating patient, I think, is an incredibly important issue for both understanding whether an organization meets minimal standards but also for the future in terms of pay for performance.

I think that the effort that the QIO in North Carolina is working on looks like it has promise. I think we shouldn't be too shy about process measures.

In looking at nursing home quality problems in the prior work at GAO, one of the things that we at one point focused on was people that die, but then looked at the care they were receiving before they died. You could distinguish the quality of care in terms of how many times were physician's orders being ignored, and this might have contributed to either their deterioration or ultimately to their death. Or how many times were changes in conditions being ignored and nothing was being done about it in terms of a new type of intervention? These are the kinds of

things that ended up with malnutrition, dehydration, and decubiti. These are potentially preventable things.

When the record isn't showing that we're taking efforts to try and do something to prevent this, there's a question that arises, is this true negligence? This can distinguish quality of care. This is not saying anything about what is happening in hospices today but it's a question of we should know that it's not happening as opposed to being totally ignorant about what the process is.

So thinking about processes of potentially good indicator of what is happening with respect to the care of a deteriorating patient is an important aspect to consider.

I agree with Nancy-Ann that the survey and certification surveys can be an important tool. I think it was just before you got to HCFA, Nancy-Ann, that we have been asking HCFA about how frequently the surveys were for things like home health and dialysis and hospice. And the answers always were that they weren't very frequent because the resources were all going into nursing homes. And then when we went and started looking at the nursing home surveys, we found the frequencies there weren't that high, either, we weren't meeting targets.

This is a problem that I think we should consider for the overall program, is how much are we investing in assuring that we're paying for providers that are meeting minimal quality standards?

In doing that we also need to be making sure that those minimal quality standards are well-defined and that we can actually assess compliance in an efficient fashion.

In the nursing homes, the review I talked about earlier in terms of people that had died and whether or not they were getting adequate care, it was aided a lot by having a common assessment instrument, by having medical records that are much more uniform than you might find among other provider types.

And so thinking about conditions of participation that lend themselves to easier oversight is also something to consider in this bigger picture because we can't -- while we want and need more resources in this area, we have to think about being efficient in terms of investing greater amounts in these areas.

So I think that what you do among the things you've identified for the future, what you do with respect to quality measurement is an incredibly important part of

our effort here. And it will have effects or benefits for consideration of other provider types such as home health and skilled nursing facility care.

Thanks.

DR. MILLER: Just a quick one, and this is for Nancy-Ann or Bill or anyone else who might have views on it. One way we could also think about this is there's always been this concept in this area -- and this has come up repeatedly in all of our careers -- of whether you try and hit everybody within a given time period or whether you have more okay, if people consistently are meeting the standards you pull them out and you just focus on -- I don't if either of you care to or have views on the kind of tactic.

MS. DePARLE: I think we did both for a while with nursing homes. And I don't have a basis to say there is a particular problem here. But I do know enough about this to know that every six to eight years or every 10 to 12 years is not adequate.

DR. SCANLON: The idea of more focused reviews I think is something that we considered at different times at GAO and thought about subsequently. It's an issue again of efficiency. The fact that for someone who perhaps is at the

margin in terms of acceptability, that you would want to look at them both more frequently and more intensively, and that for people that your experience is that they are possibly well above the threshold that you can be sort of less vigilant.

But at the same time you can't be non-vigilant. You can't ignore them because there is always this anecdote about how in a nursing home the director of nursing changes and the place changes dramatically overnight. And so it's this idea that what you need to do is you need to have enough awareness that you can be confident that things are not going bad, but at the same time where the things are potentially at the margin and problematic that you want to be there much more intensively and much more frequently.

MR. EBELER: That approach, as people have looked at it in the past, is also partly dependent on a relatively robust measurement system that allows you to get some indicators of when you may need to go back.

MR. BERTKO: I just have a quick follow-up question to one of Ron's. This is on evidence-based medicine determinations, which I think you talked about, but in the area of dementia, in particular. At least I think

I've inferred from your comments that one, the number of patients in hospice with dementia has increased and there's a corresponding length of stay. I would like to learn more, if you guys have it, about what CMS progress is on actually getting a brighter line for determining which dementia patients should be admitted to hospice and which excluded.

DR. KANE: I had a couple of questions and forgive me if I am asking a question that you answered in the last time but I don't remember the answer, which was have we looked at all of the difference in program costs for the same diagnosis for people who don't die in hospice and people who do die in hospice of those same cancer, dementia, neurological? I just was wondering if we ever looked at that. It's not that cost savings was the primary reason for this benefit but I think it was part of the reason for this benefit was end-of-life care being more cost-effective.

The other question I had is understanding a little bit more about how hospice interacts with the SNF stay. A, many people in hospice are also in skilled nursing facilities? And when, in their skilled stay, are they moved into hospice? And does it relate at all to how long their eligibility for SNF benefits is lasting or where does it

come in the stay that they might end up going into hospice? So I'm just kind of concerned that people are pretty vulnerable in SNFs to being enrolled perhaps not at the ideal time. And so I think we need particularly to pay attention to when people are being enrolled when they're in a SNF. And I don't know if we've done any research in that regard.

DR. MATHEWS: Yes. On the first point, we did talk about this reasonably extensively last time, and I can recap some of that for you off-line if you would like.

We have not yet looked specifically at the intersection of SNF and hospice but we have specifically identified this, at the staff level at least, as one of the areas in which we are very, very interested going forward. So it is something we are planning on pursuing.

MR. DURENBERGER: I'll make this quick. I've been a great believer since the guy who headed up the Democrats for Durenberger back in 1978 died in what was then an embryonic hospice.

But I'm following on something Jack said about the longer-term, and this is basically the elevator speech to sell the policy, take it out of one of seven providers and

put it into a larger context. The way you approach the Senator in the elevator is to say I need to talk to you so I'll make an appointment to talk to you about reducing the X percent -- whatever it is -- 60 or 70 percent of the cost of end-of-life care, this figure that everybody has in their head. And then there's three component parts to it, and you can pick your three component parts.

One of them would be Jack Weinberg's research and the Dartmouth research on stop hospitalizing people and doing that sort of thing.

The second interesting one that I learned on the weekend from a young man by the name of the Steven Kiernan is -- and it's important to this, I think, and important to not just the elevator speech. But the thinking about this that in the 20th century, particularly as we began the medical technology development stage, we ended sudden death and we've gone into this much longer period of slow, slow death.

In that context, talking about palliative, talking about hospice in the specific and so forth, I think takes on for somebody who doesn't know much or hasn't had an experience, takes on a better policy context because it says

here is the way we "either save money or die" more appropriately or look at dying more appropriately.

So as long as this is a long-term effort I would suggest you think about it in this larger -- presenting it in this larger context.

DR. MILSTEIN: Separate and apart from our objective of refining admission criteria, payment rules and quality assessment, it seems to me that hospice benefit is a prototype for the general policy of lowering beneficiary cost-sharing when beneficiaries select a more cost effective treatment option.

What's interesting about these longer length of stay diagnoses is they are going to begin to reduce the likelihood that hospice care will continue to be more cost-effective because you can see at the margin the satisfaction scores are going down a little bit, not yet statistically significant, and the cost -- if the caps are loosened, will go up. And so you have a benefit that we originally gave a lower beneficiary cost-sharing to because among other things it was a more cost-effective now being applied to diagnoses where it's less likely to be cost-effective.

And I think it will be extremely helpful as we

continue to engage on this issue for us to be more explicit on the wider use of lower beneficiary out-of-pocket spending as a method of sharing savings with beneficiaries when they choose more cost-effective options because if it's not -- I think we didn't put it on our list of our vision for the Medicare future. I had actually suggested we put it on and then I think there were issues of, I don't know what the considerations were. But it was with careful thought that it was not on the list of interventions.

But here we have a benefit in which we have historically engaged in that strategy. And I think this discussion is going to push us further down that track. So I guess I would, among other things, suggest that we consider putting on our list for strategy options this general concept of changing benefit design to incentivize treatment options that are either more cost-effective or more cost-effective and do not lower quality, depending on one's philosophy.

MS. HANSEN: I just would like to concur with the comments about getting the measures for quality in that direction that we're going for.

I just wanted to affirm, John, your comment about

the dementia diagnosis. I know one of the comments at the end of the last session, people were concerned that I may have said that dementia was not an appropriate diagnosis for a hospice program. And I just wanted to verify, it wasn't that. It was really was it becoming more a long-term care benefit as compared to really being appropriately what the hospice benefit was about. So I think your question, John, will help to get to defining that a little bit more.

The other one was more of a context question in terms of the history of the hospice program, which has been highly evolved and really well-developed. One of the characteristics that was a real signature component of hospice programs, as I recall, was the incredible infrastructure of volunteers that was built into a hospice program with rigorous education, training and oversight. And I just wonder how that kind of signature element of what hospice used to offer as a benefit -- maybe they were not necessarily paid, but there were staff who were involved in training and education of volunteers -- how that looks in kind of the newer hospice programs? So just more of a context, because that was part of the quality at that time, even though it wasn't anchored and measured. It was really

a signature knowledge about hospice.

Thank you.

DR. REISCHAUER: Thank you, Jim and Zach. I think over the last six months we've really gotten a tremendous education on this benefit and the organizations providing this kind of care. And I think it's a real public service and the chapter well enlighten a great number of people.

We now move on to public comments and the Hackbarth rules apply, which is identify yourself, limit your remarks to two minutes. If somebody has said what you wish to say already, me too is an appropriate response.

Before we begin that, however, I want, on Glenn's behalf and my behalf, to think publicly Dave and Nick and Nancy-Ann for their six years of service on this Commission, that they have brought both a tremendous amount of knowledge and different perspectives and a constructive contribution to the deliberations of this Commission. We've all benefitted greatly. Thank you tremendously for your service.

[Applause.]

MR. SCHUMACHER: Thank you very much. My name is Don Schumacher and I'm the President and CEO of the National

Hospice and Palliative Care Organization. I have four points for you.

First, I would like to thank the Commission for hearing us today and having this hearing, Jim and Zach for their very dedicated, comprehensive, and very thorough analysis of what's going on in the business, and our partners at CMS who continue to work with us in collaborative ways to increase the opportunity for better hospice care.

I appreciated that fact that Ms. Min DeParle acknowledged the issue of surveys that I brought up last time. It remains a concern.

I also have heard from CMS that there is the issue of resources in order to provide those surveys. They now have $300 million coming in this year from cap overpayment. I suggested to CMS that they use those dollars to pay for surveys to stop this vicious cycle of no surveys and people getting into trouble and going over cap.

So I would encourage you to recommend to CMS that they use the $300 million in cap overpayments to begin to institute a minimum survey every two to three years within the Medicare system.

Two, I want to talk just a second about the cap issue. I think a huge part of the cap issue is being driven by the fact that more and more hospices are now taking care of patients who are living in nursing homes and at home with advanced disease of Alzheimer's disease, debility unspecified, and in fact, while you've acknowledged and talked about the fact that there may be some aberrations in this, the fact of the matter is we agreed and we took on the role of providing more and more care for these patients at the encouragement of CMS, that wrote letters to physicians and encouraged the physicians to make these referrals to hospice programs because they are, in fact, appropriate to receive hospice care as they are dying within a six-month period of time.

Thirdly, Medicare, as I mentioned last time, is still out there with their CR 5567 which is an inept and incorrect data collection tool, trying to collect data on hospice programs. Some of our providers have submitted early submissions on the data collection tool, many of which have been sent back to the provider because the data that they are asking us to collect is almost impossible. We are agreeing to do it wholeheartedly in terms of an industry, we

want to collect data.

But again, I have asked repeatedly, and we're meeting with them again this afternoon at 3:30. There is an opportunity for us to work together collaboratively to collect the correct data and I'm hopeful that they will insist and move towards doing that, and I hope you encourage them to do that, as well.

And then lastly, when you do have a panel, I would encourage you to include on your panel not just the clinical people who will give you a picture of hospice care but an administrator or two of someone who's actually running a hospice program who can talk with you about some of the impacts of these issues on the day to day operations of a hospice program, not just the clinical care.

Again, thanks to the Commission, to its staff, and to CMS for our collaborative work together.

[Applause.]

DR. FINE: Good morning. My name is Perry Fine. I'm a practicing physician at the University of Utah in Salt Lake City and have been involved in hospice care as a medical director since the inception of the Medicare benefit.

I'm pleased to see the 70 percent of Utah. It's actually not by accident, it's by design, through its extraordinary work at changing the culture and the valuing of hospice by mainstream medicine. I think this is something that, in fact, can be generalized around the country. So I'm very gratified actually by the discussion of the Commission today on issues of access and quality.

I tend to be a data-driven kind of a guy, and so I wanted to make a couple of comments about some data issues which I think are confronting this reevaluation of the Medicare hospice benefit.

In the last 25 years, more or less since the benefit was legislated, diagnostic specificity and sensitivity in medicine has gone up dramatically. But prognostic certainty and predictability has actually decreased because we can do so much more to intervene, as was mentioned, in terms of diseases that used to, in fact, have fairly well defined and circumscribed end stage now being converted into chronic diseases.

And what that means is on any given day a group of patients who look very similar will have very different life expectancies. And so in fact, you're at great risk by, if

you will, tightening up specious medical determinants that really have very little to do with longevity in the absence of any real good science to demonstrate that of, in fact, obviating this benefit from those who, in fact, will both need it and who will, in fact, die within the current six-month period of time in which the benefit is allowed.

In fact one of the most interesting observations over this last couple of years is a study that demonstrates that hospice itself increases survivability. So you've got more than a Hawthorne effect here. You actually have care that begets changes in longevity.

So that's a really new challenge. Medicine has changed in the last 25 years, since the inception of the benefit, far in advance of the issues we now have to contend with. So on an issue of access, that's an important data point.

The other thing that I think is worth mentioning here is that the data that's been collected and presented so far, as I followed through MedPAC, I haven't seen a lot of attention paid to comparative margins, cap, et cetera, these economic drivers that compare and look at economies of scale in terms are what are administrative costs versus patient

care costs and use of those Medicare dollars for patient care versus SGNA.

Meaning that we don't really understand yet the efficiencies of small versus medium versus large hospice completely. And in fact there may be, from the studies I and others have done, shown that there are perhaps some really significant issues and problems with small, medium in hospice if it's not looked at in that type of a way.

So I think some of the issues around margins, cap, and so forth, adjusted for average daily census, may be very, very important to inform the process go forward.

So with that I thank you and thanks very much to the Commission.

MR. SMITH: Good morning. My name is Steve Smith. I'm the Executive Director and CEO for the American Academy of Hospice and Palliative Medicine, and I just wanted to make a quick comment.

First of all, thank you for the good work that you've been doing. I just want to echo Dr. Fine's comments and Don's comments as well.

As an Academy we have over 3,000 primarily physician members but also other clinicians involved in the

organization? And we share many of the same concerns regarding access and quality of care.

I was very pleased to hear the suggestion about the clinical review panel, and look forward to working with all of you on that process when the time is appropriate.

DR. REISCHAUER: Okay, thank you.

We are adjourned until the summer retreat.

[Whereupon, at 10:56 a.m., the meeting was adjourned.]