

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom  
Ronald Reagan Building  
International Trade Center  
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Thursday, January 10, 2008  
9:49 a.m.

COMMISSIONERS PRESENT:

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MR. HACKBARTH: Welcome to everybody.

As most of you know in the audience, this is the meeting at which we vote on our update recommendations for the various Medicare payment systems, with the recommendations to be included in our report published March 1st.

Much of today's agenda is devoted to those update recommendations. The process of developing recommendations on updates is a difficult one and often a frustrating process for commissioners. The nature of the task is that we're supposed to recommend one number that reflects the appropriate increase in rates for broad groups of providers in very diverse circumstances. It is challenging at best to know what that one right number might be.

Our fundamental mission is to bring as much rigor and analysis and data to that process as we possibly can so that the Congress has the benefit not just of our recommendation on the specific number but also has the benefit of the information behind it.

We have been using essentially the same framework for making those update recommendations for the last five or

1 six years. As those of you who follow our work closely  
2 know, we review a variety of factors in formulating the  
3 recommendation. Where the information is available, we look  
4 at financial information drawn from cost reports. We look  
5 at beneficiary access to care, changes in quality of care to  
6 the extent that they can be measured. We look at access to  
7 capital. In the case of physicians, where we don't have  
8 cost report information, we compare Medicare payment rates  
9 to private sector payment rates. So we try to zero in on  
10 the most appropriate update, looking at a variety of  
11 different types of data.

12           The framework that we've been using for the last  
13 five or six years is, I think, a reasonable one. But I also  
14 think it's important for us to regularly review our  
15 approach. And so over the course of the next number of  
16 months, in preparation for next year's cycle, we will be  
17 taking a look at the update framework, the payment adequacy  
18 framework, that we use to see if we can improve it or  
19 potentially even change it in more fundamental ways.

20           A key concept in that review, at least from my  
21 perspective, is the notion of efficient providers. Those of  
22 you who follow us really closely, as I know many of you do,

1 know that MedPAC's mandate from the Congress is to make  
2 recommendations that are adequate to support care in  
3 efficient providers. That efficient provider language was  
4 added several years ago. And so part of the review that we  
5 undertake of the payment adequacy framework will be targeted  
6 at that, in particular. Are there ways that we can define  
7 efficient provider and operationalize, if you will, that  
8 concept for the various payment systems?

9 Exactly where this discussion will lead, I don't  
10 know, but I wanted to let you know that we will be  
11 undertaking that work.

12 So now, to turn to the first of our update  
13 presentations and recommendations, John, you're going to  
14 lead the way on physicians; correct?

15 MR. RICHARDSON: Yes. Thank you and good morning  
16 everyone.

17 Today I would like to review the analysis of  
18 payment adequacy for physician services that was presented  
19 at our last meeting in December, present one new piece of  
20 payment adequacy analysis that we did not have ready in  
21 December, and then present a draft update recommendation for  
22 physician payments in 2009.

1           First, though, we want to be sure that everyone is  
2 up to speed on the changes to Medicare physician payment  
3 policy for 2008 that were enacted after our meeting in  
4 December. These policy changes were made by the Medicare,  
5 Medicaid, and SCHIP Extension Act of 2007 that passed both  
6 houses of Congress the week of December 17th and was signed  
7 by signed by the President on December 29th.

8           First, the Act put in place a 0.5 percent increase  
9 in the physician fee schedule conversion factor effective  
10 from January 1st through June 30th of this year. If this  
11 change had not been enacted, the update on January 1 would  
12 have been negative 10.1 percent.

13           The Act also stipulates that future update  
14 calculations under the sustainable growth rate, or SGR,  
15 formula shall should be affected by the new 2008 update. In  
16 practical terms, this means that the new law does not change  
17 future fee schedule updates which are currently projected to  
18 be negative every year through at least 2016 under the  
19 current SGR formula.

20           The Act also extended two payment policies that  
21 were scheduled to expire at the end of 2007, the floor on  
22 the geographic practice cost index that effectively

1 increases payments to areas with relatively lower practice  
2 costs such as rural areas, and a provision for a 5 percent  
3 bonus payment to physicians practicing in designated  
4 physician shortage areas. Both of these extensions are  
5 effective through June 30th of this year.

6 Altogether the three policy changes I just  
7 described were scored by the Congressional Budget Office as  
8 increasing Medicare spending by a total by of about \$3.1  
9 billion in fiscal year 2008.

10 To offset some of these new costs, the Act  
11 eliminated all but a fraction of a capped \$1.35 billion fund  
12 created under the Tax Relief and Health Care Act of 2006, or  
13 TRHCA, to fund either the 2008 conversion factor update or  
14 the 2008 physician quality reporting initiative.

15 As you may recall, the Secretary opted, in the  
16 final rule for the 2008 physician fee schedule, to apply  
17 this fund in its entirety to PQRI for 2008. In effect, the  
18 Congress has overridden that decision by the Secretary and  
19 instead applies almost all of the fund to offset the cost of  
20 the new 2008 update. This action by the Congress is  
21 consistent with the Commission's recommendation last year  
22 for the use of these funds.

1           The Congress did not eliminate PQRI, however. To  
2 the contrary, it was extended for another year, through  
3 2009. The difference now is that funding for PQRI bonus  
4 payments, which are equal to 1.5 percent of a physician's  
5 total allowed charges if he or she meets the program  
6 criteria, will come directly out of the Part B Trust Fund  
7 without the cap on total spending that was imposed under  
8 TRHCA.

9           Lastly, the 2007 Extension Act sets aside a new  
10 pool of funding of about \$5 billion to be used for future  
11 physician updates. We anticipate that future legislation  
12 will further define exactly when and how this new funding  
13 would be applied. But the important take away at this point  
14 is to be aware of the fund's existence and Congress' stated  
15 intent to apply these funds to future physician updates.

16           I now will review the physician payment adequacy  
17 indicators that we considered at our December meeting and  
18 present the one indicator that we have since December,  
19 specifically one that compares Medicare and private  
20 insurers' payment rates.

21           As you will recall, a central component of our  
22 adequacy analysis is a survey of Medicare beneficiaries'

1 self-reported access to physician services. This slide  
2 summarizes the key findings of the 2007 survey, which I  
3 presented in more detail in December. The survey was  
4 fielded from August through September 2007 and provides the  
5 most up-to-date information we have on beneficiaries' access  
6 to physician care.

7           First, the survey found that Medicare  
8 beneficiaries who needed to make an appointment for routine  
9 care or to treat an illness or injury reported better or  
10 equal rights of access to their physicians compared to  
11 privately insured individuals aged 50 to 64. Medicare  
12 beneficiaries more frequently reported never having to wait  
13 for an appointment and less frequently sometimes having to  
14 wait and the differences between the two groups were  
15 statistically significant.

16           Second, the survey indicated mixed access results  
17 among the subset -- about 10 percent -- of Medicare  
18 beneficiaries who looked for a new physician in the  
19 preceding year. There was a small not statistically  
20 significant increase in the percentage of beneficiaries  
21 reporting some difficulty finding a new primary care  
22 physician. That percentage went from about 24 percent in

1 the 2006 survey to about 30 percent in 2007. A greater  
2 percentage of individuals in the privately insured group who  
3 looked for a new primary care physician reported no problem  
4 finding one. And that difference between the privately  
5 insured and Medicare beneficiary groups was statistically  
6 significant.

7           Also, fewer beneficiaries who looked for a new  
8 specialist reported problems finding one in 2007 compared to  
9 2006, and fewer of them reported problems than similarly  
10 situated individuals in the privately insured group.

11           Taken together the result of our 2007 beneficiary  
12 access survey lead us to conclude that, at least from a  
13 national perspective, beneficiary access to physician care  
14 is good for the vast majority of Medicare beneficiaries but  
15 also that pockets of access difficulties do exist,  
16 especially for beneficiaries seeking new primary care  
17 physicians.

18           In December, we also reviewed the other payment  
19 adequacy indicators that are shown on this slide. Just to  
20 briefly review them for you, two surveys of physicians that  
21 were conducted in 2006, one fielded by the Commission and  
22 one by the National Center for Health Statistics, found that

1 most physicians are accepting new Medicare patients. The  
2 2006 National Ambulatory Medical Care Survey fielded by NCHS  
3 in 2006, found that among physicians for whom Medicare  
4 compromised at he least 10 percent of their revenue, about  
5 90 percent of primary care physicians and about 95 percent  
6 of specialists reported accepting new Medicare patients.  
7 These results were similar to the 2004 and 2005 surveys.

8           On the supply of physicians billing Medicare for  
9 fee schedule services, our analysis of 2006 paid claims data  
10 found that the number of individual physicians billing the  
11 program continued to keep pace with growth in total Part B  
12 enrollment. We also looked at the volume and intensity of  
13 services provided in 2006 on a per beneficiary basis and  
14 found that that continued to grow in 2006, albeit at a  
15 somewhat slower overall rate of growth than in proceeding  
16 years.

17           Lastly, our analysis of ambulatory care quality  
18 indicators found that most of them increased or remained  
19 stable in 2006 compared to the base period two years  
20 earlier.

21           Our final piece of analysis, which was not ready  
22 in time for the December meeting, I'll present now. For

1 THIS analysis, we compare the national average of physician  
2 fees paid by Medicare to those paid by two large national  
3 private insurers. Averaged across all services and areas,  
4 the 2006 ratio of Medicare rates to private payer rates was  
5 81 percent, which is lower than 83 percent ratio we found in  
6 2005. This means that averaged across all physician  
7 services and geographic areas Medicare physician fees were  
8 81 percent of the fee schedule amounts paid by the two large  
9 national private insurers represented in our analysis.

10 We also separately compared Medicare's and the  
11 private payer's payment rates just for evaluation and  
12 management services and found the ratio for those primary  
13 care services was 86 percent in 2006. In 2005 that ratio  
14 was 89 percent. So here again we see a small decrease in  
15 the ratio between the two years. One possible reason for  
16 the lower ratios in 2006 compared to 2005 could be because  
17 there was no update for Medicare physician payment rates in  
18 2006 while the private payer physician rates presumably  
19 increased, at least a bit.

20 It is important to remember that all of this  
21 analysis is based on national averages of physician payment  
22 rates and that the differences between Medicare and private

1 payers' physician fees may vary substantially from these  
2 averages within a particular market area or for a particular  
3 service.

4           Taken altogether then, our payment adequacy  
5 analysis indicates that Medicare's current physician payment  
6 system from a very high level perspective is reasonably  
7 adequate and stable. However, as the Commission has pointed  
8 out in past reports to the Congress, the current payment  
9 system has several shortcomings that I want to touch on  
10 briefly before moving to the update recommendation. We  
11 think that these payment policies need to be addressed to  
12 reach the Commission's goals of increasing the overall value  
13 and efficiency of Medicare services.

14           This slide presents three major payment policy  
15 areas where the Commission has discussed ways to improve the  
16 value of physician services purchased by Medicare. First,  
17 we have discussed how rapid increases in the volume of some  
18 services may be assigned the prices Medicare pays for these  
19 services are not as accurate as they should be. In  
20 response, we've recommended that Medicare should establish  
21 an independent expert panel to identify possibly overvalued  
22 services and we have suggested that Medicare could consider

1 automatically correcting misvalued services.

2           Second, we have analyzed the rapid growth of new  
3 diagnostic and therapeutic services that has taken place  
4 with limited or no evidence of the comparative effectiveness  
5 of these services against the older services that they are  
6 replacing. The Commission has presented its views on the  
7 need for an independent entity to sponsor and disseminate  
8 research on comparative effectiveness that could inform  
9 Medicare's decisions on coverage and payment policy for  
10 these services.

11           And third, we have discussed the extensive body of  
12 research that shows wide variation across geographic areas  
13 in the levels and growth of the volume and intensity of  
14 services delivered to Medicare beneficiaries with no  
15 apparent corresponding relationship to the quality of care  
16 or outcomes. Recognizing the physician's central role in  
17 the health care delivery system and the power of her pen and  
18 prescribing pad in allocating health resources, the  
19 Commission recommended in 2005 that Medicare should measure  
20 and provide confidential feedback to physicians on their  
21 health care resource use.

22           Again, the purpose of this brief overview of these

1 past recommendations and discussions for improving the value  
2 of services is to put the draft recommendation I'm about to  
3 discuss in some context.

4           That draft recommendation is as follows: The  
5 Congress should update payments for physician services in  
6 2009 by the projected change in the input prices for  
7 physician services less the Commission's expectation for  
8 productivity growth. The Congress should also enact  
9 legislation requiring CMS to establish a process for  
10 measuring and reporting physician resource use on a  
11 confidential basis for a period of two years.

12           Based on our current estimates of input price  
13 increases, which is 2.6 percent for 2009, and expected  
14 productivity increases, which is 1.5 percent, the resulting  
15 2009 update recommendation is approximately 1.1 percent.  
16 Compared to the projected negative 5.0 percent update that  
17 would occur under 2009 under current law, the recommended  
18 update of 1.1 percent would stabilize the physician payment  
19 system while Medicare moves forward to improve the value of  
20 physician services it purchases.

21           In terms of spending implications, the proposed  
22 update recommendation would increase Federal spending in

1 2009 by more than \$2 billion and by more than \$10 billion  
2 over the subsequent five-year period relative to current  
3 law. Again, enactment of any positive update, or indeed any  
4 update greater than the negative 5 percent update under  
5 current law, would increase spending relative to that  
6 baseline.

7           The beneficiary financial implications are that  
8 the update recommendation would increase Part B insurance  
9 and coinsurance amounts for physician services relative to  
10 current law and, of course, providers would see higher  
11 Medicare payments relative to current law.

12           I just want to make a couple of brief comments on  
13 the physician resource piece of the recommendation.

14           We are considering that CMS, at the end of the  
15 initial two-year period of confidential feedback, should be  
16 prepared to use the physician resource data as collected  
17 along with quality of care measures to set payment policy.  
18 Realistically, it will take time and perhaps additional  
19 administrative resources and programmatic flexibility from  
20 the Congress for CMS to develop the operational  
21 infrastructure needed and be ready to integrate resource use  
22 information into the payment system. We suggest the

1 proposed two-year period as a reasonable time to balance the  
2 need for developing the operational infrastructure and to  
3 maintain the sense of urgency for this policy change.

4 That concludes my remarks. Thank you, and I look  
5 forward to your discussion.

6 MR. HACKBARTH: John, could I ask for a  
7 clarification? You said that for 2009 the scheduled  
8 reduction is minus 5 percent?

9 MR. RICHARDSON: Correct.

10 MR. HACKBARTH: It might be helpful for you to  
11 connect that to the minus 10 percent that is much talked  
12 about for the current year.

13 MR. RICHARDSON: Sure. First of all, the minus 10  
14 percent that would have occurred January 1st was avoided by  
15 the Congress's action at the end of December to put in place  
16 a 0.5 percent update for the first six months of the  
17 calendar year 2008. Under current law, assuming no further  
18 Congressional action, the physician conversion factor would  
19 go down by 10 percent on July 1st of this year.

20 However, the way that the law was written, the  
21 changes in 2008 are not to be taken into consideration when  
22 calculating the 2009 update which currently is projected to

1 be minus 5 percent under current law.

2 So regardless of whether Congress extends the 2008  
3 update that it enacted from January through June, if it  
4 extends that for the entire year, regardless of that or not,  
5 the update January 1st, 2009 would be minus 5 percent as  
6 opposed to the recommendation here which would be to  
7 increase it by about 1.1 percent.

8 Is that as clear as mud to everyone?

9 DR. SCANLON: Minus 5 percent from what? From the  
10 July 1st conversion factor or the January 1st conversion  
11 factor?

12 MR. RICHARDSON: I believe from the January 1st  
13 conversion factor.

14 MS. BOCCUTI: I think, Glenn, was your original  
15 question a little bit about why was he talking about 5  
16 instead of 10? Is that what you were asking? Bob is  
17 shaking his head no and you're shaking your head yes.

18 [Laughter.]

19 MS. BOCCUTI: I think -- realize that it's a 10  
20 percent from what they got the year before. What's in  
21 legislation is about two different things. One is the  
22 conversion factor. So that they're already going to have

1 the 5 percent cut because of the SGR. But recall for 2007  
2 there was also a 5 percent bonus. So that brings the 2008  
3 update down to 10 percent had there been no legislation.  
4 Does that help?

5 MR. HACKBARTH: Yes.

6 MS. BOCCUTI: I think that's what you were asking.

7 MR. HACKBARTH: Bob did you have a different  
8 question?

9 DR. REISCHAUER: No.

10 MR. HACKBARTH: Okay. So could you put up the  
11 recommendation? The recommendation is before you.

12 I started by saying that these update  
13 recommendations were all difficult. I think for me  
14 personally, the physician is maybe the most difficult of  
15 all.

16 For me what this recommendation would say is that,  
17 number one, MedPAC does not think that physician fees ought  
18 to be cut as would happen if the SGR were just allowed to  
19 run its course. And I think that's a very important message  
20 for us to convey to the Congress.

21 The second message is that we think Congress ought  
22 to go further than just freeze the rates, as they have done

1 sometimes in recent years, and that at least a modest  
2 increase in the rates is appropriate.

3           The third message, and this would not be conveyed  
4 through the language of the recommendation but more through  
5 the text, is that the issues in physician payment as I see  
6 them are not so much about the size of the pool, which is  
7 what the update factor addresses, but how the dollars are  
8 distributed among different types of professionals in  
9 different types of activities. It is there where I have,  
10 personally, the greatest concern about the signals that  
11 we're sending about what we value in terms of physicians'  
12 work.

13           Beginning at this meeting but potentially  
14 culminating in our spring meetings, March/April meetings, we  
15 will be considering some potential recommendations on those  
16 distributive issues and how we can change the relative  
17 values and change payment for particular types of services  
18 to send better signals. I think that's very critical work  
19 but it is separate from this recommendation.

20           So those are my thoughts about what the  
21 significance of the recommendation is. Let me open it up  
22 for discussion. Any questions or comments?

1 DR. KANE: First, I want to echo your concern  
2 about the distributional impacts of the current payment  
3 system and the fact that evaluation and management services  
4 in particular, we believe, are grossly undervalued and also  
5 cannot achieve the kind of productivity that perhaps some of  
6 the more technologically advanced specialties get. If we  
7 could, I would prefer to split the update into two different  
8 parts that had a market basket or input prices for  
9 evaluation and management. And then I don't really have a  
10 lot to say about the others. But I wouldn't take  
11 productivity out of the E&M because we know there's very  
12 little productivity opportunity in the face-to-face work  
13 that a physician does plus the other hour it takes to do all  
14 of the paperwork or even the electronic medical record input  
15 it takes to do primary care in an office based face-to-face  
16 work.

17 So it would be nice if we could acknowledge that  
18 at least in our discussion since apparently we can't do it -  
19 - I'm not sure why we can't do it in our recommendation --  
20 but to acknowledge that in the discussion.

21 I'll add one more thing. The other concern I have  
22 is that the beneficiary survey as to access, it's 2,000

1 Medicare beneficiaries across the country. When you're  
2 asking 2,000 people across the country whether they have any  
3 trouble finding a doctor or seeing a doctor, I think you're  
4 getting the advantage of a lot of places where there aren't  
5 a concentration of Medicare beneficiaries.

6           The real impact, I think, of the payment problems  
7 in Medicare for physicians might be more obvious in markets  
8 where there's a higher concentration of Medicare  
9 beneficiaries, for instance maybe Arizona or maybe Florida.  
10 Because I'm hearing constantly, from the folks I know in  
11 Florida -- which include my own parents -- that there is a  
12 problem in seeing a doctor or finding a new primary care  
13 doctor.

14           And I'm wondering if there isn't some tipping  
15 point where physicians can see that Medicare are available  
16 in some markets because they have a lot of private pay  
17 patients to offset that versus markets where there's a  
18 greater concentration of Medicare beneficiaries. And that  
19 shouldn't we be oversampling, instead, the markets where  
20 it's more likely that beneficiaries are going to be having  
21 access problems?

22           So right now the survey, just so people understand

1 what's underneath that, it's 2,000 people nationwide in  
2 Medicare that we are surveying. And it's only about 150 of  
3 them or less who are looking for a new primary care doctor.  
4 That can't possibly gather -- I don't think we're getting a  
5 clear picture really of how hard it is for elderly in the  
6 markets where they tend to retire and stay to find a new  
7 primary care doctor. And I think we really need to  
8 oversample those markets or maybe only sample those markets  
9 to get a better sense of what happens when the Medicare  
10 population is the predominant population.

11 MR. HACKBARTH: On that latter point, I think  
12 that's important. You wouldn't expect access problems to  
13 materialize uniformly across the country geographically or  
14 materialize uniformly necessarily by specialty. Each of  
15 them would have its own dynamics. In fact, I think the  
16 access problems probably are more pressing in some areas  
17 than others.

18 Now CMS, in the past, has made some effort to  
19 actually target potentially problematic markets and to study  
20 them in particular. Mark?

21 DR. MILLER: I'm sure Cristina and John know this  
22 even better than me, but there was this look. And one of

1 the takeaways -- and we've discussed this in a couple of  
2 meetings and perhaps it just hasn't come up recently. But  
3 what you find in those markets is that actually those are  
4 markets that are growing uniformly. People are retiring  
5 there and they are growing demographic areas. You find  
6 access problems for lots of people, not just Medicare.  
7 Because the infrastructure for the area is trying to catch  
8 up to the growth in the population. And so privately  
9 insured people have less access to new physicians and  
10 Medicare people.

11           These studies generally haven't found this strong  
12 linkage between the payment rate in Medicare and those  
13 issues as much as those markets having surges in  
14 demographics that the infrastructure has not caught up to.

15           DR. KANE: Have they been able to do this  
16 recently. My sense is the impact of these zero updates is  
17 starting to be more telling than it was maybe even three or  
18 four years ago. I don't know.

19           DR. REISCHAUER: I think this is a very important  
20 point because we really got into this, and CMS did sort of  
21 with the general idea are Medicare folks have a harder time?  
22 I think looking over the last few years the answer is no.

1           But now we should shift to the canary in the coal  
2 mine model which is thinking about those areas where the  
3 first signs of a problem might appear. You have given one  
4 hypothesis about what those areas look like. I would give  
5 an alternative one which would be to look at areas where  
6 Medicare payment rates are significantly below those of the  
7 private sector.

8           And there's probably three or four other markers  
9 that we might use for how we went about oversampling. But  
10 it's really catching the first indications that a problem is  
11 going to develop. Because by the time we really see it in  
12 the data that we've been collecting it's going to be too  
13 late. It will take three or four years to react.

14           MR. EBELER: I think even within the constraints  
15 of the survey, I actually think that the data we've seen in  
16 table one, using that canary in the coal mine analogy, do  
17 show the problem evolving in the place where you would  
18 expect it to first occur, which is differentials in primary  
19 care physicians accepting Medicare versus other payments.  
20 You wouldn't necessarily expected it to show up on getting a  
21 visit with my current physician.

22           But it just strikes me that even within this data

1 the leading indicator one would expect has turned in a  
2 significant way in a warning flag that I think triggers the  
3 need to do a lot more work. But I actually think we're  
4 seeing the warning even within this current data.

5 MS. HANSEN: Relative to just -- besides the  
6 canary in the coal mine, the other component of fast-growing  
7 populations have to do with some states that have really  
8 diverse pockets of populations that are growing at greater  
9 speed. And that was our chapter on the future beneficiary.  
10 There are some pockets that are growing with great  
11 diversity, as well. And since some previous studies have  
12 shown already some Medicare treatment discrepancies, even  
13 with Medicare coverage, it might be just another component  
14 to begin to take a look at kind of proactively.

15 DR. BORMAN: I'd like to remind the group of a  
16 comment that Tom Dean made at the last Commission meeting  
17 which I thought was a very telling one, that this whole  
18 discussion creates such a climate of at best angst and  
19 perhaps at the other end outright hostility that it's very  
20 difficult for, I think, the provider community to sometimes  
21 move past this conversation to taking a bigger picture view  
22 of our system and what can be done to make a better system.

1 I think Tom said that more eloquently than I can.

2 So this represents, as a practicing physician, a  
3 particularly frustrating and painful discussion probably for  
4 some of us.

5 In that context, I believe that Glenn has raised  
6 an important point in that this is meant to make a very  
7 positive statement that it's not negative 10, it's not zero,  
8 that there is something worth rewarding or increasing out  
9 there. I would just like to make sure that that is cleanly  
10 on the record because I think all of us who go to various  
11 physician societies and so forth need to be able to point to  
12 that. The physician community really -- it's going to be a  
13 hard enough explanation as it is and I think it needs to be  
14 very cleanly, strongly stated that this is meant to be a  
15 strong differentiation. And I realize the Commission has  
16 said on multiple occasions the flaws of the SGR and so  
17 forth. But I think that is a very important point.

18 I think we all agree there may be issues with  
19 distribution. I'm not sure I find the issue quite so clean  
20 as some of you do about well, it's all wrong on the  
21 specialty side and it's all right on the primary care side.  
22 I would be happy to anecdotally share with you off-line some

1 of my personal impressions about that.

2 I think the whole notion of cognition versus  
3 action or perhaps intermediate interventions such as imaging  
4 and testing does have a bit more merit. For example, if you  
5 were a patient who had a mammographic abnormality and you  
6 were sent to me to give you recommendations, I need to  
7 consider a spectrum of advice here. I need to consider from  
8 doing nothing with no intervention, merely re-examining you,  
9 with some sort of intermediate plan of repeated imaging,  
10 some sort of minimally invasive tissue approach, or frankly  
11 taking it out.

12 And the right thing for that patient is going to  
13 take into the patient's level of comfort, as well. There  
14 may be the person that says I want this out regardless of  
15 what the evidence may be about it.

16 So I would like to suggest that there is a level  
17 of cognition across all specialties and that a good part of  
18 my world is trying to help you decide whether you need the  
19 intervention at all. So I would just like to speak to us  
20 maybe think about rewarding cognition in all of its forms.

21 And then finally just a semi-technical comment,  
22 which I'm probably wholly unprepared to make, but terms of

1 the part about measuring and reporting resource use, we talk  
2 in the chapter about the volume intensity calculations and  
3 so forth. I note the example we used was computer-assisted  
4 detection for mammographic services.

5 I'm a little puzzled and will talk to staff about  
6 some of the conversation. This is an add-on code. So that  
7 every time you deliver it, you're delivering a primary  
8 service with it, that is screening or diagnostic  
9 mammography. So that I think you need to regard things like  
10 that as a single event because you don't have this CAD in  
11 isolation. And the chapter, to me, somewhat suggested that  
12 we're substituting CAD for the other service. And really  
13 what we're substituting is a higher priced service, basic  
14 mammography plus CAD. And I want to be a little bit careful  
15 as we go forward about making sure our formulas and  
16 processes for measuring and reporting the resources are as  
17 accurate as we can make them. They're not going to be  
18 perfect out-of-the-box but I think we need to be real  
19 careful about that part.

20 DR. STUART: I'd like to go back to the access to  
21 care issue and actually it's a question for John. CMS  
22 conducts an annual access to care questionnaire as a part of

1 the Medicare Current Beneficiary Survey and it's delayed a  
2 year from your survey. The 2006 survey I believe is  
3 available.

4 My question is have you gone back -- and it's a  
5 much larger sample than you look at and it has more  
6 extensive questions. So my question for you is have you  
7 gone back and looked at how well the results from your  
8 annual surveys tally with what MCBS has come up with?

9 MR. RICHARDSON: We haven't done that for this  
10 year in particular but in past years -- and I'll look at  
11 Cristina -- when we've done this in the past they are  
12 reasonably consistent. Do you want to add anything to that,  
13 Cristina?

14 MS. BOCCUTI: They are pretty consistent. Of  
15 course, it doesn't have the component that our survey has  
16 that compares it to the private population. The questions  
17 are a little bit different but they're along the same lines.

18 In fact, even when we did the beneficiary survey -  
19 - the MedPAC one -- we tried to make it parallel to MCBS so  
20 we could do that for that very reason.

21 DR. CROSSON: Thank you.

22 I have some difficulties with the recommendation

1 and it's in no way a reflection on the work of the staff or  
2 the leadership. It's very much along the lines that I  
3 think, Glenn, you talked about a few minutes ago.

4           It seems like the physician payment system is kind  
5 of core to a number of the problems that the Medicare  
6 program faces, that the country faces for that matter. And  
7 specifically in this case, both the issues of long-term  
8 Medicare cost trends and the impact of physician decision  
9 making, which in very many instances -- as was mentioned  
10 earlier -- is reactive to the payment system but also, the  
11 relatively rapidly changing impact of the distribution of  
12 the payment system and its effect on physician manpower.  
13 And that seems to be happening rather more quickly than any  
14 of us would have believed it could.

15           And the fix for that -- since the time to develop,  
16 train, and influence new physicians is relatively long --  
17 the fix for that is going to take a significant amount of  
18 time. It seems to me that the physician update process, and  
19 probably the physician payment system itself, is  
20 significantly broken and needs to be fixed.

21           With respect to the specific recommendation, I  
22 have a lot of difficulty understanding, honestly, the

1 application of productivity, which is an idea derived from  
2 industry, to individual physician practice, particularly the  
3 practices of physicians involved with cognitive services who  
4 have, truthfully, not too many means to increase  
5 productivity. In fact, it has become confused, I think, in  
6 the marketplace with the idea of adding new office-based  
7 services in order to increase productivity as defined by  
8 Medicare-billed charges which is, in fact, working against  
9 the interests of the program long-term.

10           And so I have some difficulty with that notion and  
11 I actually think it does not belong in a physician update  
12 recommendation.

13           I think what we need long-term is a different  
14 approach. I'm glad that we are going to take this on  
15 starting at this meeting and hopefully over the next year  
16 and see what we can do, see what recommendations we can make  
17 both with respect to how physician payment should be  
18 updated. But to the extent that it's in the purview of the  
19 Commission look over time at the entire basis for how  
20 physicians are paid. Because I think in the end that is  
21 going to be the key to some of the goals that we have  
22 expressed here at the Commission for a number of years and

1 how to improve the Medicare program.

2 DR. CASTELLANOS: It's hard to believe that a  
3 physician sitting here can say he's slightly optimistic. I  
4 think I'm really slightly optimistic because of the  
5 conversation we had during the Executive Session where I  
6 think we all recognize that there's a significant problem  
7 and that the Commission is going to be looking at the  
8 payment system or the updates over the next couple of years  
9 or next couple of sessions. Hopefully, the payment  
10 framework needs to be reevaluated.

11 Now we all recognize, Glenn, that a plus 1 percent  
12 is much better than minus 5 or 10 percent. But it doesn't  
13 keep up with our costs. This is still, by the medical  
14 community, is going to be looked at as a terrible message.  
15 And quite honestly it's insulting.

16 The medical community has been dealing with the  
17 SGR issue as you well know -- and we have potential cut  
18 backs through 2016. This six month fix, in my opinion, is a  
19 fiasco. Our costs are going up. If you look at CMS's data,  
20 it's about 20 percent since 2001. If you look at MGMA data,  
21 it's about 40 percent. But the conversion factor is exactly  
22 the same as it was back then. So we really haven't had an

1 increase but our costs are continuing to go up.

2 I agree with what you said about the productivity.

3 I think, Nick, you've said it. Jack, you've implied it last  
4 meeting. Jay, you just said it now. I question whether  
5 this is really appropriate for the physician community.

6 What the update is, as I said, it's really a blunt  
7 tool for trying to constrain cost. This blunt tool creates  
8 a lot of pressure on the physician societies that have high  
9 costs. These are the family practice, general practice,  
10 internal medicine, and several specialties. So what are we  
11 doing to these people? We are squeezing them even tighter.  
12 This is a group that we want to try to protect.

13 What's happening in the real world? As I said  
14 before, we are small businessmen. If we're not in business  
15 today, we can't take care of patients tomorrow. And how do  
16 we stay in business? We do some things that perhaps are  
17 inappropriate. We go into ancillaries to increase our  
18 income. Perhaps we do increase volume. I don't think  
19 there's any question that happens.

20 I think what's happened is we're triggering, by  
21 our decisions on payment, some of the abnormal or perverse  
22 incentives causing us not to respond to some of the core

1 issues. As you mentioned, Jay, it's so right, the payment  
2 really affects a lot of the core issues and the behavior of  
3 physicians.

4           What am I seeing in the real world? I'm seeing  
5 doctors go out of business. I'm seeing physicians  
6 considering and going into nonparticipating issues. There  
7 is a report from CMS -- and it doesn't make sense to me --  
8 but it says that general practice has an 89 percent  
9 participating rate.

10           What is happening in my community? They're going  
11 into concierge medicine. They're increasing volume.  
12 They're increasing ancillaries. And the AAMC study two  
13 years ago showed that perhaps physicians are retiring.

14           Again, we talked about baby boomers. In the face  
15 of baby boomers coming in 2010, we're going to have a  
16 significant problem with access. We've seen it in the lay  
17 press. Just this past week the Washington Post had a big  
18 article about the state of Maryland.

19           Nancy, you brought up a good point about aging  
20 population and different pockets. I live in South Florida.  
21 I think it's fair to say, Nancy, you and I had a discussion  
22 and your father and mother lived in Naples and they've had a

1 problem. It's a real problem. It's not something that is  
2 okay. I'm seeing this. I really am seeing this. I'm  
3 seeing the aging physician in the community.

4           What's he going to do? He's not going to stay in  
5 the practice. It takes eight years to train a physician to  
6 replace the physicians that are going out of practice.

7           I don't think we can sit back and say everything  
8 is okay. And I don't think we are saying everything is  
9 okay. But this message is still going out to the medical  
10 community.

11           I agree with some of the approaches that we talked  
12 about but I can't vote for that. I would strongly say we  
13 just need a full update, very similar to some of the other  
14 Medicare providers. The hospitals are in the same situation  
15 we are. They have increased costs and they have decreased  
16 revenue. That's exactly what we're seeing. I think what  
17 we're doing is forcing physicians to do some behavioral  
18 patterns to stay in business.

19           DR. WOLTER: Just a few comments. I, too, have a  
20 problem with the update, whether it's done using  
21 productivity or just 1 percent. I think the SGR, as I've  
22 said many times, has become a destructive policy. It's been

1 very ineffective. It is driving utilization patterns  
2 outside of Part B. It has distracted us greatly from  
3 focusing on other tactics which might be more effective. I,  
4 too, am seeing -- it's noise still -- but I'm hearing a lot  
5 about access issues and decisions that physician groups are  
6 starting to make about new Medicare patients. I'm worried  
7 about that.

8           One particularly interesting thing, I was on a  
9 call with some other group practice leaders recently.  
10 There's a group in the Pacific Northwest that won't see  
11 private fee-for-service because they're sophisticated enough  
12 to know that there's a lot of money being put into that  
13 program and yet they're stuck at these fee-for-service rates  
14 that don't go up from year to year.

15           So I think the physician community is really  
16 starting to look at themselves as being treated quite  
17 differently than the other silos. I'm worried about that  
18 because I think, as many of us believe, physician leadership  
19 and accountability for cost and quality is going to be an  
20 essential ingredient to how we solve a lot of the problems  
21 we have. And we've got some policies in place right now  
22 that are driving them away rather than bringing them in.

1           And so I don't think the market basket personally,  
2    which is a different point of view update from some of the  
3    other Commissioners, is really a very effective lever. I  
4    would say that whether it's a zero percent update or a 10  
5    percent positive update, unless we start focusing on some  
6    other tactics, we're not going to get control of costs and  
7    of quality. And so I really have a hard time with where we  
8    are in this update.

9           And then I did want to comment on the resource  
10   utilization because, as I said, I very much believe in  
11   physician accountability. There's no question that  
12   physicians -- the pen does create a lot of cost. But having  
13   said that, it is a trite-ism that has a lot of truth but  
14   doesn't tell the whole story. I'm very concerned about a  
15   resource utilization approach that would attribute care to a  
16   physician who's responsible for 35 percent of the claims and  
17   has no control over the other 65 percent. And I would  
18   remind us all that Elliott Fisher's work looked at cost of  
19   care in both Part A and B. It wasn't just Part B. It was  
20   end-of-life care, it was ICU days, in addition to things  
21   like days of seeing a specialist in the last two years of  
22   life.

1           So if we don't stop only trying to impose  
2 solutions around resource use utilization in silos, we are  
3 not going to create incentives for systemness and approaches  
4 to care where physicians can become accountable. In my own  
5 experience, to tackle complex cost and quality problems  
6 takes decision support. It takes data systems. It takes  
7 administrative leadership as well as physician leadership.  
8 And I'm really worried that we haven't thought through what  
9 we might be thinking with this recommendation.

10           I would also say we don't have much text in here.  
11 Are we going to start with high volume/high cost episodes?  
12 How are we going to tackle this issue? Design is very  
13 important. I'm very, very concerned about the  
14 unsophistication, I would say, of where this could go if it  
15 is not appropriately designed and instituted.

16           I would also say that the cost of an episode is an  
17 issue, but the issue that none of us have had a good ability  
18 to get our arms around is one could reduce congestion heart  
19 failure admissions and that way have many fewer episodes  
20 that might be looked at. But the episodes of those that  
21 remain could be more costly. And so the utilization issue  
22 which drives so much cost is sort of the elephant that

1 nobody has a really good way of getting their arms around.  
2 And yet somehow we need to start talking about that as well  
3 as unit cost and episode.

4 I would also say that our experience in the group  
5 practice demo is that physicians are very ill-prepared on  
6 severity adjustment. The reason for that is in the fee-for-  
7 service system you can just circle a given code and your  
8 payment will be the same as if you are more sophisticated  
9 about any coexisting conditions and that sort of thing. My  
10 recollection is that the severity adjuster we're using in  
11 that demo comes out of the Medicare Advantage severity  
12 adjuster.

13 In capitation, of course, those systems have  
14 become more sophisticated on making sure their coding is  
15 more all-inclusive because it's increasingly affecting their  
16 reimbursement.

17 And so how severity adjustment might be looked at  
18 as we look at physician resource utilization I think really  
19 is challenging. There's many other issues. It's really not  
20 worth going into all the potential issues. But hope that we  
21 have our eyes wide open about where that part of the  
22 recommendation might go.

1           MR. HACKBARTH: I think, Ron, you said the message  
2 was everything is not okay. Before we got too far away from  
3 your comment I want to be real clear that I do not think  
4 everything is okay. And I don't think that this  
5 recommendation should be interpreted by anybody in this room  
6 or by the Congress as MedPAC saying oh, everything is okay,  
7 just adjust the conversion factor a little bit.

8           I think that there are a lot of real difficult  
9 issues in terms of the impact of the payment system on  
10 physicians, in particular particular types of physicians. I  
11 think the easy part is to say that. The easy part is to say  
12 that it's driving our health care system in the wrong  
13 direction. The harder part is to figure out exactly how to  
14 change it. We've struggled with that in the past. We've  
15 made some recommendations. I think we need to make more.  
16 We can make some more come the spring.

17           I also think it's important to keep in mind that  
18 everything is not okay for the beneficiaries that have their  
19 cost sharing premiums go up. Everything is not okay for the  
20 taxpayers who need to fund the program, many of which are  
21 low-income people who don't even have health insurance for  
22 themselves and their families. Everything is not okay for

1 our children. This train is going down the tracks at a pace  
2 on a course that I fear for the future of my children.

3 Everything is not okay. It's not just a matter of  
4 saying oh, let's pay more money to all physicians because  
5 their updates have not kept pace with input prices. It's  
6 way bigger than that.

7 MR. DURENBERGER: Thank you, Glenn. And thank you  
8 especially for making those latter comments.

9 I think the last time I had opportunity to express  
10 something like that relative to this was back in 1989,  
11 trying to make an argument for the volume performance  
12 standards laid on top of what we were doing with RBRVS, and  
13 nobody was satisfied with it. But the argument was always  
14 being made that the sight of the gallows gets people to take  
15 action that they should.

16 We've waited for 15, 16, 17 years for a lot of  
17 people in physician leadership to take some action. We've  
18 not rewarded people who have done it on their own, as Nick  
19 and others have expressed. Jay, probably in his own  
20 practice. And we have continued to reward those who have  
21 not. And so the gallows ain't doing the job. Something  
22 else has to do it.

1           The only thing I want to not let go by here is the  
2 issue of productivity. It's really hard for me, and I'm not  
3 an economist so I can't tell you what is efficiency, what is  
4 effectiveness, what is productivity and things like that.  
5 But we all saw the research this week on how many people die  
6 because we can't expedite access to cardiac care in this  
7 country. In my community several people have done it and  
8 they've probably saved hundreds and hundreds of lives but  
9 they're not getting rewarded for it because of the fact that  
10 the payment system doesn't reward them.

11           I think I referred in my last little public  
12 comments to Atul Gawande's article in basically taking Peter  
13 Pronovost's work and saying who in the world is paying for  
14 this sort of stuff? Who's is paying for the research?  
15 We're sitting around waiting for somebody to raise \$5  
16 billion to create a great center of effectiveness research,  
17 and at Hopkins this guy is sitting there frustrated as hell  
18 because people can't adapt to the notion that he  
19 demonstrated in Michigan -- Pronovost I mean -- demonstrated  
20 in Michigan. They saved in 18 months whatever it was, 1,500  
21 lives and or something like that and \$175 million.

22           We neither invest in the research or the

1 researchers. We're largely in practice. They're in  
2 Billings or they're at Hopkins or they're in Pittsburgh or  
3 they're someplace like that. We're not investing in that,  
4 either at the front end to get them to do it, nor are we  
5 investing at the back end in paying for those who adopt it.  
6 You can look at retail clinics and how they are just chewing  
7 away at the productivity issues inside the system. They are  
8 producing the kind of care for a lot less money.

9           So all I would argue for is stop using the  
10 national labor department productivity standards as a way to  
11 reward Peter Pronovost and people like that -- or penalize  
12 them if you will -- and create a health-specific medical-  
13 specific definition of productivity, effectiveness. I'm  
14 preaching to the choir when I look at you when I say this.  
15 But that's the reason why I think keeping a health-specific  
16 or medical-specific productivity reward in a payment system  
17 is really important.

18           MR. HACKBARTH: The productivity thing is clearly  
19 a difficult one for many commissioners. As I said at the  
20 outset, we will do a fundamental look at the payment  
21 adequacy approach and, of course that will be an important  
22 part of the review.

1           But for people in the audience who don't follow  
2 our deliberations that closely, I just want to be clear  
3 about what that productivity adjustment is supposed to do.  
4 It is not an estimate of the actual productivity improvement  
5 for physicians or for hospitals or skilled nursing  
6 facilities or anybody else. It is, rather, an expectation,  
7 a policy expectation or a reflection of what I think is a  
8 very important part of this reality which is that health  
9 care costs are becoming an increasing burden to society.

10           The taxpayers who fund this program have been  
11 increasing their productivity and that's where this number  
12 comes from. And the process is often a difficult, harsh,  
13 painful, ugly process where people lose their jobs, lose  
14 their health benefits, lose their retirement benefits, have  
15 their wages held down. It's not easy for them either.  
16 There shouldn't be any illusion that oh, we'll have  
17 productivity that's magical and clean and happy for the rest  
18 of the economy. That's what the taxpayers are experiencing.

19           And so the idea was to say some of that force,  
20 that pressure, ought to be regularly systematically  
21 introduced into the Medicare program.

22           Now it is, as Ron said, a blunt tool, an imperfect

1 tool. We'll take a look at whether there are ways to do it  
2 better. But that is the reason that it's there.

3 MR. EBELER: A long-term frustration is palpable  
4 and I think we all know that. A shorter term question maybe  
5 of John.

6 Nancy raised the idea of a differential update  
7 targeted on E&M services because you can't grab primary care  
8 physicians. There's no payment mechanism to do that. Do we  
9 know roughly how an E&M -- how much of E&M services are  
10 provided by primary care physicians versus others? How  
11 blunt an instrument is that approach? Is that a knowable  
12 fact?

13 MR. RICHARDSON: Yes.

14 DR. REISCHAUER: It's not how much of the total.  
15 It's of the billing that primary care physicians do, what  
16 fraction of it is E&M versus what fraction of the surgeons?

17 MR. EBELER: You can ask it two ways. It's how  
18 much of primary physicians incomes is there. But also if we  
19 gave them money for E&M, how much of that money gets to  
20 primary care physicians?

21 MS. THOMAS: There is a chart in your mailing  
22 materials in the primary care physician session. It's on

1 page 26. And it's also going to be in the slide.

2 MR. EBELER: I knew that. Page 26?

3 MS. THOMAS: Tab K.

4 DR. MILLER: Can I make one point on this exchange  
5 here?

6 Late today, at the end of the day, we're going to  
7 be discussing the issue of primary care and how to  
8 distribute payments or to discuss the distribution of  
9 payments within physicians. And this idea is contemplated  
10 pretty directly the notion of if you really want to move  
11 dollars would you create -- and I won't get into it here --  
12 but a structure in the fee schedule that would identify a  
13 particular service provided by a particular type of  
14 physician or a physician who may have -- primary care or a  
15 physician that has certain types of characteristics, has  
16 made changes in their practice that we think are positive,  
17 coordinating care, that type of thing.

18 So this notion is contemplated late in the  
19 afternoon, whether you want to link the payment specifically  
20 to sets of physicians. There's all kind of issues. One  
21 that arises immediately is that the physician can put their  
22 specialty on the bill that they send in. There's no rigor

1 about how the process works.

2 DR. KANE: [Inaudible.]

3 MS. BOCCUTI: It's from claims.

4 DR. MILLER: The specialty is on the claim. It's  
5 just that -- that's the word I'm looking for.

6 MR. HACKBARTH: We need to move ahead.

7 Before we move to the vote, Tom Dean, one of the  
8 Commissioners, has missed this meeting due to illness and it  
9 was unavoidable.

10 He asked that I share a couple of thoughts on the  
11 physician update. In fact, let me quote just a couple of  
12 sentences from the note that he sent me.

13 Tom said I support, with some significant  
14 recommendations, the recommendation for the physician  
15 update. I am sure that a 1 percent update does not  
16 adequately compensate for increases in practice costs and  
17 there is the real risk of further antagonizing the physician  
18 community, many of whom feel they have not been fairly  
19 treated by Medicare.

20 At the same time, I am very concerned about the  
21 steadily increasing volume of services and the costs  
22 associated with that, as well as the implications all that

1 has for the long-term viability of the Medicare program.

2 So that was on the update piece of the  
3 recommendation.

4 And then on the second piece, related to measuring  
5 resource use, he simply said I strongly support the second  
6 portion of the recommendation.

7 Actually, let me go on just another sentence or  
8 two. He said we need to get the message to the physician  
9 community that they -- we, since Tom is a physician -- are  
10 the ones in the best position to help revamp the current  
11 system and we need more information about our performance.

12 So those are Tom Dean's comments.

13 It's time to vote. That's the recommendation.  
14 All opposed to the recommendation? All in favor? Any  
15 abstentions?

16 Okay, thank you very much.

17 Next, we turn to dialysis.

18 MS. RAY: Good morning. During today's  
19 presentation, I'm going to highlight some key information  
20 about the adequacy of Medicare's payments for dialysis  
21 services. You have seen all this information before, at  
22 last month's meeting.

1 I will present a draft recommendation for you to  
2 consider about updating the composite rate for calendar year  
3 2009. This is the last presentation before this analysis  
4 will be published in the March 2008 report.

5 Access to care for most beneficiaries appears to  
6 be generally good. There was a net increase in the number  
7 of facilities and treatment stations from year to year.

8 During the past decade, growth in hemodialysis  
9 stations has matched growth in the patient population.  
10 There's been little change in the mix of patients providers  
11 treat. The demographic and clinical characteristics of  
12 patients treated by facilities did not change between 2005  
13 and 2006.

14 With respect to facilities that closed, some of  
15 what we found is intuitive. Facilities that closed are more  
16 likely to be smaller and less profitable than those that  
17 remained open. We see, however, that African-Americans and  
18 dual eligibles are overrepresented in facilities that closed  
19 compared to those that opened in 2006. The overall access  
20 appears to be good for these two patient groups because  
21 facility closures are infrequent.

22 I'd like to reiterate the first point, that there

1 has been a net increase in the number of facilities and  
2 stations from year to year.

3 We have made a strong statement in the draft  
4 chapter that we will keep monitoring patient characteristics  
5 for different provider types in the future.

6 Moving on to changes in the volume of services,  
7 first we see that the growth in the number of dialysis  
8 treatments has kept pace with the growth in the patient  
9 population. The use of dialysis drugs increased between  
10 2004 and 2006 but more slowly than in previous years. The  
11 change in drug use is related to the MMA.

12 As mandated by the MMA, CMS lowered the drug  
13 payment rate for most dialysis drugs beginning in 2005. At  
14 the same time, the MMA shifted some of the drug profits to  
15 the composite rate. So as the drug payment rate fell, CMS  
16 increased the payment for the composite rate through the  
17 add-on payment. In 2008, the add-on payment is 15.5 percent  
18 of the composite rate.

19 Quality of care is improving for some measures,  
20 for example the proportion of patients receiving adequate  
21 dialysis and patients with their anemia under control. In  
22 addition, more patients are using the recommended type of

1 vascular access. However, one quality measure, nutritional  
2 status, has showed little change over time. Studies have  
3 shown that being malnourished increases decreases patients'  
4 risk of hospitalization and death. At the end of the  
5 chapter we have a discussion of potential ways to improve  
6 the quality of nutritional and vascular access care.

7           We have included in the paper a summary of our  
8 discussion for the need to implement pay for performance for  
9 outpatient dialysis services. Recall that in our March 2004  
10 report we included a recommendation calling for the Congress  
11 to establish a quality incentive program for physicians and  
12 facilities that care for dialysis patients. The Commission  
13 concluded that the dialysis sector is ready for P4P.

14           Here is the Medicare margin for both composite  
15 rate services and dialysis drugs. It was 5.9 percent in  
16 2006 and we project it will be 2.6 percent in 2008. A  
17 couple of points to consider. First, drugs were still  
18 profitable in 2006 under Medicare's payment policy for  
19 drugs, which was 106 percent of the average sales price.

20           Second, in addition, part of the drug profit moved  
21 to the composite rate in 2006.

22           Next, providers received an update to the

1 composite rate in 2006 and 2007 and an update to the add-on  
2 payment in 2006, 2007, 2008. I'd like to note here that the  
3 recent Medicare legislation did not update the composite  
4 rate for 2008 or 2009.

5           You can see here that the Medicare margin varies  
6 but it is positive for the different provider types. It was  
7 larger for the largest two chains than for everybody else.  
8 This is partly due to differences in dialysis drugs'  
9 profitability between these provider groups. Even after  
10 holding patient case-mix constant, we find that the two  
11 large dialysis organizations have costs per treatment that  
12 is significantly lower than other freestanding provider  
13 types.

14           So before moving to our draft recommendation, let  
15 me summarize our findings. Most of our indicators of  
16 payment adequacy are positive. Our analysis of beneficiary  
17 access is generally good, although we will continue to  
18 monitor access for specific patient groups, in particular  
19 African-Americans and dual eligibles. Provider's capacity  
20 is increasing, as evidenced by the growth in dialysis  
21 stations. The volume of services, dialysis treatments, and  
22 dialysis drugs is increasing, dialysis drugs at a lower rate

1 than in previous years but quality did not decline for two  
2 key measures: dialysis adequacy and anemia status.

3 Providers appear to have sufficient access to capital as  
4 evidenced by the growth in the number of facilities and  
5 access to private capital for both large and small chains.

6           This brings us to our draft recommendation, and  
7 let me read it. The Congress should update the composite  
8 rate by the projected rate of increase in the ESRD market  
9 basket index less the adjustment for productivity growth for  
10 calendar year 2009. In addition, the Commission reiterates  
11 its recommendation that the Congress implement a quality  
12 incentive program for physicians and facilities who treat  
13 dialysis patients.

14           CMS's ESRD market basket projects that input  
15 prices will increase by 2.5 percent in 2009. Considering  
16 the goal for productivity growth, this draft recommendation  
17 would update the composite rate by 1 percent in 2009 based  
18 on the current market basket forecast. Note that the market  
19 basket forecast will change several times before 2009.

20           Here are the implications of the draft  
21 recommendation. On spending, there is no provision in  
22 current law for an update to the composite rate. Thus, this

1 recommendation would increase spending \$50 million to \$250  
2 million for one year and less than \$1 billion over five  
3 years. Although beneficiary cost-sharing will increase  
4 under this recommendation, we do not anticipate any negative  
5 effects on beneficiary access to care. A payment incentive  
6 program should improve quality for beneficiaries and result  
7 in some providers receiving higher payments or lower  
8 payments.

9 That concludes my presentation.

10 MR. HACKBARTH: Thank you, Nancy.

11 As I recall, the chapter also includes language  
12 saying that we continue to support bundling for dialysis,  
13 doesn't it?

14 MS. RAY: Yes, it does.

15 MR. HACKBARTH: The formal recommendation  
16 reiterates our belief that we ought to move ahead with P4P.  
17 The bundling piece is another important past recommendation  
18 of the Commission and I'd like to make sure that that's  
19 there in the chapter. It doesn't need to be in bold face,  
20 but there in a visible location, prominent location.

21 Questions, comments for Nancy?

22 DR. KANE: I might have a small mind, because I'm

1 looking for consistency here. Why is there no update in the  
2 law for ESRD?

3 And we can see, too, that these are all fairly  
4 profitable facilities, particularly the ones that have  
5 economies of scale because they're able to purchase drugs  
6 apparently on a larger scale -- which suggests one way we  
7 can save money.

8 But anyway, why is it that Congress didn't have an  
9 update for ESRD? And why are we offering to give them an  
10 update when we have other provider silos that are doing much  
11 worse for which we are not being as generous? Is there some  
12 rationale? I know, I know, it's a small mind, consistency.

13 MR. HACKBARTH: Do you want to go ahead?

14 MS. RAY: No.

15 MR. HACKBARTH: As for the reason why there's no  
16 update for dialysis, I'm not sure that there's a human being  
17 that can necessarily answer that question. But there  
18 actually -- most providers have written into statute an  
19 update. Dialysis does not. Long-term care hospitals is  
20 still a different approach. For long-term care hospitals,  
21 the Congress gave the Secretary the authority to designate  
22 the update.

1           So there are at least three different approaches  
2 across the payment systems and there may be others that I  
3 can't remember. So it is not uniform. It is an artifact of  
4 legislative history.

5           As to the last point, you said that there are  
6 other providers that are worse off financially who are  
7 getting lower updates than dialysis. Who do you have in  
8 mind?

9           DR. KANE: That are legislated to have.

10          MR. HACKBARTH: Oh, I see.

11          DR. KANE: Us, no. I'm just wondering if there's  
12 some consistently in the legislative mind or is there just  
13 some sort of bias against --

14          MR. HACKBARTH: Okay. Now a question that Nancy-  
15 Ann has raised in the past, given this checkerboard approach  
16 that exists in legislation, is should we put dialysis on the  
17 same footing as say hospitals? Should MedPAC formally  
18 recommend that there be an update in law? I think you  
19 raised that a couple of years ago.

20                 My reasons, and my reasons alone, for thinking  
21 that that wasn't the right thing to do is it seems to me  
22 that really, in an ideal world, what you would want to do is

1 put hospitals and everybody else on the same footing as  
2 dialysis.

3 MS. DePARLE: So I dropped it.

4 [Laughter.]

5 MR. HACKBARTH: Just let me say a sentence or two  
6 more about my thinking. Particularly for MedPAC, our whole  
7 shtick for updates is you look at the data. You look at  
8 margins, you look at access, you look at quality, and each  
9 year you make a judgment based on the data.

10 That is inconsistent with saying there ought to be  
11 a formulaic increase in the update. By definition, what we  
12 do is each year look at the data and see what the  
13 circumstances dictate. People could say we do a lousy job  
14 of that, but that's our approach.

15 So it always seemed to me odd for MedPAC to say  
16 no, it ought to be done by formula out into the distant  
17 future when we think, in fact, it's a judgment call to be  
18 made each year.

19 So those were my reasons to Nancy-Ann. I'm not  
20 sure that she was ever persuaded but she gracefully  
21 withdrew.

22 MS. DePARLE: I raised it because I didn't think

1 it was fair that that one sector didn't have an update in  
2 the law. And after Glenn suggested his approach would be to  
3 take them away from everyone, I decided that the better part  
4 of valor was to leave it to the Congress. And I think the  
5 Congress has been considering this issue over the last  
6 couple of cycles of looking at Medicare, is whether or not  
7 there should be an annual update for dialysis.

8 DR. KANE: It just seems that it complicates the  
9 discussion when the budgetary impacts for the same  
10 recommendation are much more negative for some silos than  
11 others.

12 MS. DePARLE: Because it's not in the baseline.  
13 You're right, it does complicate our -- you're right.

14 MR. HACKBARTH: Other questions or comments on  
15 dialysis?

16 DR. MILLER: I guess, for the record, when he said  
17 Medicare shtick what he meant was MedPAC's mission.

18 [Laughter.]

19 MR. HACKBARTH: Did I really say that?

20 DR. MILLER: Yes.

21 MR. HACKBARTH: Anything else? Anything more  
22 helpful than that?

1           Okay, we're going to make up some time here.

2   Thank you, Nancy.

3           It's time to vote on the recommendation. All  
4   opposed to this recommendation? All in favor? Abstentions?

5           Thank you.

6           We're going to change gears now with John's help,  
7   and talk for a bit about CMS's report on value-based  
8   purchasing for hospitals. I'm sure that John will explain  
9   what our role is in discussing this report.

10          John, go ahead.

11          MR. RICHARDSON: Thank you. Change gears, but not  
12   paces.

13          Good morning, again. In this session I'm going to  
14   present a summary of the key features of a report on value-  
15   based purchasing for Medicare inpatient services which was  
16   submitted to the Congress by HHS and CMS at the end of  
17   November in 2007.

18          The Deficit Reduction Act of 2005, or the DRA,  
19   Congress directed CMS to develop and submit a plan for  
20   implementing a hospital value-based purchasing program. The  
21   DRA also directed the Commission to provide Congress with  
22   its comments on the plan, and today's discussion is an

1 initial opportunity for the staff to get your feedback on  
2 the report.

3 I should note that CMS proposes to implement the  
4 hospital VBP program in fiscal year 2009 but the Agency  
5 believes that it requires additional Congressional  
6 authorization to do this.

7 In your mailing materials, you received a side-by-  
8 side analysis that compares the key features of the CMS  
9 report to the Commission's pay for performance principles,  
10 so I will touch on those briefly and then get to the key  
11 features of the report.

12 In past reports, since at least 2005, the  
13 Commission has articulated four core principles for Medicare  
14 pay for performance programs. Specifically, that these  
15 programs first should reward providers based on both  
16 improvement and attainment relative to performance  
17 benchmarks and selected performance measures. That the  
18 program should be funded by setting aside a portion of  
19 existing payments, which initially should be small -- on the  
20 order of 1 to 2 percent -- but increased over time as  
21 Medicare gains experience with implementation and more  
22 refined performance measures. Third, that the program

1 should distribute all of the funding that is set aside for  
2 performance incentives to the providers that meet the  
3 quality criteria. Forth, that the program should have a  
4 process for the continual evolution of the performance  
5 measures used in the program.

6           The Commission has also made some specific  
7 suggestions with regard to criteria for hospital performance  
8 measures which are summarized in you background materials.  
9 So in the interest of time I will move on, but I'll be happy  
10 to answer questions about those during the discussion.

11           Now to move on to the key features of the report  
12 itself. In the simplest terms, CMS's proposed VBP program  
13 for hospitals would work like this. First, Medicare must  
14 create a pool of funds that would be available to each  
15 hospital based on its performance against specified  
16 measures. The report recommends creating this pool for each  
17 hospital by withholding a fixed percentage -- initially in  
18 the range of 2 to 5 percent -- from each base DRG payment  
19 made to the hospital. In the report, CMS presents examples  
20 where only the hospital's base operating DRG payments would  
21 be affected by this withhold. Medicare payments for  
22 capital, disproportionate share hospital, indirect medical

1 education, and outlier cases would not be affected or  
2 adjusted by the withhold.

3           Then the next question in program design is how  
4 Medicare would assess each hospital's performance and  
5 ultimately distribute the funds thus created by the  
6 withhold. First, to even qualify for the financial  
7 incentive, the hospital would have to report on all the  
8 performance measures relevant to its service mix. This  
9 includes new measures undergoing testing for possible  
10 introduction later in the program, measures intended only  
11 for public reporting, and of course the measures to be used  
12 for determining the financial incentives.

13           Each hospital would be scored equally on each of  
14 the performance measures within three larger groups of  
15 measures or domains. Points would be awarded based on the  
16 higher of the hospital's attainment relative to national  
17 performance benchmarks or based on the improvement in its  
18 performance relative to its past performance. In both  
19 cases, for both attainment and improvement targets, the  
20 hospital would know where its goals are in advance of the  
21 performance year.

22           The measure domains are important because they

1 introduce the option of weighting different types of  
2 measures more or less heavily when calculating the  
3 hospital's total performance score. Initially, the three  
4 domains CMS contemplates including are processes of clinical  
5 care, outcomes, and patient experience. Based on the  
6 weights assigned to each domain, Medicare would then  
7 calculate a total performance score for each hospital.

8           In the final step, the hospitals total performance  
9 score would be multiplied by a predetermined exchange  
10 function to at last get to the percentage of the hospital's  
11 incentive pool that it would receive.

12           The exchange function is simply a mathematical  
13 equation that policymakers could adjust to translate a given  
14 total performance score into a larger or smaller percentage  
15 of the financial incentive pool that would be allocated to a  
16 hospital.

17           The most important take away point for you to get  
18 is that once the VBP program is fully phased in it is likely  
19 that some hospitals would get back a total incentive payment  
20 that is less than the amount in the pool of funds initially  
21 withheld and set aside for that particular hospital. That  
22 is, it is likely there will be incentive funds left over on

1 the table after the initial performance-based distribution.

2           The report goes on to say that these unallocated  
3 funds could be distributed in whole or in part as additional  
4 quality incentive payments to hospitals but it also  
5 contemplates the option of retaining a portion of the  
6 unallocated incentive funds as program savings.

7           CMS does not anticipate there would be any  
8 significant unallocated funds in at least the first year of  
9 the program where the allocation would be based only on  
10 reporting the performance measures, not the actual  
11 performance. However, by the third year of the program,  
12 when the performance based incentive is fully phased in, it  
13 is likely that there would be some unallocated funds by the  
14 end of the year.

15           I just want to touch briefly on performance  
16 measures and a couple of other key features of the program  
17 and then go on to the discussion. As noted earlier, the  
18 performance measures would be organized in three domains  
19 which are listed here: clinical process of care, outcomes,  
20 and patient experience. A complete list of measures for the  
21 first year is included in your mailing materials. I will  
22 return to the future of these in just a second.

1           I also wanted to touch on the data infrastructure  
2 and public dissemination of performance results where CMS  
3 would build on the processes that it's already developed to  
4 implement the current hospital quality data reporting  
5 program which has been in place since fiscal year 2005. In  
6 particular, CMS believes public reporting of performance  
7 results will be a powerful tool along with financial  
8 incentives to spur quality improvement by hospitals.

9           CMS also plans to monitor the program's effects on  
10 other aspects of care such as total costs and health  
11 disparities to guard against possible unintended  
12 consequences.

13           My last slide gives a glimpse of future of  
14 performance measurement under the proposed program. CMS  
15 acknowledges the need for measurement to evolve rapidly  
16 beyond the current measures set, particularly in the areas  
17 of clinical quality, patient-centered care, and efficiency  
18 measures. On efficiency measures, CMS indicates that it has  
19 concerns about the challenges in developing them and  
20 suggests a preference for including both resource use and  
21 outcomes when developing efficiency measures.

22           Lastly, we think it's important to acknowledge the

1 administrative resource needs that CMS will face in actually  
2 implementing and evolving the VBP program if it moves  
3 forward. Clearly, this program would be a complex and  
4 intricate undertaking for Medicare and it may require due  
5 consideration of the resources CMS may need to make its  
6 implementation successful.

7 That concludes my presentation. Thank you.

8 MR. HACKBARTH: Thanks, John.

9 So as I understand it Congress, in the same law  
10 that mandated this study for CMS, asked MedPAC to comment on  
11 the CMS report once it's published, is that correct?

12 MR. RICHARDSON: That is correct.

13 MR. HACKBARTH: As I understand it, CMS missed the  
14 statutory deadline for their report and so there's not a  
15 clear deadline now for MedPAC to report; is that right?

16 MR. RICHARDSON: That also is correct.

17 MR. HACKBARTH: My understanding is that there is  
18 at least the possibility that in the June Medicare  
19 legislation which would address the physician fee issue that  
20 Congress may take up some other issues, one of which may be  
21 pay for performance. And so there's some eagerness in  
22 having our comments on the CMS approach as quickly as

1 possible. Whether that will work out to be March or April I  
2 don't know but we're going to try to move through this. So  
3 this is our initial conversation on the report, not the  
4 final one.

5           With the preface, let me just offer a few of my  
6 own thoughts on it. I was impressed with the report.  
7 Obviously they invested a lot of time and effort in thinking  
8 through some fairly complex issues. I won't say that I  
9 understand all of it, and I certainly don't understand the  
10 implications of all of the choices that they made. But in  
11 general, I was struck that it is very consistent in basic  
12 principle, very consistent with past MedPAC recommendations  
13 on pay for performance.

14           And I think also consistent with the IOM panel's  
15 recommendations on pay for performance.

16           The two areas where I think there is potentially a  
17 significant difference are one, are all of the dollars set  
18 aside distributed? CMS, like MedPAC and I believe IOM is  
19 saying that the money for the pay for performance program  
20 ought to be taken out of the base rates. We said, MedPAC  
21 said, it ought to be budget neutral; i.e. all of the dollars  
22 taken out of the base rates ought to be redistributed based

1 on quality. Whereas CMS has left open the possibility that  
2 they would not all be distributed. So that's one  
3 potentially significant difference.

4           The second area of difference may be on future  
5 measure development and how the program evolves over time.  
6 We've not made, in the past, a bold-faced recommendation on  
7 that process. But my recommendation is that in one of our  
8 reports we did include in text some language saying a  
9 process much like the IOM recommended for development of  
10 measures might make sense. And IOM -- and Bob, correct me  
11 if I'm wrong -- IOM envisioned an entity would be created  
12 that would be responsible for a number of different  
13 activities, one of which would be measure development. And  
14 that process would be designed to bring in private payers as  
15 well as Medicare. So we're synchronizing the measures used  
16 for assessing providers. Is that right?

17           DR. REISCHAUER: It would go well beyond  
18 hospitals. It would be across all provider groups.

19           MR. HACKBARTH: And then Nick, when we talked last  
20 week I think you expressed interest in maybe going back and  
21 MedPAC's talking about that process and adopting a formal  
22 recommendation on it, in part because of the synchronization

1 issue, public/private, that Arnie has mentioned so often.  
2 But also one of your points has been that selection process  
3 really needs to be strategic. That's not just develop and  
4 use measures, whatever is available. We need to think  
5 carefully about choosing measures where there is important  
6 opportunity and then sending consistent signals for  
7 hospitals and physicians and other actors. These are our  
8 priorities for improvement.

9           So all of that is a long-winded way of saying that  
10 when we come back to this in March or April we may want to  
11 consider in some detail this process of measure development  
12 and maybe have a boldfaced recommendation on how we think it  
13 should work.

14           I will shut up and let other people talk. Any  
15 thoughts on this?

16           DR. WOLTER: Just a perspective on the 2 to 5  
17 percent. Depending on the percentage of Medicare that a  
18 hospital sees, that could represent half or more of the  
19 total operating margin. It just think we need to keep that  
20 in perspective. It's a huge incentive, which is different  
21 than 2 percent, for example, in the physician world. And  
22 especially -- which we will probably talk about in the next

1 session -- when many hospitals, after all of the moving  
2 parts of the update are finished, don't really see much more  
3 than a 1 or 2 percent change. We really have some  
4 incentives here in play that we just need to keep our eye  
5 on.

6 I do think that if it was more explicit in this  
7 program that we're going to focus on high impact areas that  
8 would be good. In fact, I think a lot of the measures do,  
9 which I'm happy to see. But if you were to tackle post-op  
10 infections and line infections and ventilator associated  
11 pneumonia and a group of high impact problems, the odds of  
12 true improvement over a reasonably shorter period of time  
13 would be much higher.

14 I will mention again the utilization issue, if you  
15 want to look at the efficiency piece, because hospitals have  
16 their ways of looking at improving volume just as physicians  
17 do. The utilization rates and the geographic variability  
18 that you might see around certain services drive a lot of  
19 costs even though the unit price per se might not be the  
20 major issues.

21 We just have to get that on the list because it's  
22 a very difficult problem to try to address.

1           Could we connect this eventually, especially if we  
2 got some of those IOM ideas about how to create more  
3 organized design? Could we connect it to the physician  
4 resource utilization issue? I would think we would want to  
5 over time in terms of how this program unfolds.

6           Those would be the main things.

7           DR. MILLER: We were pressed for time in the  
8 previous discussion when you brought up the point about the  
9 physician resource use and the notion that it shouldn't just  
10 a focus on physicians. I think part of the frustration in  
11 all of these conversations is given the format that we work  
12 in and the reports and how we do things over time, we're  
13 always dealing with things in pieces. It's very hard, in  
14 each instance, to put the grand design together.

15           But Nick, you've made this point on hospitals and  
16 putting pressure there, as well. And today, after we get  
17 through the updates, we will have that discussion on  
18 bundling the physician and hospital payment, which Nick has  
19 urged us to do.

20           So I just want you to know we're not completely  
21 blind to the point that you're making. And we'll have a  
22 discussion tomorrow morning about the delivery system reform

1 issues that you've brought up which we haven't brought this  
2 to you yet, but start to get into the accountable care  
3 organizations and looking at larger groups.

4           One of the ways to think about the physician  
5 resource use recommendation -- and this isn't going to  
6 satisfy all of you -- is if each of the areas feels like  
7 their measurement is occurring there, some of that is to  
8 create pressure so they say actually I think it's better  
9 that we get looked at as a system instead of as individual  
10 silos. And I think some of the notion that Tom Dean was  
11 making, that everybody needs to feel that there's a certain  
12 accountability here. And then, for our other policies, to  
13 try and drive people into more systems and coordinated --  
14 and measuring across that, which is I think is some of what  
15 you're getting at if I'm following you.

16           DR. WOLTER: I know we're beginning to work on it.  
17 I just think sometimes persistent reiteration has its value.

18           DR. MILLER: And I'm persistently saying I swear  
19 to god, it's coming.

20           DR. MILSTEIN: My sense of this is that it's quite  
21 good, it's directionally correct. For the reasons that Nick  
22 stated, I worry a little bit about a plan that would tax the

1 base 2 to 5 percent, more in terms of its political  
2 viability. Or if turned out to be politically viable, how  
3 the formula would be constructed so that everybody would do  
4 well.

5 I like the fact that it's a large amount but I  
6 worry that it will doom its political feasibility.

7 I guess I'd like to suggest a supplementary  
8 approach as I support this. But in addition, one of the  
9 things that we've talked about together before is the notion  
10 of some categories of providers having more potential  
11 leverage on how much is spent by Medicare on other  
12 providers, as well as in the case of hospitals a real  
13 opportunity to reduce the rate of future hospitalizations.

14 In view of those opportunities that are available  
15 to hospitals, it seems to me that it would not be  
16 unreasonable, separate and apart from this 2 to 5 percent  
17 recommendation, to really open up an opportunity for the  
18 hospital industry to gain share with Medicare with respect  
19 to its ability to reduce total spending, whether it be  
20 through reduced downstream admissions or reduced spending in  
21 other categories.

22 I think it's been signaled in the report by saying

1 at some point in the future, 2010, 2011, we'll work on  
2 measures for efficiency. I think there's a fair amount of  
3 evidence that with respect to sustainability the house is on  
4 fire now. And I don't think we need to wait that long. I  
5 think that thanks to Jack Wennberg and Elliott Fisher, we do  
6 have some quite well vetted in the peer reviewed scientific  
7 literature measures attributable now at the hospital  
8 specific level of total spending per Medicare beneficiary  
9 per year.

10 I would like to see an opportunity for hospitals  
11 to be able to gain share with Medicare to the degree they  
12 put in place changes that not only improve quality but also  
13 substantially improve how they stood on their -- I'll call  
14 it Fisher/Wennberg total Medicare fuel burn score which they  
15 have come up with.

16 I feel the same way about hospitals that would be  
17 able to -- separate and apart from that -- reduce admission  
18 rates. I think there is no reason to constrain how much  
19 hospitals might be able to earn through significant  
20 improvements in the amount of total Medicare spending or  
21 readmissions that occur for Medicare patients.

22 If we limit hospitals' opportunity to win on this,

1 sharing in a 2 to 5 percent tax on the base, I think we're  
2 missing a much larger incentive pool that might motivate  
3 much more substantial change.

4 DR. WOLTER: I totally agree with that, Arnie. In  
5 fact, that's really what the group practice demo does  
6 although not everybody in that has a hospital but 30 or 40  
7 percent of the organizations do.

8 This is not reiteration, this is perseveration,  
9 but we also need to really stay very focused on delivery  
10 system reform for the idea you just advanced to work. I  
11 know you just said that, Mark, that that would be part of  
12 what we do. But we really do need to reform ourselves  
13 around are accountable care organizations to have the  
14 capability to tackle these problems. And so it's both how  
15 we look at the financial incentives but also how we look at  
16 how we can incent the delivery system.

17 MR. EBELER: Just a question about how this is  
18 linked with MA payments to hospitals. Given the MA  
19 overpayments, more and more folks are going there, the  
20 traditional leverage we've had, the Medicare fee-for-service  
21 payments to hospitals may slowly decline. I wonder if this  
22 project envisions any efforts to work with those plans,

1 particularly private fee-for-service plans, to get them to  
2 use the same incentives so that you really can't leverage  
3 the system.

4 MR. RICHARDSON: As far as I can recall from  
5 analyzing the report, it doesn't specifically contemplate  
6 that. I can certainly follow up with the CMS staff and get  
7 back to you on that specific issue. It is oriented around  
8 the fee-for-service DRG payments for the hospitals.

9 DR. CROSSON: I'll have a brief comment on that in  
10 the next topic discussion.

11 MR. HACKBARTH: Thank you, John. More on this in  
12 March or April.

13 Our last session this morning is on payment  
14 adequacy in update for hospitals.

15 DR. MILLER: Jack, just before we start, just two  
16 quick questions. Is it correct that this is your last  
17 presentation after 19 years of service for the various  
18 commissions?

19 [Laughter.]

20 DR. MILLER: Is that correct, Jack? I'm just  
21 trying to get an answer here.

22 MR. ASHBY: That is correct.

1 DR. MILLER: Is it also correct that you're going  
2 to Hawaii?

3 MR. ASHBY: That is correct, as well.

4 DR. MILLER: Okay. I just wanted to make sure  
5 that we had all of this straight.

6 [Laughter.]

7 MR. ASHBY: The Commission leadership is to be  
8 commended for this.

9 MR. HACKBARTH: In case you can't hear it, Jack,  
10 we have a little appropriate background music for your  
11 presentation, a little Hawaiian -- would you get on with it?  
12 We're behind schedule.

13 [Laughter.]

14 MS. DePARLE: Is he going to dance for us?

15 MR. HACKBARTH: We're on Hawaii time.

16 [Applause.]

17 MR. ASHBY: My thanks to the leadership and to the  
18 staff and to the commissioners here. We will still attempt  
19 to take a good hard look at hospital payments here.

20 MR. HACKBARTH: No offense, but this is cutting  
21 off the blood to my brain.

22 [Laughter.]

1 DR. REISCHAUER: Fortunately, I have no blood to  
2 be cut off.

3 [Laughter.]

4 MR. ASHBY: This session will address the adequacy  
5 of payments for hospital inpatient and outpatient services.

6 Before I start, I'd like to just remind you of a  
7 couple of facets of our hospital analysis here, and that is  
8 that we do assess the adequacy of current payments for the  
9 hospital as a whole. And that encompasses, along with acute  
10 inpatient and outpatient services, hospital-based home  
11 health and SNF, inpatient psych and rehab and graduate  
12 medical education.

13 And then I would also note that Medicare pays  
14 separately for capital in the acute inpatient PPS. And CMS,  
15 rather than Congress, sets the update for capital payments  
16 each year.

17 So our update on the inpatient side will apply  
18 only to operating payments and comprise about 92 percent of  
19 the total, while on the outpatient side it will apply to the  
20 single base rate encompassing both.

21 Just one last introductory comment, and that is  
22 that we are just going to review and basically summarize our

1 findings today. But you do have complete details on our  
2 various analyses in your briefing books.

3 We're going to begin by looking at payment  
4 adequacy leading up to our update recommendation and then  
5 we're going to move to IME payments.

6 We found that most of the Commission's indicators  
7 of payment adequacy are positive. We have seen a net  
8 increase in the number of hospitals, as well as an increase  
9 in hospital service capacity in recent years. The volume of  
10 services per fee-for-service beneficiary is increasing,  
11 including both inpatient admissions and outpatient visits.  
12 Our quality of care results are generally positive with  
13 mortality and process measures improving but with mixed  
14 results on rates of adverse events.

15 And finally, we found that access to capital is  
16 quite good as most directly evidenced by the substantial  
17 increases in hospital spending for new and expanded  
18 facilities. The hospital industry is indeed experiencing an  
19 almost unprecedented construction boom.

20 This next slide updates our overall Medicare  
21 margin estimates from the December meeting. The margin in  
22 2006 was minus 4.8 percent, as we said in December. We

1 updated our projected margin from minus 4.5 to minus 4.4  
2 percent. The extra one-tenth comes from the provision in  
3 the extenders bill last month to change payment policy for  
4 hospital-based rehab units.

5           The slight improvement going from 2006 to 2008 may  
6 seem counterintuitive given recent trends but you'll recall  
7 from the December meeting that the impact of several factors  
8 increasing payments like fewer hospitals affected by the  
9 transfer policy under MS-DRGs and our expectation that they  
10 payment increases from coding improvement will exceed the  
11 legislated payment offsets will more than cancel out the  
12 effects of factors that will decrease payments like the  
13 weight of cost growth continuing to exceed the market  
14 basket.

15           As Jeff reported at the last meeting, we found  
16 that hospitals' costs as well as their Medicare margins are  
17 related to the financial pressure that they are under from  
18 private payers. The key criterion we used in identifying  
19 hospitals as under high financial pressure was a non-  
20 Medicare margin of less than 1 percent while a margin of  
21 greater than 5 percent identified hospitals under low  
22 pressure.

1           The high pressure group's costs, that is their  
2 standardized Medicare costs per case, are more than 10  
3 percent below those of the low pressure group. And for the  
4 industry as a whole we've seen that the rate of cost growth  
5 has been much higher during periods of low financial  
6 pressure from private payers and we've been in a period with  
7 low pressure/high cost growth since about 2000. When we  
8 isolate hospitals with consistently high costs, defined as  
9 those with standardized costs in the top third three years  
10 running, we find first that these hospitals not only have  
11 high costs relative to the national average but in almost  
12 every case they also have higher costs than their neighbors.  
13 So it's questionable whether these hospitals are competitive  
14 even in their own markets.

15           When we eliminate hospitals with consistently high  
16 cost from the margin calculation, we find that it raises the  
17 industry-wide overall Medicare margin by about 3 percentage  
18 points.

19           That brings us to our update recommendation. In  
20 considering the appropriate update, on the one hand our  
21 indicators of payment adequacy are almost uniformly positive  
22 as I mentioned a moment ago. But on the other hand, we

1 expect Medicare margins to remain low in 2007 and 2008. At  
2 the same time though, our analysis finds that hospitals with  
3 low non-Medicare profit margins have below average  
4 standardized costs and most of these facilities have  
5 positive overall Medicare margins. The Commission has  
6 generally felt that Medicare should put pressure on  
7 hospitals to control their costs rather than accommodate the  
8 current rate of cost growth which is, in part, caused by  
9 this lack of pressure from private payers.

10 So in balancing these considerations, our draft  
11 recommendation is that the Congress should increase payment  
12 rates for the acute inpatient and outpatient prospective  
13 payment systems in 2009 by the projected rate of increase in  
14 the hospital market basket index, concurrent with  
15 implementation of a quality incentives program.

16 The existing law is a market basket increase so  
17 this update would have no implication for spending and we  
18 expect no major implications for providers, but there is  
19 potential for improved quality of care for beneficiaries  
20 through the implementation of P4P.

21 The tie-in to P4P implies that poor quality  
22 performers would have a net increase in payments of less

1 than market basket while good performance would likely have  
2 a net increase of more than market basket. The P4P program  
3 would operate separately from the update. We have to be  
4 sure that qualification is understood. But it would be the  
5 update and the hospital's quality performance that determine  
6 its net change in payments for the coming year.

7           Then just to review here, we make note of the fact  
8 that the Commission recommended a quality incentive policy  
9 for hospitals in 2005 and, as you heard in the previous  
10 session, CMS's recent report outlines the value-based  
11 purchasing program it plans for 2009.

12           So at this point, we would turn our attention to  
13 the potential recommendation on IME payments.

14           MR. LISK: Aloha.

15           I'm now going to briefly discuss the indirect  
16 medical education adjustment. The IME adjustment is a  
17 percentage add-on to the PPS rates that varies with the  
18 number of residents a hospital trains. In 2006, IME  
19 payments to hospitals totaled more than \$5.8 billion and  
20 went to 30 percent of hospitals. The current IME  
21 adjustment, however, is set at more than twice the  
22 documented impact of teaching costs on hospital costs.

1           Analysis we conducted last year showed that the  
2 inpatient costs in teaching hospitals increased about 2.2  
3 percent for each 10 percent increment in teaching intensity  
4 as measured by the resident-to-bed ratio. But the  
5 adjustment is set so that payments increase 5.5 percent for  
6 each 10 percent increase in this ratio, resulting in a \$3  
7 billion subsidy to teaching hospitals with no direction or  
8 accountability for how these funds are used.

9           Having the adjustment set considerably above the  
10 true cost relationship contributes substantially to the  
11 large disparities in financial performance under Medicare.  
12 In 2006, the overall Medicare margin for major teaching  
13 hospitals was 11 percentage points higher than that for non-  
14 teaching hospitals. The difference was even bigger if we  
15 focused on the inpatient margin, which is where the  
16 adjustment is made. It's 17 percentage points.

17           In 2008, we have the introduction of severity  
18 adjustment with MS-DRGs being implemented. This difference,  
19 we expect teaching hospitals will benefit more than other  
20 hospitals from the introduction of severity adjustment. So  
21 these differences also likely will grow with this  
22 introduction of the MS-DRGs.

1           Reducing the IME adjustment closer to the  
2           empirical relationship would help to reduce disparities in  
3           financial performance. A one point reduction in the IME  
4           adjustment to 4.5 percent per 10 percent increment in  
5           resident intensity would reduce the gap in overall margins  
6           between major teaching and non-teaching hospitals by 2  
7           percentage points. It would also make available nearly \$1  
8           billion in Medicare payments that could be redistributed to  
9           hospitals for a quality incentives program, which Jack just  
10          discussed. Using the savings from reducing the IME to help  
11          support a pay-for-performance program provides a more  
12          focused use of these funds that will benefit both teaching  
13          and non-teaching hospitals.

14                 Last year, the Commission recommended that the IME  
15          adjustment be reduced by one percentage point to 4.5 percent  
16          with the introduction of severity adjustment to the  
17          inpatient PPS and that the savings be used to support a P4P  
18          program. Now that a credible severity adjustment has been  
19          implemented for the introduction of MS-DRGs starting in  
20          2008, we have the following draft recommendation for your  
21          approval. It reads the Congress should reduce the indirect  
22          medical education adjustment in 2009 by one percentage point

1 to 4.5 percent per 10 percent increment in the resident-to-  
2 bed ratio. The funds obtained by reducing the IME  
3 adjustment should be used to fund a quality incentive  
4 program.

5 Moving on to the spending implications, there  
6 would be none as the recommendation is intended to be budget  
7 neutral.

8 For providers, we would see a narrowing in the  
9 disparity of Medicare margins while at the same time making  
10 funds available to reward high-performing hospitals, both  
11 teaching and non-teaching hospitals.

12 With a P4P program, there is potential for  
13 improved quality of care for beneficiaries.

14 And with that, we would be happy to answer any  
15 questions you may have.

16 DR. BORMAN: I wonder if I could ask a couple of  
17 questions that would help me to think about this a little  
18 bit. I do believe that there are some differences in the  
19 nature and amount of costs that go into graduate medical  
20 education than existed when the formula was created. Just  
21 so, for an example, can you help me to understand where if a  
22 teaching hospital invests say \$1 million in simulation

1 technology equipment, where that's going to reflect in how  
2 that's captured in this analysis?

3 MR. LISK: We are looking at their overall average  
4 cost. So those costs would be part of the costs of the  
5 hospital cost. So those higher costs would be reflected in  
6 that 2.2 percent increment that we see on average that  
7 teaching hospitals have.

8 DR. BORMAN: So that you believe that in this  
9 calculation that new educational, program, structural,  
10 equipment costs are captured in the way we get the data now?

11 MR. LISK: Yes, if they're part of the hospital's  
12 costs. There are issues about whether those costs come from  
13 a medical school and then that would be a different story  
14 about what transactions take place between the hospital and  
15 the medical school, for instance. But yes, they're part of  
16 the hospital costs.

17 And to the extent that they are considered in the  
18 direct GME portion of the costs, in terms of the structure  
19 of the medical education program, they would be captured in  
20 that part. But that is a separate piece than what we're  
21 talking about with the indirect medical education  
22 adjustment, which is for adjusting for the differences in

1 the operating costs of the patient care costs rather than  
2 the training costs which is part of the direct GME payment  
3 which is separate.

4 DR. BORMAN: I was with you until that last part.

5 MR. LISK: We have two payments. So there's the  
6 hospital payment, which includes an adjustment for  
7 differences in patient care costs --

8 DR. BORMAN: So you're suggesting it's in DME and  
9 not IME?

10 MR. LISK: No, I would say something like that  
11 would probably be something that's part of the hospital  
12 structure.

13 DR. BORMAN: The hospital cost report.

14 MR. LISK: Part of the hospital cost structure, it  
15 would be part of that.

16 DR. BORMAN: I would still have just a little bit  
17 of concern that there may be some things that we're not  
18 appreciating here, but I also absolutely acknowledge that  
19 the academic community probably has not brought that forward  
20 in a clean and crisp way and quantitate it.

21 My next question would be I believe that a couple  
22 of years ago, if I recall right, it's the S-10. There was

1 supposed to be some additional reporting from teaching  
2 hospitals to try and get a better handle on what is being  
3 tracked here, what is being bought here by these monies.  
4 There were some issues with the nature of the form and  
5 whether it collected the right stuff, whether it was  
6 possible. Do we have any update on where that data  
7 collection process is? Are we going to ever have some data  
8 from that source?

9 MR. ASHBY: I'm not sure that I can really give  
10 you an up-to-date indication on that but it is in process.

11 DR. MILLER: Wait a second, Jack. You've worked  
12 through with CMS -- we're talking about the uninsured data  
13 collection here; right?

14 MR. ASHBY: Right. It is in process and CMS does  
15 indeed promise to implement a page to collect that  
16 information. They haven't given us a date yet but they have  
17 indicated that it is forthcoming.

18 DR. MILLER: And Karen, the point I just wanted to  
19 get across is Jack has spent a lot of time working through  
20 the form and revising the instructions so that it collects  
21 what we think would help. So we've been pushing on this.  
22 But what he's I think saying is I can't tell you what CMS --

1 DR. BORMAN: We're still nowhere close to having  
2 information from that.

3 MR. ASHBY: Let me just refine that to say we may  
4 be fairly close to their making the formal publication of  
5 their intentions. But then there will be an approximately  
6 two-year gap before we actually have usable data.

7 DR. BORMAN: And then the other thing was, as I  
8 recall when we previously looked at the mostly bell-shaped  
9 distributions of the payments, both just the IME payments  
10 and the IME plus DSH payments, that there is certainly a  
11 pretty significant tail to the right at the high end folks.  
12 I certainly think we certainly can look at the margin  
13 material that you presented to us.

14 I remain a bit concerned about the folks at the  
15 other end of the tail and I worry a bit about whether part  
16 of what we're picking up here represents in part a  
17 geographic distributional issue as much as it represents a  
18 teaching versus non-teaching fairness issue. I certainly  
19 respect the comments that Nancy has made in the past about  
20 that. But just for an example, I would hazard -- and I  
21 can't say that I have data to support this -- that, for  
22 example, sole state academic medical centers, particularly

1 in the Southeast and Southwest and perhaps parts of the  
2 Midwest, may in fact be more clustered to the leftward tail  
3 of that curve and perhaps are not experiencing quite the  
4 bonus use of these monies as might be anticipated at the  
5 other end of the curve.

6 So I remain a bit concerned that this is a  
7 relative broad brush to address what may, in fact, be a  
8 somewhat more discreetly dotted problem. But I absolutely  
9 respect the analysis that's been done and I have no data to  
10 say that you're incorrect.

11 MR. HACKBARTH: Karen, I want to just go back for  
12 one second. There are two distinct issues here. One is how  
13 much do teaching hospitals and other hospitals spend on  
14 uncompensated care? That's a difficult question to answer  
15 but I think it is answerable with some real effort.

16 Another question is where do the indirect teaching  
17 dollars go? How are they used? I would argue that that's  
18 inherently unknowable. Money is fungible. Once it goes  
19 into a hospital's general fund, the dollars that came from  
20 IME don't continue to have IME marked on them. Once it's in  
21 the general fund, everything can be used for any purpose.

22 So having teaching hospitals report this is how we

1 use the IME dollars I think is an abstract, irrelevant  
2 exercise. You couldn't take the data seriously.

3 In Washington, when I was involved in government,  
4 there used to be the notion of shutting down the Washington  
5 Monument. So you'd say we're going to cut the Interior  
6 Department's budget. What they would say is if you cut that  
7 money what we're going to do is shut the Washington Monument  
8 and try to say oh, that's impossible. If you cut the  
9 Interior Department's funding there are a million places  
10 that could be cut. But the nature of these exercises is oh,  
11 it's the most vital thing that's going to be cut. That's  
12 not a serious exercise.

13 So let's not go down the track of saying let's  
14 have teaching hospitals report what this money is used for.  
15 That's not productive. Let's go down the track of do  
16 teaching hospitals in fact do something meaningfully  
17 different on uncompensated care or other activities that we  
18 think are important?

19 DR. BORMAN: If I could just respond briefly to  
20 that, I do think that knowing or having some sense of where  
21 the money goes perhaps helps us move toward how we would  
22 incent better behaviors of those institutions. I share your

1 point. When I write my check to Georgia Tech Foundation, I  
2 am under no illusion that it doesn't enable dollars for the  
3 athletic program. So I certainly understand that concept,  
4 Glenn. And I guess I would just comment at this point, as  
5 you and I have discussed, that there certainly are issues  
6 with is the money being delivered to the right entity to  
7 achieve the values that we want from it? And that's a whole  
8 other discussion.

9 DR. KANE: So I am going to try one more shot at  
10 why I would like to see the payment from IME redistributed  
11 to the base, although it's not a do-or-die for me. I do  
12 think there's some issues that we haven't really had a  
13 chance to talk about.

14 And one of them is if you look at the bottom  
15 third, the lowest cost hospitals, not all of them are  
16 profitable. And I suspect -- and I think I asked you about  
17 this before -- if you take out IME and DSH -- I'm trying to  
18 remember and maybe you can help me, Jeff -- what percentage  
19 of them remain profitable. But I think it's 50 or 52  
20 percent or something like that?

21 DR. STENSLAND: [Off microphone] If you take out  
22 IME additions, it's going to be a little over 50 percent

1 that have a comparable overlay Medicare margins, higher than  
2 that they have a profitable inpatient work but still not all  
3 of them will have a profitable inpatient margin.

4 DR. KANE: Where I'm coming from and why I'm  
5 concerned about that the lowest cost hospitals are still not  
6 necessarily profitable is that a lot of hospitals are saying  
7 -- it's a completely different area but it's the impression.  
8 A lot of hospitals are saying they want to have Medicare  
9 shortfalls count towards community benefit because they  
10 really feel it's a charitable act.

11 I feel -- we keep saying no, the hospitals that  
12 are efficient are adequately compensated. And yet, if  
13 you're in the lowest third cost, you're still losing money  
14 even though it might be from another part of the business,  
15 the outpatient or the rehab or whatever. I feel it's really  
16 hard for us to continue to stand here and say that the most  
17 efficient hospitals are adequately compensated.

18 So it's really more philosophical but I feel if  
19 the bottom third in cost are still not -- only 52 percent of  
20 them are profitable if you take out IME and DSH -- that we  
21 aren't fully compensating the most efficient hospital.

22 So I'm really saying we need to address that.

1 I'm a little concerned, too, that it takes a  
2 little profit to be able to afford to improve your quality.  
3 Hospitals have to invest in operational analysis. They have  
4 to often hire consultants. They have to buy information  
5 support systems. They have to hire a higher skill mix. It  
6 costs money actually to get these higher improvements that  
7 come out later. If you're always on the edge, it will be  
8 much harder to look good on our quality improvement measure.

9 So I'm just trying to get a more level playing  
10 field for those who haven't been able to make money on the  
11 Medicare payment system, especially those who are already  
12 efficient. Unfortunately, we can't necessarily detect those  
13 and redistribute the money that way until eventually they  
14 get efficiency built into the pay for performance.

15 So I'm not talking permanently taking the 1  
16 percent IME out and distributing it to the base, but I think  
17 there is a real issue about equity here and ability to  
18 afford improvements to make the quality measures look good.

19 The only other thing I wanted to talk about is  
20 that in looking at the pressures that we talk about, the  
21 high payment pressure versus the low payment pressure  
22 markets, we've consistently never -- as far as I can tell in

1 the time I've been here -- we haven't said much about market  
2 concentration or made any kind of comment about antitrust or  
3 merger issues.

4           But yet I just read a great study that I think RWJ  
5 put together saying that markets have been coming  
6 increasingly concentrated over the last 10 years. The  
7 impact of that is that the private sector has less market  
8 power to produce lower payment rates. If we then say well  
9 then that's causing the pressure to have Medicare pay more  
10 because the costs are going up, should we be starting to  
11 talk about market concentration and where we think the Feds  
12 should be going or the Federal policy should be going around  
13 antitrust policy? Because we've seen in the last 10 years a  
14 definite increase in market concentration in major markets.  
15 And that's been documented elsewhere and I'm happy to share  
16 what I know about that.

17           MR. HACKBARTH: Nancy, I'd like to just go back to  
18 your previous point. In this payment system, as in every  
19 other Medicare payment system, there are important issues of  
20 equity and whether we're paying fairly for different types  
21 of providers.

22           In the case of the hospital payment system over

1 the years, we've made many, many recommendations aimed at  
2 increasing the fairness of the payment system and making the  
3 payments more accurate, a recent example being severity  
4 adjustment. But we've made recommendations on the base  
5 rates, urban versus rural, on wage index, a host of issues,  
6 each designed to improve payment accuracy and fairness.

7 Are there more out there? To be sure. But I  
8 think we've done a lot on that front.

9 Having said that, I wanted to react to the notion  
10 that well, hospitals need money to invest in improvement.  
11 The information that we have is that hospitals are making  
12 large scale investments, unprecedented investments, of  
13 various types, in new facilities and updating of facilities  
14 and new pieces of equipment and the like.

15 So I think it would be difficult to argue that the  
16 dollars aren't available for investment. The question is  
17 what is it being invested in? And there I think we do have  
18 an important payment issue that, for example, if you're a  
19 hospital administrator looking at the alternatives of  
20 investing in a new scanner or in clinical information  
21 systems, the system says oh, do the scanner. It brings  
22 revenue. It has a revenue stream. There is a return on

1 your investment. Whereas you improve the quality and  
2 there's no payback.

3 That's why I think pay for performance is  
4 important, in general. I think we're ready to go with  
5 hospitals. CMS has produced a report that addresses many of  
6 the issues that need to be addressed. It's time to get on  
7 with pay for performance to start rewarding the right  
8 investment.

9 DR. KANE: Just to respond to the rise in capital  
10 spending, I agree that it's a big opportunity to look at  
11 where the money is going. But there is a distributional  
12 aspect to that, too. The hospitals that are under a lot of  
13 financial pressure and aren't making money on Medicare are  
14 going to be disadvantaged.

15 I guess I'm just going back, I agree, we do need  
16 to address the capital spending. But the distribution of  
17 the capital spending is just as big a problem as it was, as  
18 the distribution of the payments.

19 DR. REISCHAUER: But you aren't suggesting that  
20 the money go to the "needy." You're suggesting that it go  
21 into the base, which means everybody gets it.

22 DR. KANE: If I could direct it to the lowest-cost

1 third, I would. But right now I can't. That hasn't been on  
2 the table. But that would be the ideal. I mentioned that.  
3 So the next best might be to put it in the base and then use  
4 quality, and then do the quality.

5 And I'm not against the quality adjustment after  
6 that. But I'm just saying for the IME, I'd like to see it  
7 go in the base because I think there's been historic  
8 competitive advantage distributed through the IME to the  
9 hospitals that have major teaching programs.

10 DR. CROSSON: I support both the recommendations  
11 but I'd like to make a couple of comments. The first one  
12 has to do with a point that came up earlier, and that is  
13 that in the case of Kaiser Permanente and our 31 hospitals  
14 and potentially other organizations who are paid through the  
15 Medicare Advantage program, the particular recommendation  
16 will take the IME payment away but there will be no  
17 opportunity to participate in receiving it back since the  
18 payment is through the Medicare Advantage plan and the pay  
19 for performance program that is in the recommendation is  
20 through fee-for-service payment to hospitals in traditional  
21 Medicare.

22 I would like to request that that at least be

1 noted in the text, and perhaps there might be an opportunity  
2 for later discussion about moving ahead with some process to  
3 fix that.

4           Nevertheless, I support it. The reason I support  
5 it is I think, as the staff has brought forward earlier in  
6 discussions, this particular area of IME payment is an area  
7 of pretty obvious overpayment since the formula is about  
8 twice what the analysts understand is the underlying cost.  
9 So in our fiduciary responsibility as a Commission, those  
10 are exactly the areas that we're supposed to be looking for  
11 and taking action on.

12           I do have one other concern and I think it's quite  
13 similar to Karen's, and that has to do with the fact that --  
14 as you might expect -- all teaching hospitals are not the  
15 same and not in the same situation financially. I would  
16 point out -- I think it was in the New York Times in the  
17 last week -- where they had a long page discussion about the  
18 plight of Grady Memorial Hospital in Atlanta, which has been  
19 a fixture of that community for a long time. I don't know  
20 what their operational issues are or where they are in their  
21 costs or anything like that.

22           But I do think that it might be worthwhile for the

1 Commission to spend some time in the next year or so picking  
2 apart with the data this issue that Karen brought up about  
3 the interrelationship between DSH payments and IME payments  
4 and what exactly is going on in the teaching hospitals. And  
5 do we, in fact, have -- we clearly don't have a homogeneous  
6 population. But do we have sort of discrete categories of  
7 teaching hospitals? And if we are going to continue or  
8 consider continuing this approach to reducing IME payments,  
9 would we want in the future to make some kind of more  
10 targeted approach?

11 DR. CASTELLANOS: I support both of these motions,  
12 too. I just have two points.

13 One is Jeff last time mentioned -- he talked about  
14 high quality/high cost. He talked about high quality and  
15 low cost hospitals. He kind of mentioned that the  
16 relationship there was that there was a strong  
17 physician/administration relationship. Since we're going  
18 into bundling, I would like to try to drill down a little  
19 bit on that.

20 I don't think we need to bring it to the  
21 Commission's level unless it's really pertinent, but I'd  
22 like to get some drilling down on that to see what are these

1 relationships? What are they doing? Is there any common  
2 thread?

3 I think the Hospital Association, and I think the  
4 medical associations, would like to look at that. So I just  
5 ask that if we could drill down on that and get some  
6 additional information, I think it may be very productive.

7 MR. ASHBY: Let me just add that those findings  
8 were from specific hospitals that we visited that exhibited  
9 those strong physician/hospital relationships and we could  
10 extend that.

11 DR. CASTELLANOS: I would appreciate if you could.  
12 That was, I think a point that I would enjoy looking at.

13 The IME issue has been discussed. There's no  
14 question there's an overpayment. I don't question that at  
15 all. Again, I question the message that's going out to the  
16 teaching hospitals. I think there's two good messages.  
17 One, you need to be more active in what you do. And you  
18 have to be more accountable in what you do. But again, the  
19 medical schools have been increased in numbers. We've had  
20 nine new medical schools this past year. We have not  
21 increased the specialist.

22 Again, there was an article I brought up earlier

1 in Maryland showing that there is a shortage of specialists  
2 today.

3 I agree it's going to be hard to find  
4 accountability of this but it doesn't hurt to look. And  
5 Karen's point and Jay's points are very well taken.

6 I would wonder if we could put in the text,  
7 somewhere in the text, that perhaps Congress could consider  
8 not this money but directing some monies or funds to the  
9 medical school to establish a department of health policy --  
10 for a better word -- which would include some of the core  
11 values that we discussed: the evidence-based medicine and  
12 comparative effectiveness. This needs to be started right  
13 in the medical school, not in the residency program. It's  
14 too late by then. We need to get the core values right from  
15 the get go.

16 Thank you.

17 MR. EBELER: Thank you, just a couple of quick  
18 things.

19 As I understand it, the implications of the  
20 recommendations are everybody gets market basket minus one  
21 or two. That one or two plus the IME money is in a quality  
22 performance pool of some sort that gets distributed

1 depending on how you do. That's where we're headed. I  
2 think the issue about whether or not one needs to allocate  
3 more across the board depends on how you read the public and  
4 private data. By one look, you say gee, Medicare has  
5 negative margins, private sector has positive, therefore  
6 Medicare is under paying.

7 I think the other way to read that data in a  
8 dynamic hospital market is that they manage the total  
9 margins. Given the generous payments on the private side,  
10 costs float up, and therefore Medicaid is paying less.

11 I'm inclined to read it the latter way, just given  
12 what I've seen out there. But it seems to me that's the way  
13 the analytics turn.

14 Where that takes you, I think, from my personal  
15 view as I indicated at the last meeting, I would be more  
16 than happy to try to achieve some net savings here through a  
17 productivity offset of some sort. But As I hear the  
18 discussion, and I think what we're talking about, the better  
19 part of valor is with these recommendations, to take the  
20 money from the IME savings and from the market basket update  
21 and reallocate it within the system based on performance  
22 which is really what we're talking about here.

1 DR. REISCHAUER: I think, if my arithmetic is  
2 correct, we're having a debate about nothing.

3 MR. HACKBARTH: It's a Seinfeld moment.

4 DR. REISCHAUER: It was because I had this on, I  
5 suddenly began thinking clearly.

6 If you think that the decision rule is we're going  
7 to spend X billion dollars, a fixed amount of dollars, on  
8 pay for performance in the next year, it doesn't matter  
9 whether we take the one percentage point and put it into  
10 that pay for performance pool and then reduce the DRGs by a  
11 certain percent to make up the X billion dollars or we take  
12 the money and we add it to the base and then take all of it  
13 out of the base. It's the same amount.

14 The only way it's different is if you say pay for  
15 performance should be X percent of the base, in which case  
16 it's a bigger pay for performance program under one thing  
17 than it is under the other. But that would be a stupid way  
18 to go about deciding how much to spend on pay for  
19 performance in the initial year.

20 So I don't think we have an argument here. Your  
21 hospitals will get the exact same amount down at the bottom  
22 in their standard DRG payments under either of those --

1 DR. KANE: Only if they get the quality.

2 DR. REISCHAUER: I'm saying X the quality issue.

3 DR. KANE: To go back to Dave's comment a while  
4 back about the message, I actually think the money isn't the  
5 issue. It's a message.

6 But no, I don't agree. If you're in the low-cost  
7 third and you don't get your money back because you're not  
8 able to do well on the pay for performance variables, then  
9 you would actually be paid less than you would if 1 percent  
10 of that was distributed to your base rate, I think. It  
11 depends on when you start with the base.

12 DR. REISCHAUER: You're taking the same amount out  
13 of the base to set up a pool. The pool consists of a  
14 certain amount from the IME and a certain amount from the  
15 base. But they sum together to the same amount of money.

16 DR. WOLTER: This is a striking moment in my  
17 MedPAC tenure because I was having the same thoughts as an  
18 economist.

19 DR. REISCHAUER: It's time to quit.

20 MR. HACKBARTH: It's time for you to get off,  
21 Nick. Your bell has rung.

22 [Laughter.]

1 DR. WOLTER: I guess the question is if we decided  
2 on a 2 percent pool for pay for performance and 2 percent of  
3 it came out of the base and the 1 percent IME went back into  
4 the base, it's kind of the same result as if we did 1  
5 percent out of the IME and 1 percent out of the base to most  
6 institutions. I think that's what you're saying.

7 DR. REISCHAUER: But the one percentage point from  
8 IME doesn't amount to the same percent of the base. You  
9 have to translate.

10 DR. WOLTER: Oh, good, I didn't have exactly the  
11 same thought as an economist.

12 Just a couple of things from my perspective on  
13 this. They're a little bit linked to some of what Nancy was  
14 asking about. I'm a little bit worried about the balance in  
15 the story we're telling here, that somehow the Medicare  
16 margin is totally related to the discipline of the  
17 management in 20 percent of the hospitals, which I'm sure  
18 has a role. There's no question.

19 The thing I'm interested in is can we connect some  
20 of these dots also to the other very complex moving parts on  
21 the reimbursement system? Which hospitals are reclassified?  
22 Which do get large amounts of IME and DSH? Which do have

1 large wage indexes? Have people make changes in their  
2 service mix, which might be good or not so good for their  
3 community to help drive these things?

4           And then I think it should be quite obvious the  
5 markets are not the same across the country. And so how do  
6 we take that into account? The story we're telling here has  
7 got a very sharp point but there may be nuances that we'd  
8 like to flesh out over time so that we understand what might  
9 be the next step, which I am glad to hear we're going to  
10 look at the framework for an update because I don't know  
11 what the implication of this is. Would we only give an  
12 update to that 20 percent of hospitals of one size versus a  
13 lower to the other? Even those getting a 3 percent margin,  
14 as Nancy pointed out, might need some kind of an update to  
15 continue into the future.

16           So how do we take this information and use it in  
17 the framework we want to put together for future updates? I  
18 hope we can connect some dots as we move ahead.

19           MR. HACKBARTH: Before we turn to the vote, let me  
20 just share Tom Dean's comment here, and I'll quote a few  
21 lines from it. He said I support the hospital  
22 recommendations, though again I have some reservations about

1 the fairness of the distribution. I'm bothered by the fact  
2 that so much of our -- and these aren't consecutive  
3 sentences, I'm collapsing here.

4 I'm bothered by the fact that so much of our  
5 judgment is based on average margins. I do not believe that  
6 Medicare is obligated to deliver any provider a  
7 predetermined margin. I do believe Medicare is obligated to  
8 pay a fair price for services delivered and it's up to  
9 providers to figure out how to deliver services in an  
10 efficient way. At the same time, I understand how difficult  
11 it is to determine what fair means.

12 The bottom line is he said he would vote for the  
13 recommendations.

14 It's time for everybody else to vote, so on  
15 recommendation one, all opposed to recommendation one? All  
16 in favor? Abstentions?

17 And on recommendation two, all opposed? In favor?  
18 Abstentions?

19 Thank you. Good job.

20 MR. ASHBY: If I could just say one last thing. I  
21 want to thank you all for the aloha reception you've given  
22 me today. But more importantly, I'd like to thank Bob and

1 Glenn, and particularly my boss, Mark Miller, for giving me  
2 a tremendous opportunity to grow professionally and  
3 hopefully to contribute over the 19 years that I've been  
4 here.

5 Aloha to everyone.

6 [Applause.]

7 MR. HACKBARTH: Thank you, Jack, for your service.

8 Yes, site visits, the sign-up list is...

9 Okay, before lunch we now have a brief public  
10 comment period with our usual ground rules which are number  
11 one, please identify yourself and your organization. Number  
12 two, please keep your comments to no more than a couple of  
13 minutes. I'm going to turn off my microphone but when you  
14 see me turn it back on and the red light goes on, that's the  
15 sign that the hook is coming out.

16 MS. RICHNER: I'm Randel Richner and I'm  
17 representing a home hemodialysis company called Next Stage  
18 in Massachusetts. I was formerly a home dialysis nurse for  
19 12 or 13 years and have been part of the medical technology  
20 policy world for quite some time. I have served on MCAC,  
21 the original MCAC, and they asked me back for a couple of  
22 years, I think for entertainment services.

1           Given that ESRD is 7 percent of the overall costs  
2 of Medicare and dialysis, and it's been brought up at every  
3 MedPAC meeting, I wanted to note for the public record that  
4 a small part of the ESRD program, home hemodialysis, could  
5 yield significant savings to CMS if the payment system was  
6 modified to encourage this choice.

7           Currently, home hemodialysis is a treatment choice  
8 for patients that will completely fail due to the misaligned  
9 payment systems if Congress or Medicare does not initiate  
10 some reforms. There is no payment accommodation to  
11 encourage home hemodialysis and, in fact, providers have  
12 payment disincentives to encourage it.

13           In recently published articles from Canada, from  
14 foreign countries including California -- which some  
15 consider a foreign country -- there was a robust study done  
16 at Kaiser showing the significant savings associated with  
17 home hemodialysis related to the improved patient outcomes  
18 with LVH and anemia status, nutritional status, and all the  
19 other important markers in quality of care.

20           The problem is that once again the savings  
21 straddle Part A and D. As many of the commissioners noted  
22 this morning, the issue is primarily again the problem of

1 one system realizing the benefits and the others not. So  
2 therefore, providers will continue on the status quo,  
3 encouraging institutional care with these misaligned  
4 incentives.

5 I urge the commissioners to continue to encourage  
6 Congress and Medicare to creatively examine and reform some  
7 basic payment mechanisms to support home hemodialysis. The  
8 proposed bundle change may or may not do this to ensure that  
9 providers will choose developing home hemodialysis programs  
10 without careful examination of the link to provider payment,  
11 frequency, drug payments, and utilization.

12 I applaud all the efforts of MedPAC, from the  
13 reports that have been published over the last several  
14 years, that recognize this. But we still have a long way to  
15 go and I hope that will be brought up in the March payment  
16 report.

17 Thank you.

18 MR. DICKLER: Mr. Chairman and members of the  
19 Commission, I'm Robert Dickler, Senior Vice President of the  
20 Association of American Medical Colleges. Let me make three  
21 brief comments.

22 The first is while we appreciate your continuing

1 attention to IME, we'd like to suggest that the discussion  
2 be somewhat expanded.

3 First, as was noted earlier, there are a lot of  
4 moving parts currently in Medicare and other Federal  
5 programs, including Medicaid. Many of those are targeted to  
6 teaching hospitals or have a differential impact. We would  
7 urge the Commission to take a look at those factors in  
8 aggregate in terms of the impact on the teaching hospital  
9 community and their ability to fulfill their missions.

10 Second, historically IME has been an overpayment.  
11 It's been recognized since the inception of Medicare. And  
12 it has been recognized in the context of mission and total  
13 financial viability. We would urge the Commission to  
14 reconsider looking at total margins, not simply Medicare  
15 margins, as they deliberate the IME in terms of the  
16 financial health of that community.

17 And third, a number of very interesting points  
18 were raised. We would be delighted to work with the  
19 Commission on pursuing any or all of those as you determine  
20 appropriate.

21 Thank you.

22 MR. SHAW: Hello, I'm John Shaw and I'm the

1 President of Next Wave. That's a health systems research  
2 and policy organization in Albany, New York. I'm here  
3 primarily to talk about value-based purchasing, although  
4 listening to the recent discussions, I think it has an  
5 impact on that as well.

6 In point of context, I sat with Tom Dean during  
7 both of the CMS listening sessions for value-based  
8 purchasing. And I'm sure if he was here, he would add an  
9 additional area to the areas to look at for value-based  
10 purchasing, and that is the plight of the small and rural  
11 hospitals relative to the fixed cost of collecting and  
12 reporting the data to support the system.

13 We did some analysis and made some recommendations  
14 that didn't find their way into the final paper to Congress,  
15 but essentially what we suggested is you may want to set  
16 aside a portion of whatever funds are in the pool to pay for  
17 the cost of just collecting the data. For a small facility,  
18 that could very well be 2 percent of their Medicare volume  
19 just to report the data. Under the performance scenarios in  
20 year two and three, they would very likely not get that  
21 back, in which case why would a small facility on purely  
22 financial record go forward and do it?

1           So we looked at probably the cost of reporting.  
2   The numbers we used are about \$50,000 for under 100 beds,  
3   \$100,000 from 100 to 200, and \$200,000 over that.

4           Pull that out as a separate pay to report piece  
5   and apply that before any distribution on performance.

6           The second area of refinement is to look at the  
7   other end. What to do with the funds that would be  
8   available but not distributed potentially or redistributed?  
9   We agree completely that any of the funds should be  
10   redistributed but suggest considering how to do so. There's  
11   a lot of discussion about the distributional aspects and  
12   some of the facilities that don't have the resources to  
13   necessarily implement some of the performance improvement.

14           The concept that we floated at the April listening  
15   session was to take the unallocated funds and use it to fund  
16   pay to share. In other words, looking at performance you  
17   have achievement and improvement, both of which are  
18   recognized, both of which were specific elements that MedPAC  
19   had in their papers from several years ago. Those are being  
20   implemented, measured, and defined. But there's money left  
21   for 95 percent of the hospitals. Eventually, when it gets  
22   into years two and three, that would not be distributed

1 according to those formulas.

2           Take that money, set it aside, and specifically  
3 target it to fund the top performers to share their best  
4 practices with the ones who need improvement. And that  
5 accomplishes many things. It takes the expertise and makes  
6 sure it gets in there so that it helps raise all boats  
7 because here is something more that the top performers can  
8 do. It gives the --

9           MR. HACKBARTH: I'm going to have to cut you off  
10 here. I would encourage you to share your ideas directly  
11 with the staff via letter, phone call, meeting, whatever you  
12 think is best. But we need to move on right now.

13           MR. CONLEY: Thank you, commissioners. Jerry  
14 Conley on behalf of the American Academy of Family  
15 Physicians.

16           We would just like to share with you a perspective  
17 based on an observation of this morning's discussions around  
18 certain recommendations, around the action that you take  
19 with regard to the specific recommendations, particularly  
20 with regard to hospitals and physicians.

21           If you look at the physician environment -- and  
22 this is coming from your discussion this morning -- warning

1 signals abound. You've got a history of at least six years  
2 now, almost seven, where payment updates have been  
3 insufficient and inadequate and less than the increase in  
4 the cost of managing and operating a practice.

5           You also have the adverse effects of reimbursement  
6 that are showing up in some other issues such as access and  
7 in other issues such as selection of medical specialty. I'm  
8 speaking specifically, of course, of primary care.

9           We get to the discussion of the hospital  
10 environment. And for the most part all of the indicators  
11 are positive. You have one indicator, that is the Medicare  
12 margin, which is negative but actually improving somewhat.  
13 And by the way, Medicare margins are not available for  
14 physician practices, as you know. Particularly wouldn't it  
15 be interesting to know what a primary care physicians'  
16 practice entails in terms of cost and managing for a  
17 Medicare beneficiary who has three or four or five chronic  
18 conditions?

19           So when you have a negative Medicare margin in the  
20 hospitals, obviously you're assuming in this system cost  
21 shifting. Cost shifting is increasingly something that  
22 physician practices are unable to do.

1           So at the end of the day we have a hospital update  
2 recommendation for the full market basket and you have the  
3 physician update recommendation was for MEI minus the  
4 productivity adjustment which is going to come to around 1  
5 percent. So you still another year of an update that would  
6 be less than the increase in the cost of operating a  
7 practice.

8           This is just information and perspective that we  
9 would like you to seriously consider this afternoon as you  
10 talk about distribution of payments.

11           Thank you.

12           MS. COYLE: Carmela Coyle with the American  
13 Hospital Association. Thank you for your consideration and  
14 recommendations on the inpatient and outpatient update.

15           In the year area of IME cuts, we continue to be  
16 concerned about any cuts in Medicare payments to teaching  
17 hospitals at a time when these hospitals have among the  
18 lowest financial performance of all hospitals in the United  
19 States and at a time when people continue to be concerned  
20 about the future supply of physicians in this country.

21           Two brief comments. In the area of value-based  
22 purchasing, would like to suggest that the Commission might

1 want to consider bringing in and hearing from some of the  
2 folks who are involved in that process today. As you know,  
3 there exists a hospital quality alliances that has been up  
4 and running for several years. The National Quality Forum  
5 is obviously a very important player.

6           You talked a lot about measure development. Janet  
7 Corrigan is an example at the National Quality Forum, really  
8 leading in that effort around measure development and  
9 specifically measure endorsement. But an opportunity  
10 perhaps for the Commission to follow through the entire  
11 process from measure development to endorsement to selection  
12 to implementation on to data collection reporting and then  
13 actually sharing the information publicly and evaluating  
14 that. It just may be helpful to the Commission as you  
15 consider this. I think one of the concerns is how do we not  
16 reinvent the wheel in terms of some of the activity already  
17 out there?

18           My second comment is to Jack Ashby, to say thank  
19 you on behalf of the American Hospital Association, and I'd  
20 venture to guess on many of us in the policy community.  
21 Jack, we thank you for your dedication, for your years of  
22 service, your professionalism, your thought leadership, and

1 we appreciate everything you've done on behalf of health and  
2 health care in America.

3 Thank you.

4 [Applause.]

5 MS. McILRATH: I'm Sharon McIlrath with the AMA.

6 I won't dwell a lot on what the current financial  
7 situation is for physicians other than to say that there are  
8 a number of other things that are happening simultaneously  
9 with budget neutrality that mean that even the 0.5 percent  
10 increase for only six months this year, most physicians are  
11 still going to be looking at a pay decrease this year as  
12 opposed to even that slight bump up.

13 The other thing though that I wanted to follow up  
14 on was the productivity issue and to encourage you to  
15 perhaps include something on that in the report language. I  
16 think if you go back and look at what's been happening to  
17 the MEI, which is not exactly the same as your  
18 recommendation but similar, it's gone from 2.8 to 1.8 now  
19 down to it looks like 1.1 as you are doing it now.

20 One of the key reasons for that is because the  
21 productivity factor jumped. In 2006, BLS redid the way that  
22 they make that estimate. And so that had the impact of

1 bringing down all of the updates.

2           The other impact is that next year, forget about  
3 the 10 percent that you're going to be going down because  
4 we've only built this in as a bonus. There will be, on top  
5 of that, a 6 percent -- not a 5 percent, it's been being 5  
6 percent. But it will be 6 percent because the formula calls  
7 for MEI minus seven. So you'll be looking every year, we've  
8 been looking at reductions of 5 percent a year. We'll now  
9 be looking at reductions of 6 percent a year. That  
10 obviously has scoring implications for either a long-term or  
11 the year-by-year fixes that we do.

12           Honestly, the best way to have it be fixed would  
13 be if CMS were to do it because of the scoring implications.  
14 They have actually looked at it. They did have a conference  
15 in fall of 2006 and I believe they're going to be publishing  
16 a paper soon. But the takeaway from the meeting that they  
17 had, I believe, was that the particular new adjustment that  
18 they looked at, the formula, had a lot of proxies in it and  
19 other economists were not comfortable with those. But there  
20 was some general agreement that the current one is too high.

21           So if some of the comments and the concerns that  
22 people here had expressed about that productivity adjustment

1 were in the paper, I think it would be useful.

2 MR. HACKBARTH: Okay. We will reconvene at 1:30.

3 [Whereupon, at 12:35 p.m., the meeting was  
4 recessed, to reconvene at 1:30 p.m. this same day.]

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1 briefly review that information and the draft  
2 recommendation.

3           The indicators we examined suggest that payments  
4 are more than adequate. Most beneficiaries appear to have  
5 little or no delay in accessing SNF services, especially if  
6 they need rehabilitation services. Medicare continues to be  
7 considered a good payer. The supply of SNFs was almost  
8 identical in 2007 although the share of hospital-based units  
9 continues to decline.

10           When adjusted for the number of fee-for-service  
11 enrollees, days and admissions increased. The quality  
12 indicators showed mixed performance: risk-adjusted rates of  
13 community discharge within 100 days are almost the same  
14 level they were five years ago, having declined -- that is,  
15 they got worse -- and then improved during the last two  
16 years. The risk-adjusted rates of rehospitalization has  
17 steadily increased throughout the period, indicating poorer  
18 quality.

19           Access to capital is expected to be tighter over  
20 the coming year but this is related to broad lending trends,  
21 not the adequacy of Medicare payments. Medicare continues  
22 to be a preferred payer.

1           Aggregate Medicare margins for freestanding SNFs  
2 were 13.1 percent in 2006. This was the sixth year in a row  
3 that freestanding facilities had aggregate margins exceeding  
4 10 percent. There continues to be wide variation in the  
5 financial performance across the facility groups as you can  
6 see from the margins in the top and bottom quartiles. For-  
7 profit SNF margins averaged 16 percent. The considerably  
8 lower margins of the not-for-profit SNFs are partly  
9 explained by their higher daily costs. They are about 10  
10 percent higher. And between 2005 and 2006 they had higher  
11 cost growth compared to for-profit SNFs.

12           Hospital-based facilities continue to have large  
13 negative margins, negative 84 percent. We have often  
14 discussed the reasons for the large differences in per day  
15 costs between hospital-based and freestanding facilities,  
16 and these include their higher staffing levels, unmeasured  
17 case-mix differences, the allocation of overhead from the  
18 hospital, and different practice patterns of their  
19 physicians.

20           This past spring we reported on work that examined  
21 hospital-based SNFs. We found that some hospitals elect to  
22 keep their SNFs open, even with their negative margins, in

1 part because the units allow the hospital to discharge their  
2 patients sooner than they would otherwise be able to. We  
3 found that when the hospital and SNF stays were considered  
4 together, the combined hospital and SNF payment covered  
5 their direct costs.

6           The Commission continues to be concerned about the  
7 differences in financial performance between hospital-based  
8 and freestanding facilities and between for-profit and not-  
9 for-profit facilities. In the fall, I presented research  
10 exploring alternative designs for the PPS that better target  
11 payments to non-therapy ancillary services and that base  
12 therapy payments on care needs and not service provision.  
13 We plan to present more results in March and anticipate that  
14 the alternative designs will redistribute payments to  
15 hospital-based and non-profit facilities. Redistributing  
16 payments would narrow the differences in financial  
17 performance.

18           In modeling 2008 payments and costs, we consider  
19 policy changes that went into effect between the year of our  
20 most current data, which was 2006, and the year of the  
21 margin projections, 2007 and 2008. We also take into  
22 account policies scheduled to be in effect in 2009. Except

1 for accounting for the full market basket updates for each  
2 year, there were no other policy changes to consider.

3 We estimate that the Medicare margin for  
4 freestanding SNFs in 2008 will be 11.4 percent. This  
5 continued high margin is partly the product of having  
6 received full updates for the past five years. Our  
7 projected margin is a conservative one because we use actual  
8 average annual cost increases since 2001 and not their  
9 market basket which is lower and we did not factor in any  
10 behavioral offset that may increase payments.

11 This leads us to our draft recommendation, the  
12 Congress should eliminate the update to payment rates for  
13 SNF services for 2009.

14 This recommendation would lower program spending  
15 relative to current law by \$250 million to \$750 million for  
16 2009 and by \$1 billion to \$5 billion over five years. It is  
17 not expected to impact beneficiaries or providers'  
18 willingness or ability to care for Medicare beneficiaries.

19 Now I'm going to switch gears and discuss the two  
20 quality related topics: pay for performance and measures of  
21 SNF quality.

22 When the Commission first considered the settings

1 that were ready for linking payments to quality, SNFs were  
2 not among them mainly because the widely acknowledged  
3 problems with the publicly reported quality measures. Since  
4 then we have carefully examined two measures -- rates of  
5 community discharge and potentially avoidable  
6 rehospitalizations -- and found that they meet MedPAC's  
7 criteria established for pay for performance measures. Both  
8 measures are evidence-based and accepted as quality  
9 indicators for SNF care. The risk adjustment is sufficient  
10 to deter providers from avoiding certain types of patients  
11 who might lower their quality scores. I'm going to say more  
12 about risk adjustment in a minute.

13           The measures do not require any new data and most  
14 providers can improve on them. The measures reflect the  
15 broad goals for most SNF patients, to improve enough to be  
16 discharged back to the community and to avoid a hospital  
17 readmission.

18           Paying for performance using potentially avoidable  
19 hospitalization rates as a measure is also one step in the  
20 path of holding multiple providers accountable for reducing  
21 the number of unnecessary hospital readmissions. It would  
22 also complement other policy ideas the Commission has

1 discussed, such as bundling payments around an acute  
2 hospitalization and would align incentives across providers  
3 to reduce avoidable hospital readmissions.

4           We evaluated two technical aspects of the  
5 measures, the risk adjustment and -- given the low Medicare  
6 shares in many SNFs -- the annual number of cases needed for  
7 stable estimates. The issue of risk-adjustment came up at  
8 last month's meeting when Bill raised a question about  
9 whether the measures adequately accounted for patients who  
10 were unlikely to improve. Adequate risk adjustment is key  
11 to ensuring that providers aren't penalized for treating  
12 certain types of patients.

13           You may remember Dr. Kramer's presentation from  
14 this past spring when he discussed his work on the factors  
15 contributing to changes over time in the community discharge  
16 and rehospitalization rates. In that presentation, he  
17 discussed the risk adjustment method. It includes 26 case-  
18 mix indicators, including diagnoses and measures of physical  
19 and cognitive function. Measures of physical and cognitive  
20 function are strongly associated with having been a nursing  
21 home resident and adjust for the likelihood that a patient  
22 will be discharged to the community.

1           Dr. Kramer described the risk adjustment as robust  
2 because it explained 64 percent of the variation in  
3 community discharge rates and 54 percent of the variation in  
4 rehospitalization rates across facilities. Because the  
5 models are good predictors of whether patients will be  
6 discharged home, facilities are not penalized if they treat  
7 the patients who are unlikely to improve.

8           Given the small Medicare shares in many SNFs, we  
9 also evaluated the number of cases a SNF would need to care  
10 for during the year so that the measures were stable. We  
11 found that a relatively small sample size was needed -- 25  
12 cases a year -- and that would exclude about 10 percent of  
13 SNFs that treat less than 1 percent of stays. This  
14 attrition rate is a lot smaller than the almost 50 percent  
15 of stays that are currently excluded from the publicly  
16 reported measures that rely on a second patient assessment.

17           The two measures would form a basis of a starter  
18 measurement set that would be added to over time. Once  
19 patient assessments are conducted at discharge for every  
20 patient, measures that capture changes in patient condition  
21 should be added to the starter set. Any outcome measure  
22 would need to have adequate risk adjustment so that SNFs are

1 not penalized for taking complex patients or patients who  
2 are unlikely to improve. Measures to consider adding are  
3 improvements in physical functioning and pain management.

4 MedPAC has supported the idea of having an entity  
5 vet the performance measures so that the pay for performance  
6 programs are credible, efficient, and effective.

7 Because good measures are available, we think that  
8 Medicare payments should be linked to patient outcomes.  
9 This brings us to our second recommendation. The Congress  
10 should evaluate a quality incentive payment policy for  
11 skilled nursing facilities in Medicare.

12 Consistent with our design principles, the program  
13 would be designed to be budget neutral and therefore would  
14 not affect program spending. The recommendation should  
15 improve quality of care for beneficiaries. It would raise  
16 or lower payments for individual providers depending on the  
17 quality of care that they provided.

18 The second quality related topic considers the  
19 publicly reported SNF quality measures. CMS currently  
20 reports five quality measures for short stay post-acute  
21 patients on the Nursing Home Compare website. Experts have  
22 raised a host of problems with the measures and, because of

1 these, we've used the community rates of discharge and  
2 potentially avoidable rehospitalizations to gauge the  
3 quality of care furnished in SNFs.

4           There are several problems with the publicly  
5 reported measures. First, the current measures do not  
6 capture key goals of care for most SNF patients, to improve  
7 enough to be discharged back to the community and to avoid  
8 an unnecessary rehospitalization.

9           Second, because SNFs are not required to conduct  
10 patient assessments at discharge, there is a systematic bias  
11 in the measures because about half the patients are not  
12 included in the measures. They don't stay long enough to  
13 have a second assessment.

14           Third, the patient assessment questions ask about  
15 the care during the past 14 days, which can lead that the  
16 measures can reflect care that was provided during the  
17 preceding hospitalization.

18           Another complications is that assessments are not  
19 consistently conducted at the same point in time during the  
20 stay so that differences in quality scores may be the result  
21 of when the assessments were conducted rather than  
22 differences across patients.

1           Finally, the definitions in these measures are  
2 problematic. The pain measure is narrowly defined and  
3 confusing. The pressure sore measure was found to not be  
4 valid and the delirium measure is nonspecific and misses a  
5 large share of patients with the condition. Reflecting the  
6 measurement problems, CMS does not intend to include these  
7 measures in its pay-for-performance demonstration.  
8 Revisions to these measures should be evaluated by a panel  
9 of quality experts who consider the relevant literature and  
10 the reliability and validity of alternative definitions for  
11 these measures.

12           Reflecting the availability of alternative SNF  
13 quality measures and our concerns about the current publicly  
14 reported ones, our third recommendation reads that to  
15 improve quality measurement for SNFs, the Secretary should  
16 add the risk-adjusted rates of potentially avoidable  
17 rehospitalizations and community discharge to its publicly  
18 reported post-acute measures. It should improve the  
19 definitions of the pain, pressure ulcer and delirium  
20 measures. And third, require SNFs to conduct patient  
21 assessments at admission.

22           This recommendation does not affect program

1 spending relative to current law. The changes would result  
2 in more information being available to beneficiaries and  
3 their caregivers and make the information that is currently  
4 reported more accurate. For providers, it would support  
5 their quality improvement efforts. The increased provider  
6 administrative burdens associated with conducting  
7 assessments could be minimized if the day five assessment  
8 was replaced with one done at admission, and if the  
9 discharge assessment included only a few key items. CMS  
10 would need to incur modest administrative costs associated  
11 with adding the new measures to its publicly reported set  
12 and developing a pared back instrument for use at discharge.

13 With that, I'll end my presentation.

14 MR. HACKBARTH: Thank you, Carol. Well done.

15 Questions and comments?

16 DR. SCANLON: Thanks very much. I think that the  
17 work that Carol has been leading here has really moved us  
18 forward very much in this direction. I'm particularly  
19 excited about knowing that in March we're going to hear  
20 about some possibilities in terms of reforming the payment,  
21 since this has been a problem I think we've worked on for  
22 about eight years. The notion that there may be something

1 at the end of the tunnel is really very reassuring.

2           The other thing is the idea of using the payment  
3 system to try and influence the quality of care in SNFs and  
4 nursing homes, is also something that I'm very supportive  
5 of. In the chapter you cite a GAO report, which is like the  
6 26th or 27th of those reports, talking about quality  
7 problems in nursing homes. While there are other mechanisms  
8 that have been talked about in terms of trying to improve  
9 quality, if we can use payment that would be just one more  
10 tool and hopefully an effective tool.

11           Supportive of the principle though, I guess I feel  
12 that we're not right yet at the point where recommending to  
13 the Congress we have a national program in terms of pay for  
14 performance for SNFs is the right place to be. We really  
15 need some more testing of ideas before we can implement  
16 something that we can feel comfortable about. I think I've  
17 said this before, I have this continuing fear that when the  
18 government does something and it turns out to be wrong it's  
19 very hard to reverse it. So you'd like to know as much as  
20 possible before you start something on a national scale.

21           Let me make comments about our two measures as  
22 well as the risk adjustment. I appreciate your response in

1 terms of my question from last month and I guess maybe my  
2 name should be Thomas and I can say I'm a doubting Thomas  
3 here. I still have my concerns, which is that risk  
4 adjustment and our testing of risk adjustment in part  
5 depends on the context. Right now we sort of have a  
6 situation where there wasn't an incentive for the homes to  
7 select on the criteria that we're concerned about, namely  
8 are they going to be people that are more likely to be  
9 rehospitalized? Or are they people that are less likely to  
10 be discharged to community?

11 From my experience in the past, providers  
12 information about a particular patient so vastly exceeds  
13 what we know in the public sector or as a payer that their  
14 ability in some ways to select or to identify differences  
15 among patients is so much greater that our risk adjustment  
16 methods pale in terms of their ability to make the right  
17 decision.

18 I say this in particular with respect to nursing  
19 homes because having been around when what we called case-  
20 mix systems for Medicaid reimbursement were introduced in  
21 states, to see the shift in behavior on the part of nursing  
22 homes in terms of how they screened potential residents, the

1 information they gathered from hospitals or from families  
2 before they admitted somebody, that they really do make an  
3 effort to identify who's the best resident in terms of the  
4 incentives that we face.

5           This would be one part of trying to test this,  
6 which is are the risk adjustment methods robust enough when  
7 we change the incentives for behavior, which a pay-for-  
8 performance system would do?

9           With respect to the two measures themselves, there  
10 is also an issue of the ability to risk adjust in an  
11 appropriate way and to control the measurement of the  
12 outcomes.

13           On the rehospitalizations, there's kind of like a  
14 reverse side of that which is inappropriate non-  
15 rehospitalizations, which is the idea that we've created an  
16 incentive to keep a person in a nursing home or in a SNF,  
17 but do we keep them there to their detriment when they  
18 should have been appropriately rehospitalized? You say that  
19 and you say aren't we going to know the consequences of  
20 that? A very large number of people in nursing homes die.  
21 And this is an expected outcome. So if you see someone die,  
22 that is not an indication necessarily of the wrong type of

1 care.

2 In fact, the teaching nursing home program that  
3 was a demonstration program back in the late 1980s, early  
4 1990s where they brought in and beefed-up the capacity of  
5 the nursing homes by having faculty for nursing schools as  
6 well as students. They kept people from being  
7 rehospitalized when they had developed significant acute  
8 conditions. More of them died. But that was going to be  
9 their outcome anyway. So it was not that they were getting  
10 poor care or anything. But there's a question of we're not  
11 talking about the same kind of situation where we can be  
12 confident that a change in health outcomes for residents  
13 when they're not rehospitalized is the inevitable is a  
14 benign sort of thing.

15 The other issue in terms of discharge to the  
16 community, the issues of difficulty in terms of defining  
17 exactly what we mean in providing safeguards there. Back in  
18 the late 1970s there was an experiment with pay-for-  
19 performance for nursing homes which was trying to encourage  
20 discharge to the community but wanted to make sure that  
21 discharge was meaningful, that people remained in the  
22 community and they weren't just inappropriately discharged.

1 That's more challenging than just discharging them. There  
2 wasn't any sort of behavioral response there. Whereas there  
3 was -- in terms of the nursing homes doing that -- there was  
4 a strong behavioral response in other elements of that  
5 demonstration.

6           So I think this is, again, something we need to  
7 explore. And it's more difficult to explore in today's  
8 world because, unlike the late 1970s, we have a more complex  
9 world of institutional or residential based long-term care.  
10 We have a million assisted-living facilities. We've got  
11 foster care. We've got continuing care retirement  
12 communities where they can deliver nursing home equivalent  
13 care in your unit. So all of these things, they kind of  
14 make the definition of community somewhat different.

15           I wouldn't want the circumstances of a particular  
16 community or a particular institution, say a skilled nursing  
17 unit of a CCRC, I wouldn't want that to dictate how a  
18 facility does in terms of performance. We want their  
19 performance as measured to reflect their care that they  
20 delivered as opposed to their opportunities.

21           That could maybe be handled with a different form  
22 of risk adjustment but it is a new concept, something I

1 think we need to think about.

2 I believe we would be better off, instead of  
3 making a recommendation to the Congress to say let's enact a  
4 national program, to piggyback on the CMS demonstration. We  
5 talk in the chapter about differences between what CMS is  
6 going to do and what we would have done if we had designed  
7 the demonstration. I think we should encourage them to move  
8 it our direction. We should encourage them to be  
9 expeditious about implementing this and evaluating it  
10 quickly.

11 And frankly, we should be their watchdog in terms  
12 of are they doing it? Are we learning as much as we can  
13 from it? It's not that we want to walk away from pay for  
14 performance for this type of care. It's just that we want  
15 to make sure it gets done as well as we can as quickly as we  
16 can. And I think passing it on, at this point, to the  
17 Congress is not necessarily going to accomplish all of those  
18 goals.

19 Thanks.

20 MR. HACKBARTH: Carol, any thoughts that you want  
21 to share?

22 DR. CARTER: I have a few thoughts. First, in

1 terms of patient selection, I think everybody here would  
2 agree that risk adjustment is critical, that that doesn't go  
3 on.

4           The work that we've been doing with Urban is  
5 probably a much stronger vehicle than a pay for performance  
6 program with a small set-aside could accomplish. And that's  
7 why we're moving pretty quickly in that work, because trying  
8 to target payments to patients who require non-therapy  
9 services is going to help, I think, a lot in terms of  
10 nursing homes selecting certain types of patients versus  
11 others.

12           I feel like we have maybe a two-pronged approach  
13 to trying to make sure that nursing homes and SNFs don't  
14 select against patients. One is appropriate risk adjustment  
15 for the measures and the other are the SNF payment reforms  
16 that we will be discussing probably at the next session.

17           The second thing I wanted to make sure we keep  
18 focused on measures that are appropriate for the SNF  
19 population. I know that there are measures for nursing home  
20 patients but we are trying to talk about short stay patients  
21 here. So something like a discharge to community rate  
22 within 100 days probably is a better preventer of dumping

1 than a 30-day rate because if the average length of stay is  
2 26 days, having a measure that at least captures within 100  
3 days is, I think, helping to make sure that providers don't  
4 discharge patients prematurely.

5 In terms of risk adjustment, and I knew this  
6 question was going to come up. So I talked with Andy Kramer  
7 at least three times in the last month about this. His  
8 basic take is this is as good as it gets. This is a very  
9 robust risk adjustment method. It may not be what we want  
10 but he said it is well above the standard that has been used  
11 for other measures. So his statement would be that these  
12 measures are very robust.

13 DR. SCANLON: I wouldn't disagree that maybe it's  
14 as good as we can get. But the question is is it good  
15 enough? That's the test that I'm asking to be performed.

16 I think the other issue is that the people that  
17 come into a SNF as Medicare patient are not all short stay.  
18 Some of them are going to be people that were discharged  
19 from the nursing home to go to the hospital and come back  
20 after a three-day stay and be Medicare eligible again. Some  
21 of them are starting a long stay.

22 I think it's complicated by the fact that we have

1 these variety of residential settings today so that the  
2 discharge from the skilled nursing facility is not as clean-  
3 cut as quote "return to the community." Return to the  
4 community doesn't mean return to home. It could potentially  
5 mean return to another institution or transfer to another  
6 type of institution.

7           Now how we decide to define return to the  
8 community maybe deals with part of that. But we have to  
9 also think about the fact that in doing something nationally  
10 we are dealing with long-term care systems in different  
11 parts of this country that are incredibly variable in terms  
12 of how long-term care is provided.

13           In thinking about who lives in the community  
14 versus who lives in a nursing home, I did once work that  
15 compared Karen's state with Dave's state looking at the same  
16 cohort of people. In Karen's state, 50 percent of them were  
17 living in nursing homes. In Dave's, 90 percent of them were  
18 living in nursing homes. So you've got these dramatic  
19 differences in terms of what it's going to mean to be back  
20 into the community.

21           And that again -- and it's potentially a risk  
22 adjustment requirement.

1 DR. CARTER: You and I talked about that these do  
2 adjust for nursing home bed availability.

3 DR. SCANLON: Bed availability. But there's more  
4 to it today than there was back then.

5 It's this issue of let's explore these questions  
6 before Congress enacts a law. That's all I'm saying.

7 MR. HACKBARTH: I think the point you are raising,  
8 Bill, is a profound point, that surely we don't want to make  
9 things worse. In any change there is a risk of unintended  
10 consequences and the government does not work well in  
11 reverse. I think at one meeting you said it doesn't even  
12 have a reverse gear. So it goes forward very slowly and  
13 backwards not at all. This is not a pretty picture.

14 Having said that, a point that I often make is  
15 when considering whether a new proposal is a risk worth  
16 taking. And they all involve risk of various types. You  
17 need to compare that not to an idealized status quo but  
18 reality as it exists right now. You are way more expert  
19 than I in this area, because of your long GAO experience  
20 with it. But my understanding is the status quo right now  
21 on the quality of care in particular right now he is not all  
22 that great. So I worry about the cost of just being stuck

1 where we are and not moving ahead.

2 That's not an answer. It's just the other side,  
3 something to be put in the other tray on the scales that  
4 we're using to believe these things.

5 DR. SCANLON: And I did consider that because I  
6 have certainly spent an incredible amount of time looking at  
7 the quality of nursing home care. But this gets to that  
8 issue that Medicare represents 10 percent of nursing homes  
9 on average. This morning we had this discussion about  
10 distributions. And that is the critical thing because it  
11 represents an even much a smaller share of some facilities.

12 And the question of whether we're going to  
13 actually have an impact on that quality is a very  
14 problematic. The quality problem that you're referring to I  
15 think is much more widespread and there needs to be other  
16 ways to address that.

17 I think using reimbursement to try and reinforce  
18 some of that is potentially a good thing. But I guess it's  
19 not a good enough thing to motivate me to want to move so  
20 quickly. That wouldn't be my motivation.

21 MS. HANSEN: A couple of comments and then a  
22 question.

1           I, first of all, really appreciate the level of  
2 work that's gone into this. And plus, you are including  
3 some of the questions that we had last time. I know I  
4 brought up one of the aspects about the differentials  
5 between the for-profits and the not-for-profits. So I  
6 appreciate that that's going to be looked into.

7           And Bill, I just think that your comments have  
8 been very important in terms of the context of change and  
9 the fact that right now a small percentage oftentimes of the  
10 population is Medicare only. Which brings the other side of  
11 it, with the fact that again this is about the Medicare  
12 program. But that bricks and mortar of the facility serves  
13 the Medicaid population, as well.

14           I just wonder if we would be informed by some of  
15 the pay-for-performance efforts that are happening on the  
16 Medicaid side as well, and be able to kind of have that  
17 addressed somewhat in the text, just so that again -- much  
18 as you were talking about Medicare and commercial  
19 synergistically moving along, if there's some states doing  
20 Medicaid pay for performance that we also try to look at  
21 that synergistically.

22           And then the question I had was relative to the

1 points about MDS and how these elements of pressure sores  
2 and pain are not necessarily accurate. I guess I don't know  
3 whether this is a rhetorical question, but if that is the  
4 case and so much time is being spent in facilities doing  
5 this tool, do we know whether or not there is some major  
6 effort underway to tighten this up so that it's more  
7 accurate.

8           And then finally a closing comment is as we look  
9 at this, and to take into account, Bill, that we have now  
10 assisted living facilities, we have board and care homes  
11 types of places where people go back to. I think I've  
12 brought this up before, and this is a more futuristic thing,  
13 is whether or not at some point looking at the outcomes of  
14 money following the person or outcomes following the person  
15 rather than by facility or touching the home health agency  
16 level, the skilled facility. But just what happens to the  
17 trajectory of a person and all the money as well as the  
18 services that follow that person.

19           But it just strikes me as we talk about different  
20 physical structures that people go to that the reality is  
21 the money is following them along with the services there.

22           But the MDS question, I guess is the last one.

1 DR. CARTER: The MDS has been under revision for I  
2 think two to three years. There is a draft, 3.0. We're now  
3 on the 2.0 version. The draft 3.0 version is on the  
4 website. I've looked at it pretty extensively.

5 There are major changes to the three measurement  
6 areas that I've discussed, the pain, pressure ulcer, and  
7 delirium. The sections are much more expanded. The  
8 measures are much more specific. And the look back periods  
9 are narrower, which I think will actually address a lot of  
10 our concerns with these measures.

11 That's still in draft and CMS has had a technical  
12 panel review these changes. It's been piloted. So I think  
13 they've done a really good job of trying to revise this tool  
14 because there have been problems with the accuracy of this  
15 tool.

16 MS. BEHROOZI: I have not spent not even a  
17 fraction of the time that you have, Bill, thinking about  
18 this. But in the short time I've been here I've thought a  
19 lot about -- as Carol knows particularly, and I guess the  
20 rest of you do -- that the issue of the correlation between  
21 staffing and not just how much staff you have, but the types  
22 of staffing that any institution has that Dr. Kramer had

1 found so highly correlated. And it's in the paper that it's  
2 one of the three factors, besides facility type and for for-  
3 profit or not-for-profit status, that's highly correlated  
4 with these two outcomes measures.

5           Jack actually asked last time, and I know the  
6 question is kind of a standard question, if you've got the  
7 ability to measure the outcomes why do you need to also do  
8 that structural measure? It's just occurring to me  
9 listening, Bill, to your discussion about the unintended  
10 consequences might be in terms of people gaming the outcomes  
11 by selecting patients. That's one of the reasons I think --  
12 I think I'm learning this as I'm paying attention -- to add  
13 a structural measure so that -- so it mitigates against the  
14 unintended consequences of a provider with a motive to  
15 enhance their bottom line simply going for the patients that  
16 aren't caught by the risk adjustment that help them enhance  
17 their bottom line.

18           I think that there are various other reasons why  
19 structural measures are incorporated into quality  
20 assessments, whether it's the CMS demo project that has  
21 staffing levels at the same level of value -- 30 points is  
22 accorded to staffing levels as 30 points is accorded to rate

1 of rehospitalizations. And in other areas, in the work  
2 comparing MedPAC's visions for quality measurement system  
3 against CMS's, again we list among the things that we value  
4 -- at least in certain circumstances -- those kinds of  
5 structural measures like staffing.

6           So I would again urge, particularly -- I think  
7 it's somewhat related to the topic that Bill has raised --  
8 considering that staffing level issue.

9           DR. KANE: I have really more I guess questions  
10 and then one comment about what Bill was saying about  
11 Medicare being the tail that might be wagging the dog  
12 because it's only 10 to 12 percent of the total.

13           One is it seems like it's the most attractive 10  
14 or 12 percent from what I've heard. So these SNFs seem to  
15 want Medicare patients, especially the ones with high case-  
16 mix and rehab possibilities. To me that seems like an  
17 opportunity rather than a negative to implement something  
18 because right now these are patients that they want. And  
19 maybe if you want Medicare patients, maybe that's a good  
20 time to implement something that's a little harder for the  
21 SNFs to do than would otherwise be...

22           I'm not that worried that the 10 percent that are

1 the most sought after, if they come in with more strings  
2 attached, that the nursing homes will want to stop going  
3 after them. I would think particularly the Medicaid  
4 dominated ones would want to go more after the Medicare  
5 patients, which might be good in terms of improving the  
6 quality. I guess the tail wagging the dog argument is just  
7 too small a piece of the nursing home business. I don't  
8 agree that it's the most attractive piece.

9           So maybe you could answer that before I go on to  
10 my other point.

11           DR. SCANLON: The issue is there are no strings  
12 attached after you've introduce this. Look at the average  
13 margins. You can forgo the pay for performance bonus, still  
14 make good money, and not provide any additional service.

15           DR. KANE: I don't see how that stops you from  
16 saying we're trying to up the conditions by which you get  
17 these patients though. I mean, why would that stop you from  
18 saying --

19           DR. SCANLON: The issue is that if somebody wants  
20 to compete for the pay for performance bonus, they have a  
21 choice. They can compete through providing better care or  
22 they can compete for it by selecting patients.

1 DR. KANE: I think that's difficult than the 10 to  
2 12 percent.

3 DR. SCANLON: No, it's the issue of what are you  
4 going to do? Is this going to be worth it for you to change  
5 your behavior in terms of an institution? And that's where  
6 the 10 or 12 percent over the 2 percent or the 3 percent,  
7 which is the reality in some facilities, is going to play a  
8 role. And remember, it's not just the Medicaid and Medicare  
9 patient or resident that we're talking about. There's the  
10 private pay person.

11 There's also a concern I didn't raise, which is  
12 the whole issue of nursing homes are a little bit like --  
13 think of them as hotels: one star, two star, three star,  
14 four star. And you pay according to the number of stars.  
15 You get services according to the number of stars. And so  
16 therefore there is this potential that when we start to  
17 reward people that can do a better job, they are the more  
18 expensive places. They're not going to be available to  
19 everybody across the country. We're not talking about a  
20 level playing field in terms of competition.

21 And the people that are at the bottom are not  
22 going to be in a position where they're going to want to

1     bother to compete.

2             DR. KANE:   You're actually making my same arguing  
3     about the hospitals but we won't go there, about the weakest  
4     ones are least able to fix themselves.

5             I'm not sure I buy the argument.   I guess the  
6     other piece in that relates to the same question.   Okay, 10  
7     or 12 percent are in SNF status.   But how many of those SNF  
8     patients are actually discharged to long-term care in the  
9     same facility?

10            We keep talking as though they're completely  
11    separate patient populations.   But my sense is a lot of the  
12    people that you let in on the front end then become your  
13    long-term care patients.   We never really talk about what  
14    proportion -- I know 30 or 35 percent go back to the  
15    community, 17 percent are rehospitalized.   What about the  
16    other half?   And how many of those go on to become your  
17    long-term care population?   In which case, who you bring in  
18    does become your whole population.   And you do have an  
19    incentive to try to get -- you do have an incentive to  
20    respond to the quality issues.

21            They're not all separate populations.   They're all  
22    the same people just moving through, aren't they?   Or

1 staying in place?

2 DR. CARTER: It's a pretty small percentage of SNF  
3 patients that get discharged to a nursing home, like less  
4 than 10 percent.

5 DR. KANE: When we say discharged, are we talking  
6 about people who stay in the same facility and move into the  
7 long-term care component?

8 DR. CARTER: Yes. And it's less than 10 percent.

9 DR. KANE: That would move it up to about 20  
10 percent, the ones who come in stay. No, it's less than  
11 that.

12 So where do the rest of them go? Because only 30  
13 to 35 percent go home or go to the community?

14 DR. CARTER: I haven't looked at that.

15 DR. KANE: That's a lot of people who don't go  
16 anywhere.

17 DR. CARTER: Some go to a second --

18 DR. KANE: Do that many of them die in SNF?

19 DR. CARTER: No, they have other -- some go on to  
20 other kinds of long-term care facilities. Some go onto a  
21 different SNF. There's sort of a whole -- any provider that  
22 you would expect, they go to.

1 DR. KANE: It would just be helpful for me to  
2 understand that we're talking about here because I don't get  
3 a sense of what happens to those SNF people. And if half of  
4 them die, I don't really understand where they're going.

5 DR. SCANLON: I don't what it is today, but  
6 historically some of the poorest data that we had were on  
7 discharge status of SNF patients.

8 DR. CARTER: That is a problem.

9 DR. KANE: So maybe we should recommend we get  
10 better data. Because I think it is hard to make these kind  
11 of decisions without knowing what the end result is. And 35  
12 percent going home doesn't tell you where the other 65  
13 percent go. And it would help me understand how much the  
14 tail is wagging the dog if I knew how many of them actually  
15 them ended up either sticking around or going to another SNF  
16 that has to deal with them.

17 DR. STUART: We've done some work on using the  
18 Medicare Current Beneficiary Survey to address just this  
19 question. And I think it's a very important question  
20 because if you're going to have a patient that is going to  
21 be influenced or that the facility is going to influence for  
22 a particular patient, that patient stays. Or if the patient

1 goes to another nursing home and is influenced by that  
2 nursing home's policy, that's really important.

3           The figures that we came up with were much higher.  
4 They were close to 50 percent for people that ended up --  
5 now I can't tell you that it was from a given SNF into the  
6 nursing home part of that same facility. But the people  
7 that we talked to about these rates suggested that it was  
8 pretty rare for somebody to be discharged physically from  
9 one SNF into another nursing home. That it was much more  
10 common to stay within a nursing home.

11           I think one of the problems that we have is that  
12 Medicare doesn't have a good way to track these people  
13 because once they stop being SNF covered, then Medicare  
14 doesn't care. They're just paid for Part A and for other  
15 Part B services. So this is something that I'd suggest you  
16 take a look at.

17           DR. KANE: I think there's another reason take a  
18 look at that is that even though they're no longer taking  
19 Medicare benefits in their long-term care -- they are  
20 Medicare eligible patients and we should be knowing what's  
21 happening to them.

22           DR. CARTER: They are probably receiving Part B

1 services.

2 DR. KANE: And they might end up back on Part A if  
3 they don't getting good care in the long-term care. I still  
4 worry that we don't know what these people are or who they  
5 are.

6 DR. CARTER: This is part of a longer analytical  
7 agenda for us is to understand both differences in patients  
8 in different types of facilities, which Jennie alluded to a  
9 little while ago, but also the churning of patients and who  
10 gets readmitted, who goes on to be turned into a long stay  
11 patient. We haven't looked at that at all.

12 As Bruce mentioned, it's hard because it's hard to  
13 track patients over time when then you're going to be  
14 relying on Part B claims experience to understand where the  
15 patients are after their Part A stay eligibility ends. I  
16 think the folks at Colorado are just starting to put  
17 together nursing home stays with SNF stays so you have a  
18 better longitudinal view.

19 DR. KANE: If we look at episodes are we going to  
20 capture that long-term stay?

21 DR. CARTER: We can't unless we had Medicaid  
22 claims data. For the stay portion, we would know that they

1 were getting Part B therapy services or physician services.  
2 But we don't have the stay portion in at least the Medicare  
3 claims stream.

4 DR. SCANLON: Your recommendation three, in part,  
5 is going to deal with that because you're asking for an  
6 assessment which would create an MDS record at discharge  
7 from the SNF status. And then presumably that's going to  
8 tell us where this person is going at that point in time --

9 DR. CARTER: The MDS has that.

10 DR. SCANLON: -- and then the MDS can capture it.  
11 But right now we have this limb period between the periodic  
12 MDS and the next one. And we don't know what --

13 DR. CARTER: We lose half of them because we don't  
14 have SNF -- right.

15 DR. STUART: I don't want you to recreate the  
16 wheel because the MCBS is really good on this because it has  
17 a special file which is a resident timeline. And so they  
18 actually identify each of these changes in status. It's not  
19 perfect. But it will let you get there a lot quicker than  
20 if you try to do it on your own.

21 MR. HACKBARTH: Other questions or comments on  
22 this? Jennie, the last word.

1 MS. HANSEN: Just a small one relative to  
2 capturing the data. I just was noting to Jack that even  
3 though the data amount is small, any of the PACE projects  
4 around the country capture A, B, D, the whole works. So you  
5 actually will track this. When people stay on the average  
6 three-and-a-half or four years, you could do a smaller  
7 subset just to get a sense of it. It's one place where we  
8 have both the ICD-9s and the pharmaceutical costs, even the  
9 lab cost. All of that is captured on every single person.

10 MR. HACKBARTH: Let's turn to the recommendations  
11 and do our votes. On recommendation one, all opposed? All  
12 in favor? Abstentions?

13 Number two, all opposed? In favor? Abstentions?

14 Number three, opposed? In favor? Abstentions?

15 Okay, thank you, Carol.

16 Next is home health. And you can start whenever  
17 you're ready, Evan.

18 MR. CHRISTMAN: Next we're going to do home  
19 health. As you may recall from the last meeting, the  
20 adequacy indicators for home health are positive for the  
21 most part. Almost all beneficiaries live in an area served  
22 by home health agencies. Access is nearly universal, 99

1 percent of beneficiaries live in an area served by one home  
2 health agency and 97 percent live in an area served by two  
3 or more home health agencies. The number of agencies  
4 continues to increase. We're still below the peak of 11,000  
5 agencies that occurred in 1997, but in 2007 the number of  
6 agencies increased by about 400 to a total of 9,300. The  
7 trends in growth that we've seen in recent years continues  
8 with most agencies being for profit and a few states  
9 accounting for a significant share of the growth.

10           The volume of episodes and the share of home  
11 health users -- the share of fee-for-service beneficiaries  
12 that use home health has grown faster than the overall  
13 Medicare beneficiary population. For example, the share of  
14 fee-for-service beneficiaries that use home health grew from  
15 7.1 percent in 2002 to 8.1 percent in 2006. On a per capita  
16 basis, the number of episodes per beneficiary has grown by  
17 25 percent since 2002.

18           On quality, we've seen a continuation of the  
19 trends since the measures were established in 2002. On the  
20 five functional measures, there continues to be consistent  
21 but small annual gains in functional status among home  
22 health beneficiaries every year. On the adverse event

1 rates, those rates have remained unchanged. The adverse  
2 event rates are hospitalizations and ER usage. The one  
3 exception is that in the last year we have seen a 1  
4 percentage increase in the rate of rehospitalization.

5 And then finally, in 2006, we found that home  
6 health agencies had margins of 15.4 percent.

7 Before I take you through the margins for 2008, I  
8 just want to remind you of two policy changes that we have  
9 to include in our modeling. The first of these is a payment  
10 adjustment to account for changes in coding practice. CMS  
11 found that about 90 percent of the change in the home health  
12 case-mix between 2000 and 2005 was due to changes in the  
13 coding practices of home health agencies and not changes in  
14 patient severity.

15 As a result, they concluded that the current case-  
16 mix overstates severity by about 11.8 percentage points. To  
17 account for this, CMS is reducing the base rate in the next  
18 four years to lower payment levels to account for this  
19 coding change. The adjustment will be about a 2.7 percent  
20 reduction in each of the next four years. Our margin  
21 estimates will include the impact of these base rate  
22 adjustments.

1           Also in 2008, Medicare will implement a new system  
2 of resource groups. The number of resource groups will  
3 approximately double under the new system from 80 to 153.  
4 The new system eliminates the single therapy threshold under  
5 the old system and replaces it with a system of multiple  
6 thresholds that gradually increase payment by smaller  
7 increments for additional therapy visits.

8           They've also updated the case-mix weights to  
9 reflect 2005 data on the number of services beneficiaries in  
10 each resource group use.

11           Our analysis indicates that these refinements will  
12 have a modest impact on the accuracy of the payment system.  
13 I can walk you through that during questions if you'd like  
14 to know more.

15           The other thing I would note is the new system  
16 significant expands the role of diagnostic coding in setting  
17 payment. And consequently we are assuming that the  
18 implementation of the new system will result in changes in  
19 coding practice in 2008 and will increase payments. I can  
20 provide additional information about this on questions, too.

21           With those policies, we'll turn to the payment  
22 changes for 2008. Home health agencies received a full

1 update of 3.3 percent in 2007. In 2008 they're going to get  
2 an increase of about a quarter of 1 percent. This quarter  
3 of a percent is the net impact of two payment adjustments.  
4 One, they get the full market basket update of 3 percent in  
5 2008. But that's almost completely offset by the coding  
6 adjustment that I mentioned on the previous slide, where  
7 they're reducing payment for coding changes that occurred  
8 between 2000 and 2005. So 3.0 with a 2.75 negative  
9 adjustment results in a base rate increase of a quarter  
10 point for 2008.

11 In terms of costs per episode, we saw that it's  
12 still low. We observed a rate of 2.7 percent in 2006, which  
13 is low relative to other providers but it's higher than what  
14 we've seen previously with this payment system.

15 With these assumptions, we estimate the margins  
16 for 2008 at about 11.4 percent.

17 To recap, I would note that again access to care  
18 is nearly universal with most beneficiaries having a number  
19 of providers available. Quality is improving on most  
20 indicators. The supply of providers continues to grow. The  
21 share of users continues to increase. And the episode  
22 volume continues to increase faster than the growth of the

1 Medicare population. Cost growth continues to be relatively  
2 low and the margins again are 11.4 percent.

3           With this information, we now turn to a draft  
4 recommendation for 2008. This recommendation reads the  
5 Congress should eliminate the update to payments for home  
6 health care services for calendar year 2009. In terms of  
7 spending, this would decrease spending relative to current  
8 law by \$250 million to \$750 million for 2009 and \$1 billion  
9 to \$5 billion over five years. We would expect this would  
10 have no major implications for beneficiaries and providers.  
11 That is, we expect that beneficiaries would continue to have  
12 access to care and providers would still be willing to  
13 supply it.

14           I now turn it over to you.

15           DR. STUART: Thank you, Evan.

16           I have a question about your adequacy measure.  
17 Maybe you can help us understand this industry a little  
18 better because when you talk about most areas of the country  
19 being served by one or two or more home health agencies, now  
20 if the home health agency is a mom and pop outfit, that's  
21 going to give you a very different sense of adequacy of  
22 access to service as opposed to if it's a large hospital-

1 based home health agency.

2           So could you talk just a bit about the structure  
3 of the industry and whether the size of the agencies would  
4 have an influence on accessibility?

5           MR. CHRISTMAN: You're right. The industry does  
6 vary a lot in terms of size of the individual agencies.  
7 Around 10 percent but a growing share of agencies are part  
8 of the large publicly traded home health firms like Gentiva  
9 and such. And that share is growing. Those firms are very  
10 aggressive about acquiring already operating agencies.

11           This is the challenge we face in that the size of  
12 these home health agencies is variable and it's difficult to  
13 measure what a home health agency's capacity is because some  
14 may have a different staffing ratios, they may use contract  
15 staff. We don't collect information on staffing so we don't  
16 know.

17           But I think what we have observed is that for many  
18 years now the Commission has reported the same numbers I  
19 just gave you about the 99 and the 97 percent. And the  
20 number of agencies has continued to grow. It's been  
21 concentrated but that doesn't mean that all the growth has  
22 just been in a few areas.

1           So I think in terms of more beneficiary level,  
2 beneficiary measures of access, the CAHPS fee-for-service  
3 survey used to ask questions about home health access to  
4 care. The last year they did that was 2004. As I recall,  
5 the number of beneficiaries who were able to find home  
6 health when they needed it was somewhere north of 85  
7 percent. It's been a while since I looked at those numbers.  
8 But that's probably the other measure I could give you  
9 besides the home health compare measure.

10           When you start to talk about it at the local  
11 level, there may be other factors afoot. But since we've  
12 been doing this adequacy analysis for the last couple of  
13 years, we've seen rising volumes and very high measures of  
14 availability and haven't seen anything that suggested a  
15 system level issue.

16           DR. MILLER: I was just going to make the point  
17 that you actually got in at the end. You also -- I don't  
18 like to confuse service volume with access, but you also see  
19 that on top of the other points. But he got it in right  
20 there at the end.

21           MR. HACKBARTH: So Bruce, one of the  
22 characteristics of this sector is diversity. Is there a

1 policy implication that you were getting with your question?

2 DR. STUART: I was just trying to get a better  
3 handle on this. In a previous meeting Bill was talking  
4 about the difficulty in trying to understand what this  
5 service really was all about. So if we make strong  
6 statements about access is adequate, that implies to me that  
7 we may know more about this than we do. Or we're saying  
8 that we know more about this service than we do.

9 MR. CHRISTMAN: I think one thing we have with the  
10 home health that is, I think, advantageous is the numbers I  
11 use come from Home Health Compare. They more or less look  
12 at things as ZIP code level, which in some areas is pretty  
13 tight. It's not a perfect measure.

14 I guess what makes me feel comfortable about the  
15 usefulness of that access measure -- and I hope I spelled  
16 this out and I'm going to say it again -- we look at the  
17 areas where beneficiaries live. We pull that from the  
18 master beneficiary database. And then we compare where home  
19 health agencies reported operating by ZIP code in the last  
20 year. When we did that in the last year, 99 percent of  
21 beneficiaries lived in a ZIP code where a home health agency  
22 reported operating.

1 DR. REISCHAUER: I wonder if adequacy is the right  
2 term, as opposed to more adequate than it was the last time  
3 we looked. In which case what you could do is look at  
4 services delivered by ZIP code, county, whatever as a  
5 percent of age-adjusted Medicare beneficiaries in that area.

6 Now if it went down, you couldn't say things are  
7 worse because people might be healthier. But if it went up  
8 everywhere, you would be able to say definitively it's  
9 better than it used to be. But you have no measure of what  
10 is needed and you don't even know what we're providing when  
11 it is needed. So in a way, adequacy is impossible to find.

12 MR. EBELER: I'd like, Even, just maybe to ask you  
13 to describe a little bit about what you talked about in the  
14 chapter and didn't include in the presentation on the long-  
15 term. I guess when I look at the numbers, as I said at the  
16 last meeting, even a freeze appears to result in an  
17 extraordinarily generous payment level, especially when  
18 compared with the constraints we're dealing with in  
19 physicians and other providers. I recognize that a freeze  
20 is about as far as we can go.

21 One of the answers I think was looking to future  
22 refinements in the system we may end up something that we're

1 all more comfortably. Would you say a little bit about  
2 where we can do with those future refinements?

3 MR. CHRISTMAN: Sure. Again I just would note  
4 that 2008, they are implementing a new system. It's a big  
5 change for the industry. One of the things we have found in  
6 looking at estimated payments under even the new system, it  
7 still appears that episodes with significant amounts of  
8 therapy are still more profitable than episodes that don't  
9 have them.

10 We didn't go into it in this presentation but in  
11 the chapter there's a discussion of how, especially in the  
12 last year, therapy heavy episodes have become a significant  
13 driver of growth in home health volume. To the extent that  
14 beneficiaries are receiving appropriate services that  
15 shouldn't give us any pause perhaps. But the fact that we  
16 do observe that the margins on episodes with more therapy  
17 visits pay more -- are more profitable -- it creates an  
18 incentive that may draw some concern.

19 So one of the things I wanted to look at is what's  
20 creating this imbalance. And one possible candidate is that  
21 since this was an element in the old system -- the HHRG-80  
22 system that they just finished using -- and it's present in

1 this new system as well, one issue we're going to be looking  
2 at is how they measure costs when they build these payment  
3 systems. The home health PPS is a little bit of an  
4 exception in that they don't really use the cost report data  
5 that much. They use estimated labor costs.

6 And so we'll be looking at that and taking a look  
7 at any other factors we can come up with that might shed  
8 light on this imbalance and possible refinements that will  
9 hopefully balance the incentives more evenly in the system.

10 DR. CASTELLANOS: I'd like to really ask a very  
11 naive question and it's a little out of context. But when  
12 we were voting on this, it's bothered me last time and it's  
13 bothering me this time.

14 We're going to vote to eliminate any update but  
15 productivity was this discussed this morning, which is  
16 efficiency. How is that reflected in this statement when we  
17 eliminate an update but don't mention anything about  
18 productivity?

19 MR. HACKBARTH: In essence, we've done market  
20 basket minus productivity minus some other X factor to get  
21 to zero. So multiples of productivity.

22 DR. CASTELLANOS: What you're saying is that by

1 giving no update that implies we should not encourage them  
2 to do productivity and efficiency? That's what productivity  
3 really is, isn't it? To encourage each to be a little bit  
4 more efficient in their practice?

5 MR. HACKBARTH: And the mechanism by which that  
6 happens is the price. We're saying the price ought to be  
7 squeezed here for two reasons. One, the margins are very  
8 high and to help bring those down. But two, by applying  
9 pressure for home health like everybody else, induce them to  
10 become more efficient.

11 DR. WOLTER: Just an observation, and I'm not an  
12 expert on home health by any means. But as has been brought  
13 up in the past, the hospital-based home health isn't  
14 captured, as well, in this database. Certainly in rural  
15 states -- I know in Montana what I hear from home health  
16 agencies that are hospital-based is they have much more of a  
17 struggle around their financial viability. I think we were  
18 the one state that had a net loss in home health agencies  
19 when we looked at the data last year.

20 So there is a rural flavor here that isn't  
21 necessarily captured here, I guess would be one possibility.

22 And then I had a question about the new diagnostic

1 categories, and it was similar to my questions around the  
2 MS-DRG behavioral offset. Jack has very patiently explained  
3 to me why that was logical to introduce with the new MS-DRG  
4 system but I'm going to have to come to Hawaii for a  
5 remedial lesson on that.

6 But if the new system is intended to better  
7 categorize patients, is there any chance that trying to make  
8 it budget neutral to the old system isn't necessarily the  
9 right thing to do? Or do we really believe that there  
10 somehow may be marginal indications for therapies that might  
11 get triggered or patients are selected who are more likely  
12 to need these new diagnostic categories?

13 It's been a little confusing to me and it was  
14 confusing to me with MS-DRGs also. Because the other option  
15 would be to just go with the new system and then use the  
16 update even in a negative way to deal with the overall  
17 margins.

18 MR. CHRISTMAN: Maybe I would begin with the  
19 comment that the intent of refining the case-mix is simply  
20 to account -- I'm sure Jack has been through this with you  
21 but I'll just mentioned it again -- a better measure of the  
22 relatively costliness of the patients. It's not intended to

1 adjust the overall level of compensation.

2           There was no sense that the average case-mix under  
3 the last year of the HHRG-80 was too low, for example.

4           You asked about the new codes and conditions and  
5 how that works. I would say that they really have not  
6 changed the methodology of the home health payment system in  
7 2008. What they have changed is the number of severity  
8 groups. That was possible because they had a significantly  
9 larger population to study. When they built the original  
10 case-mix system in 1997, they had the population of 20,000  
11 episodes to build off of. When they built the new system  
12 they used about three or four million episodes. So they  
13 were simply were able to detect more conditions as having a  
14 relationship with home health resource usage.

15           So the number of conditions is increased. A rough  
16 way of putting it is there were four major clinical type  
17 categories -- a number of ICD-9 codes associated with each  
18 category -- and now it's like 22. They are also accounting  
19 for secondary conditions, for example.

20           So it is a more sensitive system but the intent of  
21 it is to better account for the relative costliness of those  
22 patients and not necessarily -- their work was not intended

1 to be any kind of statement about the overall level of  
2 reimbursement.

3 MR. HACKBARTH: A case-mix system, by definition,  
4 is about how a fixed pool of dollars is allocated across  
5 different types of patients. So when you move from system A  
6 to system B, it should be budget neutral. You are, in  
7 essence, assuming the same population of patients.

8 When you move to year one of the new system if, in  
9 fact, there is a change in the type of patient coming in to  
10 the payment system because of a change in technology or  
11 something, and so you're getting a different type of patient  
12 pool in the first year of the new system than you have in  
13 the base year, then the new payment system might generate  
14 higher total payments through more accurate payment for the  
15 new more severely ill patient. That's not budget neutral.  
16 It's just setting the index values in the base year that is  
17 budget neutral.

18 Julian, Jack, anybody else, did I get that right?

19 MR. PETTENGILL: [off microphone] You're  
20 recalibrating on a single year set of data from one set to  
21 another. You haven't changed the case-mix or the mix of  
22 home health agencies. What you've changed is the way you

1 characterize it. So it should be budget neutral.

2 DR. WOLTER: That's helpful. I understand the  
3 theory, I guess. I was just trying to understand if a new  
4 system, in fact, captured a sense that the total population  
5 maybe overall had higher severity than we realized you would  
6 operate off of a different philosophy, then it probably  
7 isn't that. We're just capturing the relative patients  
8 somewhat differently and therefore we want to keep it budget  
9 neutral. So thank you.

10 DR. SCANLON: I just wanted to follow up on what  
11 Jack said. In terms of concerns over this, the average  
12 margins are astounding. So I can understand your reaction.  
13 But somewhat consistent with our discussion this morning  
14 about the need to think about what we're doing in different  
15 terms, the distribution even bothers me more. It was the  
16 fact that we have 25 percent of agencies, which is more than  
17 2,000 agencies, earning more than 25 percent. That's the  
18 kind of thing that we need to be able to change our  
19 recommendations so that we start to distinguish differences  
20 in terms of within provider type, the behavior and  
21 experience of different kinds of organizations. That really  
22 is critical for us in the future.

1           MR. EBELER: We are in this constant tension  
2 between the need to think about very longer-term reform, but  
3 yet at a practical level needing to do updates, whether it's  
4 physicians where there's a constraint, or home health where  
5 it looks pretty generous. The reality is we do need to deal  
6 it with today. And allowing these kinds of margins to float  
7 out there forever, pending the millennium of reform, is  
8 something I just think you've got to confront. We can't do  
9 it this year but if the payment policy is refined next year  
10 -- which seems to me that's a good thing.

11           MR. HACKBARTH: Any others?

12           So the draft recommendation is on the screen. All  
13 opposed? All in favor? Abstentions?

14           Thank you, Evan.

15           Next is inpatient rehab facilities and Jim is  
16 going to lead us through that. Jim, you can go whenever  
17 you're ready.

18           DR. MATHEWS: Today we'll revisit the draft  
19 recommendation on the update to the prospective payment  
20 system for inpatient rehab facilities, or IRFs, that we  
21 present last month. At that meeting some commissioners  
22 expressed an interest in considering an update

1 recommendation distinct from the prior year's recommendation  
2 of plus 1 percent that we used as the discussion starting  
3 point last time.

4           Additionally, since that time, Congress has passed  
5 and the President has signed, the Medicare, Medicaid, and  
6 SCHIP Extension Act of 2007. This legislation includes  
7 several IRF-related provisions that have significantly  
8 changed the landscape for this provider type. We'll discuss  
9 this legislation in more detail in a moment.

10           Because of these factors, we have prepared a new  
11 draft recommendation for your consideration today.

12           Before discussing the Extension Act, here are just  
13 a few quick bullets by way of reminder of some of the key  
14 points of Medicare's payment system for inpatient rehab  
15 facilities. These facilities provide intensive  
16 rehabilitation services to beneficiaries who meet certain  
17 conditions.

18           To be eligible for Medicare coverage in an IRF, a  
19 beneficiary must need and be able to tolerate intensive  
20 rehabilitation for three hours a day. Additionally, they  
21 must present with a diagnosis in one of 13 specific  
22 categories, such as stroke, hip fracture, and brain injury,

1 among others.

2 Medicare established in PPS for IRFs in 2002.

3 Medicare spending under the IRF PPS was \$6 billion in 2006.

4 To receive payments under the IRF PPS, which are  
5 much higher than the PPS for acute care hospitals, inpatient  
6 rehab facilities must comply with the so-called 75 percent  
7 rule. This rule requires that a certain percentage of a  
8 facilities' patients must be admitted having one of the 13  
9 defined conditions.

10 While the requirement had been in Medicare  
11 regulation since 1983, in 2002 CMS determined that less than  
12 14 percent of IRFs actually met this requirement. As a  
13 result, CMS began to renew enforcement of the 75 percent  
14 rule on a phased-in basis beginning in 2004. Prior to the  
15 passage of the Extension Act, CMS was on track to require  
16 that 75 percent of IRFs' patients be in one of the 13  
17 categories effective July 1st of 2008. The 75 percent rule  
18 has been a major factor in declining IRF volume since 2004.  
19 I'll discuss that in a moment.

20 The Medicare, Medicaid, and SCHIP Extension Act  
21 was signed into law on December 29th of last year. It  
22 includes several IRF-related provisions. First, it

1 eliminates the payment updates for IRFs for fiscal years  
2 2008 and 2009 but delays the effective date of this  
3 provision until April 1st of 2008.

4           Second, it changes the 75 percent rule, rolling  
5 back the compliance threshold and setting it permanently at  
6 60 percent and making permanent the use of comorbidities to  
7 count towards compliance with the rule.

8           Third, it requires the Secretary of Health and  
9 Human Services to study access to IRF care under the 75  
10 percent rule, to analyze alternatives to the 75 percent  
11 rule, and to examine the costs and outcomes of  
12 rehabilitation care for conditions not among those specified  
13 in the rule.

14           Changes to the 75 percent rule will affect IRFs'  
15 costs going forward and we have changed our FY 2008 margin  
16 projection accordingly. We have also prepared a new draft  
17 recommendation for your consideration.

18           First, to recap some of the data we presented last  
19 time on adequacy of payments, you'll recall that we examined  
20 the factors on this slide in assessing payment adequacy. I  
21 won't discuss all of these factors in detail today but I  
22 will take a little time to address volume of services and

1 payments and costs, as these are most affected by the  
2 Extension Act changes to the 75 percent rule.

3 As you will recall from last time with respect to  
4 supply of providers and beds, we saw an increase in the  
5 number of IRFs after the PPS began in 2002 through 2004,  
6 when CMS renewed its enforcement of the rule. After 2004,  
7 we see a small decline in the number of providers and beds,  
8 consistent with expectations under the 75 percent rule, but  
9 nowhere close to the reductions in admissions of 10 percent  
10 per year on average that we saw over this time.

11 As you will recall from last time, there is some  
12 underlying variation in changes in the distribution of rural  
13 and urban facilities.

14 This slide shows a little more detail regarding  
15 changes in number of admissions and payments from 2002 to  
16 2006. Most notable are the pronounced decline in the number  
17 of cases and the increase in payments per case that occurred  
18 between 2004 and 2006. This indicates that IRFs were  
19 refraining from admitting less complex cases, again  
20 consistent with the 75 percent rule. Many of these cases  
21 were hip and knee replacements, which had been highlighted  
22 in the rule.

1           As we presented last time, and as indicated in  
2 your paper, these reductions do not appear to constitute an  
3 access problem. While the 75 percent rule drove much of  
4 this volume reduction, changes to the surgical techniques  
5 used in hip and knee replacements also eased postoperative  
6 rehabilitation, permitting beneficiaries to receive rehab  
7 services in less intensive settings such as SNFs and through  
8 home health.

9           In 2006, the rate of use of rehab by fee-for-  
10 service hip and knee patients across all settings was  
11 actually higher than in 2004.

12           We'll move on now to quality of care. Recapping  
13 last time, as we discussed previously, even with the changes  
14 in admissions required for IRFs to comply with the 75  
15 percent rule, IRFs were able to continue to increase patient  
16 functional ability. The slightly lower rate of increase in  
17 more recent years may reflect the increasing complexity of  
18 IRF patients. Staff anticipate examining changes in the  
19 quality of care and outcomes more closing in the coming  
20 months.

21           As we reported last time, hospital-based IRFs'  
22 access to capital is good but freestanding IRFs are in a

1 more precarious position. About half of freestanding IRFs  
2 are operated by two large national chains, the largest of  
3 which is still dealing with the effects of financial and  
4 regulatory difficulties that it experienced over the last  
5 several years. These difficulties may continue to affect  
6 its financial performance in a way that may hinder its  
7 ability to raise capital through private investment or  
8 obtain capital at market rates.

9           The second smaller chain is somewhat better  
10 positioned to access capital, but again at somewhat higher  
11 than market rates.

12           The remainder of freestanding IRFs are generally  
13 single entities or small chains. Most are nonprofit and  
14 roughly half of these are associated with the academic  
15 medical centers. The Extension Act may improve access to  
16 capital for freestanding IRFs by reversing the need to  
17 reduce admissions, which resulted in decreased revenues.

18           We'll move now to a discussion of IRFs payments  
19 and costs. The analysis of payments and costs leading to  
20 the 2006 margin estimate that you see on this slide hasn't  
21 changed, so we won't cover this ground in detail again. We  
22 estimate an aggregate margin of 12.4 percent for 2006.

1           Our projection of IRF margins for 2008 is another  
2 story, and I'll spend a few moments going over it. When we  
3 presented last month, we projected IRFs' 2008 margins would  
4 be likely 4.4 percent within a range of 2.7 to 5.7 percent.  
5 This projection was based on the continued implementation of  
6 the 75 percent rule through July 2008. We estimated that  
7 IRFs would have to reduce volume by an additional 20 percent  
8 to comply with the rule.

9           We believed that IRFs would not be able to shed  
10 all of the indirect or overhead costs associated with these  
11 forgone admissions. These overhead costs would therefore be  
12 distributed over a smaller number of remaining cases, making  
13 them more costly and thus impacting IRFs' margins.

14           Now that the compliance threshold is set at 60  
15 percent, IRFs will not need to make any further reductions  
16 in their admissions or cost structures in order to comply  
17 with this rule. In the aggregate, IRFs are already  
18 compliant with the 60 percent threshold. Therefore, we are  
19 now projecting IRF's 2008 margins to be 8.4 percent.

20           To summarize then, many of our indicators of  
21 payment adequacy -- the supply of facilities, volume of  
22 services, quality, and access to capital -- are unchanged

1 from our presentation of last month. Access to care and  
2 IRFs' margins, however, have changed for the better as a  
3 result of changes to the 75 percent rule in the Extension  
4 Act.

5 With IRFs improved financial picture as a result  
6 of this legislation, we now believe that IRF margins in 2008  
7 will be sufficient to absorb any additional costs in 2009.  
8 As a result, we are now submitting a new draft  
9 recommendation for your consideration, which is the update  
10 to the payment rates for inpatient rehabilitation facility  
11 services should be eliminated for fiscal year 2009.

12 This recommendation has no impact on spending,  
13 given that the Extension Act has indeed sent the IRF 2009  
14 payment update to zero. Neither do we expect this  
15 recommendation to have adverse impacts on beneficiaries'  
16 access to rehabilitation services nor on IRFs' willingness  
17 to serve Medicare patients.

18 With that, I'll conclude the presentation and can  
19 answer any questions you may have in your discussion.

20 MR. HACKBARTH: Jim, could you help me reconcile a  
21 couple of points on page nine, slide nine? You're talking  
22 about access to capital being mixed, freestanding IRFs may

1 be facing difficulty accessing capital. And then on the  
2 table on page 10, for 2006 the freestanding have actual  
3 margins of 17.9 percent, much higher than the hospital-  
4 based. Can you help me reconcile those?

5 DR. MATHEWS: Yes. Mostly under the access to  
6 capital discussion, I'm referring to the financial position  
7 of a couple of publicly traded companies and their ability  
8 to procure financing for capital improvements, new  
9 construction, upgrades to existing construction. Given the  
10 situation of these companies, it's quite likely that they  
11 will not be able to have ready access to capital either  
12 through private investment or through private lending at  
13 competitive rates.

14 MR. HACKBARTH: Is that because of developments in  
15 the credit market? Or is that because these particular  
16 freestanding chains are doing less well than freestanding,  
17 in general? If in 2006 the average margin was 17.9 percent,  
18 you'd think that that would support reasonably good access  
19 to capital. So that's the piece of the picture that I don't  
20 understand.

21 DR. MATHEWS: Some of it did reflect the larger  
22 credit market. Some of it did also reflect, until very

1 recently, analysts expectations of IRFs need to reduce  
2 admissions to comply with the 75 percent rule had that gone  
3 to it's bitter end.

4           So I can't say with certainty that they would  
5 still have as difficult access to capital after the passage  
6 of the Extension Act as might have been projected a month  
7 ago.

8           MR. HACKBARTH: Okay, thank you.

9           Questions, comments?

10          DR. MATHEWS: It's getting to be a trend.

11          MR. HACKBARTH: Hearing none, we're ready to vote.  
12 Could you put the recommendation up, Jim?

13          All opposed to this recommendation? All in favor?  
14 Abstentions?

15          Okay, thank you.

16          For the people in the audience, for those who may  
17 be attending their first meeting, you should be aware that  
18 for all of these update recommendations we've had multiple  
19 discussions already. So people have had opportunities to  
20 ask questions, look at the data. So this is the last step  
21 in the process, not the first.

22          Now we're on to long-term care hospitals. This is

1 the last of the update presentations.

2 MS. KELLEY: Good afternoon.

3 Today I'm going to highlight some relevant  
4 portions of the Medicare, Medicaid, and SCHIP Extension Act,  
5 which made some important changes to long-term care hospital  
6 payment policy. Then I'll review the analysis of payment  
7 adequacy for LTCH services that Craig and I presented at our  
8 last meeting. And finally, we have a draft update  
9 recommendation for you to consider.

10 First, I wanted to answer some questions that were  
11 raised to last month's meeting.

12 Nancy-Ann asked about CMS's progress in developing  
13 patient and facility criteria for LTCHs. Jack, you were  
14 interested specifically in the question of clinical  
15 conditions for treatment. We discussed this a little bit  
16 last month but we have got some new information to share.

17 As you know, last year CMS convened two technical  
18 expert panels to help determine the feasibility of facility  
19 and patient criteria for LTCHs. At the most recent TEP,  
20 held in November, small groups of clinicians from LTCHs,  
21 acute care hospitals, IRFs and SNFs used case studies to  
22 identify patient populations and discussed the types of

1 resources needed to treat these patients and the relative  
2 costliness and outcomes of treating them in LTCHs versus  
3 alternatives sites of care.

4           Regarding facility level criteria, there was  
5 general agreement among the TEP members that LTCHs need a  
6 critical mass of patients with the targeted conditions --  
7 for example, ventilator dependence -- to ensure that  
8 providers had adequate experience treating the conditions.  
9 This was something that Nick mentioned last month, as well.

10           If this is the case, then the proliferation of  
11 LTCHs in some areas of the country might be cause for  
12 concern because an LTCH in an area with a lot of other LTCHs  
13 might not able to generate that critical mass.

14           Regarding patient criteria, TEP participants  
15 agreed that the most consistent identifying feature of  
16 critically ill patients is probably the need for intensive  
17 nursing care. For example, LTCHs and acute care hospital  
18 step-down units often have a registered nurse to patient  
19 ratio of one to four or five, compared with a typical ratio  
20 of one to 12 on an acute care medical/surgical floor.

21           This finding underscores a crucial point. There  
22 may be no such thing as an LTCH-only patient. We might be

1 able mail to identify patients who are candidates for LTCH  
2 care but those patients generally can be treated  
3 appropriately in other settings, as well, particularly acute  
4 care hospitals and some SNFs. Of course, this has  
5 implications for our payment systems, as well.

6 Jay, you asked how Medicare Advantage plans used  
7 LTCH care. I spoke with representatives from a few national  
8 organizations and learned that for managed-care plans, LTCHs  
9 are not the provider of choice in most markets. Plans find  
10 that in most cases the care is too expensive and the benefit  
11 is too open-ended. They report that staying in the acute  
12 care hospital longer or transferring to a SNF if a suitable  
13 facility is available is preferable for many patients. The  
14 representatives I spoke with said that when they approved  
15 transfers to LTCHs, it's primarily for patients who are  
16 ventilator dependent in markets where SNFs are not equipped  
17 to wean patients and for patients who require very complex  
18 medical care. One representative gave the example of a  
19 dialysis patient who also need needs hyperbaric oxygen  
20 treatment. If admitted to a SNF, that type of a patient  
21 might spend most of his or her days being transported to  
22 different facilities receiving the care that they need.

1           So in such a case, an admission to an LTCH would  
2 be more appropriate if remaining in the acute care hospital  
3 was not an option.

4           Plan representatives reported that they faced a  
5 lot of pressure from acute care hospitals, particularly in  
6 certain regions of the country, to move patients out of the  
7 hospital as quickly as possible, but that in many cases if  
8 the patient can stay a few more days in acute care they are  
9 then stable enough to be appropriately transferred to a SNF.  
10 The representatives we spoke with reported that acute care  
11 hospitals with co-located or co-owned LTCHs were more  
12 aggressive in pushing for discharge to LTCHs.

13           Finally, you'll remember that about 20 percent of  
14 Medicare fee-for-service admissions to LTCHs are direct  
15 admits with no previous acute care stay. Plan  
16 representatives told us that they found those kind of direct  
17 admissions were almost never appropriate and therefore were  
18 almost never approved.

19           Finally Mitra, you asked about CON states and how  
20 they evaluate the need for new LTCHs in their states. I  
21 looked at the process in a few of the states and Florida  
22 provides a good example of what goes on. Florida evaluates

1 the need for new LTCHs by considering evidence that high  
2 acuity patients place a burden on area acute care hospitals  
3 through extended stays or that high acuity patients are  
4 receiving inappropriate care leading to poorer health  
5 outcomes, acute hospital readmissions, or higher mortality  
6 rates. Florida appears to have the expectation that LTCHs  
7 should serve more than the immediate area, that they should  
8 act almost as referral centers for the most medically  
9 complex areas in a wider catchment area.

10 Turning now to the Medicare, Medicaid, and SCHIP  
11 Act, it included several provisions relevant to LTCHs.  
12 First, the Act changes the definition of LTCHs to include  
13 some of the facility criteria recommended by MedPAC in 2004.  
14 In addition to meeting the conditions of participation  
15 applicable to acute care hospitals, LTCHs must now have a  
16 patient review process that screens patients both prior to  
17 admission and regularly throughout the stay to ensure  
18 appropriateness of admission and continued stay.

19 But the Act does not specify the admission and  
20 continued stay criteria that should be used. You'll recall  
21 from last time that the admission criteria currently used by  
22 QIOs does not distinguish whether a patient needed LTCH

1 care, as opposed to acute hospital care. LTCHs are now  
2 required to have an active physician involvement with  
3 patients during their treatment with physicians on site on a  
4 daily basis to review patient progress and consulting  
5 physicians on call and capable of being at the patient's  
6 side with a period of time to be determined by the  
7 Secretary.

8 LTCHs must also have interdisciplinary treatment  
9 teams of health care professionals, including physicians, to  
10 prepare and carry out individualized treatment plans for  
11 each patient.

12 The Act also rolls back the phased-in  
13 implementation of the 25 percent rule for hospitals within  
14 hospitals and satellites. As you know, beginning in fiscal  
15 year 2008 hospitals within hospitals and satellites could  
16 admit no more than 25 percent of their Medicare patients  
17 from their host hospital each year. The Act rolls the  
18 threshold back to 50 percent and holds it at this level for  
19 three years. In addition, the Act prevents CMS from  
20 applying the 25 percent rule to freestanding LTCHs for the  
21 next three years.

22 The Act also makes changes to CMS's policies

1 regarding short stay outliers. You'll recall that beginning  
2 last July CMS applied a more stringent standard to the  
3 shortest stay outliers, called the very short stay outliers,  
4 which have an average length of stay that is less than or  
5 equal to the average length of stay for the same DRG at  
6 acute care hospitals plus one standard deviation. The Act  
7 prohibits the Secretary from applying this new rule for the  
8 next three years. So very short stay outliers will be  
9 treated the same as the other short stay outliers.

10           The Act also reduces aggregate payments for fiscal  
11 year 2008 by implementing a zero update for discharges  
12 occurring during the final quarter of the fiscal year. It  
13 provides \$35 million in fiscal year 2008 and 2009 for  
14 expanded review of medical necessity. And the Act imposes a  
15 three-year moratorium on new facilities -- a limited three-  
16 year moratorium on new facilities -- and requires the  
17 Secretary to conduct a study on the use of LTCH facility and  
18 inpatient criteria to determine medical necessity and  
19 appropriateness of admission and continued stay.

20           So on to payment adequacy. I'll just summarize  
21 the findings Craig and I presented last month.

22           First, supply appears to have stabilized. After a

1 long period of rapid growth, the increase in the number of  
2 LTCHs participating in the program has leveled off.  
3 Preliminary data suggest a fairly stable situation for 2007,  
4 as well. Beneficiary use of services suggest that access to  
5 care was maintained during the period. We have no direct  
6 indicators of beneficiaries' access to services, but  
7 assessment of access is difficult regardless because we have  
8 no criteria for LTCH patients.

9           Turning to quality, we looked at several measures  
10 that can be calculated from routinely collected  
11 administrative data. Last month we told you that the  
12 evidence on quality was mostly positive. New data have  
13 changed our findings a bit and now show quality to be a bit  
14 more mixed. I can go into that more later if anyone has  
15 questions.

16           Access to capital going forward is difficult to  
17 determine. Until recently, the industry's access to capital  
18 has been very good. We saw fairly dramatic growth in the  
19 number of facilities, and private equity firms were  
20 investing quite heavily in the industry.

21           Some financial analysts argue that in the current  
22 environment, even private equity firms might not have access

1 to capital and that some of the smaller chains are already  
2 highly leveraged, which makes things certain going forward.

3 On the other hand, some financial analysts we  
4 spoke with believe that dire predictions about Medicare  
5 payment reductions have not come to pass, that business  
6 should stabilize over the next year, and certainly that  
7 payment policy changes under the Medicare, Medicaid, and  
8 SCHIP Extension Act will improve the financial picture.

9 Regarding payments and costs, in spite of the  
10 changes wrought by the new law, we are projecting that  
11 payment policies implemented in 2007 and 2008 will reduce  
12 aggregate payments. Historically, cost growth in this  
13 industry has closely track growth in payments. It remains  
14 to be seen whether the industry will constrain cost growth  
15 in response to these recent payment reductions.

16 Margins for LTCHs rose rapidly after the  
17 implementation of the PPS, rising from a bit below zero  
18 under the cost-based TEFRA system to a peak of 12 percent in  
19 2005. And in 2060, they remain very high at 9.4 percent.  
20 As you can see, there's a pretty wide spread in the margins,  
21 with a quarter of hospitals having margins 3.5 percent or  
22 less and another quarter having margins of 19 percent or

1 more.

2           For purposes of projecting the 2008 margins with  
3 2009 policy, we modeled a number of the policy changes that  
4 have taken place since 2006. Since we last met, we've also  
5 had to make some adjustments to our model based on recent  
6 changes in law. We've included the payment increasing  
7 effects of updates and coding improvements due to  
8 implementation of the MS-LTC-DRGs. We've also included the  
9 payment decreasing effects of DRG weight changes that were  
10 made in 2007, as well as changes CMS made to the short stay  
11 outlier policy in 2007, changes that were not affected by  
12 the new law.

13           Since the enactment of the new law, we've removed  
14 the effects resulting from the very short outlier policy,  
15 which was revoked. And we've also included the  
16 implementation of the 25 percent rule to the 50 percent  
17 level for hospitals within hospitals and satellites. Last  
18 time we had it all the way phased into the 25 percent rule.

19           And of course, we're not including the phase-in  
20 for the 25 percent rule for freestanding facilities any  
21 longer. As I said, we do anticipate a net decrease in  
22 payments and thus we're projecting a substantial decline in

1 margins, assuming provider costs go up at market basket  
2 rates of increase. If the industry responds to these  
3 payment changes by restraining their costs, margins could be  
4 somewhat higher than we're projecting. We project a margin  
5 of between minus 1.4 percent and 0.4 percent for 2008 and  
6 the difference in these projections reflects different  
7 assumptions about the impact of the 25 percent rule.

8           The lower margin assumes hospitals within  
9 hospitals and satellites will make no changes in the  
10 patients they treat in response to moving to the 50 percent  
11 threshold in 2007 and beyond. The higher number assumes  
12 hospitals within hospitals will adjust their admissions so  
13 they stay under the limits and thus will not have payments  
14 reduced.

15           So in summary, assessing the current payment  
16 adequacy in this sector is a little difficult. Recent  
17 policy changes have reduced payments. Growth in facilities  
18 and cases has slowed, which calls into question the adequacy  
19 of payment and access to care. However, it's difficult to  
20 determine when the use of services is appropriate and  
21 necessary. Frequently LTCHs enter the program in market  
22 areas where LTCHs already exist, raising questions about

1 whether there are sufficient numbers of very sick patients  
2 to support the number of LTCHs in some communities. So seen  
3 in this light, recent slowing in facilities, cases, and  
4 Medicare spending may be desirable.

5           The payment changes under the Medicare, Medicaid  
6 and SCHIP Extension Act do improve the financial outlook.  
7 Nevertheless, our estimated Medicare margins suggest that  
8 LTCHs may not be able to accommodate the cost of caring for  
9 Medicare beneficiaries in 2009 without an increase in the  
10 base payment rate.

11           So that brings us to our draft recommendation,  
12 which reads as follows: the Secretary should update payment  
13 rates for long-term care hospitals from rate year 2009 by  
14 the projected rate of increase in the rehabilitation,  
15 psychiatric, and long-term care hospital market basket index  
16 less the Commission's expectation for productivity growth.

17           Under current market basket assumptions this  
18 recommendation would update the LTCH payment rates by 1.6  
19 percent. This recommendation would decrease Federal program  
20 spending by less than \$1 billion over five years. And we  
21 don't expect it would adversely affect Medicare  
22 beneficiaries' access to care or providers ability to

1 furnish care.

2 So now I'll turn it over to you.

3 MR. HACKBARTH: Thank you, Dana.

4 Let me just highlight one thing. I think this is,  
5 other than hospitals, the only provider group for which we  
6 project negative margins. I think that's right. Here the  
7 recommendation is market basket minus productivity, whereas  
8 for hospitals we did full market basket concurrent with pay  
9 for performance. I just wanted to highlight that and why I  
10 think differently about the two issues.

11 In the case of inpatient hospitals, the margins  
12 are somewhat more negative, number one. And they have been  
13 persistently negative over some period of time.

14 Here we have a different history. Here, until  
15 recently, the history was not just positive margins but  
16 substantially positive margins. And so I think that  
17 warrants thinking about it a little bit differently.

18 Let me just stop there, having highlighted that.  
19 Nancy-Ann did you have a comment?

20 MS. DePARLE: Thanks for that explanation because  
21 I do think it's important. We've discussed before and today  
22 our desire to be consistent as we look at the different

1 sectors to the extent that we can. So I think that's  
2 helpful.

3 I just wanted to ask about the quality data that  
4 you mentioned, the more recent data that appears to show a  
5 more mixed picture with respect to quality of care in LTCHs.

6 And also, I'm a little bit surprised, I think in  
7 response to Mitra -- or no, her question was about CON. In  
8 response to someone, you provided some information about  
9 commercial insurers and their proclivity to use LTCHs.  
10 That's a little bit at variance with what I've heard from  
11 some of the LTCH providers about their increases in  
12 utilization by managed care organizations. It may not be  
13 inconsistent with what you found but I'm kind of surprised  
14 by it.

15 So you looked at national managed care contracts?  
16 Or how did you determine that?

17 MS. KELLEY: I spoke with representatives from a  
18 couple of the major plans and just asked them specifically.  
19 I spoke with a medical director, a regional medical  
20 director, and some utilization review people.

21 MS. DePARLE: Did you ask them whether or not  
22 their utilization of LTCHs has increased overall?

1           MR. LISK: I think they said that it had  
2 increased. One of the companies have both a private fee-  
3 for-service plan and they have no real control over use of  
4 LTCHs in that plan, whereas in the Medicare pure HMO where  
5 they have a little bit more control over that and they use  
6 them, where they have to get permission.

7           I can't remember whether they said 40 or 60  
8 percent of the cases they end up approving for use. And  
9 then the others they tell them to go back. A lot of times  
10 they don't ask again. That was one of the things that  
11 happened.

12           But again, we're talking about interviews with a  
13 couple of people on this.

14           MS. DePARLE: I'm talking about discussions with  
15 one. So were you only looking at Medicare patients or did  
16 you ask them about -- I realize a large percentage --

17           MS. KELLEY: We were primarily talking about  
18 Medicare.

19           MS. DePARLE: It could also be the case that for  
20 other patients they were using them more.

21           MS. KELLEY: They certainly reported that the  
22 requests for transfers to LTCHs had increased markedly in

1 recent years, particularly in certain regions of the  
2 country, Texas, the Southwest and Southeast was mentioned.

3 So there did seem to be a correlation to where  
4 we've seen growth in the number of facilities, the requests  
5 for transfer to those facilities seems to be increasing  
6 along with that growth.

7 MS. DePARLE: I interrupted my first question to  
8 you, which was could you talk a little bit more about the  
9 quality measures?

10 MS. KELLEY: The quality measure was a refinement  
11 we did to the analysis. We look at four patient safety  
12 indicators that are used in acute care hospitals but that  
13 seem to be appropriate for use in LTCHs. They are decubitus  
14 ulcers, infection due to medical care, pulmonary embolisms  
15 and deep vein thromboses, and postoperative sepsis.

16 When we initially did our initial analysis, we  
17 removed patients who had any diagnosis in the acute care  
18 hospital that would trigger the PSI. So that we're not  
19 penalizing the LTCH for accepting a patient that already has  
20 this condition. In refining the analysis, we also decided  
21 to remove patients who were admitted directly to the LTCH  
22 and didn't have an acute care stay because we couldn't

1 control for their condition when they came in the door.  
2 When we did that, our numbers changed very slightly but one  
3 of our number slipped from a slight improvement in quality  
4 to a slight decline in quality. And that just made the  
5 picture a little bit more mixed.

6 MR. EBELER: I was going to offer a productivity  
7 offset on the hospital side to solve your equivalence  
8 problem but I think we already voted on that.

9 This assumption that the institution's behavior  
10 won't change, their cost growth won't change, and they will  
11 then move into this negative margin category is interesting.  
12 I guess there's no other assumption we can make. But  
13 realistically, I wouldn't assume that would happen. They're  
14 going to respond.

15 I don't know this business that well. What is the  
16 likely response? How do they not make those negative  
17 margins happen? Because they won't let those happen.

18 MS. KELLEY: I can only speak about the historical  
19 trends. Under the TEFRA cost-based system, cost growth in  
20 this industry is very low, sometimes negative. Since the  
21 implementation of PPS, payments have increased dramatically  
22 and cost growth has tracked very nicely right along with the

1 payment growth.

2           So as I said previously, cost growth has tracked  
3 very well with payment growth historically in this industry  
4 and I would be somewhat surprised to see that change at this  
5 point.

6           MR. EBELER: If that's the assumption, then the  
7 margins will stay roughly where they are because payment  
8 growth has stopped.

9           MS. KELLEY: Margins have declined in the past  
10 couple of years from the high of 12 percent in 2005.

11           MR. EBELER: Thank you.

12           DR. MILLER: I'm going to pick this up because I  
13 think this is a good question. And the three of this us  
14 have been through this many times. And actually I  
15 appreciate the fact that you guys didn't just leave the  
16 table when this question came up again because we've gone  
17 through these estimates time and time again. I would say a  
18 couple of things.

19           If we had come in here and said you know, they're  
20 going to eliminate all of this cost immediately, people  
21 would have said wait a minute, that's a pretty aggressive  
22 assumption. So we're trying to strike some balance there.

1           And it came through in the presentation but I just  
2 want to hit it again, we're getting very mixed signals out  
3 there. You talk to the capital markets, you look at the  
4 assumptions. To the extent that we can quantify these  
5 assumptions, this is our best shot at the margin.

6           But if they respond on cost, this will be higher.  
7 If that half of the capital markets who says you know,  
8 there's a lot of revenue that these people have, and they're  
9 very good at selection and also cost control, they're coming  
10 back, these margins are going to be wrong.

11           This is an area that we spent a lot of time back  
12 and forth trying to get our head around this. This is our  
13 best shot based on the quantitative and some sense that we  
14 didn't want to come here and be way over on one side of yes,  
15 they're going to recover. We're trying to be a little  
16 conservative here.

17           DR. REISCHAUER: I want to offer a technical  
18 corrections amendment here, both in the dialysis -- which I  
19 apologize for being out of the room for -- and the draft  
20 recommendation here. It has to do with how we explain what,  
21 in fact, we're doing.

22           In the dialysis one it says market basket index

1 less the adjustment for productivity growth for the calendar  
2 year 2009. That makes it sound like we're estimating what  
3 productivity growth is going to be in 2009, which we aren't.  
4 What we're doing is we're taking trend productivity over the  
5 past 10 years as estimated by BEA.

6 And then this one says market basket less the  
7 Commission's expectations for productivity growth. That  
8 also makes it sound like we're looking forward.

9 I suggest we change for both of those into market  
10 basket index less the Commission's adjustment for  
11 productivity growth, period. We've explained elsewhere what  
12 that adjustment is, which is 10-year moving average of total  
13 factor productivity. Just so we don't create confusion  
14 here.

15 MR. HACKBARTH: Is that clear to everybody?

16 MS. THOMAS: Can you say it one more time so I get  
17 it?

18 DR. REISCHAUER: [off microphone] Market basket  
19 index less the Commission's adjust for productivity growth.

20 MR. HACKBARTH: Other questions and comments  
21 before we move to a vote?

22 DR. CROSSON: I had just one, and maybe I'm

1 catching the economics virus, too -- economist virus, excuse  
2 me.

3 I just wanted to understand the spending  
4 implication as an expected decrease. Is that because what  
5 was built into the budget was market basket? Or did I miss  
6 something about the 2009, I mean about the recent  
7 legislation and its impact on 2009?

8 DR. MILLER: I think your situation is worse than  
9 you think. You're starting to get a budget virus here  
10 because this is a baseline issue.

11 MS. KELLEY: There's no -- what am I trying to  
12 say? There's no stipulation in law for an update for LTCHs.  
13 CMS has stated that they're going to stick to the policy of  
14 a market basket increase. They've applied different  
15 adjustment in the last several years that have prevented a  
16 full market basket increase from being implemented.  
17 Adjustments for coding improvements being one of the  
18 factors that's been used.

19 So our spending implication is based on the  
20 assumption that there would be a full market basket  
21 increase, but that is not in law.

22 DR. MILLER: Which is also what the CBO baseline

1 is assuming, which is what we use for all of these to figure  
2 out what the budget effects would be.

3 MS. DePARLE: But we won't really know that until  
4 the President's budget comes out; right? That could change,  
5 what the Administration is proposing.

6 MR. HACKBARTH: Any others? Okay, let's vote.

7 All opposed to the draft recommendation, as  
8 amended by Bob? All in favor? Abstentions?

9 And just for the record, on amending the ESRD  
10 recommendation so that it confirms, and we're clear, all in  
11 favor of doing that?

12 Okay, thank you. Well done.

13 We're going to shift our focus here for our last  
14 session, having completed our update work for another year.  
15 The last year two sessions, the first on bundled payment and  
16 the second on primary care, go back to our longer term  
17 agenda on how to reshape the incentives that we provide for  
18 the delivery of care.

19 And among the themes that we talked about at our  
20 retreat last summer and in our fall discussions of this was  
21 let's talk about ways that we can break out of the siloed  
22 payment systems for different providers by type. Let's look

1 at ways that we can encourage -- as Arnie has put it often -  
2 - think about longitudinal efficiency, how we improve care  
3 for patients over longer periods of time, not just very  
4 discrete encounters.

5 Third, let's think about payment approaches that  
6 can provide a solid foundation for rewarding a more robust  
7 version of pay for performance in the future that emphasizes  
8 efficiency and quality.

9 And finally, let's consider proposals that will  
10 help shore up, indeed improve, our primary care system.

11 So those are a few of the themes that we talked  
12 about before. And in these last two discussions today we're  
13 going to dig into those issues a bit further.

14 MS. MUTTI: As Glenn mentioned, this past fall we  
15 discussed the concept of bundling payment for Part A and  
16 Part B services surrounding a hospital admission. We talked  
17 about the related issues involved in that effort.

18 At this juncture, we'd like to take a moment and  
19 almost step back and see if there's a general consensus  
20 among you on some of the general points around bundling. We  
21 feel that this kind of conversation at this point would help  
22 us begin to think how we might shape a June chapter.

1           So today, I will present some themes where we  
2 think we've heard agreement from you, or more or less  
3 agreement. And then I'll outline a phased-in approach, a  
4 type of glide path, that would ultimately move Medicare to  
5 making a unbundled payment for care around a  
6 hospitalization.

7           Our hope here is that by having a specific policy  
8 approach laid out that it will help you assess what the  
9 implementation issues are and where you really are on this  
10 issue, exactly how it could be implemented.

11           A key fundamental theme to our conversation on  
12 bundling is a recognition that fee-for-service payment does  
13 not reward efficiency over an episode of care. By paying  
14 providers piecemeal, Medicare gives providers no financial  
15 incentive to work cooperatively to manage patients' care  
16 over time. As a result, patient care can suffer and  
17 Medicare and beneficiaries may spend more than is really  
18 needed.

19           This statement is grounded in the research that  
20 shows geographic areas that spend more on health care do not  
21 have better quality of care over areas that spend less.

22           Bundling payment can improve incentives for

1 efficiency over an episode of care. Just to briefly step  
2 back for a moment, bundled payment is where Medicare pays a  
3 lump sum to a provider entity. This lump sum is then  
4 designed to cover the costs for efficient providers for  
5 providing care during a designated episode or window of  
6 time.

7           So why does bundling improve incentives? There's  
8 two dynamics at play here that we've just talked about.  
9 First, when the bundle includes care provided by just one  
10 provider, the provider has a clear incentive to monitor or  
11 restrain the volume of service use under the bundle. More  
12 services are not rewarded with higher payment.

13           When bundling payment across different providers -  
14 - something Medicare has not done before outside of the MA  
15 program -- an added dynamic is in motion. Providers have an  
16 interest in collaborating with one another, with other  
17 partners, to improve their collective performance. This  
18 collaboration might mean better communication among  
19 providers, less redundancy in care, more attention to the  
20 mix of prescription drugs that a patient is taking, and just  
21 general improvement in the coordination.

22           Another important point that I think you all have

1 expressed is that we don't get value with low resource  
2 alone. We need to encourage and reward quality, as well.  
3 Accordingly, concurrent accountability for quality is  
4 essential. This is particularly important because while  
5 bundling changes incentives to reduce overuse, which is part  
6 of a quality problem, it also creates some incentives for  
7 stinting or underuse.

8           So here we are envisioning that providers are  
9 accountable for quality through a P4P program, concurrently  
10 with bundling.

11           Hospitalization episodes may be a good place to  
12 start in expanding application of bundling traditional  
13 Medicare. This is for at least a couple of reasons. First,  
14 hospitalization is a clear, cogent episode of care, making  
15 it very reasonable to hold multiple providers accountable.

16           Second, there is value in engaging hospitals in  
17 identifying cost savings rather than focusing on physicians  
18 and their power of the pen alone. Hospital's managerial and  
19 financial resources can be an asset in enabling delivery  
20 system reforms as can the economies of scale they command.

21           They need a financial incentive, however -- a  
22 business case if you will -- to use these resources to

1 better manage physician visits during the stay and patients'  
2 care after discharge.

3           We've also heard from you that there is value in  
4 first focusing on selected conditions. To gain experience,  
5 achieve early success, and limit unintended consequences,  
6 any bundling policy could first apply to a select number of  
7 conditions. They could be selected based on the frequency  
8 of the condition, the relative high cost of the condition,  
9 availability of quality measures, and the ability to improve  
10 performance, among other factors. We do recognize the  
11 potential flip side here, I think one of you mentioned it a  
12 couple meetings back, that the investment required to  
13 implement bundling may be significant enough that  
14 considerable economies of scale would be achieved by  
15 applying it to a greater number of conditions, perhaps all  
16 conditions. --

17           So that's just something to bear in mind as we go  
18 forward with this.

19           Another theme that we heard from you is that there  
20 is value in defining episodes that extend beyond the stay,  
21 but that you recognize the need to start slowing. First,  
22 why is beyond the stay important? This is where the

1 variation is in spending, and we showed you that in some of  
2 the slides this past fall. These transitions in care are  
3 occurring during this time. So by definition there are  
4 transitions during this time and some of them are not  
5 particularly well handled. We've talked about the frequency  
6 of readmissions in a two-week through 30-day window and the  
7 costliness of that for Medicare amounting to something like  
8 \$15 billion in the 30-day window.

9           But as you've said, a slow start is needed. Why  
10 is that? Bundling payment, especially for an episode that  
11 extends across sites, require significant changes for  
12 providers and design challenges for CMS. These include  
13 providers having signed legal contracts among themselves,  
14 refining risk adjustment to better account for reasonable  
15 differences in post-acute care costs, providers developing  
16 systems to not only better manage the patient care but then  
17 to figure out ways to pay one another.

18           We've also alluded to the fact that we might need  
19 some policies to control any possibilities of increasing the  
20 number of bundles, the number of admissions that might  
21 occur.

22           For bundling to achieve its potential, we will

1 likely need to ease current regulatory restrictions like  
2 that on shared accountability or gain sharing. We've talked  
3 about this before. Those kinds of restrictions might  
4 prohibit providers from constructively collaborating with  
5 one another to improve efficiency.

6           At the same time, we will need to consider new  
7 regulatory approaches to discourage possible growth in  
8 admissions, as I just mentioned. Growth in the number of  
9 admissions is a concern because bundling aligns hospital and  
10 physicians incentives. While growth in admissions was also  
11 a concern with the creation of DRGs, we feel that this  
12 policy is different. DRGs in and of themselves did not  
13 align hospitals and physicians. In a sense, the potential  
14 effect of bundling on volume is more analogous to the  
15 development of physician-owned specialty hospitals. And  
16 here MedPAC and others have found an increase in volume.

17           The broad point is that if financially physicians  
18 are better off admitting patients -- as may be the case  
19 under newly negotiated physician rates under bundled payment  
20 -- then we have inadvertently created a business case to  
21 admit patients who could have been treated just as  
22 effectively on an outpatient basis. We need to be mindful

1 of this possibility and consider ways to balance incentives.

2           Here we get a little bit more concrete and offer a  
3 policy glide path that takes into account some of the themes  
4 I just mentioned. On this slide, I will briefly list the  
5 four steps and then say a bit more on two, three and four in  
6 the following slides. An overarching consideration to keep  
7 in mind is that we envision that this glide path would start  
8 by applying to a few selected conditions and expand that  
9 number over time, perhaps over the course of the policy  
10 phase-in. But we aren't any more specific than that at this  
11 point.

12           The first step is to provide information to  
13 hospitals and physicians about the resource use during the  
14 stay, as well as some post-discharge period, perhaps  
15 something like 15 days after discharge, so that they can  
16 know how their performance compares to others and possibly  
17 identify ways they can improve. Information would be  
18 provided for the two time frames in anticipation of  
19 ultimately holding them accountable for the longer one.

20           The next step is virtual bundling for the stay  
21 only. That is, Medicare would pay providers separately but  
22 adjust payment to each based on the relative average

1 Medicare spending for care during the stay. I'll come back  
2 to this in a moment.

3           The third step is then to implement mandatory  
4 bundling, again for the stay only, so that Medicare would  
5 only pay providers for inpatient care for certain conditions  
6 if they were able to accept a bundled payment. The bundled  
7 payment would be for all hospital and physician services  
8 during the hospitalization.

9           The fourth step here, Medicare would increase the  
10 bundled payment to cover the care delivered during the stay  
11 plus some time after.

12           So now, having given you the overview of the  
13 phase-in, let me spend a little bit more time on some of  
14 these steps. The second step would be to apply a virtual  
15 bundling policy for care delivered during the stay -- just  
16 during the stay, as I mentioned, not the post-discharge  
17 period.

18           As you might recall, virtual bundling is where  
19 Medicare would continue to pay separate amounts to each  
20 provider but would penalize providers -- reduce payment  
21 amounts to those provider groups -- whose risk-adjusted  
22 spending exceeded benchmark or expected resource use. There

1 could also be a reward for high-performing provider groups.

2 Virtual bundling is an appealing incremental step  
3 to truly bundling payment because it can make providers  
4 conscious of their role in creating efficient episodes and  
5 aligns provider incentives without requiring providers to  
6 fully establish an administrative and legal construct to  
7 jointly accept a bundled payment and then share it.

8 There are a variety of implementation issues to  
9 consider here and that we can discuss in the chapter. They  
10 include how large the penalty should be, whether it should  
11 grow over time. Should there be a reward or a carrot for  
12 good performers? What are the budgetary effects of  
13 implementing that aspect of the design? What should the  
14 benchmark or expected spending levels be? Is it the 50th  
15 percentile, the 75th, other options?

16 I will just step back for a moment after I've  
17 talked about steps one and two, is that you might notice  
18 that this glide path, those first two steps, sound a lot  
19 like our vision under physician resource use measurement.  
20 That is, we first share information with providers with  
21 their practice styles and then ultimately adjust payment for  
22 those who use excessive resources.

1           We think that notionally the two approaches can  
2 coexistence and indeed can be mutually reinforcing. But if  
3 the two were pursued simultaneously, thought would need to  
4 be given to simplifying implementation.

5           The third step is mandatory bundling for the stay  
6 only. This means that in order to get paid by Medicare for  
7 select conditions, hospitals and physicians will have to be  
8 able to accept a bundled payment. Our thinking here is that  
9 the first two steps should have given providers sufficient  
10 time to reengineer and align incentives to allow them to  
11 accept the bundled payment. Once under the bundle, the  
12 providers would then have the incentive to work together to  
13 reduce costs. They may reduce the unit of service like the  
14 number of physician visits, as well as the cost of services,  
15 such as supplies, length of stay, ICU time, that kind of  
16 thing.

17           The fourth step would be mandatory bundling for  
18 the stay plus some post-discharge period. This step  
19 requires that the entity accepting the bundled payment be  
20 responsible for paying services delivered subsequent to  
21 discharge. This includes SNF care, home health services,  
22 and readmissions within some window. Again, we throw out

1 the idea of 15 days but that's kind of open here.

2           While the entity is managing a degree of insurance  
3 risk here, it is very likely that the hospitals and  
4 physicians involved in the hospitalization do have the  
5 ability to directly influence the efficiency of care within  
6 this time frame.

7           Implementation of this step would be contingent on  
8 the availability of acceptable risk adjustment.

9           Over the next couple of slides, I want to point  
10 out what this policy doesn't do. First, it does not allow  
11 providers to voluntarily opt to receive a bundled payment  
12 during steps one and two, that is prior to it becoming  
13 mandatory in step three. This may seem frustrating because  
14 we know that some systems are ready to accept that bundled  
15 payment.

16           The logic for not allowing voluntary bundling has  
17 to do with the challenge of setting the right payment rate.  
18 If we set it at the national average amount, which was done  
19 under DRGS, and only the low-cost systems -- those that have  
20 the greatest ability to gain under this -- if they are the  
21 only ones that opt for the bundle, Medicare loses money. A  
22 way around this problem might be to set the payment rate

1 differently, as a discount off each hospital's current  
2 combined payment amount, as was done in the heart bypass  
3 demonstration. But because each hospital has its own base  
4 rate -- it's the combination of the hospital and physician  
5 payments per condition -- and that would have to be  
6 calculated by CMS and subject to appeal, this could be quite  
7 a laborious administrative task and seemingly prohibitive if  
8 potentially every hospital pursues that option.

9           Second, this policy glide path requires no  
10 accountability for readmissions until step four. Depending  
11 on the phase-in, this could be a fairly long time. It is  
12 possible to pair a readmissions policy with bundling, and if  
13 you're interested in this we can come back you and discuss  
14 how this might work in more detail.

15           So with that, let me leave you with a few  
16 questions. Are there additional main themes that we should  
17 highlight? What do you think of the glide path? And in  
18 that context, we have a couple of specific questions. How  
19 specific should we be in the defining post-acute period?  
20 I've thrown around the example of 15 days. Is that right?  
21 Is there a better way? Are you okay with a no voluntary  
22 bundling approach here? Would you like us to explore a more

1 aggressive readmission policy?

2           Another question for you is whether or not to make  
3 a recommendation. Given the range of design issues still  
4 left to analyze, you may not want to recommend the full  
5 glide path. One possibility though is to recommend step one  
6 only, the disseminating information step, and wait for more  
7 details to coalesce and further discussion on the other  
8 steps. Or perhaps there's a place for a recommendation  
9 somewhere in between those two.

10           I'd also like to note that this policy option  
11 implicates some large strategic and philosophical issues,  
12 and you may want to talk about those, also. For example,  
13 particularly if bundling were enacted in isolation and not  
14 in tandem with some other policy options we've talked about  
15 -- physician resource use measurement or that kind of thing  
16 -- it would be giving hospitals a very strong role in  
17 catalyzing delivery system reform. That might give you  
18 something to think about.

19           Also, this policy would likely create powerful  
20 hospital physician entities positioned to have influence in  
21 setting future Medicare payment rates and in negotiations  
22 with private insurers, again something to think about.

1 I'll stop there.

2 MR. HACKBARTH: Well done, Anne.

3 Let me pick up with the virtual bundling piece.

4 As Anne indicated, one of the reasons for including virtual  
5 bundling had to do with the problems created if it's an  
6 optional system and the potential increasing effect of an  
7 optional system.

8 The other theme that I remember from the fall  
9 originated with Arnie, which is not everybody is going to  
10 want to enter into formal organizational relationships with  
11 corporate structures and all of that. And virtual bundling  
12 might be a way to allow people to legally continue to be  
13 disaggregated and not part of the big organizations but  
14 still create incentives for them to behave the way we want  
15 them to behave. So I think there was a two-pronged  
16 rationale for thinking about virtual bundling.

17 One of the implications of the second point of  
18 view might be that you continue it longer term and not just  
19 as only a transitional device.

20 So I just wanted to highlight that as something  
21 for discussion.

22 MR. BERTKO: The first thing is to compliment Anne

1 and Craig on a very thoughtful glide path. Then of course,  
2 once you get to this the question becomes down into some of  
3 the details.

4           So I'm with you on step one and step two. And  
5 then, since I live in a little one hospital town, step three  
6 becomes a question.

7           Arnie and I and Jay, people who have had  
8 experience in the West where we had all kinds of PHOs  
9 springing up like mushrooms in the 1980s and 1990s, saw them  
10 blow up. And so in your glide path I noticed for step three  
11 you have what appears to be a very big stick. So if  
12 somebody checks in to the hospital in my town and nothing is  
13 there, the hospital doesn't get paid. Which would seem to  
14 create an access problem because they would have to go 150  
15 miles down the highway to some hospital in Phoenix that, in  
16 fact, accept this.

17           You're nodding, so I interpreted that correctly  
18 then?

19           So then that brings up the next question that I  
20 think Glenn might have been alluding to is do you have some  
21 kind of bifurcated system in the early days because I'm  
22 absolutely certain that hospitals and physicians will move

1 into step three at very different speeds. Is there a way  
2 that that's allowable without creating selection? And then,  
3 after you've answered that one I have a follow up but  
4 different question.

5 MS. MUTTI: Not that I have an answer for it, but  
6 just to be clear in the presentation, when we said no  
7 voluntary bundling, that was envisioning -- we have talked  
8 about this inclination like wouldn't it be nice to get those  
9 who are ready to go ahead with it? And we just have not  
10 been able to figure out a way -- and we'd certainly welcome  
11 suggestions of how to do it in a responsible budget way that  
12 was also administratively feasible, because you could  
13 imagine a system where you kept the virtual bundling for  
14 those that did not opt to take the bundled payment. And  
15 there would be some penalty if they were high cost.

16 But as we play it out, we just find so many  
17 different uncertainties, unintended consequences of gaming  
18 the system. You have physicians that admit to two different  
19 hospitals, one that takes the bundle, one that's under  
20 virtual. It gets complicated.

21 MR. BERTKO: Could I offer and see whether you've  
22 thought about this. My state has very, very large

1 geographic counties and whether it's county or MSA, there  
2 wouldn't be a choice but it could click on by county. So  
3 Maricopa County, the moment one hospital entered, all would  
4 have to be in. whereas Coconino County might be slower and  
5 so it might lag in turning on before Maricopa County did. I  
6 don't know if that's an acceptable thought or not.

7 DR. MILLER: John, could I just ask one thing  
8 about that? How did that solve the initial problem that you  
9 said? So if that one hospital doesn't do it, is somebody  
10 still driving down the road?

11 MR. BERTKO: Not likely. Not at 150 mile  
12 difference for these big ticket items, the selected  
13 procedures.

14 DR. MILLER: Then why was it a problem in the  
15 first place?

16 MR. BERTKO: If you live in Maricopa County, you  
17 would have the hospital that was efficient in cardiac care  
18 turn the bundle on, and the one that was inefficient stay in  
19 the fee-for-service if that was advantageous to them, or  
20 vice versa, where there were two or three competing  
21 hospitals in the same catchment area.

22 DR. MILLER: This is not disagreement. I didn't

1 follow set up and then the solution.

2 MR. BERTKO: In Arizona, outside of Phoenix and  
3 Tucson, there are basically single hospital towns. And the  
4 distances are large, 50 to 100 miles. So you don't really  
5 have much choice except for tertiary procedures, and then  
6 they helicopter you down. I'm thinking there are other  
7 parts, at least of the West, that look a lot like that.

8 In this spirit of discussion here.

9 DR. MILLER: [off microphone] It's really not  
10 disagreement. I caught the problem and then I caught what I  
11 thought the solution was. And I couldn't [inaudible].

12 MR. BERTKO: In other places like in California  
13 there are frequently fairly intense competition in most of  
14 the urban areas. You pick the nine county greater San  
15 Francisco Bay Area, the moment one hospital clicks on you  
16 turn on the whole nine counties because there is, in fact,  
17 competition even with traffic flow and such.

18 I've kind of exhausted my thoughts on that one.

19 Now I'd like to ask the more difficult question  
20 than that, which is interesting. Glenn, you alluded to  
21 this. I think of our episode grouper work on Minneapolis  
22 versus Miami, if I'm thinking of it correctly. We had many

1 more episodes down in Miami than in Minneapolis, and had  
2 cheaper rates. Under something like this, without an  
3 appropriate geographic adjustment, the people in Miami could  
4 have a huge benefit under this kind of payment system.

5           Would you think of it geographically to adjust for  
6 this? Or is there some other way to constrain utilization  
7 that you thought about?

8           MR. HACKBARTH: The benefit, John, would be more  
9 lower-cost episodes and Miami would allow them. If you used  
10 a national average rate they could gain and Minneapolis  
11 lose.

12           MR. BERTKO: Yes.

13           DR. REISCHAUER: I thought that started with a  
14 diagnosis of congestive heart failure, not entrance to a  
15 hospital. The big difference was fewer people in Miami  
16 ended up going into the hospital. The ones that went in --  
17 and they were less severe, even the ones that went in, than  
18 the people that were in Minneapolis.

19           MR. BERTKO: I agree you're correct on that, but I  
20 was taking it to the next logical conclusion. If that  
21 happened you could game the system to get more admissions in  
22 Miami because you have people stacked up on these.

1           MR. HACKBARTH: This is an empirical question and  
2 we'd have to look at the data. But it goes to how set the  
3 rate. And do you use national averages? Do you use local  
4 averages? The different options that you can pursue there  
5 with this as one of a number of issues in mind.

6           MS. MUTTI: One other thing that we've begun to  
7 think about with respect to that is looking at admission  
8 rates. Maybe I alluded a little bit to this. We have  
9 concern with this policy that you might see a bump in  
10 admission rates. But whether you see that bump up or not,  
11 it would be nice if we could start measuring and comparing  
12 hospital specific admission rates. And we're hoping to do  
13 some research.

14           The trick here, I think you pointed this out at  
15 the last meeting, is developing a denominator of  
16 beneficiaries for each hospital. We're going to work with  
17 some of the Dartmouth algorithms in assigning and explore  
18 what possibilities there might be on that.

19           MR. HACKBARTH: Capitation is way simpler than  
20 this.

21           [Laughter.]

22           MR. HACKBARTH: I just thought I'd note that.

1 DR. KANE: I am on the same mindset as John,  
2 actually, around some sort of geographic rather than  
3 provider specific beginning.

4 Even if it is at the geographic level you're  
5 worrying about population health measures that help set the  
6 level of payment and that as the geographic health measures  
7 get better the level of payment gets better. I don't think  
8 you should do this unless you can do something about the  
9 population's health at the county or whatever the natural  
10 market area is that helps you adjusted for the admission  
11 rate.

12 And also, I remember the guy fro -- was it  
13 Virginia Mason who came in and said they did some huge  
14 outreach in flu immunizations and he said it killed them to  
15 go out and try to do that because then they didn't have a  
16 huge flu season to pay the hospital with all the sick  
17 people. And there should be a reward for that.

18 I think I would be hesitant to do that without  
19 some kind of a geographic -- even if it's only part of the  
20 payment design. I agree, capitation is easier. But we  
21 don't know what happens when we capitate. We never find out  
22 after that where the resources went. Whereas under the fee-

1 for-service program at least we'll have some idea of where  
2 the resources are going and be able to measure quality more  
3 directly.

4           Anyway, I do think something about the geographic  
5 -- the health of the population in a geographic area has to  
6 be part of the payment system.

7           The other part about the incentive, whether it  
8 should be a withhold versus one year to the next. I thought  
9 we've already heard that the closer the payment is to the  
10 behavior the better impact it is. So I'm more for the  
11 quarterly settlement idea than two years later you get the  
12 impact of good behavior. Some organizations won't have the  
13 financial wherewithal to get to that two years later. I  
14 think it's better to have that payment reward connected as  
15 close as possible to the time the behavior happens.

16           DR. MILLER: Just on that point, a mandatory  
17 payment based on the bundle is about as close as you can get  
18 it.

19           DR. KANE: And it goes up and down by quarterly  
20 adjustments by what's happening --

21           DR. MILLER: I'm saying steps three and four,  
22 which you need to sort out, is here's your payment. Now

1 manage to it.

2 DR. KANE: It's pretty immediate.

3 DR. MILLER: Pretty immediate.

4 DR. WOLTER: I wanted just to highlight a few  
5 things in my thinking. First of all, I really do think this  
6 was very thoughtfully laid out and a measured approach you  
7 took to implementation is probably necessary if we're going  
8 to take it somewhere beyond just an experiment or a demo.  
9 So I really like that. I like the theme of continuing the  
10 virtual bundling along the whole pathway. And I certainly  
11 would agree with Glenn. Who knows, maybe that stays in  
12 place in some way, depending on how these relationships  
13 evolve.

14 I wanted to highlight the importance of the  
15 regulatory restrictions that would have to be dealt with to  
16 get into this. That's a very large deal and we'll need to  
17 be very thoughtful and maybe even emphatic about the need to  
18 get those things addressed because, Anne, one of the  
19 concerns you've voiced that these relationships could lead  
20 to incentives for increased admissions at all that, in my  
21 view sometimes get in the way of our ability to look at new  
22 innovative organizational models of care.

1           And if the issue that we've identified in Fisher's  
2 work is that in any case most admissions to a hospital come,  
3 largely speaking, from a similar group of doctors. And on  
4 the physician's side most of the patients they admit tend to  
5 go to the same hospital, which is at least part of his  
6 summary.

7           We're already in that boat and I can tell you  
8 hospitals are already doing everything they can to incent  
9 volume in one way or the other, especially where the DRGs  
10 are profitable.

11           And so if we could create a tighter relationship  
12 between the physicians who admit high-volume, high-cost  
13 patients to hospitals, and then put in place the appropriate  
14 accountability for how that care is delivered both cost and  
15 quality-wise -- and I would agree, continue look at  
16 geographic utilization variation -- we then have an  
17 accountable care organization we can start to give  
18 information to.

19           I was at a meeting up at Dartmouth and Elliott and  
20 Jack presented to those of us who were in attendance our  
21 comparisons in the ICU days in the last two years of life.  
22 It was fascinating and very revealing. I mentioned that one

1 because we looked very good.

2 [Laughter.]

3 DR. WOLTER: But we didn't look so good on  
4 neurologic procedures, actually. So it creates all sorts of  
5 opportunities if we can find a way to do this.

6 The P4P part, looking at these geographic  
7 variations and then having that information in a way that we  
8 can incent people to narrow those variations is really the  
9 opportunity we have here.

10 I really would like us to look at readmission  
11 rates. What time frame that is I don't know. I wasn't  
12 crazy about the financial framework report we put on that in  
13 the last look we had at it, but I think we can play with  
14 that some more. And I think readmission rates are a huge  
15 opportunity, as we've said.

16 And then I want to comment on the issue of  
17 hospital control and territorialism which, of course,  
18 physicians really do worry about. I don't think this only  
19 has to happen with bundled payment going to the hospital.  
20 One could imagine new organizational forms springing up that  
21 respond to this that include physicians in governance in  
22 ways that we need to have happen anyway.

1           I keep referring to the Middlesex Group that's in  
2 the group practice demo. They're actually taking  
3 responsibility for an entire year of payment for all Part A  
4 and Part B payment, in a way, because of the way the demo is  
5 set up. And they are not employed by the hospital, most of  
6 them. It's a virtual kind of a group that's come together.

7           So I think there's ways through that issue and  
8 it's a very important issue so that physicians feel they are  
9 part of how these things are designed and implemented and  
10 lead.

11           And then just lastly I would say, as you all know,  
12 this is the type of transformational change and innovation  
13 we have got to find our way to try if we're going have a  
14 chance to deal with the problems that we're dealing with.

15           MS. HANSEN: I just wanted -- hearing these  
16 structures, I also want to say that capitation not only  
17 should be easier, having been in it, it is a lot easier  
18 doing it that way. But just building on Nick's last point  
19 about changing the whole culture of practice, that again the  
20 variations that you're going to be looking at with the  
21 Dartmouth folks is great.

22           The whole area of readmissions is one that I think

1 is one that I would also underscore and refer back to  
2 perhaps other types of entities, whether they're the ones  
3 like Middlesex Physician Group, or work that is already  
4 being done right now that I think was reported even publicly  
5 in the Wall Street Journal with the health plan side of it,  
6 with Kaiser I believe and Aetna, with the work from the  
7 University of Pennsylvania and Mary Naylor with the  
8 transitions work that she does with Eric Coleman.

9           And I wonder if we could have some presentation at  
10 some point about that, because we look at it in terms of  
11 just the results of better care for people and the  
12 rehospitalization rate is really one of the things that  
13 comes out strong, at least in some of the initial NIH  
14 studies that have been done.

15           If we live that a little bit more and remember  
16 that that's what we're driving for, not so much the  
17 structures but the impact to the beneficiaries not having to  
18 use these services. And then couple that with Nancy's point  
19 about the population base itself.

20           So I just wonder if we could live that component  
21 to look at it from the endpoint of the quality of the care  
22 to the beneficiaries that gets increased because of, for

1 example, unnecessary readmissions in certain conditions.

2 MR. EBELER: I can be quick here because a lot of  
3 the points have been made better than I would make them.

4 Thank you for doing this. I think this issue of  
5 what is the entity that can collect the money, and Nick's  
6 point that in our heads of sort of sounds like the hospital  
7 distributing the money. But we really should be open to  
8 very different arrangements in that world. Because what  
9 we're challenging the community to do here is change. We  
10 want changes. I think that's really critical.

11 There is an issue I suspect substantively and  
12 politically of hospital size that may be what John was  
13 getting at where neither the volume of procedures nor the  
14 structure of the institution merits going much beyond  
15 virtual bundling. It seems to me it would be worth looking  
16 at that, whether it's worth taking on that fight or just  
17 simply leaving that.

18 I don't know how to deal with it but there's a  
19 size here that is just, I suspect, hard for them to do and  
20 not worth us pushing it because the issue in those  
21 communities is are there resources to do something, not how  
22 do you reorganize the resources to do it. It just seems

1     worth looking at.

2                   A question on the time frame.  Should we look at  
3     these steps pragmatically as years?  Or is each step two  
4     years?  Do you have a sense of how long it takes to get from  
5     step one to step four?  Days?

6                   DR. REISCHAUER:  Decades.

7                   MS. MUTTI:  In my thinking, I was playing off what  
8     I had heard you all say.  I think at one point you said this  
9     could be 10 years.  Somebody said I don't know about that.

10                   I'm trying to reflect what you're saying.  We do  
11     not have an independent vision for how long this takes.  I  
12     think there was some recognition that this is complicated.  
13     So if you'd like to offer up a time frame, that's fine.

14                   [Laughter.]

15                   MR. EBELER:  I had it written down by month.  I  
16     just don't have a feel for how long this takes.

17                   DR. REISCHAUER:  Anne and Craig, I think this is  
18     terrific work and it's really the kind of thing we should  
19     do, which is think quite clearly how one would really go  
20     about doing this.  You've solidified my pre-bias that it's  
21     impossible, quite frankly.

22                   [Laughter.]

1 DR. REISCHAUER: What we're trying to do is sneak  
2 up in a politically acceptable way on the fact that to get  
3 what we want a strong accountable care organization or a  
4 group or staff model HMO is the only answer. But we can't  
5 say that, so we're going to pussyfoot around the edge and  
6 try and sneak up on it.

7 And I'm sitting here thinking about virtual  
8 bundling. And I'm thinking well, we could pay the people  
9 separately based on the average episode spending. So let's  
10 take one thing, whatever it is, and everybody goes into the  
11 hospital and gets the same thing done.

12 And then there's four doctors. And some people  
13 have an episode and see one, some see two, some see three,  
14 some see four. There's three post-acute care things. Some  
15 go to one, some go to none, on everything. So how do we  
16 figure out what the average is for all of these episodes?

17 And then the payment, you might be making the  
18 payment for some doctor who only was involved in episodes  
19 where there was one doctor visit and so "efficient" things.  
20 And he's getting smashed because half of the other cases saw  
21 four doctors and he has no idea why he's getting from  
22 Medicare half of what he used to get.

1           What I'm afraid of is by going down some of these  
2 roads you're going to create such a backlash that it's going  
3 to be equivalent to managed care during the early 1990s,  
4 everybody, great idea, great idea. And then people say oh,  
5 you're stinting on care because we didn't measure quality,  
6 et cetera, et cetera. And we turn back the clock on  
7 something that maybe was an okay idea.

8           I think you go into this with teeth or not at all.  
9 And it's conceivable that in certain areas it's just  
10 inappropriate because of the scale, because of the lack of  
11 competition it just can't be done. And this kind of stuff  
12 can only be done in large metropolitan areas with five or  
13 more hospitals.

14           Then we run into the whole problem of but this is  
15 Medicare and we have to offer everybody -- whether they live  
16 in Bering Point, Alaska or New York City the same thing.

17           I await your next chapter.

18           MR. HACKBARTH: And I await the punch line here.

19           [Laughter.]

20           DR. REISCHAUER: It's impossible wasn't good  
21 enough for you? What do you want, the movie?

22           [Laughter.]

1           MR. HACKBARTH:  So, Mr. CBO Director, how is it  
2   you think we slow the rise of Medicare costs?  You want to  
3   just squeeze the updates?

4           DR. REISCHAUER:  No, I don't.  This is a longer  
5   discussion and I'm not sure I want to provide my secret  
6   solution --

7           [Laughter.]

8           DR. REISCHAUER:  -- before the patent has been  
9   approved.  But quite frankly, I think you create  
10  organizations such as I have said could work, and you  
11  provide payment through the Medicare system equal to what  
12  those folks need to provide high quality.  And if other  
13  people want to be in some other system, that's just fine but  
14  the differential cost, they're going to have to bear.

15          MR. HACKBARTH:  As you can imagine, Bob and I have  
16  talked some about this.

17          DR. REISCHAUER:  He's pretending he doesn't agree  
18  with me.

19          MR. HACKBARTH:  I think if I could snap my fingers  
20  and make something happen, I'd enroll everybody in Kaiser  
21  Permanente sort of organizations.  Ain't going to happen.

22          So one way to think of all of this, in spite of

1 all of its complexity, is that what you're trying to do is  
2 use payment to drive organization and start creating the  
3 building blocks that are part of the path to a more Kaiser  
4 Permanente sort of organizations.

5           We tend, in the political world, to think our  
6 payment systems always have to adapt it to the existing  
7 organization. And then we bemoan how bad the organization  
8 is and we get caught in this vicious, negative cycle. We're  
9 going to have a different mindset, which is to use payment  
10 to force changes in organization.

11           The problem there, as you well point out, is the  
12 political barriers. So we get into thinking about  
13 transitions and virtuals and whatnot.

14           I'm searching for a path to try to get us on to  
15 delivery system reform without us writing a stupid report  
16 this says everybody ought to be in Kaiser Permanente.

17           [Laughter.]

18           MR. HACKBARTH: You know what I mean. It ain't  
19 going to happen, not in my lifetime.

20           So bear with us and let's try to figure out if we  
21 can come up with something. I'm under no illusion about the  
22 complexity and the political barriers. Maybe we'll decide

1 at the end it just isn't worth the candle. But let's go a  
2 little further before we...

3 DR. REISCHAUER: My contribution was simply to say  
4 that I don't think there's a way out of the virtual bind.  
5 And you can convince me that I'm wrong by going down to the  
6 next level and showing me how these people -- not the  
7 hospital but the other people -- are going to get paid and  
8 what they're going to get paid, just sort of an example.  
9 You don't have to do it now. And why, when they aren't part  
10 of the forced team, they will understand what's happening  
11 and all, or think it's fair.

12 MS. MUTTI: Maybe just a word would add some  
13 clarity now and we can keep playing this out in future  
14 meetings, too. But just to be clear, our vision of virtual  
15 bundling is that the Medicare payments rates would still --  
16 the current ones -- would still go for each provider. There  
17 would be something like -- and this gets to what Nancy  
18 mentioned -- there would be some kind of withhold, some kind  
19 of reconciliation process. You understood that. Okay.

20 And then some reporting would have to coincide  
21 with this so you would know why you were not getting your  
22 withhold back.

1 DR. REISCHAUER: You were engaged in 10 episodes  
2 but it was part of a 100 episode of pool and the other 90  
3 were bad. That's why you aren't getting paid.

4 MS. MUTTI: Right. We will play that out a little  
5 more.

6 DR. CROSSON: How opportune that I'm the next one  
7 on the list. However, I have to admit to being somewhat  
8 speechless.

9 DR. REISCHAUER: We've just enrolled everybody in  
10 America in your plan.

11 DR. CROSSON: Then we do have some budgetary work  
12 to do. Thankfully, I'm becoming smarter in that category.

13 I think Glenn said it exactly correctly, that what  
14 we're really looking for here are financial mechanisms,  
15 incentive systems, whatever you want to call it, within the  
16 fee-for-service system that have the effect of creating  
17 incentives to create different structures that could  
18 subsequently be paid on a population basis. Because  
19 whatever you want to call it -- capitation is probably not  
20 the right word anymore for political reasons -- but paying  
21 on a population basis is much simpler.

22 And anything that we do, and we've talked about

1 several over the years, of looking at episodic care and  
2 trying to incent efficiency within the episodes, however  
3 good that is, it still leaves unaddressed the issue of how  
4 many episodes and opens up the possibility for gaming.

5 I think while I completely support this notion for  
6 the reasons that Nick has said and Glenn and even Bob has  
7 said, I do think we have to be -- this is really about  
8 creating new organizations with appropriate incentives  
9 because new organizations without appropriate incentives  
10 have the potential to make the situation worse. I think  
11 we've battled that issue in some ways already on the  
12 Commission.

13 I do think the notion on page eight that even if  
14 we select high cost, pretty major, not that common and  
15 discrete conditions for this, we still I bet, if not well  
16 done, open up the possibility for gaming and increasing  
17 lower intensity hospitalizations for congestive heart  
18 failure, for example, that might have been able to be  
19 managed by a good disease management process and a nurse.

20 And so I think as we go through this, we need to  
21 spend some time on what was said to be improvements in  
22 regulations and incentives to discourage the growth in

1 admissions. Because I don't know offhand exactly what that  
2 might be.

3 I think unless we do, then we're going to run  
4 smack dab into the political injections when we try to deal  
5 with existing regulatory obstacles because it will be thrown  
6 up very quickly. And even if we get past that, we could end  
7 up creating a system that has consequences which are  
8 actually opposite to what we intend.

9 So I really think we need to spend time working on  
10 that. And the whole viability of the notion could hang on  
11 that.

12 DR. CASTELLANOS: First of all, I think it's  
13 really great work and I really appreciate that.

14 Just to emphasize what Nick said on the glide  
15 path, I think one of the first things you have to do is the  
16 regulatory issues. As you well know, New Jersey Medical  
17 Society tried to get some gain sharing done and that was  
18 turned down by the state court system. I think you need to  
19 look at that, and maybe David could give us some idea  
20 whether that's even feasible.

21 I think we all have to understand what we're doing  
22 now isn't working. It isn't working very good. We may go

1 down this path and we may have a lot of bumps in the road,  
2 and we may hit some curves, and we may hit a stop sign where  
3 it says no. But we have to go there. We have to see if  
4 this works. We have to get the physician community and the  
5 hospital community together.

6 This is why I stressed this morning where Jeff's  
7 work on the high-quality, low-cost hospitals.

8 I don't know how you're going to get the AMA and  
9 the AHA on the same table. I can't even get them in the  
10 same hemisphere, they're so far apart. But that's not our  
11 problem. Our problem is to do the right thing. And I think  
12 that's what we really need to do.

13 I have a feeling, and it kind of bothers me just a  
14 little bit. We're looking at a good path to look at, but  
15 we're starting by looking and trying to find a crook behind  
16 each tree. Yes, there's going to be some issues on  
17 stunting, there's going to be some things like that. But  
18 let's not make that an impediment. There isn't a crook  
19 behind each tree.

20 Thank you.

21 DR. MILSTEIN: I agree with prior comments, that  
22 this is a very nicely laid out analysis. You really pointed

1 out all the pros and cons of most of the policy variables.  
2 I think the glide path toward bundling via virtual  
3 capitation is workable. There are some preceding models for  
4 how we might do it.

5 I think the idea of incepting it all with the  
6 hospitalization works well because most of the money that  
7 we're spending is for patients who are at high risk for  
8 hospitalization.

9 My comments, I think, actually reinforce a number  
10 of the comments that were made previously so I'll just touch  
11 on them lightly. We don't get that many opportunities for  
12 major change like this, where there is general consensus  
13 that average performance ain't good and we need to do  
14 something. We have it now. And so we want to make sure  
15 that we don't squander the energy that's there and the  
16 dissatisfaction with the baseline.

17 For that reason my inclination is, I think I said  
18 previously, would be not to be overly modest in figuring out  
19 what the geographic unit ought to be. If we thought we  
20 could move toward the total spending over the course of a  
21 year for any patient, a year subsequent to a patient  
22 rehospitalization, I would be in favor of it because it gets

1 us out of all the problems of a repeat episode.

2           And if we decide that that's not doable, then I  
3 would be in favor of more flexibility in terms of the  
4 geographic -- I need more sleep at night -- the time  
5 interval of the bundle so that we don't force advanced  
6 delivery systems down to the lowest common denominator which  
7 I think we have here, which is hospitalization plus 15 days.  
8 It's just too short and it deprives delivery systems that  
9 are prepared to take on a whole lot more longitudinal  
10 responsibility than that.

11           One idea would be to allow -- to take a page out  
12 of the CMS paper that we just read and let every provider  
13 determine what longitudinal unit they want to bid on and let  
14 the unit of comparison be whatever their baseline was but  
15 making an exception -- as Glenn has tutored me on the phone  
16 on this issue -- make an exception for those delivery  
17 systems that are already America's Toyotas. Don't take  
18 those delivery systems that are already top decile in terms  
19 of low spending and high quality and say your opportunity is  
20 only to improve upon that. I would be very generous with  
21 the very top tier, and then let the rest of them run against  
22 their prior baseline. It creates problems but it solves a

1 lot of problems in terms of fairness, I think.

2 I would err on the side of encouraging delivery  
3 systems to reach for total per person spending over the  
4 course of a year and see if we can -- that's really what I  
5 want America's hospital managers and physicians to be  
6 obsessed with. How do we achieve better health with lower  
7 per person per year spending? That's what we want. Again,  
8 I think there's some private sector models that provide some  
9 precedent for how we might do that.

10 And last but not least -- actually, this is a  
11 point I made earlier, that this is a complex system. And to  
12 the degree you can easily explain what this is all about,  
13 it's a huge advantage. I think to the degree we were to say  
14 to professors look, it's whatever your baseline was plus an  
15 opportunity for the hospital and their participating  
16 physicians who agree to this to take accountability with the  
17 hospital, it's improvement on your baseline that we will  
18 gain share with you around, obviously subject to quality  
19 simultaneously.

20 It isn't like we're starting from scratch. We  
21 have all of these demos that have been evolving over the  
22 last five years, and a lot of them -- we know now in

1 retrospect -- had some design flaws. But that's the beauty  
2 of starting now, because we have all the learnings from five  
3 or six years of Medicare demos, most of which are aimed at  
4 this issue of for a very high-risk population reducing total  
5 per member per year spending. We have a lot of learnings to  
6 build on if we allow ourselves to reach for this more  
7 ambitious longitudinal unit.

8 MR. HACKBARTH: Let me just put a place holder for  
9 one thing that I'd really like to think through between this  
10 meeting and the next meeting. I haven't thought of this as  
11 the only new payment model that might be offered. We've  
12 often talked, Nick has talked to us some about the group  
13 practice demo model which is very much what you're talking  
14 about, Arnie, where it's population over a year -- albeit  
15 still within the basic fee-for-service construct. So that's  
16 another stepping stone between where we are today and a full  
17 capitation approach.

18 My interest in this has not been at the expense of  
19 my interest in the group practice idea. I'd like to see if  
20 we can think how they can exist as alternative paths within  
21 same system. So for the most ambitious organizations, the  
22 most organized systems, you don't have to go backwards to

1 start here. We've got an advanced path for you.

2 I think we'll get into some of those selection  
3 issues again, the most advanced ones having lower cost  
4 structures and how do you avoid that, not increasing  
5 outlays. But I'd like to work through if we can have a  
6 couple of paths to walk on.

7 MR. DURENBERGER: I'm glad you said that because I  
8 was going to say something similar but in a different  
9 context.

10 First, I would just endorse the work of the staff.  
11 It is really very good, and it makes this whole thing much  
12 more understandable.

13 Secondly, to endorse all of this discussion today.  
14 It's terrific.

15 And then to endorse the continuation of your  
16 debate. Whatever is going on behind the scenes I think is  
17 very, very healthy.

18 And then to endorse what Arnie just said about  
19 what is our Toyota? To some degree, it's probably already  
20 been invented. There's probably several things out there  
21 that have already been invented, like capitation. We've  
22 said it doesn't work, or it didn't work, so we're not going

1 to give it another chance.

2           But for presentation, two thoughts. One, I think  
3 the most important way to present all of these issues is in  
4 the context of the doctor-patient relationship. So when we  
5 start a discussion like this, rather than starting it with  
6 efficiency or something like that, we ought to start it with  
7 the doctor-patient relationship. We ought to talk about the  
8 benefits to the beneficiaries of that relationship, and the  
9 benefits to the physician in the doctor-patient  
10 relationship.

11           Each time, whether we head down this one or one of  
12 the alternative courses, I think it would really be helpful  
13 to us because that will inform a lot more people about what  
14 we are doing.

15           That means basically we're realigning incentives.  
16 We have to realign not only the physician incentives and the  
17 hospital incentives, we've got to realign mine in this whole  
18 system, as well. When we think about what's the vehicle by  
19 which we do that, whether it's payment system or delivery  
20 system or something, keeping in mind the business of the  
21 aligned incentives as we articulate what are the values of  
22 bundled or bundling or something like that, I think is

1 really important.

2           And then finally, just putting this in the context  
3 of what we're going to talk about next and what we're going  
4 to talk about tomorrow morning, to add just one thing to the  
5 issue of -- this is in the context of delivery system reform  
6 or something like that. So is primary care. So is this and  
7 so forth.

8           But the one word that it would pay for us to add  
9 in there some place is accountability. Because if we are  
10 going to say this is about incentives and that sort of  
11 thing, we really need to add reforming the accountability  
12 and how does this match that as a principal?

13           MR. HACKBARTH: That's my favorite word,  
14 accountability. We're trying to build a system that has  
15 clear accountability for the results that we all care about.

16           DR. BORMAN: I would echo that I think this is  
17 obviously elegant work that's been very nicely presented.  
18 Just a couple of thoughts.

19           First off, I don't know that I'm convinced that  
20 we're going to get it right the first time we lay it out. I  
21 think we have to give ourselves some freedom to posit  
22 models, including models that will fail. I think we have to

1 be mindful of what Bill Scanlon has said about embodying  
2 models in law because they are difficult walk away from.  
3 But I think if we don't allow ourselves some room to be  
4 wrong, we will inhibit our ability to get to somewhere  
5 worthwhile.

6 I think that we all need to be aware that  
7 regardless of our vision in moving forward, the market is  
8 certainly moving more rapidly perhaps than we will ever get  
9 to. It is becoming, I think, a reasonably evident trend  
10 that we're moving toward a dichotomous provision of care in  
11 the sense that we have the capability of doing some very  
12 entrepreneurial almost fee-for-service base ambulatory and  
13 short stay kinds of things and more complex things are  
14 certainly more migrate on the in-hospital side. And  
15 physicians are migrating into two populations and primarily  
16 doing one kind of work or another. That's happening  
17 regardless of what we say.

18 I think that this certainly has some of the  
19 benefit of this will primarily pull in what has become a  
20 more homogeneous group of physicians who are providing  
21 inpatient care, particularly of the non-major procedural  
22 side so that it gives us some possibility of working.

1           A couple of concerns about this. Number one, when  
2 we talk about somebody is getting admitted to a hospital  
3 today, they're a pretty sick puppy. This is not somebody  
4 that's coming in for the spring tune up to just get the  
5 executive physical and have some things tweaked. This is  
6 somebody who truly has some significant illness.

7           And I think if we don't at least get some data  
8 about some short time period before that, we'll lose a big  
9 chance to influence the system on what could have been  
10 prevented and some education to the individuals involved.

11           And I think, in addition to using payment to force  
12 organization, this sounds to me a bit that we're using a  
13 payment to get to an education.

14           A little bit, touching on what Bob brought up, I  
15 think when you report resource use, you're going to have to  
16 share something about the entirety of the episode for the  
17 individuals to know, to become agents of peer pressure, but  
18 also to understand what they can do better. So I think  
19 you're going to need to know what the ED did versus what the  
20 hospitalist did or whatever and provide not just an  
21 individual's own use to him or her. But you're going to  
22 have to provide some fairly significant information of the

1 episode or that educational opportunity will be lost. If  
2 you don't have the educational opportunity, you're going to  
3 have anger and backlash and not education and peer working  
4 together result from it.

5 I am somewhat less worried, and probably naively,  
6 then some about that this will move things back into the  
7 hospital for inappropriate reasons. I think a fair amount  
8 has gone on in the background that will make that very  
9 difficult to do. I think there's a whole host of  
10 practitioners that only go to the office know or only go to  
11 the hospital. And the notion that all of a sudden you're  
12 going to flip that switch and they're going to change that,  
13 I think is less a possibility than it might have been 10  
14 years ago.

15 I think some of the things we did inadvertently  
16 moved stuff to the outpatient setting. I'm not sure that it  
17 will turn around and react in exactly the same way. The  
18 market is different. The expectations of people finishing  
19 medical school and residency are different about what their  
20 lifestyle is going to be.

21 And while I have to admit there's clearly got to  
22 be risk, I'm a good bit more confident that there will be

1 some market and practitioner behaviors that will reduce that  
2 risk.

3 MR. HACKBARTH: Like Karen, as I listened to the  
4 conversation I was listening about Bill's earlier comments  
5 in the context of skilled nursing facilities and not having  
6 a reverse gear and the like.

7 So as we think about the path from here to there,  
8 wherever there might be, we've got a few concepts on the  
9 table for how to structure that path. One is the measured  
10 implementation that is shown on slide nine. That's one type  
11 of way to get from here to there.

12 Another very traditional one is demo first.

13 And the third is the pilot concept that was used  
14 for the disease management and now I think health support  
15 project, where for areas of the country it would be  
16 required. And then you would do evaluation and the  
17 discretion would be vested in the Secretary to move to  
18 implementation without having to go back through the  
19 legislative process again.

20 There may be some others out there. I'd like to  
21 sort of keep all of those in mind. They're not necessarily  
22 mutually exclusive. They can be combined to create a path

1 from here to there.

2 Good work. Thank you very much, and look forward  
3 to the next conversation.

4 Last, but certainly not least for today, is  
5 promoting the use of primary care. Cristina, Kevin and John  
6 are going to do it.

7 Welcome back, Cristina. We missed you.

8 MS. BOCCUTI: Thank you. It's nice to be missed,  
9 and nice to be back.

10 MR. HACKBARTH: You said that with less  
11 enthusiasm.

12 MS. BOCCUTI: The Commission has expressed  
13 interest in exploring ways to promote the use of primary  
14 care services and the professionals who provide them. By  
15 primary care we're talking about comprehensive, acute, and  
16 maintenance health care that includes coordination with  
17 other health services. Typically, primary care physicians  
18 are trained in internal medicine, family practice, and  
19 geriatric medicine. Advanced practice nurses, such as nurse  
20 practitioners, may also be providing primary care.

21 Today, Kevin and John and I are going to review  
22 the importance of primary care and its risk of

1 underprovision and then introduce an initiative to promote  
2 the use of primary care services. I'll first talk about  
3 medical programs with specific attention to design  
4 questions, and then John is going to talk about maintenance  
5 of certification efforts, and Kevin some fee schedule change  
6 ideas.

7           The Commission's SGR report included a chapter on  
8 ways to improve value in Medicare. One of those ways was to  
9 increase the use of primary care services and reduce  
10 reliance on specialty care. This goal can improve the  
11 efficiency of the health care delivery without compromising  
12 quality. Research from Elliott Fisher and colleagues show  
13 that areas with more use of specialty-oriented care are not  
14 necessarily associated with improved access to care, higher  
15 quality, better outcomes, or even greater patient  
16 satisfaction. Other research has found that nations with  
17 greater reliance on primary care have lower mortality rates  
18 on certain measures.

19           Despite these findings, Medicare's fee-for-service  
20 payment system provides no encouragement for beneficiaries  
21 to seek services, when appropriate, from primary care  
22 providers instead of our or before specialists.

1           Primary care services really do risk being  
2 undervalued. Previous MedPAC work has found that compared  
3 to procedurally based services, cognitive services, which  
4 are a hallmark of primary care, are less able to realize  
5 those efficiency gains. Thus, they really risk becoming  
6 undervalued and consequently under provided when physicians  
7 view them as less profitable. Further, we see a steady  
8 decline in the share of U.S. medical students entering  
9 primary care residency positions.

10           The first initiative we're going to discuss is  
11 medical homes. Broadly speaking, a medical home serves as a  
12 central resource for patients' ongoing terror. They're  
13 often associated with patients' primary care providers but  
14 patients could choose a different kind of specialist for a  
15 mate chronic condition such as endocrinologist for patients  
16 with diabetes. Medical home initiatives have the potential  
17 to add value to the Medicare program. Ideally, through  
18 better care coordination, medical comes could enhance  
19 communication among providers and thus eliminate redundancy  
20 and improve quality. They may also improve patients'  
21 understanding of their condition and treatment and thereby  
22 reduce patients' use of high-cost settings like emergency

1 rooms.

2 Another important goal includes enhancing the  
3 viability of primary care practice.

4 In its June 2006 report, the Commission discussed  
5 care coordination programs, which is a major component of  
6 medical homes. Through literature reviews and interviews we  
7 found two functions essential for good care coordination,  
8 namely care manager -- usually a nurse -- and that person  
9 assists the patient in self-management and monitors patient  
10 progress.

11 The second is an information system to identify  
12 eligible patients and store and retrieve patient information  
13 and share information with those who need it. We also found  
14 that integration with the patient's physician was key.

15 So the details of designing and implementing a  
16 medical are numerous and involve trade-offs. Your mailing  
17 material included 10 questions on implementation but today  
18 I'm only going to select five of them because of time. We  
19 can, of course, discuss others if you'd like during the  
20 question-and-answer period.

21 I also want to mention that CMS is grappling with  
22 some of these issues, too, as it's in the design phase of

1 the demo, the medical home demo that was enacted by the  
2 TRHCA legislation

3           So a crucial question rests on our definition of a  
4 medical home. Frankly speaking we, meaning the staff here,  
5 have been in meetings and attended conferences where it  
6 becomes clear that people in the same room have very  
7 different concepts of what they're talking about when they  
8 talk about a medical home. So there does lack some  
9 consensus in the policy community about what really defines  
10 a medical home. So I think it's important for the  
11 Commission to first have a discussion about what exactly  
12 it's envisioning what it's talking about a medical home.  
13 And then when we get into the implementation questions we're  
14 all on the same page about our initial concept.

15           So in this slide I've listed dimensions that you  
16 might consider when defining a medical home. For example,  
17 do you define a medical home by the services it provides  
18 beyond the diagnosis and treatment, such as health IT and  
19 electronic medical records? Or do you further define a  
20 medical home by its size? Do practices need certain types  
21 of providers to be called a medical home? Are medical homes  
22 defined by their responsibility for overall resource use and

1 patient health outcomes? And finally, would an external  
2 body be used to accredit and thus define a medical home?

3 A major component for medical home design is its  
4 payment structure. This slide presents a continuum of  
5 payment models organized from left to right by the amount of  
6 financial risk borne by the medical home. Among these four  
7 payment models which are in the columns three concepts  
8 generally are in play: the size of the a monthly payment;  
9 whether or not the medical home could continue billing fee-  
10 for-service; and the amount of risk that the medical home  
11 takes on. So for example, would the medical home be at risk  
12 for Part A and Part B or just Part B, or none?

13 And of course, across all of these payment models,  
14 payments to medical homes could also be at risk for quality  
15 indicators.

16 An important question is whether or not  
17 beneficiaries would be able to seek care from specialists  
18 without a referral from their medical home. On the more  
19 restrictive end of the continuum, a referral could to be  
20 required from the medical hope to see all specialists. Or  
21 for a medical ground, one might consider certain specialties  
22 such as gynecology for women to be exempt from referral

1 requirements. And then on the looser end, no referrals  
2 would be required to seek specialty care.

3 This question is important and certainly involves  
4 trade-offs. Encouraging beneficiaries to seek guidance from  
5 their primary care provider on whether or not to see a  
6 specialist could result in lower spending, on average,  
7 without necessarily compromising health outcomes. Requiring  
8 referrals also gives more leverage and prestige to the  
9 medical home. However, beneficiaries may object to apparent  
10 restrictions on access to specialists. Similarly, some  
11 specialists may object that access to their care is being  
12 impaired.

13 If medical homes are at a financial risk for  
14 patients' resource use then they may need tools to influence  
15 specialty visits and referrals, as we were going through on  
16 the slide before.

17 Another consideration in designing a medical  
18 program is the size of the program and which beneficiaries  
19 could be eligible to participate. A targeted approach, say  
20 on beneficiaries with a selected condition like CHF, could  
21 focus efforts where they might be needed most and also allow  
22 the program to start on a smaller scale and then grow more

1 slowly. However, opening up the eligibility pool encourages  
2 beneficiaries to establish relationships with their medical  
3 home from the beginning of their enrollment in Medicare.

4           Finally, some have suggested that in order to  
5 promote the use of primary care services we should consider  
6 beneficiary incentives. Such incentives could go toward  
7 joining medical homes or for seeking primary care services  
8 in general. For example, beneficiaries who join medical  
9 homes could have a reduced monthly Part B premium. They  
10 could also have tiered cost-sharing for fee schedule  
11 services, say 15 percent for primary care services and 25  
12 percent for specialty services. But these differences are,  
13 of course, mitigated for those who have supplemental  
14 insurance, which is most of the Medicare population.

15           Medicare could also undertake public education  
16 efforts to inform beneficiaries about the benefits of  
17 primary care, and, of course, of medical homes.

18           John is going to take you through our next  
19 section.

20           MR. RICHARDSON: Thank you, Cristina.

21           I'm going to talk about maintenance and  
22 certification programs that are another option that Medicare

1 could consider to promote the delivery of high-quality  
2 primary care services to Medicare beneficiaries. First,  
3 I'll describe what MOC is and then go over some options from  
4 Medicare to use maintenance and certification to promote  
5 primary care.

6 MOC programs are voluntary continuous professional  
7 developing programs that have been developed over the past  
8 few years by small but growing number of the physician  
9 specialty boards that are affiliated with the American Board  
10 of American Specialties, or ABMS. MOC programs build on the  
11 traditional board certification process, under which a  
12 physician must have valid unrestricted medical license, must  
13 pass a comprehensive formal examination of medical knowledge  
14 and clinical judgment -- typically every 10 years -- and  
15 must periodically test the currency of their medical  
16 knowledge using board approved self-examination tools.

17 MOC programs incorporate all three of these parts  
18 of the traditional process but add a key new component,  
19 self-evaluation of the physicians' practice performance.  
20 The details of this component of MOC programs vary based on  
21 the specialty board that's developed the program but all of  
22 the programs are developed according to general criteria set

1    forth and maintained by the ABMS and the Accreditation  
2    Council for Graduate Medical Education.

3           The MOC program developed by the American Board of  
4    Internal Medicine provides an useful illustrative example of  
5    the practice performance self-evaluation processes that make  
6    these programs distinctive from the traditional Board  
7    certification process.  So we'll give you a quick overview  
8    of the ABIM Practice Improvement Modules.  The ABIM has  
9    developed 15 practice improvement modules that range from  
10   condition specific, such as treatment of patients' diabetes  
11   or hypertension, to practice structure and systems, such as  
12   how the practice communicates with subspecialists or manages  
13   its hospitalized patients.

14           Basically, the participating physician or group  
15   practice works with the ABIM through a web-based tool to  
16   analyze its current prices and outcomes, identify areas for  
17   improvements, and then reevaluate its performance after  
18   redesigning some of its processes to achieve the desired  
19   performance goals.  The ABIM determines whether the  
20   physician or group has satisfied the program's requirements  
21   and should be designated as having completed the module and  
22   thus receive credit card toward maintenance of his or her

1 board certification.

2           For Medicare, the self-evaluation aspect of the  
3 practice improvement modules or other MOC programs  
4 equivalent processes raise an important policy issue about  
5 where the ultimate locus of responsibility and  
6 accountability should be for ensuring that physicians or  
7 groups have met the program's requirements. This is one of  
8 the issues that we will be looking into in more detail as we  
9 research this further.

10           How could Medicare use MOC to promote primary  
11 care? One approach Medicare could consider would be to  
12 increase payments to physicians who meet MOC criteria from  
13 the primary care specialty boards that have developed MOC  
14 programs, which currently includes the ABIM and the American  
15 Board of Family Medicine. Payment increases could be  
16 implemented through a pay for performance program or through  
17 an across-the-board increase in payments to physicians who  
18 have met Medicare's designated MOC requirements. In either  
19 case, the payment changes could be made in a budget neutral  
20 fashion by decreasing payments to physicians who do not meet  
21 the designated criteria.

22           It's also worth noting the potential impact on the

1 quality of primary care services that recognizing and  
2 working with MOC programs could have on those services.

3           There is precedent for this activity. Over the  
4 past few years some private health insurance payers have  
5 begun incorporating primary care MOC programs into their pay  
6 for performance and other provider recognition programs.  
7 For example, the Aetna Mid-Atlantic region recognize certain  
8 network primary care physicians in the plan's provider  
9 directory if they are enrolled in ABIM's process and if they  
10 have completed ABIM's diabetes practice improvement module.  
11 Qualifying physicians receive credit towards their  
12 performance scores under Aetna's pay for performance  
13 program, as well as being recognized in the provider  
14 directory.

15           Other payers that are recognizing aspects of  
16 ABIM's MOC program in particular include the BlueCross  
17 BlueShield Association and some regional BlueCross  
18 BlueShield plans, CIGNA, Humana, United HealthCare, and the  
19 Detroit-based Health Alliance Plan. MedPAC could analyze  
20 these private payer programs and determine what components  
21 of them are adaptable to Medicare's fee-for-service  
22 reimbursement system. We would also want to assess their

1 compatibility with other Medicare program changes  
2 recommended for being considered by the Commission, such as  
3 implementing physician pay for performance or measuring  
4 physician resource use.

5           One potential policy concern is that MOC  
6 requirements could be weakened if Medicare decides to base  
7 payment increases on individual physicians' participation.  
8 Medicare's recognition of MOC for payment purposes could put  
9 pressure on certifying boards to dilute the standards for  
10 their programs so that more physicians would qualify for the  
11 enhanced payments. To address this concern, Medicare could  
12 create its own process for reviewing and approving MOC  
13 programs, or could adapt a third-party evaluation framework  
14 such as the one currently under development by the National  
15 Quality Forum.

16           Next, Kevin will discuss options for the physician  
17 fee schedule adjustments that could be used to encourage  
18 more primary care.

19           DR. HAYES: Thank you. With some changes, the  
20 current fee-for-service payment system for physician  
21 services, the physician fee schedule, could be a tool used  
22 to pay for medical homes and reward careers in primary care.

1 One way to do so is to increase the fees for specific  
2 services in the fee schedule of services such as visits.  
3 This is what we mean by the fee schedule adjustments listed  
4 first on this slide.

5 We have some new ideas to discuss on this and I'll  
6 get to them in just a minute. Before doing so however, it  
7 is worth recalling that the Commission has already  
8 considered some policy changes that could help reward  
9 primary care. Time prevents me from reviewing each of them  
10 in detail. Let me just say that some of the policy changes  
11 you have discussed would indirectly increase payments for  
12 primary care. I say indirectly because the fee schedule is  
13 budget neutral. Decreases in fees for some services result  
14 in redistribution of dollars to other services. Decreases  
15 in fees for specialty care and, therefore increases for  
16 primary care, could incur as a byproduct of three changes in  
17 policy the Commission has considered: improving the five-  
18 year review of relative values for physician work, improving  
19 the accuracy of payments for practice expense, and  
20 automatically adjusting relative values for services with  
21 rapid growth in spending.

22 By contrast, the more direct way of increasing

1 payments for primary care could be through use of  
2 comparative effectiveness information. We would expect  
3 primary care services to compare better in their  
4 effectiveness than many other services. Because of this,  
5 primary care could garner higher payments if comparative  
6 effectiveness information is used to inform the level of  
7 payment.

8 Another fairly direct way to intervene would be to  
9 have an expenditure target structured on type of service.  
10 In other words, a type of service SGR. While not listed  
11 here, such a change in policy is discussed in the  
12 Commission's SGR report. As the report shows, with a type  
13 of service expenditure target if primary care services have  
14 a primary growth rate that is lower than their target, they  
15 could get a higher update.

16 So there we have a kind of summary of some of the  
17 ideas that you've discussed previously. Now let's move on  
18 to this idea of fee schedule adjustments.

19 Briefly, they can include either adjusting fees  
20 for selected services or further targeting the adjustments  
21 toward not just selected services but also specifying that  
22 the adjustments are available only to selected specialties

1 and those furnishing a medical home.

2           Let's look first at fee schedule adjustments that  
3 apply to selected services. The adjustments could occur  
4 through the conversion factor with a conversion factor that  
5 is higher for primary care than for other services. Another  
6 way to implement the adjustments would be to define new  
7 services in the fee schedule and assign relative value units  
8 to them that are high enough to reward primary care. Either  
9 way, the adjustments would depend only on the service  
10 billed.

11           The difficulty here -- and Jack, this gets us to  
12 the chart that came up earlier when you were asking about  
13 billing for E&M services by specialty. The difficulty here  
14 is basing the adjustments only on the service is that it is  
15 a somewhat efficient way to adjust payments for those  
16 furnishing primary care. Depending on the service, many  
17 types of physicians and other providers could furnish the  
18 service eligible for the adjusted payments. For instance,  
19 we see here that in the case of office visits, physicians in  
20 multiple specialties furnish the service. The two  
21 specialties that account for most of the billing for these  
22 services -- internal medicine and family practice -- are

1 typically thought of as furnishing primary care.  
2 Nonetheless, much of the billing for office visits is  
3 attributable to physicians who also furnish more specialized  
4 care, such as those in cardiology and orthopedic surgery.  
5 If a payment adjustment were based only on the service  
6 furnished, physicians in a number of specialties could  
7 receive the adjustment along with primary care physicians.

8           To target the adjustment toward those who furnish  
9 primary care, it is possible to have a policy that considers  
10 not just the service but also specialty and whether the  
11 service is furnished in a practice with at least some of the  
12 features of a medical home. In specifying which specialties  
13 are eligible, the specialties could be say internal  
14 medicine, family practice, and geriatric medicine. Other  
15 specialties may step forward, also. In addition, there  
16 could be a decision that advanced practice nurses are  
17 eligible for the adjustments.

18           As to basing the adjustments on whether the  
19 services are furnished in a medical home, Cristina spoke to  
20 that topic, of course, so I will not go into it here but we  
21 hope that there is some further discussion of the points  
22 that Cristina made. For now, let me just say that there

1 would need to be say a performance measurement system that  
2 would allow physicians to attest to furnishing a medical  
3 home.

4           To summarize then, we are talking about fee  
5 schedule adjustments that would have requirements in three  
6 areas: one, what services they are and whether they're  
7 eligible for the adjustment; two, the specialties receiving  
8 the adjustment; and three, the medical home. A payment  
9 adjustment would occur if a claim meets the requirements in  
10 all three areas.

11           In submitting a claim for payment, those billing  
12 Medicare could say that they have met these requirements by  
13 including a special code number -- known as a modifier --  
14 with the billing code for the service furnished. Modifiers  
15 are used in the payment system now to adjust payments for  
16 such things as receipt of a bonus for furnishing services in  
17 a health professional shortage area. The presence of a  
18 primary care modifier on the claim would trigger an  
19 adjustment which, as a multiplier for a service's RVUs,  
20 would bring about higher payment.

21           With such adjustment, an issue to resolve is how  
22 to reliably determine physician specialty. Physicians

1 declare a specialty when they apply to bill Medicare.  
2 However, they can change their information when they add a  
3 billing location or for some other reason. With payment  
4 adjustments that depend partly on specialty, further  
5 policies may be needed that would define what specialty  
6 means and to set criteria for a change in one's specialty.

7 To conclude, it is worth observing here that the  
8 fee schedule adjustments we have presented represent a  
9 change in the underlying intent of payment for physician  
10 services. Adjustments that considers say specialty and  
11 medical home would be different from the current system,  
12 which tries to account for differences among services and  
13 resource costs but, as we have seen, does so in a way that  
14 is not without its problems.

15 Instead of accounting for just resource costs,  
16 adjustments that reward primary care would be a way to  
17 achieve other policy goals. Doing so would require the  
18 exercise of judgment, however. Instead of a formula, as we  
19 have now, decisions would be necessary to set the level of  
20 the adjustments, basing them say on the availability of  
21 budgetary resources.

22 That concludes our presentation. These are the

1 key points that we covered. We look forward to your  
2 discussion.

3 MR. DURENBERGER: Thanks very much.

4 I've already made reference to this in my previous  
5 comment, the context comments, that looking at the  
6 importance of primary care and its risk of under provision  
7 is a really important element in redesigning health care  
8 delivery. But commenting, if I may, on the presentation the  
9 way it's presented, it seemed like we got very quickly into  
10 the medical home. We got very quickly into the solutions.  
11 And I'm going to suggest that perhaps we spend just a little  
12 bit more time defining primary care in the beginning or do  
13 it perhaps in a different way.

14 The first question is what is it? It's  
15 physicians, but it's also a lot of ancillary health  
16 professionals. It's also cognitive and a lot of these other  
17 things you've talked about. But then there's a variety of  
18 these specialties. Some of them have been mentioned,  
19 geriatrics and mental health and behavioral health and oral  
20 health. There's just a lot of things that will help people  
21 understand the breadth and the depth of the services. So  
22 that when we talk doctor/patient relationship, we're

1 reminded that primary care is all around us and it has a  
2 higher value than most of us give it, and certainly a higher  
3 value than third-party payers give it.

4           The second thing is why is it important? Simply  
5 stated, it's like health maintenance and care coordination.  
6 Because it's at that level that we expect to get the  
7 professional advice we need on health maintenance. Whether  
8 we take it or not, that is the level of expectation that  
9 most of us resort to. Ask any mother who is just having a  
10 child, or particularly if it's their first child. That's  
11 where we go.

12           Third, the problems with it, which are in part  
13 alluded to here. But I'm trying to think of it in a  
14 different way to present it. The first is a quality  
15 problem. That's the way I look at the overvaluing of  
16 specialty medicine and specialty services. The result of  
17 that, of course, is that supply induced health care  
18 delivery, which is called overuse by the Institute of  
19 Medicine and a lot of other people. So we have a serious  
20 quality problem with the current system.

21           As you point out, we also have an efficiency  
22 problem because we really haven't defined value and how we

1 pay for it.

2           Thirdly, the way I define productivity, we have a  
3 productivity problem that comes from professional barriers  
4 to primary care. The last time I went in for my physical,  
5 I'm sitting there with my internist and my computer and all  
6 my information. I say what's the next thing you're working  
7 on? He said we're trying to break through the grasp that  
8 gastroenterology has on diagnostic colonoscopies but they  
9 won't let go. Well, you can take this to anesthesiology and  
10 nurse anesthetists. You can take it through all of these  
11 professionals. I think it is worthwhile -- again in the  
12 context of what is value in primary care -- to lay out some  
13 of the barriers that the professional associations over time  
14 have built to getting value from primary care.

15           The fourth one then deals with education.  
16 Clearly, we're over educating a lot of physicians, in  
17 particular, and we're under financing education in this  
18 country. There's no doubt about that. We're driving people  
19 away.

20           But a third factor that we learned exploring  
21 whether or not our university ought to get into the medical  
22 school business is we are admitting the wrong people to

1 medical schools if we expect a family practitioner or a  
2 community health person physician or a geriatric specialist  
3 to come out the other end. We need to be admitting into the  
4 medical schools of this country and using whatever our  
5 financing techniques are to reward a different kind of a  
6 person, largely being -- and Tom Dean taught me that and he  
7 sent me to a professor at the University of Nebraska. We  
8 need to go to the same place that all the universities go to  
9 that want health professionals. They go to the same people  
10 that want to go into the ministries and that want to go into  
11 other caring professions.

12           So I think it -- I know our business is financing  
13 access and how do we change the financing of the access.  
14 But in terms of making the case, whether it's for the  
15 medical home or these other solutions we have, it seems  
16 important to be making a case for primary care and its  
17 importance, whether it's the geriatric population like me or  
18 it's some other population, and showing the existing  
19 barriers that seem to favor the more specialized approach  
20 that also need to get taken down.

21           DR. CROSSON: I'd like to start by complimenting  
22 the staff for laying out these ideas. We have said we want

1 to do something about the primary care problem. It's a lot  
2 easier to say we want to do something than it is to figure  
3 out how we would exactly go about doing that, although we  
4 have made some, I think, progress on the payment side.

5           With respect to the medical home thing, it seemed  
6 to me -- and I'm at the risk of oversimplifying here. But I  
7 have heard John Tooker present a number of times and others,  
8 and remember actually when the American Academy of  
9 Pediatrics first started this notion. What I thought this  
10 really was was the idea that primary care physicians, mostly  
11 in small practices, using information technology and team-  
12 based care, using ancillaries, could be enabled to improve  
13 quality at least -- the issue of efficiency, I think, has  
14 been hedged a bit -- but improve quality through better  
15 coordination of care. And that many small practices just  
16 don't have the time and money to invest in some of these  
17 tools, whether it's information technology or different  
18 types of communication with patients by phone or through the  
19 Internet, unless they have some financial resources to do  
20 that. And that was essentially the proposal.

21           As the notion was laid out here, and I suspect  
22 this has something to do with some of the discussions that

1 are going on around the CMS project and NCQA and the like,  
2 it does appear to take this in a rather different direction.  
3 And to me -- we can call it anything that we want to -- but  
4 it doesn't really sound very much like the original notion.  
5 It sounds to me more like it's heading in the direction of a  
6 euphemism for an accountable care organization.

7           Because when you start talking about issues like  
8 risk bearing for hospital services, you can't do that at the  
9 level of a small practice. You can't even do it really at  
10 the level of a medium-sized practice. It takes a  
11 significantly larger organization. I think if you're  
12 talking about even capitation for physician services, and  
13 certainly for capitation for specialty services at the  
14 primary care level, you're also dealing with a potential  
15 ethical concern. I would never promote that sort of pre-  
16 payment. And also, if you want to throw in there the  
17 gatekeeper notion, then we really have a back to the future  
18 element here.

19           I'm just concerned about us following down that  
20 direction. Unless we really think that what we've got going  
21 on is a set of discussions which are eventually going to  
22 lead back to the same place we were talking about a little

1 while ago, which is the need to create coordination at an  
2 integrated institutional level, in which case we ought to  
3 say that.

4           The last point is just on the maintenance and  
5 certification thing. I think I agree with the point that  
6 was made, which is that this direction is going to have to,  
7 in the end, include most of the physicians in the specialty.  
8 I don't really think it's going to be broadly supported over  
9 time if it, in fact, starts to exclude a significant portion  
10 of the physicians in a specialty.

11           So if we assume that that's the case, even without  
12 linking it to Medicare, then I'm not sure I get why we need  
13 to connect -- because in the end if we're going to reward  
14 the physicians who succeed in maintenance and certification  
15 through the Medicare program, then we drop to item three  
16 which is how we're going to pay them. What the payment  
17 increases would be based, which is the third consideration.

18           And if you assume that most of the physicians in  
19 primary care are probably going to be successful in  
20 maintenance and certification, then we've just created I  
21 think a lot of complexity to what otherwise would be just  
22 simply increasing the payments.

1           MR. HACKBARTH: Can I get you to react to the  
2 first point about bearing of financial risk and whether  
3 that's consistent with the medical home model?

4           MS. BOCCUTI: My first reaction I think is  
5 analyzing a policy or a program like this, it's important to  
6 look at the whole continuum. That's why this is up there.  
7 So you could say that that's not defining a medical home.  
8 The Commission doesn't think that a medical home is one that  
9 takes on risk for Part A and Part B.

10           Then if you keep moving down towards the right on  
11 this continuum, you get to no risk or some share of fee-for-  
12 service spending. If they got a monthly fee, that could  
13 only go for the medical home activities.

14           So there are spans, I think, within the model that  
15 I'm hearing from you, a payment mechanism. Is that where  
16 you're going?

17           MR. HACKBARTH: As I understand the medical model  
18 that ACP and the family physicians and others have been  
19 talking about, there is a monthly fee but no insurance risk.  
20 The purpose of the monthly fee is to cover expenses, as Jay  
21 said, that aren't paid for under the fee-for-service system.  
22 Those could be expenses related to infrastructure like

1 clinical information systems. They can also be for  
2 physician and nurse practitioner and other services provided  
3 to the patient but are currently not recognized for payment,  
4 educational activities or telephone consoles or e-mail  
5 consults and the like.

6 Part of the idea, as I understand it, is that when  
7 -- for example, paying for e-mail consults has been talked  
8 about. There's some very obvious problems that that raises.  
9 You'd be talking about small payments, incurring lots of  
10 claims processing expense and big issues of potential fraud  
11 and the like. And so they're suggesting let's bypass that.  
12 It's not an activity that's appropriate for a fee-for-  
13 service payment. But there may be still real value in it.  
14 So let's use a flat per patient payment as the vehicle.

15 But it's very different from the old primary care  
16 capitation model, which proved so problematic in the 1990s,  
17 where physicians were asked to bear financial risk for  
18 referrals and drugs and hospital services.

19 MR. BERTKO: I just wanted to say, I think I  
20 interpreted Cristina's comment exactly right. She presented  
21 a continuum and then -- I'll take Jay's comment and earlier  
22 Bob's impossible comment, and say this glass might be half

1 full rather than half-empty. You pick that third column  
2 there and say let's look at the primary care fee models that  
3 happened in Medicaid, this is it. We could actually do this  
4 in a year-and-a-half. The third column, the risk-adjusted.

5           There are models in Medicaid. You take a year to  
6 define it and you turn it on 1/1/10, and we have something.  
7 With the goal that we all explicitly or implicitly say.  
8 This is all morphing towards ACOs some day. But this would  
9 begin setting up some of this infrastructure. So in that  
10 sense, Glenn, you just described most of the decisions that  
11 would be made. There just needs to go through the process  
12 to get there.

13           DR. MILLER: I would also draw your attention to  
14 the bottom of that third column. It does involve some risk,  
15 which a lot of people are not talking about the medical home  
16 doing. All we're trying to do is force this conversation.

17           You said, Jay I'm uncomfortable with these two  
18 columns over here. You've talked just to the third column.  
19 There are people who I think are still pretty uncomfortable  
20 even with the bottom part of that next to the last column.  
21 This is the conversation we need to have.

22           DR. REISCHAUER: [off microphone] The bottom

1 could also be bonus payment at the end of the year based on  
2 all of the book of business.

3 DR. MILSTEIN: I think it would be helpful for me  
4 just if there was clarity as to what is a job we're trying  
5 to do? One definition of the job is to stay look, despite  
6 our best efforts primary care fared very poorly over the  
7 last 10 years and we want to, on a one-time basis, reset.

8 The second idea, which is more what we're talking  
9 about now, it could be a completely independent idea, is do  
10 we want to begin to incentivize a more robust variant of  
11 primary care? I just want to point out, those are two  
12 different jobs. It would be helpful for me to just maybe  
13 have clarity as to are we trying to get both jobs done? Or  
14 can we do one and not the other?

15 MR. HACKBARTH: Your point is a good one. They  
16 are different jobs. In the full range of the presentation  
17 there were some ideas discussed that would address each.  
18 The medical home idea is more about changing the structure,  
19 building a structure. An example of the other is type of  
20 service SGR. It's strictly a redistributinal device. It  
21 doesn't try to change how the services are divided. It's  
22 let's divide the money differently. And then some of the

1 other proposals may fit somewhere in between on the  
2 continuum.

3 DR. REISCHAUER: I'd like to say it's not clear  
4 that these are totally separate because a lot of what  
5 medical home is going to do does go on now and is not  
6 reimbursed. So it sort of kills the two birds with one  
7 stone.

8 DR. CASTELLANOS: I like the idea. I really do.  
9 I think, from a physician's viewpoint, what we're trying to  
10 do is enhance the respectability and the desirability for  
11 primary care. One of the ways we can do that, again I'm  
12 going to be repetitious, is starting in the medical school  
13 right from the get-go and talking about the goals that we  
14 have talked about in our core programs and getting the  
15 medical school student right from the beginning interested  
16 in primary care and the value of primary care.

17 However, the viability is going to be tied to and  
18 related to reimbursement. And we really need to, as we all  
19 discussed earlier on many times, we need to increase the  
20 reimbursement issues for the primary care. We can do it  
21 through the medical home or the E&M charges. How do we do  
22 it? What are the payment schedule changes? I would

1 certainly avoid the RBS's. I really would. It's a domino  
2 effect and it would affect too many other issues.

3 I think it would be much easier to do with a  
4 conversion factor or a modifier, as we do so often.

5 One of the things that Dave said earlier is what  
6 are the goals? We need to start not from the top down but  
7 right where the patient is and work from the bottom up. I  
8 think once we go there, I think it's going to be pretty easy  
9 to work out a lot of the goals.

10 As far as referrals to specialties, again I think  
11 we knew what happened in the 1990s with the HMOs. I would  
12 certainly suggest maybe a cost-sharing progressive increase  
13 to see specialties.

14 DR. WOLTER: Most of mine is a pick up on some  
15 things others have raised, but I too thought we had sort of  
16 a couple major themes unfolding in this chapter. By the  
17 way, I think it's really excellent in terms of it outlines  
18 some of the questions we have to answer. One is promoting  
19 primary care, and the other really is coordination of care.  
20 I think those two circles highly overlap but they don't 100  
21 percent overlap.

22 So how do we want to draw that distinction? Are

1 we primarily focused on the patient here who needs  
2 coordination of care? Because I think that leads to a  
3 slightly different list than if we're primarily focused on  
4 better reimbursement for primary care patients.

5           And I'm very supportive actually of the idea of a  
6 medical home and of primary care docs being in the thick of  
7 that and giving them incentive to kind of do a better job on  
8 some things that can really make a difference to patients.

9           In my own organization we're doing a lot of this,  
10 but it isn't focused only on primary care. Our cardiology  
11 department runs our congestive heart failure clinic and the  
12 patients who go through that actually might have a primary  
13 care doctor. We often try to keep them seeing that doctor.  
14 But in between these visits actually the key players are  
15 nurses. And they're not always advanced practice nurses.  
16 But that's really where the rubber hits the road in managing  
17 these patients between doctor visits.

18           Also, we have found that, for example, the  
19 importance of registries is really high. Most practices  
20 really couldn't, if they were asked, on the same day pull  
21 out a list of all of their diabetics. It took us six months  
22 to rewrite some software for our new IT, which I've

1 mentioned here in the past, to be able to know who our  
2 diabetics were and then to be able to give our internists  
3 lists of all of their diabetics so we could start holding  
4 them accountable to getting diabetics all the appropriate  
5 measures. It's been an incredibly valuable program since we  
6 put that together.

7           But there's a lot of intersecting pieces. I think  
8 the major point I'm trying to make here is I think however  
9 we define the medical home, there are some infrastructure  
10 standards that will need to be in place. And I think some  
11 of those can be met by small practices. For other much more  
12 complex patients maybe it will be more difficult. But to me  
13 that would be key if one of our goals is better coordination  
14 of care, in addition to incenting development of more  
15 primary care providers.

16           So I think the distinction there and how do we  
17 want to position this chapter is really important. Do we  
18 really want to coordinate care? And then within that,  
19 primary care is a major thrust but there are going to be  
20 some other options. Or is it primarily about primary care  
21 development and how it can coordinate care, and we can deal  
22 with the other approaches sort of in another place?

1 I think some clarity might help us there.

2 MR. HACKBARTH: Helped me, Nick, think about that.

3 As you know, there are a number of existing Medicare demos  
4 aimed at the broad issue of care coordination, for example  
5 the health support demos that identifies patients with  
6 certain costly diseases. They work on that care  
7 coordination plane. It isn't primary care, it's patient  
8 focused, disease focused. And so the way I sort of fell  
9 into this conversation, not through reason but just by  
10 accident, is more thinking about primary care.

11 To get back to Arnie, I think of the tasks being  
12 both tasks, to increase payment for the specialty to improve  
13 its relative attractiveness, but also help to build  
14 infrastructure so that primary care practices can do their  
15 job better or pay for infrastructure that exists but has  
16 been uncompensated in the past.

17 So I'm thinking of primary care, not so much care  
18 coordination.

19 DR. WOLTER: We're going to pay the primary care  
20 doctors for something, and it seems like we're talking about  
21 care coordination.

22 MR. HACKBARTH: They cross, absolutely.

1 DR. WOLTER: So I'm just saying that that's great.  
2 I am 100 percent supportive of it because I think that's a  
3 great place to do a lot of this work. But there is an  
4 infrastructure need around mid-level providers and  
5 registries. And then there's an accountability issue. Even  
6 if we're not holding people at risk for the annual cost of  
7 care for a beneficiary, will we be able to track that this  
8 work actually does a good job starting to deal with that? I  
9 think we'd want to do that. We'd want to at least provide  
10 the information.

11 Now we are into care coordination. So do we want  
12 to allow group practices to be medical homes? Or groups of  
13 cardiologists if you've got somebody with congestive heart  
14 failure and hypertension that needs cholesterol control and  
15 you can do it very effectively.

16 I just want to think through some of the nuances  
17 of it. That doesn't mean I'm not 100 percent supportive of  
18 really trying to create a lot of emphasis on primary care.

19 DR. KANE: First, I wanted to say I am very  
20 supportive of the medical concept and just recognizing  
21 primary care and paying for what they do would be terrific,  
22 however we do it.

1           But what I'm thinking about as I listen to the  
2 discussion also about the bundling and the A and B is how  
3 many reforms can you start at once? And is there some  
4 better than others to start with? Do we want to start on  
5 the acute side with the Part A/B bundle and watch that blow  
6 up politically? Or do we want to start with something that  
7 has an earlier win like a medical home or chronic disease  
8 management payment?

9           I'm just thinking, one of our alums is a German --  
10 he's the head of an institute that's now involved with  
11 health care reform. And they just implemented a giant  
12 nationwide disease management program for diabetics, paying  
13 every primary care doctor a certain amount to be willing to  
14 be in the protocol, and then paying the patients to sign up.  
15 It's been in place for about three or four years and it's  
16 had huge impact so far on the evaluations.

17           Those are the kinds of things where early wins are  
18 kind of simple, they're kind of easy. It wasn't easy, he'll  
19 still tell you it's not easy.

20           But I wonder if we're going to eventually look at  
21 all of these and try to rank them by where we really want to  
22 start? Is bundling in A and B really the place to start?

1 Or is it more in this chronic disease management primary  
2 care? And then is it everybody or is it the chronically ill  
3 already? It would be nice to start that way. I feel like  
4 we're getting into the details before we kind of know where  
5 our big wins are likely to come from.

6 And my only other question is -- I think I did  
7 this before, so I'm going to start like a broken record --  
8 but is Part D part of any of this? Or is that just outside,  
9 kind of running along on its own lack accountability or  
10 whatever? Do we want to start making -- certainly you'd  
11 think that for chronic disease management, if you can't  
12 include Part D utilization, and how will that be brought  
13 into the payment model and the responsibility model?

14 I feel that's been left out of the bundle for A/B  
15 and also the medical home. Where is Part D in all of this?

16 MR. HACKBARTH: Let me just react to the first  
17 part of what you say, Nancy. It's a really important point.  
18 The system -- system broadly defined, MedPAC, CMS, the  
19 Congress -- has a finite and distressingly small capacity  
20 for change. We've noted that from time to time.

21 So one way to conceive of our task is to say well,  
22 we need to set priorities like we ran this system and we

1 managed the resources and so here's the path. This is the  
2 top priority, this is second, this is third, and the like.

3 I don't think that's the right role for MedPAC to  
4 be in, for two basic reasons. One is that although we're  
5 all vaguely aware about the system capacity and limits, we  
6 really don't in many meaningful sense understand the system  
7 capacity. So any judgments we made about what could be done  
8 would be really seat-of-the-pants, ill-informed.

9 But even more important than that is a point that  
10 Mark has taught me, which is the policy process has a  
11 certain quixotic element to it. You don't know when the  
12 time is going to be right for a particular idea. And maybe  
13 the best way to think about the way we can contribute is to  
14 work on a number of important ideas. We ought to filter for  
15 importance but not try to be too rigid about this is first  
16 and this is second, or even necessarily how they all  
17 integrate with one or another in the final plan. We need to  
18 be opportunistic in creating ideas that can go into the  
19 policy process and if the conditions are right, move  
20 forward.

21 So I wouldn't try to be overly rational about what  
22 we do, although I understand the impulse. It's where I

1 live. But as Mark tells me, I need to sit back and relax a  
2 little bit and accept. He is clearly the role model for  
3 doing that.

4 DR. KANE: I feel you're already doing it with the  
5 Part A/B, saying here's the way the trajectory should work.  
6 I guess maybe we shouldn't spend a whole lot of time either  
7 worrying about whether we're virtual or mandatory because as  
8 you say -- what do they call it, the garbage can theory, the  
9 stars line up? How sausage is made, right.

10 I guess that goes back to how deep do we want to  
11 go into any of these ideas if it's really going to be a  
12 sausage -- oh, I don't like sausage.

13 MR. HACKBARTH: I do think there's a bit of a  
14 difference in saying here in concept is a path to get from  
15 here to a destination, as opposed to saying okay here's how  
16 many resources are required to do a medical home and here's  
17 how many for bundling and here's how many for something  
18 else. We don't know what those resources are. We couldn't  
19 make informed judgments about those things.

20 I do think it's reasonable to only talk about  
21 ideas we think are important. And then, when we talk about  
22 those ideas, to say here are some ways that you might get

1 from here to there. I do think those are reasonable steps.

2 DR. BORMAN: First to say a couple of things about  
3 MOC. I would tell you, and you might want to verify with  
4 ABMS, but this is not an entirely voluntary effort by a few  
5 boards. All 24 member boards of the American Board of  
6 Medical Specialties must be in the process of implementing  
7 MOC. This is not some little mom and pop show by a few  
8 boards. This is all boards, in order to remain member  
9 boards of the ABMS, are at various stages in their MOC  
10 development. MOC has some standard pieces, parts one  
11 through four, that each board must address. And each board  
12 must get its MOC plan signed off on by the ABMS. So just to  
13 give a little background about MOC.

14 In parallel, there is an effort going on that's  
15 under the leadership of the Federation of State Medical  
16 Boards that relates to MOL, maintenance of licensure. There  
17 are some pieces of that, as well, that will relate to all  
18 physicians.

19 I would like to just offer a note of caution about  
20 integrating this too tightly, MOL or MOC, in anything we  
21 propose. This has got a lot of rapidly moving parts. And  
22 while I think we all want to look at various quality

1 designators -- and I, for one, believe that Board  
2 certification is a quality designators -- I think we want to  
3 be a little bit careful about getting so far down the road  
4 as saying this might be a way to attach payment or whatever.  
5 I just regard that as very premature and I would offer some  
6 caution on that.

7           Relative to the issues of payment favoring primary  
8 care and the medical home, that kind of thing, trying to  
9 tease out what it is we're really trying to represent here  
10 as I listen to this is something -- I think maybe what  
11 characterizes it is the deepest or the most ongoing doctor-  
12 patient relationship. I think doctor there, as Nick has  
13 pointed out, may be doctor plus. And very often various  
14 ancillary individuals are a piece of that team.

15           If that's the case in what we're really seeking,  
16 then I think that it's -- I'm not sure whether it's best  
17 connoted by primary care, medical home, or what it is. I  
18 was only urge that we try to come to some agreement about  
19 what four or key elements of it are. Just like was said in  
20 the presentation, every time I hear somebody talk about the  
21 medical home I think I hear new twist on it that I didn't  
22 hear from the other folks.

1           In my view, a few of those things might be if this  
2 is indeed marked by the depth or breadth or longevity of the  
3 doctor/patient relationship, it relates to care  
4 coordination. It relates to 24/7 responsiveness. And I  
5 don't hear that necessarily coming out in most discussions  
6 of the medical home. And I think if the medical home is  
7 going to have any impact, it's going to have a take on 24/7  
8 responsiveness. I would urge that as a feature of it.

9           Another is that I think a huge cost area of the  
10 Medicare program and health care in general relates to end  
11 of life and futile care. And I think one of the pieces of  
12 this relationship needs to use that somehow as a marker.  
13 And whether that's something as simple as your medical home  
14 and you document a conversation about your advance directive  
15 wishes or something more sophisticated, I really don't know.  
16 But that seems to be, to me, another very important element  
17 of this.

18           I would like to echo Bob's comment about maybe  
19 considering this in the form of a performance based bonus  
20 over a period of time based on an aggregate of patients and  
21 their outcomes, as opposed to trying to attach this to  
22 individual services or individual patients. I think all we

1 do there is we take a very complex system that we already  
2 have and make it even more complicated. And I would be more  
3 in favor of trying to make this simple.

4 I also think that making it simple maybe asks us  
5 to be a little bit up front about what we're really trying  
6 to do because I think it makes the options more simple. If  
7 the action here is to say that our goal here is to pay  
8 certain specialties or certain service givers more, then we  
9 just need to be real up front about that. And finding back  
10 door ways to do it through manipulating RVUs I think is  
11 really not in anybody's best interest. It just relates to  
12 creating more hostility and resentment, I think, for the  
13 dishonesty really that it represents.

14 And so I think that if we want to say we're going  
15 to define a body of services for which we wish to provide  
16 payment in a nontraditional way that's not face-to-face,  
17 that's not subject to the RBRVS or any other constraints, I  
18 think that's fine. But I think that's what we need to say  
19 it is that we're trying to produce here and do our very best  
20 to define what that is and measurement what that is and  
21 reward quality and doing it.

22 I think the interdigitation with Part D, I would

1 support Nancy very much, because obviously advice about  
2 drugs and their appropriate use. In some cases, trying to  
3 make drugs go away. I think what I hear from geriatricians  
4 is that oftentimes the very biggest benefit they can offer  
5 is stopping all the drugs and starting over. So I think to  
6 leave the drugs out of it is probably not a very good idea.

7           And then the last thought I would leave is that I  
8 keep hearing cognition and procedures. I'd like to remind  
9 you there are some other pieces to the system here. And  
10 that relates to tests and imaging, and maybe some other  
11 things other than major procedures. And that E&M and major  
12 procedures both have experienced relatively smaller growths,  
13 and that one of the goals may be to set out a medical or  
14 coordination of care or primary care or whatever it is we're  
15 going to get ready to pay for here is making sure that we're  
16 paying only for the appropriate services and tests. In some  
17 case that may mean increase in volume of certain tests that  
18 are good in chronic disease management.

19           But for every patient with a thyroid nodule that  
20 comes to me with sono, a thyroid scan, and either a CT or an  
21 MRI, clearly is a place where savings could be made and it  
22 rests in the hands of the owner of that patient initially.

1           Those would be just some thoughts to throw out.

2           MR. EBELER: Quickly, I think in part what we're  
3 trying to do is narrow the scope of future staff work. But  
4 if you start with page six, I would agree with the general  
5 consensus that we're talking about column three. Columns  
6 one and two aren't what we're talking about here.

7           If you go to page eight in terms of targeting, I  
8 don't know what to pick here. My impression is a chronic  
9 care medical home is a very different thing than a primary  
10 care case management medical home. It just strikes me as  
11 you're asking it to do -- it would be useful to me just to  
12 have a straw man, what is a complex chronic care medical  
13 look like? And what is a primary care medical home for the  
14 average non-chronically ill person? Because if we have to  
15 pick, we've got to pick. But it strikes me as two different  
16 animals.

17           On page 10, I'd agree with Karen. It's terrific  
18 that the professions are doing this. It doesn't strike me  
19 as something that Medicare payment will help, and might  
20 kill. It comes out for purposes of this discussion.

21           On page 12 on the fee schedule stuff, in some ways  
22 to me this looks like a phasing schedule. I know the fee

1 adjustments are blunt. Evaluation and management is blunt.  
2 On the pie chart, only two-thirds gets to primary care  
3 physicians, if you read it aggressively. But my guess is  
4 it's a pretty good portion, to get to Bob's point earlier,  
5 of that primary care physician's income.

6 So it may well be that's something you start with.  
7 I'd worry that we missed an opportunity to follow up on  
8 Nancy's recommendation this morning.

9 Then you move to these longer-term policy changes  
10 where you are in effect trying to get that. So it strikes  
11 me that you start with one and then move to two possibly, as  
12 a way to think about this.

13 MR. HACKBARTH: Okay, thank you. Good work.

14 We'll now have a brief public comment period. The  
15 same ground rules as this morning, no more than a couple of  
16 minutes and identify yourself again.

17 MR. SHAW: John Shaw from Next Wave.

18 Just something brief, trying to get hands around  
19 the bundled payment around the hospitalization. I had a  
20 hard time conceptualizing, as well. Maybe it's not  
21 impossible but difficult.

22 What makes it easier is trying to take a patient,

1 Alice, and conceptualize here into maybe three families of  
2 glide paths. The first that was presented looks like an  
3 acute glide path and might be a good fit for AMI or  
4 pneumonia. There may be another glide path where looking  
5 across the time frame, you may want to look out prior to  
6 admission for avoidable hospitalizations, looking out  
7 however long is appropriate for that particular avoidable  
8 hospitalization. And then the third family might be those  
9 that have an extended recovery that we talked about a lot  
10 during the day, post-acute care and things like that.

11           The glide path for the extended recovery, I'm not  
12 sure step two and three apply to. That just looking at the  
13 hospital and doctor, without looking at post-acute care,  
14 probably may not be meaningful.

15           The other thing that would be necessary in that  
16 glide path is to have a uniform assessment tool across all  
17 the different silos that fit in that category.

18           The last thing with all of them, step one may be  
19 the most important of all the steps. Because if you get the  
20 transparent view of the entire stay for a particular  
21 condition and make that available, I think you will get a  
22 lot of ideas coming out from that, just that alone.

1                   MR. HACKBARTH: Okay. Thank you, and we will  
2 convene at nine o'clock tomorrow.

3                   [Whereupon, at 5:42 p.m., the meeting was recessed  
4 to reconvene at 9:00 a.m. on Friday, January 11 2008.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, January 11, 2008  
9:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair  
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.  
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.

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

2 MR. HACKBARTH: Good morning, everybody.

3 We are going to depart briefly from the published  
4 agenda and quickly go back to our discussion and  
5 recommendation on special needs plans that we voted on at  
6 the last meeting.

7 Jennifer, you will take it from here and explain  
8 what's going on?

9 MS. PODULKA: No problem. This is just a brief  
10 correction on one of our list of seven recommendations --  
11 let me just go ahead and put this up.

12 This is the draft recommendation six, that the  
13 Congress should basically change dual eligible  
14 beneficiaries' enrollment opportunities. If you remember  
15 from December's meeting, what I said was that dual eligibles  
16 are able to change plans on a monthly basis. The  
17 commissioners were concerned that this was one factor that  
18 contributes to marketing abuses to dual eligibles.

19 Bill, at that time, I believe you asked a question  
20 about special enrollment opportunities for institutionalized  
21 beneficiaries. I erred in my answer to your question.

22 Dual eligibles and institutionalized beneficiaries

1 enjoy the same enrollment opportunities. So right now what  
2 we're going to discuss is a very limited wording change, and  
3 that's extending this draft recommendation to both dual  
4 eligibles and beneficiaries who are institutionalized.

5 DR. MILLER: Italicized word.

6 DR. HAYES: Right, so the only change to the  
7 wording in the bold-faced recommendation is on the screen in  
8 the bold-faced word. The Congress should eliminate dual  
9 eligible -- and this is the change -- "and  
10 institutionalized" -- the rest of the same -- beneficiaries'  
11 ability to enroll in Medicare Advantage plans, except  
12 special needs plans with state contracts, outside of open  
13 enrollment. They should also be able to continue to  
14 disenroll and return to fee-for-service at any time during  
15 the year.

16 MR. HACKBARTH: Okay, so we need to vote on that  
17 amended language.

18 All opposed to the new language? All in favor?  
19 Abstentions?

20 Thank you, Jennifer.

21 Now we'll go back to the published agenda, the  
22 first item on which is delivery system reform.

1           MR. GLASS: Good morning. I don't think we'll be  
2 quite that fast on this one.

3           We're thinking of a chapter in the June report  
4 with ideas for improving program sustainability through  
5 payment and delivery system reform. At our November meeting  
6 you asked us to include our policymaking framework as part  
7 of the chapter. We'll briefly review this framework today  
8 as well as a possible direction for delivery system reform  
9 that follows from it. This should help put in context the  
10 discussion of medical homes and bundling that you had  
11 yesterday.

12           The motivation for the Commission to talk about  
13 payment and delivery system reform is the current status of  
14 the Medicare program. Medical technology has advanced, life  
15 expectancy has increased, and the Medicare program has  
16 fulfilled its basic mission of providing the elderly and  
17 disabled access to medical care. However, in spite of, or  
18 maybe because of, that success the Medicare program is  
19 projected to be fiscally unsustainable over the long-term.  
20 We must increase the value of what the program is buying to  
21 increase quality and reduce cost growth. Even if that's  
22 done, sustainability could still be a problem and other

1 changes to Medicare financing or benefits might still be  
2 necessary but they are not the subject of today's briefing.

3           The Medicare program is unsustainable over the  
4 long term because of the size of the projected financial  
5 shortfalls. The Congressional Budget Office estimates that  
6 Federal spending on Medicare and Medicaid will rise from 4  
7 percent of GDP today to 12 percent in 2060. CBO also points  
8 out that most of the increase is from higher costs per  
9 beneficiaries, not an increase in the number of  
10 beneficiaries. It is the growth rate of spending.

11 Moreover, the incentives that are inherent in the current  
12 payment system will continue to drive rapid growth if  
13 unchanged. The fee-for-service system will always reward  
14 increases in volume.

15           Now if more were always better, there might be an  
16 argument for trading off other social goods for more health  
17 care spending. But the evidence is that more is not  
18 necessarily better. Looking at differences in spending  
19 across geographic areas shows that higher spending is not  
20 associated with better outcomes or higher quality. In fact,  
21 there's often an inverse correlation, more is worse. Or to  
22 put it another way, value for the dollar is lacking.

1           Others, such as IOM, have determined that small  
2 changes at the margin are not going to change the direction  
3 of cost growth. Fundamental changes are needed in the  
4 payment system to help catalyze the fundamental delivery  
5 system changes that are needed to increase value. So let's  
6 look at what we mean by increasing value.

7           As the first part of our policy framework, we have  
8 defined four determinants of the program's value. The first  
9 of these is access to care. Beneficiaries need to be able  
10 to obtain care, and the care that is delivered should be  
11 appropriate for their clinical needs. For example, they  
12 have access to primary care and not just the emergency room.

13           Second, quality of care. Care should be safe,  
14 effective, patient-centered, and timely.

15           Third, efficient use of resources. Efficiency,  
16 that is producing a given quality outcome with the least  
17 resource input. This influences the cost and sustainability  
18 of the program and makes the best use of the taxpayer's  
19 dollars.

20           And finally, equity. This is fairness among  
21 providers and beneficiaries and it is a judgment. It's  
22 subjective. But it encompasses issues such as beneficiary

1 out-of-pocket costs, adequacy, and comparability of provider  
2 payments.

3           Some of these concepts overlap. For example,  
4 beneficiaries cannot have high quality care if they do not  
5 have any access to care. Access and equity are also  
6 interrelated.

7           Just for clarification, although some of the  
8 concepts may be applicable inside the Medicare Advantage  
9 program, as well, this presentation concentrates on  
10 increasing value in the fee-for-service program. The  
11 pressing issues with the MA program have a different focus  
12 and we have discussed them elsewhere so we'll not do so  
13 today.

14           To help judge whether policy proposals will help  
15 increase value, we analyzed some of the problems in the  
16 current Medicare fee-for-service program such as lack of  
17 accountability and care coordination, lack of usable  
18 information, inaccurate prices, and poorly targeted  
19 technology diffusion, and arrived at the following  
20 principles for improving value. These principles are the  
21 second part of our framework.

22           First, we would want any policy to promote

1 accountability and care coordination. Will providers be  
2 held accountable for the Medicare resources used by the  
3 beneficiaries they treat? Will the policy encourage  
4 providers to coordinate care with other providers and break  
5 down some of the barriers that current payment systems may  
6 create?

7           Second, we need to create better information and  
8 tools to use it. So we would ask will the policy encourage  
9 the collection and dissemination of clinical resource  
10 information, and tools to make collection dissemination and  
11 analysis of the information easier, and not place an undue  
12 burden on CMS, providers, and beneficiaries?.

13           We also want to improve incentives. We want to  
14 encourage higher efficiency -- both lower-cost production  
15 and higher quality -- rather than increases in volume.

16           In addition we would ask does the policy address  
17 the problem that it's intended to solve efficiently? For  
18 example, does an intervention focus on the provider or  
19 beneficiaries for which it creates the most value?

20           And finally, we want to set accurate prices. Will  
21 the policy send the correct signals to the providers,  
22 beneficiaries, and purchasers and avoid unduly favoring some

1 services and beneficiaries with certain characteristics over  
2 others?

3           If these principles were put into practice, it  
4 would be a major step for Medicare. But to get maximum  
5 value, policies should also promote alignment with the  
6 private sector. Coordinating programs in the public sector  
7 with those in the private sector would provide greater  
8 leverage on providers and at the same time decrease the  
9 administrative burden on providers. For example, using the  
10 same measures in public and private P4P programs would  
11 greatly simplify and reduce the cost of gathering data.

12           With this as our analytic framework, we now turn  
13 to realizing value through payment and delivery system  
14 reform.

15           This is the big picture for outlining a long-term  
16 direction for payment and delivery system reform and it puts  
17 into practice our principles for improving value. Glenn, we  
18 didn't have enough room for the fourth column that you  
19 mentioned yesterday with the ultimate solution at the other  
20 end. We'll work on that.

21           We are now in the first column, under current fee-  
22 for-service payment systems. The basic problem with all

1 fee-for-service systems is that they reward increasing  
2 volume, although to varying degrees. In general, if you do  
3 more you get paid more. Also, because they're distinct and  
4 separate, there's a problem of coordinating across payment  
5 systems.

6           The Commission has recommended using the tools in  
7 the middle column to try to increase value in the fee-for-  
8 service system consistent with the policy framework we've  
9 just discussed: a comparative effectiveness entity to give  
10 providers and payers information on what works best; pay for  
11 performance programs within existing fee-for-service payment  
12 systems to reward quality providers; reporting resource use  
13 to inform physicians of the consequences of their practice  
14 patterns and how they rank relative to their peers; bundling  
15 individual services within a payment system to encourage  
16 efficiency within the bundle as recommended for outpatient  
17 dialysis; and creating pressure through updates to limit  
18 cost growth, as you discussed yesterday in the hospital  
19 system.

20           However, there are two major limitations to these  
21 tools. First, marginal rewards may not be sufficient to  
22 overcome the incentives for more volume. A small quality

1 bonus won't drive someone who is seeing five patients an  
2 hour to seeing only three. Second, working within  
3 individual systems inhibits changes in the delivery system  
4 that either cross borders or extend over time. For example,  
5 as Dr. Kaplan from Virginia Mason discussed with the  
6 Commission some time ago, physical therapy may be less  
7 costly, more effective, and provide greater patient  
8 satisfaction than an MRI for back pain but there's no reward  
9 for doing that substitution now.

10           So we're exploring three approaches for overcoming  
11 these limitations. They pay for care that spans provider  
12 types and time and they hold providers accountable for  
13 quality and resource use.

14           You discussed the first two concepts, medical home  
15 and bundling, yesterday. The medical home, I won't go  
16 through those discussions but it's interesting that the  
17 medical home discussion you had yesterday links in with the  
18 determinants of value we've discussed in this briefing, the  
19 24/7 access that Karen talked about as being a feature of  
20 the medical home, for instance, would increase access.  
21 Several people thought it would increase quality. It would  
22 certainly increase equity between primary care and the

1 specialist providers.

2           You also discussed bundling, and that's either a  
3 good theory for the things we've shown up here or perhaps  
4 impossible, as was discussed yesterday.

5           But the third concept is accountable care  
6 organizations. This is a broader concept. It would be a  
7 group of physicians, and possibly a hospital as well, that  
8 would take responsibility for a population of patients for a  
9 broad set of services over some period of time or episode.  
10 They would be held accountable for performance on quality  
11 and resource use for that population and have an incentive  
12 to control volume. Payment could be fee-for-service with  
13 some add-on or possibly some form of capitation or virtual.  
14 This would present many difficult issues of its own, which  
15 we will discuss if you want us to develop that issue.

16           The goal of all of these approaches is increasing  
17 value for the Medicare program, its beneficiaries, and the  
18 taxpayers. That means is creating payment system incentives  
19 for providers that reward value and encourage closer  
20 provider integration, which in turn would make use of tools  
21 such as P4P even more beneficial. Each of these proposals  
22 will require careful consideration of unintended

1 consequences and will present many thorny issues to be  
2 resolved, including the following fundamental questions.

3           Should incentives be based on individual physician  
4 performance, physician group performance, or the joint  
5 performance of physicians and hospitals? It may be  
6 desirable for groups of physicians and hospitals to be  
7 jointly responsible for a common set of process and outcome  
8 measures. If they share responsibility for each measure,  
9 their incentives would be aligned to work together to  
10 improve performance. However, some providers may be  
11 reluctant to be held responsible for outcomes that are not  
12 completely in their control, and making a group rather than  
13 an individual the locus of responsibility may dilute the  
14 magnitude of individuals' financial incentives to improve  
15 their performance.

16           The second question is what responsibilities do  
17 beneficiaries have? Should cost-sharing be designed to  
18 motivate patients to use certain providers? To what degree  
19 should patients be locked into seeking care from the set of  
20 providers once they pick their provider? These were raised  
21 in the medical home discussion yesterday.

22           Should we wait for payment policy proposals to be

1 fully demonstrated and evaluated, or should we move more  
2 rapidly? Even if payment reforms were adopted relatively  
3 quickly, we may need to wait another five or 10 years to see  
4 improvements in the value of care delivered. It is  
5 difficult to determine how long we should spend gathering  
6 additional information while delaying changes in the current  
7 health care system. Some observers may be reluctant to risk  
8 harming the system with rapid untested changes. Others, who  
9 feel the current system is performing poorly, may be more  
10 willing to take risks to speed health care system reform.

11 Another question is are changing the financial  
12 incentives enough or will additional steps be needed? For  
13 example, several commissioners have suggested that graduate  
14 medical education needs to change. Others have suggested  
15 that restrictions on physician self-referral may need to be  
16 tightened.

17 And finally, does there need to be a penalty if  
18 providers do not participate? Providers attaining high-  
19 quality, improving quality, and restraining resource use  
20 should receive above average Medicare payments. However, to  
21 induce physicians to be active in new incentive systems,  
22 does there need to be a substantial penalty for those who do

1 not actively participate? Should the existing SGR or  
2 something similar to it be used to constrain payment to non-  
3 participants to induce participation?

4 I leave these questions for your discussion.

5 Thank you.

6 MR. HACKBARTH: Okay, thank you, David. Well  
7 done.

8 Let me offer a few thoughts to get us started.

9 First of all, this is for the June report. I  
10 can't remember if you mentioned that in your presentation.  
11 It's not for the March report. We've got some time to work  
12 on this and refine it to get it ready for June.

13 A second comment, as I see this chapter it's a  
14 directional statement. What we're trying to do is capture  
15 the Commissioners' thoughts about the general direction that  
16 policy needs to those over a fairly long period of time.  
17 That was the spirit that we discussed at the summer meeting.

18 With that in mind, I think the shorter, the  
19 tighter the statement we can make the better, the more  
20 useful it is. I have some thoughts, David, about where we  
21 might take out some material in order to highlight the  
22 really major points about the direction that we want to go.

1           In that same vein, I think we need to think  
2 carefully about how much detail and how much specificity we  
3 want to use in our examples, medical home, et cetera.  
4 Because concurrently, on a separate track, we're sort of  
5 looking at those as potential policy options for bold-face  
6 recommendations. We may decide to do them and embrace them  
7 in that discussion or we may decide to modify them. So we  
8 need to think about how -- obviously, we want to give some  
9 examples to give some meat to this directional statement but  
10 we have to be careful that we don't go too far.

11           One last thought is in terms of the directions we  
12 want to go, I think an important theme worth underlining a  
13 little more prominently is the synchronization idea. You  
14 mentioned it here in your presentation and it's in the  
15 paper, as I recall. At least to my way of thinking, that's  
16 sort of a major idea. And by synchronization here, I'm  
17 referring to trying to get the signals sent by public and  
18 private players more clearly outlined. There are multiple  
19 components on that. We should be using common measures,  
20 potentially using common datasets so we give consistent  
21 feedback to providers, maybe even be setting common clinical  
22 goals so that we can focus people on Nick's low-hanging

1 fruit. I know there's lots of issues to be discussed in  
2 there but that's my perspective.

3 So there are a few thoughts that I have.

4 MR. DURENBERGER: Thank you. I agree with  
5 everything that you've said and I really love the way the  
6 paper is shaping up. My comments are intended largely for  
7 context.

8 When I present on this subject, I usually start  
9 with a picture used in my 1982 campaign of me in my shirt  
10 sleeves like this, my arms crossed, holding a pipe in my  
11 hand, looking endearingly at whoever's looking at the  
12 picture. And I say that picture was taken when I was  
13 chairing the Health Subcommittee in the Senate Finance  
14 Committee, the guy with the pipe. Then I will laughingly  
15 say to younger audiences that had tobacco in it, not the  
16 kind of pipe you guys got raised on, that sort of thing.

17 And then I will mention, because he is deceased  
18 and wouldn't mind my saying it, that my predecessor as  
19 Chairman of the Health Committee, Herman Talmadge, sat there  
20 and smoked a cigar.

21 But the tagline on it is if I had known then what  
22 I know now, and then the rest of the comments.

1           What I did know in the early 1980s, because of  
2 experiences that we had had in Minnesota prior to that, my  
3 own personal experiences before I was elected to the Senate  
4 involved building what is now Buyers Health Care Action  
5 Group. They were no buyers in the system so how could you  
6 buy intelligently? And so we built that capacity.

7           So what I did know as we began this change of the  
8 health policy from reasonable and customary charges of  
9 Medicare into something else, I did know the value of real  
10 competition. I did know the value of informed consumer  
11 choice. I knew the importance of aligning incentives and of  
12 informing those choices. Part of that was instinctive  
13 maybe, but the larger part was all the work that had  
14 proceeded getting into the Senate.

15           What was good about that period in the 1980s, and  
16 particularly looking at the Senate side, was there were a  
17 lot of people just like me, starting with Russell Long and  
18 Bob Dole and Bob Packwood, and I can mention plenty of  
19 others.

20           The two of us, probably, that felt the most  
21 strongly about changing the direction that we're talking  
22 about doing here from this volume-based bill paying service

1 were John Heinz and I. And I think both of us had had  
2 experiences, he in Pennsylvania and I in Minnesota, with the  
3 importance of doing that.

4           So prior to 1982 we were experimenting -- despite  
5 objections from John Cogan, who was then at OMB -- we were  
6 experimenting with HMO cost-based choices. Obviously we  
7 thought they worked pretty well. But it was kind of hard to  
8 prove that because somebody would say yes, that's Minnesota  
9 or that's Seattle or Portland or wherever it was, one of  
10 those kind of deals.

11           My point is that in a contextual sense from the  
12 time that we did the TEFRA risk amendments -- John Heinz put  
13 that on the budget bill in 1982 and then we did prospective  
14 payment in 1983 -- we intended a two-track course to finding  
15 ways to build accountability through the payment system.  
16 They both emerged about 1985. But the earlier track, the  
17 1982 track, was basically to privatize the Medicare program  
18 eventually by using the then-existing HMO-like  
19 organizations, paying them 95 percent of the fee-for-service  
20 dollar and seeing what they could do with it. And the other  
21 track was prospective payment for everybody.

22           When I reflect on what we did at that period of

1 time, I say I wish I'd been smart enough to say let's keep  
2 the risk contract HMO thing going in the communities in  
3 which it was working. We went, for example, in the Upper  
4 Midwest we were that top quartile -- including Nick and  
5 North Dakota and places like that -- of spending AAPCC. And  
6 in two or three years we went to the bottom quartile. And  
7 was all because doctors changed their behavior working with  
8 local health plans in one way the other.

9           So let the rest of the country do the prospective  
10 penalty thing or opportunity thing and the rest of us will  
11 do the competition among the health plans, the competition  
12 between providers, and all that sort of thing.

13           I'm not going to go through the evolution of that  
14 except to make the argument that as we present this paper  
15 and a clear, succinct, straightforward way, and as you urge  
16 us to think about synchronization, I really think it's  
17 important, particularly for the policymakers -- all of whom  
18 are new and their staffs are all new to this sort of thing -  
19 - not to think that somehow Medicare Advantage started in  
20 2003. It had a 20-year or more lead time. This is not new.  
21 It's not that it hasn't been tried.

22           And I'm refortified in thinking about this by this

1 little thing Arnie said yesterday, which is what's our  
2 Toyota. There's one here on my left that's an American  
3 Toyota. And we have other examples around the country.

4 But from a policy standpoint it just seems to make  
5 sense to set up all of this work that we suggest doing in  
6 delivery systems with the particular accent on  
7 accountability and that sort of thing, to set that up with  
8 that kind of a context.

9 And so I would hope that we can figure out how to  
10 do that.

11 MR. HACKBARTH: Yes. In a nutshell we're talking  
12 about one of those two tracks, the non-private plan track,  
13 and how to build in accountability to that track and to  
14 bridge the silos, et cetera. Those are of the themes we  
15 want to be prominent.

16 Where did he go? I was going to move John up in  
17 the queue because I know he has to leave. I already missed  
18 my opportunity.

19 DR. CROSSON: Thank you. I have a feeling I  
20 should be delivered these remarks in Japanese but I don't  
21 have that facility, so you're going to have to bear with me.

22 Thank you for the report. I think this is heading

1 in the direction that a number of us had hoped it would head  
2 and I'm really looking forward to the June report.

3 I have a few points that are both small and large.  
4 First, a small one. The issue of the values and the point  
5 about equity I think is a good one. I was a little bit  
6 concerned that it overstated the subjectivity.

7 Now this is a strange thing to say in January  
8 after working our way through the updates that we just did.  
9 But actually, I think that to say that equity is inherently  
10 subjective is a little bit of an overstatement because, in  
11 fact, a lot of the work that we do here at the Commission,  
12 when you think about it, in the updates and some other areas  
13 is an attempt to objectify the issue of equity through the  
14 analysis that we do and we present. And I think it  
15 understates a bit our mission to say that it's just  
16 inherently subjective.

17 On the issue of the question that was raised about  
18 performance at the institutional or at the individual  
19 physician or individual provider level, it's a complex  
20 answer. I think the simple answer is that the right place  
21 is both, for two reasons. First of all, performance at the  
22 institutional level solves a number of problems in

1 performance reporting. It solves some of the mathematical  
2 problems in trying to develop a large enough N to produce  
3 statistical significance for comparison purposes. And by  
4 doing so, increases the number of things like can be  
5 measured accurately.

6           It also solves, to a large degree, the problem of  
7 attribution. That is if you have a bad result, or a good  
8 result for that matter, whose responsibility is that? In  
9 some cases it's easy to attribute that to an individual but  
10 in many cases -- particularly as care becomes more complex -  
11 - it is not.

12           There are some issues that are attributable to  
13 individual physicians. I think the direct level of  
14 satisfaction of a patient with their care is often one of  
15 those things.

16           Another reason is -- and I think here there is a  
17 natural tension that's present in this field, and I think it  
18 was well played out recently -- I think it was last week --  
19 by Arnie in his article in the New England Journal. There's  
20 a bit of a natural tension between the desire of organized  
21 systems to manage individual performance internally and to  
22 battle resistance against measurement by some levels of

1 confidentiality, at least for some period of time, versus  
2 the desire of the public if you will to have information  
3 available about individual performance. There's no easy  
4 answer to that. I think a balance needs to be created at  
5 some point.

6           And finally, I'd just like to make a couple of  
7 comments that are similar to the ones I made yesterday, and  
8 it has to do with the medical home and the bundling issue.

9           I have this notion that as we play these issues  
10 out, if we take them beyond relatively simple concepts, that  
11 they walk their way in the end back to the accountable care  
12 organization notion. I think the medical home -- I said  
13 this yesterday and I'll just repeat it briefly -- if you go  
14 beyond the initial definition as a medical home as a couple  
15 of doctors and their staff coordinating care armed with a  
16 bit of technology, and you begin to take that further into  
17 the area of using this for payment, particularly the  
18 acquisition of risk, then you begin to push it towards the  
19 kinds of structures that I think we're going to identify as  
20 accountable care organizations. You simply can't do that at  
21 that small of a delivery system level.

22           I think to the same degree a bit the bundling does

1 that. We talked a little bit about it yesterday. As we  
2 play the bundling idea out and begin to then deal with how  
3 to get physicians and hospitals to work together to deal  
4 with the payment, who controls the payment, how is it  
5 divided, how are decisions made about whether to enter  
6 bundling or not enter bundling, issues of structure and  
7 governance, there's a great likelihood that if the bundling  
8 is successful that it will eventually lead to the creation  
9 of structures. This is not a bad thing but it will  
10 eventually lead to the creation of different structures  
11 that, then properly incented, take us towards the  
12 accountable care organization idea.

13 We might think about how we want to structure  
14 these. Or are they in fact discrete? Or is there some sort  
15 of a natural dynamic that we could consider among them?

16 MR. HACKBARTH: Potential building blocks towards  
17 something different.

18 MS. BEHROOZI: Thanks. At the risk of sounding  
19 like I might be contradicting a principle that Glenn laid  
20 out, I actually really liked the comprehensiveness of  
21 bringing everything together in one place. Maybe there's  
22 just something that I need and it's very helpful for me.

1           But on that theme, there's actually something that  
2 would be -- I think it would be valuable to add in  
3 connection with some of the other concepts.

4           Even in my short time here I guess a few times  
5 I've talked about the concern about costs presenting a  
6 barrier to access for beneficiaries to appropriate care.  
7 Not an appropriate barrier to inappropriate care, but an  
8 inappropriate barrier. And sometimes the response has been  
9 well, that's what we have the low-income subsidy programs  
10 for -- I know that's the name in Medicare Part D -- but  
11 programs for people who meet certain income thresholds that  
12 are unrealistically low. Whatever else you think about Mike  
13 Bloomberg, at least he's talking about the notion that maybe  
14 the Federal poverty level is not necessarily a realistic way  
15 to judge whether people can afford what it costs to live in  
16 this society, particularly when it comes in this case to  
17 medical care.

18           So I think it's important to think about  
19 beneficiaries not only as poor or everybody else but in  
20 various strata of being able to afford or wanting to be able  
21 to conserve their resources -- we're talking largely about  
22 people on fixed incomes -- wanting to be able to conserve

1 their resources to pay for other things, like the prices  
2 that are going up because of the skyrocketing cost of fuel  
3 or whatever.

4           And we see that people behave consistently with  
5 wanting to save money by joining Medicare Advantage plans.  
6 Again, here the terminology is often "for the extra  
7 benefits." But in my experience, whether it's with my  
8 family or the retirees that we cover or whatever, it's  
9 because they want to save the money. And so they're willing  
10 to forgo a certain amount of choice. They are willing to  
11 join a plan in order to, as I said, conserve their resources  
12 to use it somewhere else and not spend it all on medical  
13 care. And that is not producing any value to Medicare, that  
14 choice that they're making, based on the lowering of costs.

15           And we've had a presentation here on value-based  
16 benefit design. And I think the concept is kind of woven in  
17 when we asked yesterday, in the presentation on medical  
18 homes, should beneficiaries be incented to join up with a  
19 medical home by having their Part B premium reduced?

20           I think it would be helpful to reflect some of  
21 that kind of concept in the paper about -- there's  
22 acknowledgment that beneficiaries will make better choices

1 based on information about higher quality providers. But I  
2 think we also have to recognize that they are already  
3 responding to economic incentives. And it's not so much the  
4 stick but the carrot of lowering costs. And like I said, I  
5 think that kind of merges very naturally into this concept  
6 of value-based benefit design. Because no matter how  
7 accurate the pricing is, as you point out in the paper, the  
8 structural flaw of the fee-for-service system is that  
9 whether it's too low a price or too high a price -- and I  
10 presume that means also if it's the right price -- there's  
11 still the inherent motivation to increase volume.

12           So that's an additional thing that I'd like to see  
13 in there. Sorry, Glenn.

14           DR. SCANLON: I wanted to relate this to a couple  
15 of themes that we had yesterday. One was the issue of how  
16 long it's going to take for all of these things to happen.  
17 And from that perspective, I think that it's important on  
18 your slide seven to recognize that we're going to live in  
19 this current fee-for-service payment world for a while.

20           The second theme from yesterday is this issue of  
21 can't we improve upon this process of updating? And I would  
22 say can't we improve upon the process of the base rates for

1 the fee-for-service program as well without some of the  
2 kinds of changes that we're talking about?

3 We talk about the update in terms of being a blunt  
4 tool for efficiency. I think one of the ways that we might  
5 get people to start to focus on doing things more  
6 sophisticated is to stop talking about how we are driving  
7 efficiency. We're driving, through our systems, incentives  
8 for lower costs. Sometimes they might be coming from  
9 efficiency gains. Other times they're coming from lower  
10 costs, which involves changing the product.

11 There are companies that can produce cars cheaper  
12 than Toyota. Does that make them more efficient than  
13 Toyota? Or are they producing something different? I think  
14 we forget that when we talk about health care when we say  
15 okay, we've done a bypass and that all bypasses are the  
16 same. It's not true in terms of the care that's going on in  
17 the hospital. A hospital, when it's facing high cost and is  
18 overpaying its executives and is under pressure, can decide  
19 we're going to cut staff, we're going to cut supplies in  
20 ways that really do have an effect on the patients. We  
21 don't capture any of that.

22 And I think that we need to consider in our

1 discussion starting this summer in terms of revising the  
2 update, also think about do we need to make more  
3 differentiation in terms of defining the product so that we  
4 are getting more value for the dollars under the current  
5 system without something that is labeled pay for performance  
6 but within the current system.

7 DR. MILSTEIN: First of all, as a Commissioner, I  
8 feel there are these periods where we go into phases of  
9 diversions where all the comments seem to take a  
10 recommendation and pull it in a million recommendations, and  
11 them moments of convergence. I'm sensing the latter this  
12 morning. It's a good feeling after yesterday, my first  
13 comment.

14 DR. MILLER: [Inaudible.]

15 [Laughter.]

16 DR. MILSTEIN: The second comment is that in the  
17 spirit of that, on the list of recommended tools one of the  
18 things that we discussed yesterday -- and as I looked at the  
19 recommended tools it seemed to me an important one for our  
20 consideration that I didn't see listed -- is CMS/provider  
21 gain sharing relative to the providers' own individualized  
22 starting point. I don't think that any of the tool

1 descriptions fit that. I think it's exemplified by most of  
2 the Medicare demos where the individual just takes whatever  
3 the baseline is, improve upon it, and then share with the  
4 government a percentage of the savings.

5 MR. HACKBARTH: Just a question on that. The way  
6 I read the recommended tools list, these are past MedPAC  
7 recommendations. And then the potential system changes was  
8 where we might go from here. Did I interpret that  
9 correctly?

10 MR. GLASS: Yes.

11 MR. HACKBARTH: So your idea would go in the third  
12 box.

13 MR. GLASS: Right.

14 DR. MILSTEIN: Thanks for that clarification.

15 DR. MILLER: Can I just also say something,  
16 because in some of the e-mail exchange that we've had, and  
17 in some of your comments -- and I want to crystallize this  
18 for people. Because a point in your thinking has only  
19 recently become clear. Some of it was the e-mail exchange  
20 over article and that type of thing.

21 I just want to make sure this is correct and then  
22 that everybody's following. You're talking about a standard

1 here where whatever the efficiency incentive that's put in  
2 place is peculiar to the given provider or group or entity  
3 that is defined by it. And then it's efficiency off where  
4 they're starting from and accumulating it over time and then  
5 saying if I have established a baseline and you come in  
6 below that, you can share in some of the savings.

7           And why I wanted to just draw that out is because  
8 I think sometimes we talk -- there are conversations that  
9 are well, we're going to have efficiency standard which may  
10 not be peculiar to the specific provider.

11           And what Arnie is saying -- and it's only  
12 recently -- and I apologize for this -- that it became  
13 clear in my mind what you're talking about. You have a  
14 different idea in mind. And I think we've had exchanges  
15 here where we've all been saying the efficiency, standard,  
16 benchmark. And I think sometimes it's been different in  
17 people's minds. And it only recently became clear to me  
18 that that was going on.

19           DR. MILSTEIN: Thanks, Mark. Thanks for  
20 articulating that. Because my intuition is that a situation  
21 in which everybody has a chance to win is better than one in  
22 which you start out with half the people winning and half

1 the people losing.

2 MR. HACKBARTH: Just one further question on that,  
3 Arnie, just so I understand your idea. The first problem  
4 that comes to my mind in thinking about that is that the  
5 Toyotas, the existing Toyotas, start from a low base. So  
6 would you address --

7 DR. MILSTEIN: I tried to clarify that yesterday  
8 in saying I think that any provider that meets our standard  
9 for excellence -- Toyota or whatever it may be -- and  
10 yesterday I speculated it might be providers that score  
11 nationally in the top quintile on both aggregate quality and  
12 aggregate efficiency. For those providers we may want to  
13 make a supplementary payment so they're not held to the  
14 standard of improvement if they're already at the very top.

15 MR. HACKBARTH: Different pool.

16 DR. MILSTEIN: Yes, for a small slice of those  
17 that we think are really -- represent the benchmark  
18 nationally.

19 So, anyway, that's a comment or two. And thanks  
20 for the clarification about the columns.

21 The third comment I want to make -- and this is  
22 really a question for everybody because I don't really know

1 the answer. It came out actually, and I remember very  
2 distinctly, in Bob's questioning of Virginia Mason, Gary  
3 Kaplan. That is when I sometimes talk about this idea of  
4 any of these payment reforms, because at the end of the day  
5 -- in the end what you're trying to do is to take out of  
6 American spending whatever fraction is associated with no  
7 gain in health.

8           The challenge for us, it seems to me today, is  
9 that number, according to many observers, is large. Gary  
10 Kaplan's estimate was 50 percent. Peter Orszag's recent  
11 compilation of expert opinion was 35 percent. The IOM  
12 estimate in their systems engineering report was 30 to 40  
13 percent. It's a huge fraction.

14           I wonder if we should maybe at some point be more  
15 explicit in our consideration of whether and the degree to  
16 which we want to think about some kind of -- I know it's a  
17 crazy term -- but reparation payments. We've got an  
18 American industry that grew and is supplying a large amount  
19 of services. There are a lot of mortgages being paid by  
20 people who are delivering on the old model.

21           And in retrospect we sort of say shame on us for  
22 creating these incentives. But 35 percent of those

1 mortgages are based on services -- if I can stretch the  
2 metaphor a little bit -- that are of no value or of value  
3 but are being produced very inefficiently and could be  
4 produced a lot less inefficiently.

5           So what is our theory by which we remove that 35  
6 percent? And when I talk to hospital executives they get  
7 this right away and they go -- or health systems  
8 representatives. They say what's the deal? Are you telling  
9 me you're going to reduce my revenue? Are you going to  
10 offset that with improved margins? They're wanting to know  
11 what the nature of the deal is.

12           And I think that if we just go after value  
13 improvement and pretend like the industry is going to accept  
14 a solution that takes away 35 percent of their mortgage  
15 payments, it's unrealistic. Maybe we should think more  
16 explicitly about what we're going to do about that 35  
17 percent waste and all of the American income, livelihoods,  
18 and future college educations that depend on that 35 percent  
19 continuing to flow.

20           My last comment, this is more of a reinforcement  
21 of what I said yesterday, anything we can do to adhere to  
22 the principles of so-called complex adaptive systems -- what

1 we're trying to do is we want quality increase in all of its  
2 dimensions while removing whatever percentage of waste is  
3 currently occurring, which is a lot. I'm no expert on  
4 complex adaptive systems theory, but what I have been able  
5 to pull from it is that what you want to aim for is the  
6 smallest number of changes likely to create the biggest  
7 forward movement.

8           And sometimes when I reflect back on our list of  
9 things, it seems to me that we don't fulfill that. When  
10 somebody says to me what did MedPAC recommend last year, oh  
11 boy, I have to go back and reread it. And even then I would  
12 be challenged to say what is the essence of it.

13           And I think that's one of the beauties of this  
14 chapter is it will, as Mitra said, will enable me to say  
15 really what we're after your is X, and X is something along  
16 the lines of what Jay described which is the creation of  
17 accountable care organizations, the scale of which is TBD,  
18 and creating an opportunity for provider gain through  
19 improved performance in both quality and efficiency.

20           It's that last point about anything we can do  
21 directionally to be able to answer in one or two sentences  
22 what it is we have in mind, I think, would be welcome among

1 many parties, including myself.

2 DR. MILLER: I'm sorry to keep responding so much  
3 or asking questions. I think there's some very fundamental  
4 things that we're discussing here, fundamental things that  
5 I've seen in our processes that I'm trying to draw out by  
6 this very conversation and by the questions we put up there.

7 Just to your final comments, which I understand,  
8 particularly the one about multiple versus single.

9 Sometimes I think the thing you have to think about is if  
10 you go for one big bang, you've arrayed so much resistance  
11 to that that you can't get it, as opposed to a series of  
12 small things where you take on things one at a time.

13 You said I don't know the answer to this, and I  
14 don't think there is an answer to this. But I think we  
15 should think from time to time sometimes you want to -- and  
16 certainly at a principle level, it's really easy to say what  
17 principles you are pursuing. And everybody agrees to the  
18 words. But then it's the policies that actually have to  
19 execute the principle. And I think sometimes we have to  
20 think about is it a single or a couple of big things or  
21 small things? And I think different answers are right at  
22 different times.

1           And then there was one other thing that you said  
2   that I just want to tease out. You said the 35 percent,  
3   when you go to provider systems, people say so what's the  
4   deal? But implicit in that statement is leaving some of  
5   that out there for them, I think, unless you meant something  
6   else. Because that's the only way a system is going to say  
7   I'm going to enter into a deal is if I get to keep some of  
8   this.

9           So it's sort of we can't get it all. So I'm  
10   taking your comment as we can't get it all, let's figure out  
11   what the flex point is to bring people to the table.

12           DR. MILSTEIN: That's exactly right. That's why I  
13   was referencing Bob's comment to Virginia Mason because I  
14   think at one point Virginia Mason said now that we know how  
15   to take all this waste out, we're very happy to be capitulated  
16   at current rates. And Bob's comment was that just allows  
17   you to internalize all the efficiency capture and implicitly  
18   saying, from Medicare's point of view, that's not going to  
19   work. We need some -- I would hope a majority -- of that 35  
20   percent in the form of either less pressure on the Treasury  
21   or less pressure on lower income beneficiaries who are  
22   struggling to pay their Part B premiums.

1 DR. MILLER: I just wanted to make sure I  
2 understood.

3 DR. SCANLON: On that point, I guess, there's a  
4 question in terms of how you address it. In some respects  
5 there's a sense -- I get it very often -- that in health  
6 care everyone thinks they have tenure. These are lifetime  
7 appointments, we don't have to worry about it. And that's  
8 what you're talking about here. And I think popping that  
9 bubble would be potentially extremely valuable.

10 But then realistically it's not going to be  
11 possible to pop the bubble unless we do provide some sort of  
12 trade-off. There's a question of how you do it, whether you  
13 do it in the form of building some inefficiencies in forever  
14 or whether you take sort of like the trade adjustment  
15 assistance approach which is saying okay, the world has  
16 changed. We don't have any typewriter repairman anymore.  
17 And what we're going to do is we're going to compensate for  
18 that for the current generation, the current cohort. But  
19 we're not subsidizing training in that area for the future  
20 or create more people that are going to be unemployable.

21 And so I think we've got to think about a  
22 transitional strategy here instead of just building in a

1     bribe to say okay, go along with our efficiency gains.

2             DR. REISCHAUER: I just disagree with this as a  
3     problem. We're looking at this sort of like it's Michigan  
4     and the auto industry and we're going to have a shrinkage of  
5     activity. We are in a sector which has been growing  
6     extremely rapidly. Employment has been growing faster than  
7     any other sector and we're building hospitals left and right  
8     -- maybe not increases in beds but fancier stuff. There's  
9     all this discussion of will we have the manpower, will we  
10    have the capital needed to produce the health care that  
11    Americans, as they age, are going to need?

12            And so I don't see this as -- using Virginia  
13    Mason, but you can't internalize within that silo this  
14    stuff. The problem that they aren't going to have as many  
15    resources devoted to them, they're going to provide services  
16    for the same amount of resources or 4 percent more rather  
17    than 50 percent more, to a greater number of people. And  
18    what we're really talking about is just slowing down the  
19    amount of resources that go into this sector while at the  
20    same time providing improved care to a greater number of  
21    people.

22            And so I don't think we need reparations. I don't

1 think we need trade adjustment assistance. We don't need  
2 any of that. What we need is a restructuring of the  
3 delivery system.

4 DR. SCANLON: We do disagree but it's a numbers  
5 issue, which is that if we realign the resources to a more  
6 optimal model for the future, there's a question of whether  
7 or not we would be below the current projections in terms of  
8 how many people we need for different things, and the  
9 current supply, too.

10 Because we are so far ahead of the rest of the  
11 world in terms of what we are spending, there a question of  
12 is there a slack there even when we take into account future  
13 demographics future technologies, et cetera. It's a numbers  
14 issue.

15 DR. REISCHAUER: I guess what I'm saying is this  
16 is going to take several decades to pull off. If 35 percent  
17 is the perfect number, we are going to be lucky to get 25  
18 percent. And we're looking at a sector that's going to  
19 double over the next 20 years. I don't see that this is a  
20 big problem.

21 MR. HACKBARTH: Let's get some other people  
22 involved in the conversation here. Nick, did you have your

1 hand up?

2 DR. WOLTER: No.

3 MR. EBELER: Nick, who is involved in an organized  
4 delivery system and has expertise, but let the rest of us  
5 talk.

6 [Laughter.]

7 MR. EBELER: A couple of things. And I think the  
8 discussion reflects how hard this is.

9 There is an implicit assumption here, and I think  
10 Jay answered it looking at the question of individual group  
11 performances and the answer is both. We have to be careful  
12 that the assumption isn't there's a vector that we're headed  
13 toward where we know what the right delivery system looks  
14 like and all of American health care delivery needs to look  
15 that way in 20 years.

16 I didn't think any of us are saying that but I  
17 think you have to be careful of that presumption, with all  
18 respect to KP. And I'm a fan of KP, I've worked for them.  
19 I don't think KP describes themselves as Toyota,  
20 particularly on the efficiency side. I just think that you  
21 really need to think here about different delivery systems,  
22 reforms that are different forms of accountability in

1 different communities.

2           Second, I think it's important to think about the  
3 unit of analysis here. There is a possibility that a unit  
4 of analysis is the community. Does one think of Virginia  
5 Mason as the place we're heading for or KP is the place  
6 we're heading for? Or does one think of the Twin Cities,  
7 and all of the stuff that's going on there with a variety of  
8 financing and delivery? There's an analytic construct that  
9 I think we have to be careful of here.

10           The issue of synergy with the private sector, I  
11 think as MedPAC I think we have to look really carefully at  
12 our MA/Medicare fee-for-service presumed dichotomy because I  
13 think the assumption that MA is heading in this one way  
14 towards accountable care organizations and Medicare fee-for-  
15 service isn't, I think is flawed. And in fact, I'm as  
16 worried if not more worried about the evolution of MA in the  
17 current environment where it is becoming private sector fee-  
18 for-service that may well be purchasing health care in a  
19 more inefficient way than Medicare does.

20           So I would challenge us, I think, as we think  
21 about this to do something -- I think Nancy said this two or  
22 three meetings ago -- sort of backward map MA policy against

1 what we think we should be getting there and be really clear  
2 about that.

3 And in fact, as a leverage point, I would argue  
4 that may well be a way for demonstrations to proceed  
5 rapidly. I'm not a fan of demonstrations at all or waivers  
6 or any of those other things.

7 Proceeding with sort of backward mapping MA, as  
8 well as with things like medical homes and models like John  
9 talked about yesterday. It may well be places to actually  
10 start here in very good ways.

11 By backward mapping MA I mean things like getting  
12 the same data from fee-for-service that we get from MA and  
13 vice versa on both efficiency and resource use and quality  
14 so that you can do both quality and efficiency comparisons  
15 among those systems, probably changing payment structures.

16 But it just seems to me that -- my mental image is  
17 that we've really nailed down what we want to do in Medicare  
18 fee-for-service and MA private fee-for-service plans are 50  
19 percent of the market and we no longer even have leverage  
20 over the very system we're talking about. So I would push  
21 pretty hard there.

22 Finally, I think in this aggregate costs question,

1 I think I lean to Bob's answer. You deal with that through  
2 rates of growth. To try to slow the rate of growth is how  
3 you try to strip out some of that money. You clearly need  
4 some gain sharing and whatever. But it strikes me that that  
5 is logically the way you do that.

6 MR. HACKBARTH: Jack, could I ask a question about  
7 your MA point, which I think I agree with your basic  
8 message.

9 I don't think that we're on a track with MA right  
10 now that's going to produce what we want in terms of value  
11 for the Medicare program and its beneficiaries. In my view,  
12 a big part of that problem is the price we're paying. The  
13 payment mechanism itself, an overall population-based  
14 payment, is I think a very good payment approach.

15 But if the price signal that we're sending to the  
16 market is oh, it's okay, we want to buy things that not only  
17 cost as much as this fragmented chaotic Medicare fee-for-  
18 service system, we're willing to pay 12 percent more, and in  
19 some places 40 percent more. That's the price signal that  
20 we're sending. And that causes MA plans to evolve in a  
21 certain direction, and exactly the wrong direction. Would  
22 you agree with that?

1           MR. EBELER: Partly. I think there's also a  
2 question, a word you used yesterday, of accountability. I  
3 think that we are not asking MA plans to do the things that  
4 we think should be done. Again I just think -- now, I don't  
5 know how you square the presumption about where we're  
6 heading to organized delivery with a fully capitated private  
7 fee-for-service plan.

8           You can't hold those two facts in your head  
9 simultaneously. At least I can't. If you're smarter than  
10 me, maybe you can. So I think there's a huge accountability  
11 piece. And I think the accountability comes with lots more  
12 rigorous data reporting on the MA side as well as on fee-  
13 for-service.

14           As well as I'm very skeptical about 100 percent  
15 capitation. Large employers don't do it with their health  
16 plans. And it's not totally clear to me why Medicare would.  
17 I think differential payment policy coupled with  
18 differential reporting policy can help drive towards some  
19 accountability there.

20           MS. HANSEN: Probably three different aspects.  
21 One is kind of a set point. Another thing is to kind of go  
22 through some of the fundamental questions. And the third

1 area I'll probably do is emphasize the responsibilities of  
2 the beneficiaries.

3           Using some of the metaphors of Jay saying he  
4 should be speaking Japanese, I think what I will speak about  
5 is the delivery system. So think of it as if I'm speaking  
6 Chinese with an American accent here. So what I would like  
7 to emphasize, since it is about the delivery system, I'd  
8 like to take the point that it may well be, in terms of not  
9 1,000 flowers bloom but some. The experience that I have is  
10 at the real community level over a period of time, and  
11 whether a small entity, an accountable care organization,  
12 can be responsible.

13           I was just going back through some of the old  
14 numbers here as to what it took to caring for an N of say  
15 250 when PACE programs first began, with a ballpark of \$10  
16 million. But what that entity does, the accountable care  
17 organization -- which also, a.k.a., has a medical home --  
18 does take the full risk there. So that's the financing  
19 lever.

20           But the delivery lever is where -- I think I've  
21 brought up on different occasions -- there really is a  
22 culture change of practice.

1           And speaking to your point, Arnie, it's like do  
2 all parties win in this one? I think that the short answer  
3 is yes in that people come, even the physicians, they stay.  
4 And people are inspired to work and there's a fixed budget  
5 that goes on.

6           And going then to the tool sets that we use, at On  
7 Lok where I came from, since 1993 we've had an electronic  
8 medical record with all physicians on it. We have had  
9 individual and group performance. Physicians get their --  
10 we used national benchmarks. And their ability to perform  
11 on preventive screens and tools of that nature to see what  
12 they do. They have a full open formulary. A formulary but  
13 they can prescribe without asking for permission. But there  
14 are pharmacy reviews about this.

15           Part D was included, Part B with the medical care  
16 and all, Part A we paid for the hospitalization. We also  
17 paid for the skilled nursing facility. So basically,  
18 yesterday's chart, it's the full end of the continuum, a  
19 full risk, all services, not only A, B and D, but it's also  
20 chronic care, Medicaid services tossed into the pot as well.  
21 But I won't go there. That includes, when we talk about  
22 dual eligible SNFs and should we would be doing care

1 coordination, that care coordination is there including  
2 dental care, for example, and things like this.

3           The beneficiaries, in the second point here. The  
4 beneficiaries and their families, caregivers, do have  
5 responsibilities. I'll go that, as I said, a little bit  
6 later. It turns out we were a demonstration. Jack, you  
7 were part of our world of demonstrations during that time.  
8 And demonstrations can't proceed rapidly. It took us 10  
9 years to do that. Nancy-Ann was a part of HCFA at that time  
10 for us.

11           We were the financial incentives enough? It was  
12 full capitation, meaning it's fully there. But it was not  
13 enough just to have the financial incentives. It really was  
14 changing the pattern of behavior of delivery. It goes back  
15 to the care coordination, the teamwork. Perhaps using  
16 providers that may be less expensive to do a result.

17           But we ended up with a margin. And if there was a  
18 margin one, we had to save for our rainy day just like a  
19 private business of any kind. But the rest of it we  
20 redistributed amongst staff. So this is where all boats  
21 rise in this.

22           And then part of it is something that's a little

1 different that Mitra -- from the standpoint of lower paid  
2 workers. We would also do an equity readjustment that  
3 physicians would get a certain amount, professionals would.  
4 But the lower paid workers would get a disproportionately  
5 higher amount because of the relative percentage. If you  
6 give everybody 4 percent then 4 percent doesn't mean a whole  
7 lot as much when you're making \$12 as when you're making \$70  
8 an hour.

9           So these are the kind of things, it's a culture  
10 change that happens. And one of the downsides is it can't  
11 grow rapidly because those kind of cultures don't change  
12 when you're talking about major levers.

13           But I just wanted to give a face to the fact that  
14 the accountable care organizations can actually be fairly  
15 small. And we have 14 physicians on staff, with the whole  
16 panoply of cardiologists and surgeons as panels.

17           It's doable but I'm not saying it's easy. But  
18 it's possible. But we had people who wanted to be there.  
19 We had beneficiaries and family members who knew -- talking  
20 about end-of-life issues -- that we talked about what their  
21 plans were really on so that when that crisis hit, which we  
22 knew would hit, we would be able to manage that with the

1 family. And the family members not going kabonkers, wanting  
2 everything for that last six months of life. The majority  
3 of them didn't. Some people did want it and that was within  
4 their right. And it was a voluntary program, so therefore  
5 people could exit.

6           So I just wanted to give a sense that a delivery  
7 system and a financial system go hand in hand. But the  
8 delivery system is not composed of widgets. It's composed  
9 of well oiled wheels that turned in an alignment that go  
10 forward.

11           That's the reason I brought up GME in the past,  
12 that I think that kind of culture change starts early and it  
13 starts in settings where people can really learn and get  
14 their behavior reinforced financially, as well as in terms  
15 of the reason they choose to work, which is something we  
16 never talk about at a policy level. But I just wanted to  
17 say that for my accented language that I offer you right  
18 now, it's one of the things that makes it work for a health  
19 system possibility to change.

20           And I'm delighted that at this point we're even  
21 testing it out in rural areas. I understand Nick is going  
22 to be testing one out in his site.

1           But hopefully, just to understand, delivery system  
2 changes incorporate them all, but if we tease them all out -  
3 - which I think you have to do to understand it's the money  
4 but it's the practice. And the practice is about the  
5 results of the beneficiaries. And they have  
6 responsibilities as well, to take their medications. They  
7 get eyeglasses and all, but if they lose two pair, they pay  
8 out of pocket. So there are responsibilities.

9           And then finally, the one thing is we haven't  
10 mentioned this about beneficiary decision making but the  
11 Foundation for Informed Medical Decision Making that is, I  
12 think, an offshoot from the Dartmouth Group but based in  
13 Boston, have shown through their research that when you let  
14 beneficiaries really know about procedures and decision  
15 making, people do not choose more necessarily. But part of  
16 it is the time you have to invest in having people both get  
17 information, absorb information, and then make that  
18 decision.

19           So I hope we look at that part about reducing  
20 costs because it doesn't mean, just because we have a lot of  
21 procedures, that people want it.

22           And then I'll just say one thing about the

1 litigation. I'm just frankly amazed, if not delighted to  
2 say, I was there for almost 25 years and we've never had a  
3 litigated issue in the organization.

4           So I think there are possibilities of working.  
5 But I think it really takes, for me, culture change with a  
6 big C.

7           Thank you.

8           MR. HACKBARTH: I can see Nick is still working on  
9 his comments, so we'll go to Nancy.

10           DR. KANE: I'm probably along the same lines as  
11 Jennie, just saying in terms of the principles for improving  
12 value we should maybe -- which I think are on five and six  
13 or at five, maybe six -- that we may need to add something a  
14 little more broad picture like go back and look for  
15 opportunities to tweak the environment in which the  
16 beneficiaries and providers operate. Jennie gave a great  
17 example of going after medical schools and medical  
18 education. But I think there's other places to tweak the  
19 environment as well where we might want to be involved or at  
20 least make comments.

21           One I've already mentioned before, which is  
22 looking at market structures and thinking about whether

1 there needs to be a little tweaking in the environment of  
2 market concentration. It also relates to working with the  
3 private sector. And we have made the point very clearly  
4 that less financial pressure from the private sector  
5 increases cost.

6 We should go back to that stream of thinking and  
7 think why is it that the private sector is doing less  
8 pressure? Often it relates to the market structure that  
9 they're finding themselves in.

10 I think there is a real need to think about  
11 whether we need to make recommendations to further  
12 investigate the wave of mergers and the lack of competitive  
13 environments that I think a lot of markets are now facing.

14 But the area that I think I haven't brought up  
15 lately anyway, that I'd like to remind us of, is I think  
16 there needs to be accountability not only for one's group of  
17 patients. But there needs to be something -- I would like  
18 to see it reflected in the payment system actually. For  
19 population health, even if it's shared, even if there's a  
20 way to say you're in a market where people have an excess  
21 amounts of obesity or hypertension out of control or  
22 whatever, and make that market -- even if it's not one locus

1 of control, but that their payment levels reflect the health  
2 of the market and changes in the health of that market that  
3 everybody has to deal with.

4 I'm working on a case right now where in  
5 California they're trying to expand health insurance. The  
6 number one cost containment -- at least the top -- one of  
7 the top cost containment vehicles that the governor is  
8 expressing anyway is going after obesity because he feels  
9 the diabetic costs, the cost of diabetes, the rising cost of  
10 diabetes, is going to overwhelm the state's economy is  
11 someone doesn't try to get at it.

12 Medicare kind of gets it at the end, the 65-year-  
13 old coming in with out-of-control blood sugars and  
14 hypertension and the poor eating habits. Is there any way  
15 we can start thinking about incentives for the private  
16 sector employers and insurers to deliver a healthy 65-year-  
17 old or somehow get back and think about where the real costs  
18 are.

19 Public health people know that the medical care  
20 system only affects what, 10 percent of health, something  
21 like that? And the bigger issues are really lifestyle and  
22 exercise, nutrition, controlling basic problems of

1 hypertension and cholesterol, et cetera.

2           Can we create some incentives, either for the  
3 private sector or at least when we do get 65-year-olds, for  
4 the beneficiary themselves? And I think that's related a  
5 little bit to the value-based purchasing. But those are  
6 more, in the sense, a copayment. What can we get people to  
7 do, and preferably earlier than 65, to try to stop people  
8 from arriving in the Medicare program with giant health  
9 problems that they live with much longer than they used to,  
10 20 or 25 years of chronic problem.

11           What I'm saying is in terms of principles for  
12 improving value, we're looking at, I think, how do we get at  
13 the providers. But I think there's a lot of environmental  
14 pieces that we're really just churning around at the margin  
15 unless we start thinking about the bigger environmental  
16 pieces and what we could try to have an impact on, even just  
17 by talking about it and getting a conversation going.

18           The last piece is that all of our different  
19 models, accountable home, medical home, accountable health  
20 care -- I'm going to repeat the last time. We haven't  
21 thought about how does Part D get put in there? How do we  
22 get the accountability for Part D into the medical home or

1 the accountable health care organization?

2           Is the provider going to be able to work with the  
3 Part D plans of these different beneficiaries and get  
4 information on compliance and utilization? I think that's  
5 vital. I don't know how you can manage a hypertensive  
6 without knowing what drugs they're taking, or a congestive  
7 heart failure patient, without knowing what their drugs are.

8           So I guess the interaction between Part D and the  
9 rest of the fee-for-service system really has to be  
10 addressed directly. It just astounds me that we can't even,  
11 for public safety, get information from the Part D plans.

12           I'll stop there.

13           MR. HACKBARTH: Two quick thoughts, Nancy. On the  
14 Part D issue, as we discussed with the panel on value-based  
15 benefit design, the decision to separate the insurance risk  
16 for the drugs versus everything else has big ramifications  
17 for the integration that needs to occur in the real world,  
18 looked at from a delivery system standpoint.

19           Now it can happen in Medicare Advantage where a  
20 plan offers both the A and B coverage and Part D. But when  
21 you're talking about traditional Medicare, you've got  
22 separate insurance pots, you've introduced a major

1 distortion in the system.

2 DR. KANE: Especially if they're not telling the  
3 providers what they see in their claims database. I don't  
4 see how you can manage care without that information.

5 MR. HACKBARTH: I think you're absolutely right to  
6 flag it and we need to think what can be done in the face of  
7 this distortion that's been introduced. But it's a big  
8 barrier that's been put in place.

9 The second thing is I've been reflecting on your  
10 comment at the end of the day yesterday about the need to  
11 maybe communicate priorities.

12 I have this vague, vague, vague vision of a  
13 schematic. There are lots of important processes, for lack  
14 of a better term, that need to be influenced here. Ron has  
15 mentioned the education and training process. You mentioned  
16 population health. Jennie mentioned how patients make  
17 decisions. There is the primary care delivery process that  
18 we talked about yesterday. There's the inpatient process  
19 and the immediate post-acute that we talk about in bundling.

20 You can envision mapping some of the key processes  
21 and say here are what we think the most critical policy  
22 levers before these major processes. And you may not do it

1 all in one fell swoop, but when we talked about developing  
2 this chapter I think part of what we wanted to do was number  
3 one, communicate with the outside world about our  
4 priorities. But also set a framework through which we can  
5 evaluate our own work and say are we addressing these major  
6 processes? Have we established clear priorities that we  
7 think have real leverage? It gives us a tool to go back to  
8 and evaluate what we're doing and then use that evaluation  
9 for our future planning.

10 Does that make sense to you? Is that responsive  
11 to what you're getting at?

12 DR. KANE: Yes. There's little pieces, there's  
13 big pieces. I think we need a lot of pieces. I'm convinced  
14 about that.

15 But where are we going? How do we know we're  
16 getting there? Where are we trying to get to? And how do  
17 these pieces fit into that? And then it may help us also  
18 think about what level of effort to put into any one piece.  
19 I think it's much easier, in fact, to put a whole lot of  
20 effort into a tiny piece, the medical home, and then spend  
21 lots and lots and lots of time and miss a much more likely  
22 to have impact piece because we're down there in the -- so

1 it's nice to keep going up and in terms of the level of  
2 detail.

3 MR. HACKBARTH: So let's think if we can...

4 DR. STUART: Thank you. Coming at the end, most  
5 of what I had to say has already been said. But there's one  
6 thing that I think is really important to set the atmosphere  
7 for this chapter. It's actually built on something that  
8 Dave Durenberger gave us. I was really appreciative of your  
9 perspective on if we only knew then what we know now.

10 And this also has Minnesota roots, and it goes  
11 back a decade earlier to Paul Elwood and his coining of the  
12 term health maintenance organizations. There was a lot of  
13 excitement at that time in terms of what these organizations  
14 can do.

15 What's happened over time as that term is  
16 completely debased. Jay's organization and some of its  
17 cousins really go back to that origin. But most do not.

18 And my fear is that here we've come up with a new  
19 term, accountable care organizations. And if Paul Elwood  
20 were sitting here, he'd say what's the difference between an  
21 accountable care organization and a health maintenance  
22 organization? It's just language.

1           And I think the difference, however, today is that  
2 we've become a lot more cynical about this language. And I  
3 think we have to be very careful and should address this  
4 directly, that if people think that accountable care  
5 organizations are just some other acronym that is same old,  
6 same old -- which I fear they will -- then I'm not sure that  
7 we will have accomplished very much.

8           And so even though I agree in principle with what  
9 you say, Glenn, about having this thing at a high level and  
10 talking about principles, I think you have to bring it down  
11 to the level of saying there is something different here  
12 from what we've had before. And I think this really does  
13 belong just not here in his room but also belongs in the  
14 chapter.

15           Because language is a very, very powerful tool and  
16 it's very easy in this world to just simply disregard what  
17 somebody says because it sounds like a lot more of the same  
18 thing.

19           I've got two other things that are building upon  
20 what other people have said. The second bullet point here,  
21 creating better information and tools. And again this is  
22 building partly also on what Dave said. We do have this two

1 track of having coordinated care -- or we hope we have  
2 coordinated care -- and then trying to provide the right  
3 kinds of information and incentives for individual  
4 providers.

5           And frankly, the information expectations and  
6 needs are very different for individual providers than they  
7 are for coordinated care organizations. I mean, you can  
8 reasonably expect and hold large organizations accountable  
9 for having the information in order to provide the service  
10 and to be accountable. For individual practitioners, that's  
11 not the case. You have to have some mechanism by which they  
12 can be kept informed about the progress of their patients.  
13 That gets into Part D and some other things.

14           But we really don't talk in this chapter about  
15 what kinds of specific informational tools would be  
16 different in the private fee-for-service sector than they  
17 would be in the coordinated care sector.

18           And then thirdly, and this really does pick up on  
19 what Nancy said and what you said, Glenn, about Part D --  
20 although I think it's broader than Part D. And that is not  
21 only do we want to have incentives to build coordinated care  
22 that meets accountable objectives, we also want to remove

1 artificial organizational impediments to care coordination  
2 and value purchasing. And that's terminology I'd like to  
3 see something like that in there.

4           Because the standalone part of Part D really does  
5 do that. There's just no way that individual medical home  
6 would be able to deal with a large standalone PDP and get  
7 the kind of information necessary to provide good care  
8 coordination.

9           But it's also the private fee-for-service plans in  
10 MA. It's probably three-quarters of the so-called  
11 coordinated care plans under MA. And so I think that if we  
12 think about this from a structural standpoint rather than  
13 simply from a provider standpoint, that there are  
14 organizational impediments that Medicare should work to  
15 reduce, if not eliminate.

16           MR. HACKBARTH: Bruce, I think your point about  
17 language is an important one. I think that we can breed  
18 cynicism about what we do and propose if you just change the  
19 labels and not the content. It just sounds like you're  
20 trying to dress up something else.

21           To me there is a fundamental difference between  
22 what we describe as an accountable care organization and

1 Paul Elwood's definition of a health maintenance  
2 organization. The way we've used the term accountable care  
3 organization, I think, is this is in the context of fee-for-  
4 service Medicare. So it's a non-pre-payment method of  
5 trying to reward organized delivery of care and  
6 accountability.

7           So for example, in the group practice demo, which  
8 is sort of the closest embodiment, the basic payment method  
9 is still fee-for-service. And then there's an accounting of  
10 performance against targets, much as Arnie has described,  
11 and rewards. So the insurance risk remains with traditional  
12 Medicare and is not shifted to the provider organization, as  
13 in the case of Kaiser Permanente. So that is, I think, an  
14 important difference and worthy of two separate names.

15           DR. STUART: They're clearly not identical. As  
16 far as shared their risk, however, accountable care  
17 organizations, as we've seen, there is certainly implicit  
18 shared risk among the providers that are part of that. So  
19 think we have to be a little careful again in terms of  
20 you're right, there wouldn't be a capitation payment. But  
21 if all of the money came to a particular organization that  
22 then had responsibility for distributing it out, there are

1 going to be winners and losers in terms of who gets those  
2 funds.

3 So at the final end of the game you've got some of  
4 the same mechanisms working for you.

5 MR. HACKBARTH: Two ways of trying to achieve  
6 accountability through different payment mechanisms.

7 DR. BORMAN: To go to one of the things you  
8 brought up early in the conversation, Glenn, and that was  
9 the issue of synchrony or synchronization, and I'd like to  
10 just encourage that as a thought a little bit.

11 If I look at my particular world as a physician, I  
12 also look at providers and non-physician professionals,  
13 whatever, in terms of how you can reward us, if you will,  
14 for being better participants. You can give us more money,  
15 which clearly we're in a system that's not prepared nor  
16 capable of doing that. You can give us time so that you can  
17 do things that allow us to do our part of the system in less  
18 time. And somewhat linked to that, you can allow us to do  
19 it with less hassle.

20 Beyond its intrinsic value to me as being  
21 incredibly a wonderful thing to do, being in the operating  
22 room, it's also a period of time in my life where I'm pretty

1 much not hassled with thinking about business issues,  
2 delivery issues, whatever they may be.

3 I think that practitioners in all disciplines feel  
4 a considerable sense of hassle that to some degree relates  
5 to the dissynchrony, if you will. Everything we propose now  
6 is collecting more information, reporting more things, doing  
7 more things. And we are, to some degree, potentially  
8 increasing that hassle factor at a time when we want to  
9 reduce the money factor. And we're not exactly giving some  
10 time factor.

11 And so I would just suggest that this synchrony  
12 piece here may, in fact, represent something very important  
13 in building the culture change that Jennie has talked about  
14 allowing people to embrace that. So I think that would be  
15 one point.

16 I think another point relates to the issue of  
17 options and beneficiaries. Most people, and certainly not  
18 the very bright people in this room who think about health  
19 care and so on and so forth, but most people out there don't  
20 really know what they've bought in terms of their health  
21 care until they have to use it.

22 And so this notion that we can provide a whole

1 bunch of up front education and have no surprises when  
2 somebody goes to use it and to have complete satisfaction  
3 when they go to use it is not entirely realistic. And I  
4 think maybe what that says to us is that there need to be  
5 options for beneficiaries that not everybody -- and Mitra, I  
6 was struck, you said that you see a lot of people where cost  
7 is their primary motivator at their original purchase, if  
8 you will, of the benefit. When they have to go use the  
9 benefit, however, they don't necessarily remember that  
10 piece. There are other things they have values for at that  
11 point.

12           So maybe what everybody buys is something basic  
13 and then they have to have options either up front and/or at  
14 the point of service to be able to change or to add to the  
15 pot to get more. Because I'm constantly talking with  
16 patients who say oh, I never realized that this wasn't  
17 covered or I couldn't get this, couldn't do this, can't have  
18 that drug, whatever.

19           And so I think an expectation that a beneficiary  
20 up front can make a choice that will serve them well over a  
21 period of time, we may be imputing just a bit much here.  
22 And for me the practical piece of that is that we need to be

1 endorsing systems that do allow options, that recognizes  
2 that that complicates it.

3 MR. HACKBARTH: Nick, it's going once, twice.

4 DR. WOLTER: I guess I would make a pitch that  
5 this chapter, which is kind of the way we talked about it at  
6 the retreat, it does become a framework to refer back to.

7 And I do agree with Jack, it's not like we're  
8 hitting the Garmin device that will show us the exact  
9 roadmap to anything. But it could be a framework that helps  
10 us maybe every 12 to 18 months take a look at it and see  
11 whether these things are indeed creating a framework that  
12 help us to move into something better.

13 And Arnie brought up complexity theory, which  
14 we've spent a little time on my organization. I think the  
15 idea that you do multiple small things that add up to  
16 something bigger than the sum of them -- that's called  
17 chunking -- there's some truth to it.

18 Mark, you in essence said that without using that  
19 phrase. And I think there's a lot to that, which is why we  
20 do need to look at this again in a year or a year-and-a-half  
21 so it just doesn't become the 2008 June Red Book chapter  
22 that is dusty.

1           I think that would have value if we could use this  
2 reference over and over again to try to stick to some of the  
3 principles.

4           I really like the IOM six aims, for example, and  
5 what are these multiple small actions that might move us  
6 toward those six aims. So since I won't be part of that  
7 annual exercise, that's really my pitch without commenting  
8 on some of the specifics, many of which I like, in the  
9 chapter.

10           MR. HACKBARTH: Thanks, Nick, for that.

11           DR. MILLER: We're way over time so we can't  
12 discuss this --

13           [Laughter.]

14           DR. MILLER: No, no, no. I'm not going to make  
15 pronouncements. I want you guys to track on -- your session  
16 yesterday was on the updates and how upsetting that was.  
17 And part of this was, particularly the questions at the end  
18 were to tease some of these out. Let me just give you a  
19 couple examples.

20           Nancy made the point about consolidation and its  
21 potential effect on the -- why is the private sector unable  
22 to extract deficiencies? Good point. Think of it at the

1 philosophical level. We're talking about building larger  
2 organization, ACOs, that type of thing.

3 Even though it's a small point and you think yes,  
4 that's very logical. In a philosophical sense, we have to  
5 think about that because it runs in the other direction.

6 And just very quickly, on Karen's point, everybody  
7 wants accountability and the providers want less hassle. So  
8 there's no resolution but these small points actually do  
9 have large ramifications.

10 That was it. I'm sorry.

11 MR. HACKBARTH: Thank you. Well done.

12 Our final session is an update on our episode  
13 grouper work and Jennifer and Megan are going to do that.

14 MS. PODULKA: Good morning again.

15 We're sort of switching from really big picture on  
16 this last one to very technical, so I hope you bear with us.  
17 The interesting stuff is all at the end but we need to get  
18 through a few things first.

19 The analysis that we're going to represent was  
20 prepared by Thomson Healthcare using their medical episode  
21 grouper software. And we would like to, of course, thank  
22 them for all their work and assistance in getting us ready

1 for this. Their report isn't final yet so the results we're  
2 presenting are preliminary and subject to change.

3           Just an update, the Commission recommended in  
4 March 2005 that CMS use Medicare claims data to measure fee-  
5 for-service physicians' resource use and to provide  
6 individual physicians with confidential information on their  
7 resource use relative to their peers. The Commission has  
8 been exploring the use of episode groupers which group  
9 claims into clinically distinct episodes adjusted for risk.  
10 Our past analysis of both the MEGs and ETGs episode groupers  
11 show that it's possible to use these software packages with  
12 Medicare claims to measure physician resource use. Both  
13 groupers in our analysis assigned more than 95 percent of  
14 claims to episodes across the six MSAs that we studied. The  
15 types of episodes to which claims were assigned also appear  
16 to have face validity. For example, most psychiatric  
17 hospital claims grouped psychiatric episodes.

18           However, in our earlier work we felt that there  
19 were some technical and analytic issues that would need to  
20 be resolved before final implementation.

21           One of those issues that we needed to explore is  
22 whether there is year-to-year stability in physicians'

1 relative resource use. We had not been able to do this in  
2 the past because we only had episodes for one year, 2002.  
3 Because we have added an additional year of claims to our  
4 dataset, we now can analyze episodes for 2002 and 2003.  
5 This allows us to consider the stability of physicians'  
6 resource use results over two points in time. Stable  
7 physician scores would add to our previous results to  
8 further indicate that episode groupers are suitable for  
9 analyzing Medicare claims.

10 Of course, this would be true if most physicians'  
11 practice styles remain relatively the same from year to  
12 year. We understand that, of course, some physicians'  
13 practice styles may change over time, especially if their  
14 circumstances change. For example, if they see a different  
15 mix of patients or treat different types of episodes.

16 Before I tell you about the stability results from  
17 the analysis, Megan is going to briefly describe the  
18 methodology that Thomson used in their analysis.

19 MS. MOORE: Thank you, Jennifer.

20 I'm going to give a brief overview of the methods  
21 Thomson used and if anyone has questions I can answer them  
22 later.

1           In order to assess year-to-year stability, Thomson  
2 first decided to explore how physicians are compared to  
3 their peers. They chose to use two statistical models to  
4 compare physicians observed resource use to the average of  
5 their peers, which we refer to as expected. Peers here are  
6 defined as physicians in the same specialty in the same  
7 Metropolitan statistical area.

8           Thomson used these two models in order to explore  
9 different ways of accounting for the random variation we see  
10 when measuring resource use. Their two models build on the  
11 simple observed to expected ratios we have used in the past.  
12 In each case, the observed resource use is the same, and  
13 what changes is the measure of expected resource use.

14           Quickly, the multilevel regression is commonly  
15 used for physician and hospital profiling applications.  
16 Using this approach physicians differences from the mean  
17 form the basis for each physician's estimated efficiency  
18 score.

19           Monte Carlo randomization compares episodes to  
20 like episodes. So an episode is compared to other episodes  
21 of the same type, severity, and disease stage. Monte Carlo  
22 creates a distribution by randomly drawing episodes similar

1 to the physician's episodes and then compares the  
2 physician's observed resource use to the expected, which is  
3 represented by a distribution.

4           Using this approach, physician outliers are based  
5 on how likely the physician's resource use is given the  
6 expected resource use shown by this distribution of randomly  
7 drawn episodes.

8           I'll give an example but first note that both  
9 models yield similar results. So on the X axis here, you  
10 have efficiency scores for physicians using the multilevel  
11 model. And then for the same physicians, the Y axis shows  
12 efficiency score using Monte Carlo randomization. As you  
13 can see, these scores are highly correlated. Physicians who  
14 tend to have high scores under one models also have high  
15 scores using the other, and so on. In this session, given  
16 that results were similar, we're going to just focus on  
17 those produced by the Monte Carlo model.

18           For a quick example, each row in this table  
19 represents an episode attributed to an example physician.  
20 While we only show five episodes, this physician had 22.  
21 The last value in the table, \$1,521, labeled mean, is this  
22 physician's average payment across all his episodes. The

1 Monte Carlo method works by matching each episode --  
2 represented by a row -- to randomly drawn episodes of the  
3 same episode type, stage, and relative risk score. And then  
4 this is repeated 10,000 times, and each time a sample mean  
5 is created this has a mix of episodes as our example  
6 physician. Then we can compare their mean to this  
7 distribution, which we see on this slide.

8           This is the distribution of 10,000 sample mean  
9 payments. Based on these sample means, the physician's  
10 observed mean payment of \$1,521 appears to be high. About 5  
11 percent of the 10,000 sample means exceed this physician's  
12 observed payment.

13           This method has some flexibility and allows the  
14 analyst to look in more detail at a physician's performance  
15 by type of service because we can compare resource use to  
16 distributions separated by type of service. Physicians may  
17 find feedback that includes detailed information like this  
18 to be more actionable.

19           The results from the Monte Carlo and multilevel  
20 models were aggregated for all physicians in six MSAs to  
21 examine the year-to-year stability.

22           Now Jennifer is going to tell you about those

1 year-to-year stability results.

2 MS. PODULKA: This table here shows the  
3 correlations between the 2002 and 2003 efficiency scores,  
4 which are the measures of relative resource use, weighted by  
5 each physicians' average number of episodes per year. The  
6 correlations are quite high, indicating good year-to-year  
7 stability in the efficiency scores based on both models, the  
8 multilevel and the Monte Carlo.

9 Physicians with high efficiency scores in 2002  
10 also tended to have high scores in 2003 and vice versa.  
11 Remember again that to the extent that physicians' practice  
12 patterns remain similar year to year, these efficiency  
13 scores suggest that the episode groupers are suitable for  
14 analyzing Medicare claims.

15 Those correlations in the table are for the  
16 universe of physicians across our six MSAs. We also further  
17 analyzed physicians' efficiency scores year-to-year when the  
18 first year scores qualified the physicians as outliers.

19 Before I talk about the results up here on the  
20 screen, I want to note that the analyst chose very high  
21 thresholds for identifying outliers. What that meant was  
22 that a physician was considered an outlier in 2002 if one-

1 tenth of 1 percent of the matched case-mixes using the Monte  
2 Carlo model exceeded his practice profile. And then if in  
3 the second year, 2003, he remained in at least the top 5  
4 percent he was labeled an outlier in both years.

5           So with that in mind, using the definition, we  
6 found that there were 611 outliers in 2002. This was 3  
7 percent of the total. And 572 of those 611, or 94 percent,  
8 were also outliers in the second year. The 6 percent of  
9 physicians who were labeled outliers in 2002 but not in 2003  
10 may not have actually been outliers in the first year.  
11 However, it is also possible that they were truly an outlier  
12 in the first year and not in the second year because one  
13 would expect some natural variation in physicians'  
14 efficiency from year to year. Overall, those results are  
15 somewhat encouraging.

16           Which leads us to our conclusions from this work.  
17 The year-to-year stability results, both for the universe  
18 and for the outliers, are encouraging in that they suggest  
19 that we are measuring an actual phenomena of outlier  
20 physicians who routinely practiced inefficiently.

21           I want to note that the contractor has also looked  
22 at year-to-year stability results for a few specialties and

1 thus far those results are similar to the overall results  
2 presented here. Thomson Healthcare is finalizing their full  
3 report which, in addition to looking at stability, will also  
4 explore alternative attribution methods. You may remember  
5 from past presentations we've used a single attribution  
6 method for our own work and now we're exploring multiple  
7 attribution and some other ideas.

8 We plan to present those results at future  
9 Commission meetings.

10 We also plan to conduct stability analyses using  
11 the other episode grouper software package that we've used,  
12 ETGs. Of course, we'll come back around, too, to the  
13 discussion we had in September about appropriate ways to  
14 disseminate this information to physicians so that it's  
15 actionable and has a lot of input.

16 So with those things in mind, please let us know  
17 if you have any questions or additional analyses that you'd  
18 like to see included for the future work.

19 MR. HACKBARTH: Thank you.

20 My palms start to get clammy when my lawyer mind  
21 sees Monte Carlo randomization model. So let me just make  
22 sure I'm oriented as to what we're talking about.

1           So basically what we're doing is stress testing,  
2 as it were, the technique of using episode groupers to  
3 analyze claims. This is good news. The consistency, the  
4 stability and results is what you would want.

5           Having said that, it doesn't prove that we have a  
6 great tool yet. There are still issues such as Nick raised  
7 yesterday when we talked about this, very important issues  
8 about the use of the attribution rules and how you attribute  
9 responsibility for what goes on. And there are many other  
10 issues, as well.

11           So this is focused on a very narrow thing and it's  
12 good news.

13           Physicians won't see any of this. This is all  
14 behind the curtain. We don't need to worry about physicians  
15 reviewing Monte Carlo models; right? Please tell me that's  
16 right.

17           [Laughter.]

18           MS. PODULKA: I imagine it would be a very select  
19 group of physicians who be that interested in the  
20 statistical underpinnings but I'm sure that --

21           MR. HACKBARTH: It needs to be available.

22           MS. PODULKA: It would be available and physicians

1 would, I'm sure, want to know whether they are likely to be  
2 stable from year-to-year.

3 MR. HACKBARTH: Yes, right. Okay, I feel better  
4 now and I can wipe the sweat off my palms.

5 MS. DePARLE: I've got sweaty palms, too. Maybe  
6 it's the lawyer thing, as opposed to the economists look  
7 calm here.

8 For this to be a tool that we can use effectively,  
9 it does need to be very accessible. And I think physicians  
10 would want to understand it. Look at RBRVS. They sort of  
11 had to try to understand that. And to the extent they  
12 don't, it just creates hostility, puzzlement, derision.

13 I'm thinking that if it ever goes anywhere it  
14 needs to be either the Minneapolis method or the Meridian,  
15 Mississippi method, as opposed to the Monte Carlo method.  
16 That might go down a little bit better.

17 I want to make sure I understand what it is we  
18 consider to be resource use. What effect would a new  
19 technology becoming available have in this, our a new  
20 treatment? I see Dr. Bill Rich sitting there. A couple of  
21 years there were some major changes in ophthalmology where  
22 there were new drugs available and new treatments available

1 for macular degeneration. I would think that would have  
2 increased a physician's resource use a lot, not because he  
3 or she was inefficient but because there's a treatment  
4 available to really help somebody.

5 So how would we tease that out of it?

6 MS. PODULKA: Actually, it is encouraging as well  
7 the way these two models and the current episode grouper  
8 softwares function in the sense. As Megan mentioned, it  
9 becomes very specific in comparing like episodes to like  
10 episodes.

11 So as opposed to just doing a very high-level  
12 look, which is a good start, about total spending a  
13 physician, we're comparing that physician's episodes of that  
14 specific type -- so for a macular degeneration episodes --  
15 to similarly severe patients. So not just all patients but  
16 women 65 with no comorbid conditions. And the severity  
17 staging of that episode. So is early degeneration? Is it  
18 final stages?

19 So in that sense, to the extent that physicians  
20 are now treating that type of episode, that's severity, and  
21 that disease stage similarly, you're comparing like to like  
22 instead of comparing it to a different type of episode with

1 a different type of treatment option.

2 MR. HACKBARTH: The reference point of similar  
3 physicians in the same specialty in the same community  
4 should help address it.

5 DR. REISCHAUER: The issue is early adopters of  
6 new technology.

7 MS. DePARLE: Those people would be outliers.

8 DR. REISCHAUER: It depends on what you're going  
9 to use this stuff for. But if you're really looking at the  
10 top few percent, a lot of this can evolve into a  
11 conversation and they should realize -- it should be so  
12 evident that their resource utilization is so much greater  
13 than the average that the discussion would lead to fruitful  
14 reduction in resource use. But it's not going to lead to a  
15 great deal of savings.

16 MS. DePARLE: Yes. If you use it the way you  
17 said, it won't.

18 DR. REISCHAUER: If you were talking about the top  
19 one-tenth of 1 percent or whatever. When you bring the  
20 threshold down, then the complexities of this type begin to  
21 multiply.

22 DR. MILSTEIN: I think Bob's comments also would

1 apply, even if one were using a less extreme definition of  
2 outliers. If one, for example, were to use what the GAO  
3 used in their report last year, that was I think -- they had  
4 a standard deviation but in the end it boiled down to just 5  
5 percent. But if you said what would happen if essentially  
6 those what appear to be inefficient practice patterns were  
7 brought back down to the average, it generated quite a bit  
8 of savings in the GAO model.

9           The other comment I have with respect to Nancy-  
10 Ann's question, is that it sort of signals one of the  
11 interesting positive consequences of using these groupers,  
12 is the impact of a new technology -- for example, let's say  
13 Dr. A adopts new technology much more quickly than his peers  
14 and as a result his comparisons, even on an ETG or MEG  
15 adjusted basis is going to look different. But it could  
16 look different in either of two directions. That is, if the  
17 new technology -- even if the technology is more expensive -  
18 - reduces total resource use, it's going to make their  
19 profile look more favorable or vice versa. And because of  
20 the vice versa opportunity, that's why quality ratings also  
21 have to be judged concurrently.

22           But I think it wouldn't necessarily push in one

1 direction or the other because it's the impact on total  
2 resource use that becomes relevant for this analysis.

3 MS. DePARLE: I wasn't finished but I do think, to  
4 your point, we have to be careful how we use the word  
5 efficiency. And to the extent we can, we have to factor in  
6 quality and outcomes with this.

7 Now that's going to be very hard, and we have to  
8 start -- as my friend, Bob Reischauer, keeps telling me, we  
9 have to crawl before we can walk here. But I'm just  
10 concerned about how this would be received if we just talk  
11 about efficiency in a very narrow way.

12 As we go on in this, I think it would be really  
13 useful for us to have some -- I think doctors call them  
14 vignettes -- something that could show us in a more granular  
15 way some episodes compared and what the resources actually  
16 were underneath the big number. At least I'd be interested  
17 in hearing that and some of our clinicians on the panel  
18 could tell us whether it makes sense to them.

19 DR. CASTELLANOS: I guess I have a couple of  
20 questions. Last year somehow I remember CMS, Herb Kuhn,  
21 said that this data would be available in the spring of  
22 2008. Do you know what resource use on the physician level?

1 He said it was going to be available. Do you know if it's  
2 going to be publicly available, personally available, or  
3 what?

4 DR. MILLER: We had a conversation -- I want to  
5 say a few weeks back. What Herb said there was with the  
6 proper resources and attention and focus we could have the  
7 capabilities of producing data like this. What's happening  
8 in the organization is they have been working along these  
9 paths, too, looking at these same kinds of groupers and how  
10 they behave, I think in part spurred by the fact that we  
11 were doing it. They are not up to the point where they're  
12 just about to release or put that information out.

13 What he was trying to say in front of the  
14 Committee was if this is what you want, with the proper  
15 focus and resources we can get to the point of putting that  
16 data out. But they aren't at that point now.

17 MR. HACKBARTH: Which is one of the reasons, Ron,  
18 that I think we recast our recommendation on this. When we  
19 first talk about episode grouper we said CMS ought to do  
20 this. The recommendation that we voted on yesterday was a  
21 recommendation to the Congress that the Congress ought to  
22 tell CMS to do it. That was the reason for that change.

1 DR. CASTELLANOS: A couple of other points. I  
2 agree with what Nancy said. Somehow we have to factor in  
3 quality, outcomes, and it has to be risk-adjusted. It's  
4 just not macular degeneration. It's the impact of the risk.  
5 And that needs to be -- if this is going to be given out, we  
6 need to risk factor in all of these.

7 DR. MILLER: I want to be sure that everybody  
8 understands here how much risk adjustment is present. I  
9 mean, there's two levels of complexity going on here. The  
10 dilemma that we have is we could have showed up and said  
11 it's highly correlated, things are stable from year to year.  
12 And then certain people at this table would have said well,  
13 how would you know? Do you know that? And Meg was  
14 insisting that she wanted to present these models.

15 [Laughter.]

16 DR. MILLER: That we went through the grinding of  
17 the data, so that certain of you who have those kinds of  
18 minds could go oh, I think I understand how you did this.

19 But there's two levels of severity adjustment  
20 going on here. The groupers themselves actually do things  
21 like stage by disease, stage by condition, disease, risk  
22 score to put physicians into comparable episodes. Then

1 there was some additional statistical analysis on top of  
2 that that said I want to control for some random variation  
3 here and then make a comparison to some distribution. And  
4 really all those two models were doing were giving you  
5 different distributions to compare physicians to. That's  
6 all they did in a little fancier and more complicated way.

7           So in this analysis that we put in front of you,  
8 there's actually a high degree of risk adjustment going on.  
9 And particularly when the analyst chose -- in addition --  
10 set a very high threshold to identify an outlier here. So  
11 this is a highly conservative approach to identifying  
12 outliers, I would say.

13           DR. CASTELLANOS: I appreciate that.

14           A couple of other things. I like the comments on  
15 new technology because you don't want something like this  
16 impeding progress in medicine. Unfortunately, sometimes new  
17 technology is a gang buster and sometimes it's a balloon,  
18 it's a lead balloon that doesn't fly. Unfortunately,  
19 without good comparative effectiveness information we don't  
20 have that. Sometimes it's being the first kid on the street  
21 with new technology is good and it's bad.

22           The last point, and it's really a positive point.

1 As you mentioned, the GAO study did come out. And there was  
2 an issue in that of 12 communities that the communities had  
3 high resource use and outliers in each community. It wasn't  
4 the top 12 but it was just, my understanding, 12 random  
5 communities.

6 Well, fortunately or unfortunately, one of those  
7 communities is where I live. And let me tell you the impact  
8 that had. The hospitals picked that up, the community  
9 physicians picked it up. And I'm saying to you that I think  
10 the people in that community are looking at what they're  
11 doing a little bit more carefully and really looking on  
12 their practice patterns.

13 Now obviously, it's not the individual physician,  
14 but they labeled the community. And I think it did have a  
15 positive effect.

16 MR. EBELER: It may be a follow-up on that. It  
17 would be useful to see, you mentioned at the end  
18 differentiating between this as an analytic tool which you  
19 are validating and then thinking about it as a  
20 communications and behavior change tool.

21 It would be useful to see what a report back to a  
22 sample physician might look like, what a report at a

1 physician level might look like, at a community level might  
2 look at like, at a hospital, just to get a sense of how  
3 people out there could grapple with this and identify  
4 things.

5 DR. MILLER: No problem on that. Jennifer has  
6 actually developed one for some other kinds of briefings we  
7 were doing. We were on the Hill over the last year with GAO  
8 to talk about it. And she had put together a little thing  
9 and we can bring that through and make sure that you see it.

10 MS. HANSEN: Just to build on that, and I think  
11 with, Ron, your example and, Jack, your comment.

12 I'm struck by when CMS gave some data back on some  
13 cardiac surgeries. And I think it was Nevada or Utah really  
14 got some really poor results for a community. In it caused  
15 that whole community apparently to pull together and find  
16 out that transportation was really one of the issues.

17 So I wonder if you could build in this point about  
18 what does it do to change not just the individual practice  
19 but how even a community itself has brought together the  
20 hospital, the ER ambulance system, really to say there's a  
21 different model in this community that's rural that has to  
22 address the data that comes out of CMS.

1 DR. BORMAN: I'm going to assume that the Monte  
2 Carlo part suggests that there is some origin in game theory  
3 to at least a part of this. And frankly, I'm pretty  
4 comfortable with that because when we actually look at  
5 examination security in board certification examinations, we  
6 use some models that, in fact, come from gaming theory in  
7 terms of looking at levels of potential cheating. And so if  
8 you like, I also hear it called queuing theory. Maybe that  
9 makes it more comfortable than Monte Carlo for you attorney-  
10 type people.

11 I personally like this a lot in the sense that it  
12 embodies a couple of things. Number one, it embodies a  
13 relatively smaller step, but one that in aggregate with  
14 other steps is a build toward something else. I think  
15 there's no question that that's a case here. And as we look  
16 for those, this is one that may not achieve gigantic  
17 savings. But it is a building block and it's one that seems  
18 to be coming within reach in a pretty credible way.

19 The second thing about it is that it avoids a  
20 potentially draconian action against all to target on a  
21 relatively smaller number where the bigger problems are. In  
22 that sense, I think it has enormous value as a principle.

1 It gives it credibility as a place to start.

2           If you could go to the slide where you talked a  
3 little bit about the one-tenth of 1 percent and that kind of  
4 thing, and I would just ask was there also some sensitivity  
5 analysis done? That is, for example, if you wanted on the  
6 second year to get to 100 percent, what did that mean in  
7 retrospect, that one-tenth of 1 percent of 600 or whatever?  
8 What would that number have to change to get to 100 percent  
9 in the second year? And similarly, the other way around.  
10 With varying the first choice, how much -- how sensitive --  
11 where do you have to set the bar to get sensitivity and  
12 specificity?

13           DR. MILLER: The answer is that there is no  
14 sensitivity analysis that we've done to this point. But  
15 what would have to happen in order to capture 100 percent --  
16 and you guys make sure this is right but I'm pretty sure  
17 this is right -- is in the second year you would move to a  
18 wider standard than 5 percent. But we're just kind of  
19 rolling this out, seeing what your reaction is.

20           DR. BORMAN: Because I think that physicians  
21 actually, in many ways, will leap to understanding of the  
22 sensitivity specificity piece here fairly quickly because we

1 talk about that in terms of therapies and drugs and a  
2 variety of things. And I think that when you are screening  
3 for something -- and in this case if we think of it as  
4 screening for behavior that we'd like to report on and  
5 correct -- then you want the sensitivity here to be maximal  
6 and not worry so much about the specificity.

7           If we're trying to say that we want this to be  
8 absolutely credible and reliable that everyone we label as  
9 an outlier is indeed an outlier, then we're going for 100  
10 percent specificity.

11           I think that will relate to how we present it to  
12 people. And the sensitivity analysis to get to 100 percent  
13 sensitivity versus 100 percent specificity may help us know  
14 how to use it as we go to roll it out. Looking at these  
15 practical examples of what a report will look like and stuff  
16 will help to answer that, as well.

17           DR. MILLER: I think your point is really well  
18 taken. And I also think it's the former, at least for  
19 starters, rather than the latter, the notion of trying to  
20 identify blocks of physicians where there's got to be some  
21 interaction, as opposed to at least initially saying this is  
22 absolutely where you are and here's know what's going to

1    happen.

2                   DR. BORMAN:  I would agree with that.

3                   DR. REISCHAUER:  Unless I've misunderstood what's  
4   going on for the last 45 minutes, I think it's impossible to  
5   get to 100 percent unless certain people, physicians, for  
6   genetic reasons were outliers and there was no randomness in  
7   this at all.

8                   DR. MILLER:  That's what I'm saying, I think it's  
9   the former concept, the first concept, that says no, it's  
10  not about getting to 100 percent.  The sensitivity here  
11  doesn't have to be down to the exact --

12                   DR. REISCHAUER:  But you identify people who have  
13  used lots of resources in year one, and there's lots of  
14  reasons for that.  And some of it is just that they're  
15  inefficient.  But there are others who randomly bad draw, in  
16  another year are the lowest.

17                   DR. MILLER:  The other thing that this kind of  
18  analysis entered -- we didn't say anything along these lines  
19  -- but the other thing that this analysis begins to allow  
20  you to think about is if you watch a physician's performance  
21  over one year or two years and the person occupies the top  
22  year after year, you're starting to get to the genetic issue

1 that Bob is pointing to.

2 And so with multiple years and this much  
3 stability, you can start to say look, I'm telling you,  
4 you're showing up every time.

5 MR. HACKBARTH: Last comment, Jack.

6 MR. EBELER: Can I just ask a risk question here?

7 As I understand it, there's a presumption of a norm here.

8 And the norm is current practice statistically aggregated.

9 One, overall we're presuming the norm is pretty  
10 expensive and inefficient, when you look at national  
11 numbers. Is there a risk here that those at the low  
12 utilization end, particularly in some practices, will say  
13 gee, I could be generating more fees? There's norming and  
14 renorming that I just think you have to worry about it. I  
15 don't understand how it works.

16 DR. MILSTEIN: Is up to the user -- in this case  
17 CMS -- as to what the frame of reference for right is. You  
18 could use either the average, which would incur the risk  
19 that you just described. Or I think one of the things we  
20 heard described when Virginia Mason came in to talk to us is  
21 using the subset -- within a given specialty using the  
22 specialists that are at the top of the charts, both on

1 quality measures and resource use measures. Top of the  
2 charts meaning most favorable, lowest resource use, highest  
3 quality.

4 I think it's a great question and I would hope in  
5 whatever model reports that we formulate that Medicare might  
6 use we not only use as the normative frame of reference  
7 what's average in your specialty but also what represents  
8 the pinnacle in your specialty in terms of that subset of  
9 peers that are getting the highest quality scores with the  
10 lowest amount of total resource use.

11 MR. HACKBARTH: It might be interesting, if there  
12 was a really good group or delivery system that uses this  
13 tool, just to hear somebody present here is how we use it,  
14 here are the issues that come up, this is how we try to deal  
15 with those issues.

16 DR. REISCHAUER: Our IOM panel, some of you might  
17 remember, had several presentations along these lines, where  
18 providers were divided into four quadrants, and they tried  
19 to analyze the high quality low resource use groups and see  
20 what does define them. We can get that information.

21 MR. HACKBARTH: Any other comments?

22 DR. SCANLON: It was slightly related to this. We

1 did a study once where we were, in some ways, looking at  
2 something equivalent because we were very narrow in terms of  
3 the diagnosis and the kinds of treatment, and identified  
4 this distribution and had clinicians review it. And there  
5 was a clear pattern of underuse among some providers. You  
6 can use it also for counseling, saying this is clinically  
7 necessary, why isn't it happening?

8 MS. BEHROOZI: My palms are still sweating, so  
9 this isn't a technical question. Just actually following on  
10 what you and Bob were just following on Glenn. The wheel is  
11 being invented in lots of different places, whether it's  
12 other policy organization or whether it's private payers. I  
13 wonder if we could have, in the future, some kind of survey  
14 sort of what else is going out there and how this might  
15 measure out and figuring out the best practices so the wheel  
16 doesn't have to be reinvented too many times. And  
17 particularly, if you're doing the most in-depth careful  
18 analysis, putting it out there as a model.

19 MR. HACKBARTH: Okay, well done. Thank you.

20 We'll now have a brief public comment period. Dr.  
21 Rich knows the ground rules well. Please identify yourself  
22 and keep your comments to no more than a couple of, please.

1 DR. RICH: Thank you, Mr. Chairman.

2 My name is Bill Rich. I am Chair of the RUC and  
3 Director of Health Policy for the American Academy of  
4 Ophthalmology. I'd like to address the staff presentation  
5 on groupers.

6 I think that there is a lot of work that is  
7 already being done, and I'd like to raise some of the access  
8 issues that grouper analysis has led to.

9 In 2006 some of the staff members of MedPAC and  
10 myself met in Chicago with the Ambulatory Quality Alliance  
11 Cost of Care Group to look at both grouper commercial  
12 products that were discussed here.

13 Unfortunately, these are very, very -- they're  
14 proprietary. And there is no physician and no analysis has  
15 been made of what underlies the assumptions of the risk.  
16 And I must disagree with Mark a little bit. The risk is  
17 imputed with claims data. And the problems when this is  
18 applied to the population -- and both of these products are  
19 used extensively now. The N, as staff pointed out, of 26  
20 has been shown not to be statistically valid. The N is 76.  
21 So all of a sudden you have an analysis within the staff  
22 report which has been rejected. I don't know anyone that

1 accepts that.

2           The implication of that is that this is unable to  
3 identify really truly risk-adjusted patient populations and  
4 physicians who care for them. This is widely used in  
5 Massachusetts and Texas.

6           What we see now, the inability to really identify  
7 complex patients, is this is tied to tiering. That's how  
8 money is saved. In Massachusetts every glaucoma specialist  
9 is tiered at the lowest highest copay. That means the  
10 patients with end-stage disease have to pay more. Why?  
11 Because this software is unable to identify complex glaucoma  
12 patients so their utilization of resources and surgery is  
13 higher. Duh.

14           The same thing with ocular plastics. If someone  
15 has a tumor on their lid, I save it off in the office, no  
16 problem. However, if that tumor requires Mohs dissection,  
17 that gets referred to a subspecialist. In the state of  
18 Texas every single ocular plastic surgeon and every patient  
19 with invasive carcinoma of the face is tiered at a higher  
20 pay level.

21           So you have to really understand the proprietary  
22 nature and the assumptions have no validity at all and

1 absolutely no transparency. CMS recognizes this and that's  
2 why you have not seen the release of the physician use  
3 reports.

4           The medical community was hoping that this would  
5 let us get at churning. It has not. So I would urge a  
6 little caution and a little further analysis of looking at  
7 maybe the 5 to 10 percent outliers. You're going to find  
8 not just the churners, but you're going to find stick  
9 patients and the doctors who care for them.

10           So I would urge a little caution and a little  
11 further analysis before making really strong  
12 recommendations.

13           The issue of tying it to quality is a major  
14 concern of the medical community, a major concern of CMS.  
15 And there have been some new studies that have been funded  
16 with CMS to really kind of look at this issue. How can we  
17 truly risk-adjusted this?

18           And again I'm going to stress, the risk adjustment  
19 is based on claims data and no one understands the -- there  
20 is no transparency to see if that really does reflect sick  
21 patient and the docs who take care of them.

22           Thank you.

1 MS. WILBUR: Hi. I'm Valerie Wilbur with the  
2 Special Needs Plan Alliance. I just wanted to make a  
3 comment on the recommendation that was discussed today,  
4 which would include the institutional population along with  
5 the duals as being excluded from open enrollment for special  
6 needs plans.

7 I just wanted to start out my comments by saying  
8 that the SNP Alliance overall is very pleased with the  
9 recommendations you're submitting to Congress on SNPs. We  
10 think they're going to raise the bar on SNPs and prevent MA  
11 plans that aren't really interested in targeting and  
12 developing specialty programs from coming in and making sure  
13 that targeting and specialization is a part of the SNP  
14 program moving forward.

15 But I think closing down open enrollment for  
16 beneficiaries like the institutional is inconsistent with  
17 what Congress had in mind. I think the reason that SNPs  
18 were created is because Congress didn't think that people  
19 with complex chronic conditions and complex medical needs  
20 were being well served by fee-for-service and regular MA  
21 plans, and so they created this specialty model that would  
22 address those needs better.

1           So by closing down open enrollment and not  
2 allowing people like the institutionalized from getting into  
3 the SNPs at the time when they demonstrate that need is  
4 inconsistent with the idea of being able to go ahead and  
5 provide the services that are needed when they're needed so  
6 that they can have a better impact on health outcomes.

7           Now we really appreciate the change that you made  
8 to the dual population where you're going to allow dual SNPs  
9 that have contracts with states to go ahead and maintain  
10 that open enrollment because it's going to allow SNPs to do  
11 the coordination between Medicare and Medicaid, which would  
12 have been prevented under the closed enrollment rule. So  
13 that's very good there.

14           But with the institutional population, we have a  
15 concern about the clinical issue that's involved. I think  
16 people that are placed in nursing homes and other  
17 institutions have the most significant medical needs. One  
18 of the things that institutional SNPs are intended to do is  
19 help keep people out of hospitals. Hospitals are very  
20 dangerous places, as you all know, for people that are frail  
21 elderly. They have all kinds of adverse impacts on health  
22 care. And so to require people that need institutional care

1 to wait up to a year to be able to get access to those SNPs  
2 is going to interfere with that.

3 I guess what I'm asking is the way to deal with  
4 the concern of closing down -- the reason for the  
5 recommendation about closing down open enrollment -- was I  
6 think that there were plans that were setting themselves up  
7 as SNPs as a way to get around the closed enrollment or the  
8 lock-in rule.

9 I think a better way of dealing with that without  
10 interfering with the ability to get to the clinical needs of  
11 people when they need it is to do what you did with your  
12 other recommendations. Make more stringent requirements for  
13 the way you define chronically ill. Require special  
14 evaluation methods for SNPs to show that they're really  
15 doing something different from other MA plans. Require SNPs  
16 to have contracts with states so that you can go ahead and  
17 facilitate that coordination.

18 So I guess what I would recommend is that assuming  
19 Congress goes ahead and accepts some of those recommendation  
20 that create a higher bar, which we very much support, I  
21 would suggest that you go back and revisit that open  
22 enrollment rule so that if SNPs, in fact, start really

1 targeting the high-risk population and developing those  
2 specialty interventions as a result of some new legislation  
3 Congress may pass, that you would consider reopening the  
4 enrollment period so people can get access to these  
5 specialty services when they're needed.

6 Thank you very much.

7 MR. HACKBARTH: Okay. We are adjourned.

8 [Whereupon, at 11:14 a.m., the meeting was  
9 adjourned.]

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