

## MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

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

Thursday, April 7, 2011  
9:15 a.m.

## COMMISSIONERS PRESENT:

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ROBERT BERENSON, MD, FACP, Vice Chair  
SCOTT ARMSTRONG, MBA  
KATHERINE BAICKER, PhD  
MITRA BEHROOZI, JD  
KAREN R. BORMAN, MD  
PETER W. BUTLER, MHSA  
RONALD D. CASTELLANOS, MD  
MICHAEL CHERNEW, PhD  
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JENNIE CHIN HANSEN, RN, MSN, FAAN  
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HERB B. KUHN  
GEORGE N. MILLER, JR., MHSA  
BRUCE STUART, PhD  
CORI UCCELLO, FSA, MAAA, MPP

AGENDA	PAGE
Improving payment accuracy and appropriate use of ancillary services - Ariel Winter	3
Enhancing Medicare's technical assistance to and oversight of providers - Anne Mutti, John Richardson	82
Public Comment	153
Medicare's fee-for-service benefit design - Julie Lee, Joan Sokolovsky, Scott Harrison	157
Improving the accuracy of payments to physicians and other health professionals - Kevin Hayes, Ariel Winter	237
The Sustainable Growth Rate system: policy considerations for adjustments and alternatives - Cristina Boccuti, Kevin Hayes	282
Private-sector payment rates for physician and hospital services - Julie Lee, Carlos Zarabozo	333
Public Comment	375

1 P R O C E E D I N G S [9:15 a.m.]

2 MR. HACKBARTH: Okay. Good morning. So this is  
3 our last public meeting of this cycle and the last  
4 opportunity to discuss topics that will be included in our  
5 June report to Congress.

6 Our first two sessions today are on topics that we  
7 have discussed multiple times each now, and we have  
8 recommendations on which we will be voting this morning.

9 The first topic is improving payment accuracy and  
10 appropriate use of ancillary services. Ariel, lead the way,  
11 please.

12 MR. WINTER: Good morning. I want to begin by  
13 thanking Carol Frost, Kevin Hayes, Kelly Miller, and Matlin  
14 Gilman for their help.

15 At the February meeting, we discussed four draft  
16 recommendations to improve payment accuracy for ancillary  
17 services and ensure that advanced imaging services are being  
18 used appropriately through prior authorize. Today we will  
19 be presenting revised draft recommendations for your  
20 discussion and vote.

21 I am going to start with the review of some key  
22 background points. First, there has been an increase in

1 imaging, other diagnostic, physical therapy, and radiation  
2 therapy provided in physicians' offices. In addition, there  
3 is evidence from the literature that imaging services are in  
4 at least some cases ordered inappropriately. The rapid  
5 growth of ancillary services has led to questions about  
6 payment accuracy and concerns about self-referral.

7 In last June's report, we talked about options to  
8 narrow the in-office ancillary services exception to the  
9 physician self-referral law. This exception allows  
10 physicians to provide ancillary services in their offices.

11 However, several Commissioners expressed concerns  
12 that limiting the in-office exception could inhibit the  
13 development of integrated delivery systems. So we shifted  
14 our focus to improving payment accuracy and ensuring the  
15 appropriate use of advanced imaging.

16 Before describing the draft recommendations, I  
17 want to review data from an industry coalition about changes  
18 in imaging volume that you may have seen. This information  
19 has been discussed in the trade press. The industry  
20 estimates are different than ours, and I want to walk you  
21 through these differences.

22 According to industry coalition's data, the volume

1 of all imaging services declined by 7.1 percent from 2008 t  
2 2009 and advanced imaging volume declined by 0.1 percent.  
3 In our March report, we reported that volume of imaging  
4 services per fee-for-service beneficiary increased by 2  
5 percent from 2008 to 2009, and volume in our measure  
6 reflects changes in both the number of services and the  
7 relative complexity or intensity of those services.

8 We also reported that the volume of advanced  
9 imaging services per fee-for-service beneficiary bene  
10 increased by 0.1 percent from 2008 to 2009.

11 We have not seen nor received a full description  
12 of the methodology used to produce the industry's data, but  
13 it appears that a couple of major factors explain the  
14 differences between our numbers and theirs.

15 First, it appears that the industry's numbers are  
16 not adjusted for changes in fee-for-service beneficiaries.  
17 Because the number of fee-for-service beneficiaries has been  
18 declining, not adjusting for this change can make it appear  
19 that service growth is slower.

20 Second, it appears that the industry's numbers  
21 appear to only measure changes in units of service rather  
22 than both units and intensity, which is what we do with our

1 work.

2 Third, it appears that the industry's numbers do  
3 not account for a significant coding change for  
4 echocardiography that occurred in 2009, which we accounted  
5 for.

6 MR. HACKBARTH: Ariel, I'm sorry to interrupt at  
7 this point, but I just wanted to pick up on one real narrow  
8 issue. The decline in fee-for-service beneficiaries, this  
9 is due to people electing to enroll in Medicare Advantage.

10 MR. WINTER: Right.

11 MR. HACKBARTH: And so our calculations focus on  
12 per beneficiary use for people who remain in traditional  
13 Medicare.

14 MR. WINTER: Correct.

15 I want to make some other points about imaging  
16 growth. It's important to look at the broader trend in  
17 imaging, which shows that from 2000 to 2009 the cumulative  
18 growth of imaging was faster than all other categories of  
19 physician services except for tests. Imaging rose by a  
20 cumulative rate of 85 percent during this period compared  
21 with 47-percent growth in all physician services.

22 Although growth of imaging slowed between 2008 to

1 2009, this was preceded by several years of rapid increases.  
2 This growth has raised questions about appropriate use and  
3 the risks of increased radiation exposure for beneficiaries.

4           The first draft recommendation is to combine  
5 discrete services often furnished during the same encounter  
6 into a single payment rate. The rationale is that the  
7 payment rate should account for duplications in work and  
8 practice expense that occur when multiple services provided  
9 together.

10           The AMA/Specialty Society Relative Value Scale  
11 Update Committee, or the RUC, has established a process to  
12 review codes frequently performed together. This process  
13 involves combining two or more discrete codes into a single  
14 comprehensive codes. The RUC recommends work RVUs and  
15 practice expense inputs for these new comprehensive codes to  
16 CMS. CMS must then review and approve the new values  
17 through its rulemaking process.

18           For 2011, for example, CMS adopted RVUs for a new  
19 comprehensive code for CT services that include two  
20 component services: CT of the abdomen and CT of the pelvis.

21           This approach is an important step forward in  
22 accounting for duplications in physician work that occur

1 when services are performed together. But it's important to  
2 note that it takes several years to develop and value new  
3 codes, and a relatively small number of comprehensive codes  
4 have been created to date.

5           There are some ways to accelerate and expand this  
6 process. For example, CMS could help by analyzing codes  
7 that are commonly performed together. CMS and the RUC could  
8 prioritize codes for review based on their share of total  
9 volume.

10           This leads to the first draft recommendation: The  
11 Secretary should accelerate and expand efforts to package  
12 discrete services in the physician fee schedule into larger  
13 units for payment.

14           With regards to the implications: This would have  
15 no impact on program spending because the changes would be  
16 budget neutral. The savings would be redistributed to other  
17 physician fee schedule services, and we do not anticipate a  
18 reduction in beneficiaries' access to services or providers'  
19 willingness or ability to furnish care.

20           Because the process of creating comprehensive  
21 codes is time-consuming and a long-term effort, CMS could  
22 pursue more rapid changes to improve payment accuracy, and

1 this leads to the second draft recommendation, which would  
2 reduce payment rates for the professional component of  
3 multiple imaging studies performed in the same session. The  
4 professional component covers the physician work involved  
5 interpreting a test and writing the reports.

6           The rationale for this approach is a GAO study  
7 which found that when pairs of imaging services are  
8 performed together, certain physician work activities are  
9 not duplicated -- namely, the physician's review of the  
10 patient's history and records before interpreting the  
11 images, and reviewing the final report and following up with  
12 the referring physician. However, the RVUs usually assume  
13 that imaging services are provide independently and that  
14 each activity is performed twice.

15           GAO recommended that Medicare reduce payments in  
16 these cases to account for these efficiencies. This policy  
17 could apply across settings because there are likely to be  
18 efficiencies in physician work regardless of where the  
19 imaging study is interpreted.

20           This change would align the policies for the  
21 technical component and professional component of imaging  
22 studies. Medicare currently reduces payments for the

1 technical component of multiple imaging studies done in the  
2 same session. There is a 50-percent reduction to the  
3 payment rate for the second and subsequent services in order  
4 to account for efficiencies in practice expense. The policy  
5 applies to CT and MRI services as well as some ultrasound  
6 and some nuclear medicine services.

7           It applies to multiple services done on non-  
8 contiguous body parts in the same session such as the head  
9 and abdomen as well as services that use different types of  
10 imaging in the same session, such as CT and MRI. It does  
11 not apply to new comprehensive codes like CT of the abdomen  
12 and pelvis, what I mentioned earlier, because these codes  
13 already account for efficiencies in practice expense.

14           The second draft recommendation reads: The  
15 Congress should direct the Secretary to apply a multiple  
16 procedure payment reduction to the professional component of  
17 diagnostic imaging services provided by the same  
18 practitioner in the same session. The reason we use the  
19 word "practitioner" instead of "physician" in this  
20 recommendation is because this recommendation as well as the  
21 following two would include nurse practitioners and  
22 physician assistants. According to a recent IOM report,

1 several states allow advance practice nurses to order and  
2 interpret diagnostic tests, so we want to make sure that we  
3 cover those other practitioners.

4           With regards to the implications, there would be  
5 no impact on program spending because the changes would be  
6 budget neutral. We do not anticipate a reduction in  
7 beneficiaries' access to care. And this would reduce  
8 revenue for providers who do the professional component of  
9 multiple imaging studies in same session, but we do not  
10 anticipate a decline in providers' willingness or ability to  
11 furnish these services.

12           The draft recommendation would reduce payment  
13 rates for imaging and other diagnostic tests, such as  
14 cardiac stress tests, when they are ordered and performed by  
15 same physician. The rationale for this policy is that there  
16 are likely to be efficiencies in physician work in these  
17 cases.

18           The work RVU for an imaging service or test  
19 includes reviewing the patient's history, records, symptoms,  
20 medications, and indications for test. If the practitioner  
21 who orders the service is same one who performs it, they  
22 should have already obtained much of this information during

1 a prior E&M service.

2 The work RVU for a test also includes discussing  
3 the findings with the referring provider, and this is  
4 unnecessary if the referring provider is the same one who  
5 performs the test. Therefore, payment rates for these test  
6 could be reduced to account for these efficiencies.

7 Here we mention a couple of implementation issues.  
8 CMS could develop the payment reduction based on an analysis  
9 of the efficiencies that occur when the same physician both  
10 orders and performs the test. The payment reduction could  
11 be uniform, or it could vary by type of service. And the  
12 policy could apply to physician fee schedule services  
13 regardless of whether they are provided in an office,  
14 hospital, or other setting.

15 The third draft recommendation is: The Congress  
16 should direct the Secretary to reduce the physician work  
17 component of imaging and other diagnostic tests that are  
18 ordered and performed by the same practitioner.

19 With regards to the implications, there would be  
20 no impact on program spending because the changes would be  
21 budget neutral. We do not anticipate a reduction in  
22 beneficiaries' access to care. This would reduce revenue

1 for practitioners who both order and perform imaging and  
2 other diagnostic tests, but we do not anticipate a decline  
3 in providers' willingness or ability to furnish these  
4 services.

5 Now we'll move on to fourth draft recommendation,  
6 which is to require prior authorization for physicians and  
7 other practitioners who order significantly more advanced  
8 imaging services than their peers. And by advanced imaging,  
9 we are referring to MRI, CT, nuclear medicine, and PET.

10 This policy would focus on outlier providers who  
11 order many imaging services to ensure that they are using  
12 imaging appropriately. We're not saying that all physicians  
13 who order a lot of imaging are using it inappropriately;  
14 instead, we're trying to limit the burden of prior  
15 authorization by focusing it on a subset of physicians.  
16 Because both self-referring and non-self-referring  
17 practitioners may be high utilizers, this approach would  
18 apply to both types of providers.

19 CMS has tried to manage inappropriate use of  
20 imaging, as well as other services, primarily through  
21 retrospective claims review. In 2008, GAO recommended that  
22 CMS examine the feasibility of adopting a prior

1 authorization program to manage imaging services.

2 Many private plans use prior authorization for  
3 advanced imaging. These programs vary in terms of the types  
4 of tests they cover, their approval criteria, and their  
5 administrative processes. However, there are certain  
6 similarities. They usually exclude tests that are provided  
7 in inpatient settings and emergency rooms. The programs are  
8 generally administered by radiology benefit management  
9 firms, or RBMs. The approval criteria are usually based on  
10 clinical guidelines developed by specialty groups,  
11 supplemented by literature reviews and expert panels of  
12 clinicians.

13 Some plans have a "gold card" exception for  
14 physicians who have high approval rates. They still have to  
15 notify the plan when they order imaging and submit clinical  
16 information to the plan, but they do receive automatic  
17 approval. And as we described at the last meeting, the  
18 long-term impact of these programs is unclear.

19 There would be several key issues involved in  
20 developing a prior authorization program within Medicare.  
21 I'm going to describe a couple of them, but they are all  
22 discussed -- more of them are described in further detail in

1 your paper.

2           A key issue is limiting the administrative burden  
3 on physicians and the wait time for patients. One idea  
4 would be to use web-based interfaces and other tools to  
5 streamline the review process, which is what RBMs do in the  
6 private sector.

7           Second, it is critical that CMS use transparent  
8 guidelines that have been developed in consultation with  
9 specialty societies and RBMs and other interested parties to  
10 review and approve requests for imaging.

11           Third, CMS would have to determine how to identify  
12 practitioners who order significantly more advanced imaging  
13 than their peers.

14           And, finally, CMS would require significant  
15 administrative resources to develop and operate a prior  
16 authorization program.

17           This slide illustrates how a prior authorization  
18 policy could work within Medicare. Starting with the box at  
19 the top, CMS would identify practitioners who are outliers  
20 in terms of the number of advanced imaging studies they  
21 order. CMS could examine the amount of imaging used by  
22 practitioners on both a per episode and a per capita basis.

1           Practitioners who are identified as high users  
2 would then fall into one of two categories, depending on  
3 their rate of inappropriate use. As show in bottom left-  
4 hand box, practitioners with relatively high rates of  
5 inappropriate ordering would be subject to prior  
6 authorization. In this case, CMS or a contractor would  
7 review and approve their requests to order imaging services  
8 before they could be provided.

9           As show in bottom right-hand box, practitioners  
10 with relatively low rates of inappropriate ordering would be  
11 subject to prior notification; in other words, they would  
12 submit their imaging requests to CMS so that CMS could track  
13 their ordering patterns and provide them with feedback, but  
14 they would not have to receive prior approval.

15           To address some questions that were raised at the  
16 last meeting, we examined the distribution of physicians who  
17 ordered advanced imaging services in 2009. We found that  
18 top 10 percent of physicians in terms of advanced imaging  
19 use accounted for over half of all advanced imaging services  
20 in terms of volume. We also found that a significant share  
21 of physicians in this top decile of use are also self-  
22 referring physicians.

1           For example, over one-quarter of the physicians in  
2 the top decile of use for CT and MRI were self-referring,  
3 and over half of the physicians in the top decile of nuclear  
4 medicine use were self-referring.

5           This leads us to the fourth draft recommendation:  
6 The Congress should direct the Secretary to establish a  
7 prior authorization program for practitioners who order  
8 substantially more advanced diagnostic imaging services than  
9 their peers.

10           With regards to the implications, we estimate this  
11 would decrease program spending by less than \$50 million in  
12 the first year and by less than \$1 billion over five years.  
13 We do not anticipate a reduction in beneficiaries' access to  
14 appropriate imaging services. This would reduce  
15 beneficiaries' unnecessary exposure to radiation. And we  
16 recognize there would be an administrative burden on the  
17 providers who would be subject to this program.

18           I want to conclude with some thoughts for next  
19 steps. Although most of the draft recommendations do not  
20 directly address the issue of self-referral, we do remain  
21 concerned about the growth of diagnostic and therapeutic  
22 services.

1           In particular, we're concerned about physical  
2 therapy, radiation therapy, including IMRT, and anatomic  
3 pathology services. We plan to continue tracking volume  
4 changes and evidence of inappropriate use. And we may  
5 revisit options in the future to narrow the in-office  
6 ancillary services exception.

7           I am going to put up the slide with the four draft  
8 recommendations for your discussion, and I would be happy to  
9 take any questions.

10           MR. HACKBARTH: Okay. Thank you. We will, as  
11 usual, have two rounds of questions and comments, the first  
12 round being strictly clarifying questions. So, Mitra, let  
13 us begin on your side. Any clarifying questions?

14           MR. GEORGE MILLER: Just a quick question on the  
15 savings on Slide 23 and other cost savings. Are those net  
16 of the costs to CMS?

17           MR. WINTER: Yes.

18           MR. GEORGE MILLER: Okay. Thank you.

19           DR. CASTELLANOS: Just a couple of clarifications.  
20 One, do we have any idea how much has already been done by  
21 the RUC? Do we have any idea of the change in the ultimate  
22 payment changes already done that is implemented already by

1 the DRA, et cetera? I am just curious. Do we have any of  
2 those ideas? And I have just one other clarification  
3 question after that.

4 One, do we have any idea what -- how much of this  
5 has already been done by the RUC? Are we reduplicating or -  
6 - that's what I'm asking.

7 MR. WINTER: So the RUC is going through a process  
8 where they are looking at pairs of services, imaging  
9 procedures and others services, that are performed at least  
10 75 percent of the time in the same encounter. And based on  
11 that review, they recommend certain codes, certain pairs of  
12 codes to the CPT Editorial Panel for combining into a  
13 comprehensive code, which after that process is done, they  
14 work with the specialty societies to recommend -- develop  
15 new work RVUs and practice expense inputs for these new  
16 comprehensive codes, which are then referred on to CMS for  
17 review and put into the -- done through the rulemaking  
18 process.

19 They so far have done codes in five or six deficit  
20 categories: the CT of the abdomen and pelvis that I  
21 mentioned, nuclear cardiology code, echocardiography codes,  
22 diagnostic cardiac cath, and there are a couple of others.

1           In terms of the reduction in payment rates for  
2 those codes, it does vary by type of code. So for CT of the  
3 abdomen and pelvis, the new comprehensive code, the work  
4 RVUs were 25 percent less than the total work RVUs for the  
5 code pair that they replaced. The practice expense RVUs  
6 were also lower, but I do not have the number with me for  
7 that.

8           For the echocardiography code, the work RVU went  
9 down from, I believe, 3.07 to 3.0, so there was a small  
10 reduction when they combined three echocardiography codes  
11 into a single comprehensive code.

12           So it does vary depending on the type of  
13 comprehensive code, but our main point is that this is a  
14 fairly long process, and there have been a relatively small  
15 number of comprehensive codes that have been created thus  
16 far.

17           DR. CASTELLANOS: Do we have any idea about the  
18 changes, the ultimate payment changes that have been already  
19 done, already implemented, like DRA is over with now but we  
20 have a lot of practice expenses going on, I think through  
21 2012?

22           MR. WINTER: Right. So we have not estimated the

1 cumulative impact of all the different changes that have  
2 been going on over the last three or four or five years. We  
3 talk about the different changes, the DRA, for example, the  
4 new practice expense changes, the new PPIS data from the  
5 physician survey. We talk about those changes. We have  
6 separately estimated the impact, for example, of the  
7 practice expense changes alone, the new method. We did that  
8 in our 2007 report. The DRA impact, that has been estimated  
9 by GAO. I believe they estimated that it reduced spending  
10 in 2007 by about 10 percent across the board for all imaging  
11 services.

12 DR. CASTELLANOS: Okay. And just the last one,  
13 could we go to Slide 24? I think it is 24 -- or 21, I am  
14 sorry. You talk about self-referring physicians here. In  
15 the chapter you're defining a self-referring physician as a  
16 person who refers more than 1 percent of their imaging  
17 studies to their practice. Now, that would mean the Mayo  
18 Clinic, the Geisinger Clinic, almost every doctor in their  
19 practice, 1 percent. Where did you get that 1-percent  
20 figure?

21 MR. WINTER: So there are different ways to look  
22 at this. You can set the threshold at 1 percent or 50

1 percent. We went with a lower threshold to try to get  
2 people a sense of sort of the outer bound of how many self-  
3 referring physicians could be included in a prior  
4 authorization program. Let's say you focused on the top 10  
5 percent. This is not sort of a policy judgment. The other  
6 way, we also looked at it by setting the threshold at 50  
7 percent, and we found that a smaller share of physicians  
8 were in the top -- a smaller share of self-referring  
9 physicians were in the top decile. But for nuclear  
10 medicine, for example, it was still pretty high. It was  
11 still 49 percent. For CT and MRI it was lower, in the range  
12 of 14 to 17 percent.

13 DR. CASTELLANOS: I would just question the 1  
14 percent. That is pretty low.

15 MR. WINTER: Okay. We can emphasize more the  
16 alternative definition of 50 percent.

17 DR. CASTELLANOS: Okay. Thank you.

18 MR. HACKBARTH: Clarifying questions?

19 DR. KANE: When you combine some of these -- the  
20 combined bundling payments, either multiple body parts in  
21 one visit, is there any likelihood that people might start  
22 to unbundle those and provide them in separate visits? I

1 just do not -- you know, I don't know how easy it would be  
2 for the response to the bundling to be to unbundle and break  
3 up the provision of the service. Is that a likelihood or is  
4 that just not likely to --

5 MR. WINTER: That's a concern that has been talked  
6 about with regards to the multiple procedure reduction for  
7 the technical component of imaging. I don't think that CMS  
8 has seen evidence that it's actually occurring, but it's  
9 something that they're aware of is a possibility that they  
10 might ask the patient to come back on the following day to  
11 get the studies and pay for it. They can get the full  
12 payment for both components.

13 There is the inconvenience to the patient, the  
14 risk that they might not come back the next day, that sort  
15 of thing. It also might be difficult for scheduling  
16 reasons.

17 MR. HACKBARTH: And if that were to happen, you'd  
18 just end up in the current situation where you are paying  
19 the full fee for the two services. So you end up where we  
20 are today, not someplace worse.

21 DR. KANE: Except that you've made it a lot less  
22 convenient for the patient. I'm just going back to what's

1 the impact on the beneficiary.

2 MR. HACKBARTH: [off microphone] -- depends on  
3 what sort of a strategy they use. If it's just use another  
4 physician, it may or may not.

5 DR. KANE: When they do multiple things in one  
6 visit, they might just unbundle the --

7 DR. BERENSON: I mean, the theory here is that  
8 there are efficiencies in doing them, and so to do it on two  
9 consecutive days you lose the efficiencies of actually  
10 having done it together. So it's not clear it's financially  
11 desirable to do it on two different days if the calculations  
12 are done right. I mean, there are real efficiencies with  
13 this bundling.

14 DR. KANE: But now CMS is going to say we are  
15 taking those back, and so the provider would say, well,  
16 yeah, I'm just going to lose revenue for being efficient, so  
17 why don't I just not be efficient and gain revenue? I mean,  
18 I hear --

19 MR. HACKBARTH: But Bob's point is they also  
20 increase their own costs --

21 DR. KANE: No, I -

22 MR. HACKBARTH: -- so their revenue would go up,

1 but their costs would go up.

2 MR. BUTLER: Slide 3, Ariel. I want to make sure  
3 I understand the differences between the industry and  
4 MedPAC's view of the world here. The 2-percent on volume  
5 where you say the units and intensity, how do we measure  
6 intensity? Is it simply price times volume so you have a  
7 higher -- you know, you take the payment, the actually  
8 payment?

9 MR. WINTER: We're using the RVUs.

10 MR. BUTLER: Okay. Then my other clarification on  
11 the recommendations on the recommendation slide, the last  
12 slide. On 1, I am just trying to understand a little bit  
13 more, like Nancy was, this bundling of discrete services,  
14 because this kind of example isn't in the chapter and I want  
15 to know if it's covered. And, Ron, you can comment on this  
16 one.

17 Let's say a urology group employs a pathologist to  
18 do their biopsy readings, but they bill out that  
19 professional component service as part of the group, and  
20 they also bill out the biopsy itself as a procedure. Would  
21 those two things be considered one under this bundling of  
22 discrete services? Is that an example where you have the

1 procedure coupled with a --

2 MR. WINTER: It certainly could be. I mean, it's  
3 not an example we've used, but the notion is that if there  
4 are services commonly performed together in the same  
5 encounter, you could think about -- I mean, we talk about --  
6 I think the recommendation language is same provider, same  
7 practitioner. I'd have to go back and look. So in that  
8 case, it would not apply to the example you've given where  
9 it's different physicians doing each component. So you  
10 could think about extending the policy to different  
11 physicians doing something to the same patient in --

12 MR. BUTLER: The bill, though, would go --

13 MR. WINTER: -- the same encounter.

14 MR. BUTLER: It wouldn't look like it's a separate  
15 physician, right, Ron? The group would bill it out, and  
16 they would employ the pathologist to provide the service,  
17 but it would be the urologist charging for the service.

18 DR. MARK MILLER: I think the disposition of his  
19 question as to whether it gets billed as one or two, you  
20 know, transactions depends on the relationship of the  
21 practice with the pathologist. Was it a pathologist in your  
22 example?

1 MR. BUTLER: Yeah.

2 DR. MARK MILLER: So whether it's a consulting  
3 arrangement, employment arrangement, that type of thing, so  
4 I suspect it could vary depending on what the actual  
5 arrangement is.

6 MR. BUTLER: By the way, I'll let Ron answer, but  
7 the same could be on, say, an orthopod that employs a  
8 radiologist to do the readings, because it's a more  
9 profitable way of doing it, and then collects a professional  
10 component that is higher than what they're paying the  
11 employed person.

12 DR. CASTELLANOS: I think, to answer your  
13 question, there are three ways of doing it. One is the  
14 doctor does the biopsy and then sends it to the pathologist  
15 separate from the practice, and the pathologist bills for  
16 the technical component and the professional component of  
17 the prostate.

18 Another way of doing it is the practice does the  
19 biopsy and does the technical component and then sends the  
20 slide out to the pathologist for his professional fee.

21 And the third way is that the pathologist is part  
22 of the in-office ancillary exception, has some kind of a

1 contract and there's all sorts of ways that where the  
2 practice totally bills both for the procedure, its technical  
3 component, and the professional component. So there's lots  
4 of different ways of doing it.

5 MR. BUTLER: And it's the third example that I'm  
6 talking about that I think is my question. You're saying  
7 this could cover that kind of arrangement, right?

8 MR. WINTER: It could. The complication that you  
9 would run into is in Ron's first two examples where it's a  
10 separate provider on whether or not they're employed by the  
11 practice who's actually doing the service and billing under  
12 their NPI. SO --

13 DR. CASTELLANOS: I think if it was the same  
14 doctor doing everything it would fall under this. But I  
15 don't think it's the urologist looking at the slides.

16 MR. WINTER: Generally the way they -- the  
17 comprehensive codes that have been created assume that it's  
18 the same physician doing all the components of the service,  
19 if that helps. You could think about expanding that to  
20 different physicians doing the different components, but the  
21 way it has been done up until now has been same physician  
22 doing all the components.

1 DR. STUART: I also have a question about growth  
2 and volume, so if you could go back to Slide 3, and it's  
3 this: We know that over the past few years there has been a  
4 marked increase in acquisition of physician practices by  
5 hospitals, and it strikes me that that could well change,  
6 you know, the nature of the incentives for practices  
7 obtaining their own imaging equipment. Have you looked at  
8 that? And do we know whether that has had an effect on this  
9 type of volume growth?

10 MR. WINTER: It's hard to determine whether a  
11 physician is referring to -- we can't determine from the  
12 claims whether a physician is referring to a hospital that  
13 employs them, so we can't sort of look at that directly.  
14 What we can do is try to look at it indirectly by looking at  
15 changes in the distribution of settings where imaging  
16 studies are being performed. So we've tried to do that, and  
17 we looked at a couple of recent years, and between 2008 and  
18 2009 what we're seeing is a shift of imaging from inpatient  
19 hospital settings to both outpatient department settings and  
20 physician fee schedules -- physician offices and IDTFs, that  
21 is, free-standing imaging centers. So they're really  
22 shifting to both of these settings. This shift is happening

1 a little bit faster towards the OPD, the outpatient  
2 department, than it is to the office/IDTF. But it is going  
3 both -- you know, services are migrating to both of those  
4 settings, just a little bit faster in OPD.

5 Now, it's hard to really -- as far that because  
6 more practices have been purchased by hospitals and there's,  
7 you know, a reason for them to refer to the hospital, to the  
8 OPD, instead of doing it in their office. Is it because of  
9 payment changes? Is it for other reasons? So it is hard to  
10 disentangle the different factors?

11 MR. HACKBARTH: So the pattern would be consistent  
12 with the hypothesis that there may be some shift from  
13 physician office to a hospital, but it doesn't prove the  
14 hypothesis.

15 MR. WINTER: That's right [off microphone]. And  
16 we did some work for the March report that looked at the  
17 shift in clinic visits from offices to hospital outpatient  
18 departments, and we are seeing a shift there. It is  
19 something we plan to look at in the future.

20 DR. STUART: It seems to me that there are a  
21 number of issues that come up when we look at this shift in  
22 ownership of practices. And you say that you can't look at

1 this directly. I think you said that you can't identify  
2 whether the physician is part of a practice that's owned by  
3 a hospital. Is there a way that that can be done? Because  
4 it strikes me that that would be something that would be  
5 important to a number of the areas that we're going to be  
6 looking at in the future.

7 DR. MARK MILLER: The only thing I will say is I  
8 think, you know, there's been a general sense among the  
9 Commissioners of this need to kind of look at office, OPD,  
10 you know, the kind of ambulatory, and the ability to move  
11 across it. You know, obviously we have been trying to get  
12 this work done, but also looking ahead to more of an  
13 advanced conversation on that front, and we've actually been  
14 making some inquiries with CMS about how do you know when  
15 these practices shift over, and it's not as clean as you  
16 might think.

17 And so as the Commission goes forward, there also  
18 may be a need for making comments about how this is measured  
19 and tracked, as it were. I think that's what you're  
20 implying. Can it be known? And it's looser than you might  
21 think.

22 MR. HACKBARTH: When I testified on the March

1 report before the Ways and Means Committee Health  
2 Subcommittee, one of the things that struck me was how many  
3 questions there were from members about this issue of paying  
4 a different price for the same service based on location.  
5 That's a topic that we've begun to focus on increasingly,  
6 and it seems to be very much on their radar as well.

7 MR. ARMSTRONG: First, it's a great analysis, and  
8 in particular, the way we deal with the balance between the  
9 value of efficiency and access, whether it's service or  
10 quality and so forth. But one question -- maybe you did  
11 this in the analysis -- that I'm still left with is whether  
12 we've analyzed these utilization patterns for ancillary  
13 services in the fee-for-service Medicare program compared  
14 with in the Medicare Advantage program, just given its  
15 different kind of financial construct. And if we have, was  
16 there anything interesting that we saw in the differences?

17 MR. WINTER: I'm not sure if we have the data at  
18 that level for Medicare Advantage beneficiaries. I'm  
19 looking over to see if Scott is here and wants to address  
20 that. But he's not giving me an indication otherwise, so  
21 I'm going to assume we don't have the counter level data by  
22 type of service to be able to look at that unless, you know,

1 some MA plans voluntarily wanted to share those data with  
2 us.

3 There was the study done, I'm sure you know, by  
4 your colleagues at Group Health, published in Health Affairs  
5 a few years back, which looked at trends in the growth of  
6 imaging within the Group Health system, and it was, you  
7 know, pretty consistent with what we're seeing in Medicare  
8 and in the private sector.

9 MR. ARMSTRONG: I ask that partly because what we  
10 want to be sure to do is distinguish between good growth in  
11 utilization and not good growth in utilization. And maybe  
12 there's some insight we could get from MA plan kind of  
13 studies that really pay attention to that.

14 MR. HACKBARTH: Although in the Group Health  
15 study, as I recall, the rate of growth was similar, but from  
16 a much different level. So the level of use was lower, as I  
17 recall the article, but then the rate of growth was similar.

18 MR. ARMSTRONG: But it was also still too much.

19 MR. HACKBARTH: Right. And he's an authoritative  
20 source on that.

21 DR. BORMAN: Two quick things. If you go to the  
22 first draft recommendation, I just want to make sure -- I

1 believe it to be the case -- that this and the text around  
2 it do not preclude that a part of this bundle could be an  
3 office visit or other evaluation and management service that  
4 could be bundled with diagnostic testing. We're not  
5 limiting this to merely bundling lab and imaging. Am I  
6 correct in that?

7 MR. WINTER: Yeah, that's correct. We could add  
8 that as an example in the chapter.

9 DR. BORMAN: Okay, because many of these will  
10 focus around a disease encounter.

11 And then the other thing, I think it's on Slide 9,  
12 because the same thing happened to me when I read it on your  
13 slide and I read it in the chapter. If I'm correct, what  
14 you're saying here is certain physician work activity is not  
15 duplicated. So what you're saying is they're not being  
16 performed twice, correct? Okay. When you say not  
17 duplicated, it almost sounds like you're saying that they do  
18 need to be performed twice, if you understand just how that  
19 hits a little bit. And I might suggest for clarify of other  
20 readers that you consider some language like "not performed  
21 twice" or something that makes it very clear what you mean,  
22 because I think on casual first glance and not with the

1 richness of this background discussion, that might be  
2 misinterpreted or seem to be in conflict with what you say  
3 later.

4 MR. WINTER: [Off microphone] That's a good point.

5 MR. HACKBARTH: Is it just me or did Round 1 have  
6 a bit of a Round 2 feel to it? It took us an unusually long  
7 time to get through Round 1 so let's be careful as we go  
8 through the day to focus Round 1 questions or strictly  
9 clarifying questions, and I emphasize that because some  
10 people exercise a lot of self-discipline about that, and if  
11 they do and then they see everybody else sort of ask much  
12 more complicated questions, it's really not fair to the  
13 self-disciplined folks.

14 So now let's go to Round 2 comments, and I'm going  
15 to actually take the prerogative of making the first one.  
16 Mine's going to span really the whole set of  
17 recommendations, but I think it probably makes sense to take  
18 the recommendations one by one and ask people for comments  
19 on each recommendation in turn. But let me just say a word  
20 about the overall package.

21 For me at least, the evidence is persuasive that  
22 self-referral is associated with higher use of services and

1 probably an increase in inappropriate use. The problem, as  
2 I see it, however, is not self-referral per se, but it is  
3 the combination of self-referral combined with fee-for-  
4 service payment and services that are often mispriced and  
5 overly generous in terms of the price.

6 My concern, as I've said many times here, is that  
7 a ban, just a broad ban on self-referral could have  
8 undesirable effects on organized practice, and that's not  
9 where we want to go. So the approach embodied in these  
10 recommendations is to focus on mispricing of services. In  
11 the case of the fourth recommendation, add an administrative  
12 check on potential overutilization hopefully in as  
13 unobtrusive a way as possible. But ultimately the solution  
14 to this problem, as I see it, is through developing new  
15 payment methods, paying physicians in different ways that  
16 reward the efficient delivery of high-value services and not  
17 just doing more. And everybody's well aware of the efforts  
18 underway through CMMI to operationalize new payment methods  
19 that would help address these incentives, ACOs being one  
20 recent example of that.

21 If at some point in the not too distant future I  
22 hope we have a robust ACO program with a different incentive

1 structure, that could create new opportunities for  
2 rethinking how we address the issue of self-referral. So if  
3 we can say to organized practices, well, you can self-refer  
4 all you want as long as you're within a risk-bearing ACO,  
5 then that would open the possibility to taking a much  
6 stronger stance against self-referral when they're not in an  
7 ACO, they're just in fee-for-service. But right now at the  
8 moment we're addressing this issue, I think a narrower, more  
9 careful approach is the way to go with self-referral  
10 focusing, as I say, on mispricing of services with the  
11 addition of prior authorization. So that's my comment on  
12 the whole package. Now, let's go through each of the  
13 recommendations in turn.

14 On Recommendation 1 any further questions or  
15 comments?

16 DR. STUART: This actually applies to all three,  
17 but we can handle it with 1. That is, in these first three  
18 recommendations, we are suggesting that this be budget  
19 neutral, and it is a question. How do we make it budget  
20 neutral? If CMS reduces prices for these particular codes,  
21 then in order to make it budget neutral, it would imply to  
22 me that there would be a forecast in terms of how much that

1 would save and then the forecast savings would be put back  
2 into an estimate of how much the other all fees would rise  
3 by that. Is that what we have in mind here?

4 MR. HACKBARTH: So are you asking, Bruce, whether  
5 there's sort of a behavioral assumption, what happens to  
6 volume in response to --

7 DR. STUART: Well, there are two parts here. One  
8 is the very technical part in terms of are we suggesting  
9 that, in fact, CMS would reduce rates and then do that  
10 forecast and then increase all rates by a commensurate  
11 amount. But the point you raise is also an element of that.  
12 In other words, what kind of behavioral assumptions do you  
13 include in those forecasts?

14 MR. WINTER: They've done this repeatedly for  
15 creation of comprehensive codes, even when work RVUs or  
16 practice expense RVUs are changed for individual codes, and  
17 I believe it's a fairly simple calculation. They estimate  
18 the amount that would be saved based on the RVU change  
19 multiplied by the volume for that code, and maybe they make  
20 a projection for, you know, the year in which they're making  
21 the change. I don't know. But I don't think they  
22 incorporate behavioral assumptions about how a change in,

1 you know, payment, a reduction in payment might affect  
2 volume going forward in terms of an offset.

3 DR. STUART: So it could be --

4 DR. MARK MILLER: The way that I would say it --  
5 and, Bruce, I know -- I mean, just think about it first this  
6 way. It's just like you have a static set of dollars. You  
7 changed, you know, the price on some of the units and you  
8 basically reallocate within that static set of dollars. I  
9 don't think there's a forecast about volume. It's sort of  
10 given the volume that you have and given the dollars, right?  
11 Okay.

12 Then your second question is about behavioral  
13 offset assumptions or maybe -- let me stop there. The basic  
14 way to think about the way the budget neutrality works, and  
15 works as a regular course when these changes are made --  
16 and, you know, often it's across codes that are going both  
17 up and down. It's sort of a static reallocation based on  
18 the volume and dollars that they have at that point.

19 DR. STUART: It really was a question, although  
20 that raises another point. Has there been an evaluation of  
21 whether these technical forecasts without behavioral  
22 assumptions have been correct?

1 DR. MARK MILLER: Okay, then there is -- and you  
2 keep using the word "forecast," and I don't want to pull  
3 that into my vocabulary because that's at least not the way  
4 I think about it, and maybe it's a vocabulary thing. There  
5 is some sense when this is done that if you pull a price  
6 down there can be a volume response, and so how much you  
7 reallocate back into that calculation that I just went  
8 through can be influenced by, well, if I took the price down  
9 ten but I think the volume is going to recapture three, if  
10 you will, then the budget neutrality adjustment contemplates  
11 that difference and sort of makes the adjustment that way.  
12 And there are different assumptions about -- well, at  
13 different points in time there have been different  
14 assumptions about how much of a volume offset there is, and  
15 there's some back and forth in the literature about how much  
16 there is.

17 MR. HACKBARTH: But the overriding point is your  
18 first answer was that they're not doing behavioral  
19 adjustment in these. They're assuming the volume is the  
20 volume and you're just changing prices. At least that's the  
21 way I interpreted your first statement.

22 MR. WINTER: Correct.

1 MR. HACKBARTH: Is that correct?

2 DR. MARK MILLER: Yeah, I mean, I made the first  
3 statement in a sense to kind of get the concept in your  
4 mind, and what I was trying to wall off is this forecasting  
5 thing for the moment. It's sort of a static operation,  
6 dollars-volume. And I will take some help here if Bob or  
7 Ariel wants to chime in.

8 However, when you make a static price adjustment,  
9 even though you're working within this block of dollars, I  
10 do believe they make a volume offset assumption within that,  
11 and that's the question.

12 DR. BERENSON: Although I would just distinguish  
13 the technical aspects of recalibrating the values, which is  
14 a pretty mechanical thing, without assumptions about  
15 offsets. You've reduced service one by a certain amount;  
16 you give that across all the other services. Separately,  
17 the actuary -- I mean, these are sort of different actors.  
18 The actuary may make some assumptions about volume offsets  
19 in terms of --

20 DR. MARK MILLER: [off microphone] For the total  
21 dollars.

22 DR. BERENSON: For the total dollars, but that

1 doesn't affect the specific assignment of values.

2 DR. MARK MILLER: Very good distinction because I  
3 -- very good distinction because, you know, you always have  
4 the RVU and then you have the conversion factor out there,  
5 and the statement about, you know, within a static framework  
6 certainly refers to the RVUs. That is done in a way that it  
7 is [off microphone].

8 MR. HACKBARTH: Okay. Any additional comments on  
9 Recommendation 1?

10 [No response.]

11 MR. HACKBARTH: Okay. Let's move to  
12 Recommendation 2, again starting with Mitra. Any comments  
13 or questions on Recommendation 2?

14 DR. CASTELLANOS: Yeah, I think we really need to  
15 define what you mean by the same session. Is that the same  
16 day? Is it the same disease process? I'll give you an  
17 example. I saw a patient just the other day with a lot of  
18 blood in the urine and I did an ultrasound, which is a non-  
19 invasive, non-radiology-exposure study, and I found a mass  
20 in the kidney. So that mass needed to be further evaluated.  
21 I ordered a CAT scan that was not done that day but the next  
22 day, and obviously -- is it within the same session or that?

1 And we need to define what we mean by "in the same session."

2 MR. WINTER: CMS has defined this, the same  
3 session, as the same encounter with the provider, and they  
4 use this definition for the technical component payment  
5 reduction. And they do allow for -- if there are multiple  
6 sessions on the same day, so, for example, the patient is in  
7 the office for chest pain, they get a chest X-ray -- well,  
8 that's not a good example, but let's say an MRI scan of the  
9 chest in the morning, they come back in the afternoon and  
10 get a different imaging study, different problem, or maybe  
11 the same problem, those are considered different sessions,  
12 and so those would get the full -- each one would get the  
13 full payment. They would not be subject to a reduction.  
14 That's how it works for the technical component. We can say  
15 in the chapter that it should work the same way. We've sort  
16 of assumed the same definition in the recommendation and in  
17 the chapter.

18 DR. CASTELLANOS: I think we need to clarify that  
19 in the chapter. Thank you.

20 MR. HACKBARTH: Okay, Recommendation 2, comments,  
21 questions?

22 MS. HANSEN: Actually, this relates to 2 but

1 probably crosses over. I think one of the questions that  
2 Nancy raised earlier was about the impact to the  
3 beneficiary, so the example that you just gave would allow  
4 this possibility to have the person still there the same  
5 day, have two different sessions, and not have the penalty  
6 to the practitioner but also still have the convenience for  
7 the beneficiary, because that's the other thing that  
8 oftentimes is somewhat concerning, that the efficiency of  
9 having multiple things done as appropriately that makes it  
10 effective for the beneficiary not to be traipsing back and  
11 forth just to get different sessions paid for. So I guess  
12 the core question is: Through all of this -- and I know  
13 that the recommendation, the impact of access to the  
14 beneficiary is stated to be no affected, but the whole  
15 convenience component that I know the industry has also  
16 commented on, is that sufficiently addressed in the way we  
17 are posing our recommendations?

18 MR. WINTER: What I can tell you is that CMS  
19 implemented the multiple procedure reduction for the  
20 technical component of many imaging services in 2006. We  
21 have not seen a decline in access to those imaging studies  
22 to which it applies, primarily MRI, CT, and as I said, some

1 ultrasound, some nuclear medicine. It primarily applies to  
2 MRI and CT. We are not seeing access problems in those  
3 areas.

4 DR. KANE: You can't measure the inconvenience  
5 that they have to come back twice. All you're saying is  
6 they're still getting the test, but we don't know whether  
7 it's as --

8 MR. WINTER: Right.

9 MR. HACKBARTH: The objective here is to match  
10 prices to costs, and so if, in fact, you do that well, the  
11 providers should be indifferent between doing it in one  
12 visit versus two if you match prices to cost accurately.  
13 There shouldn't be more profit in one approach versus the  
14 other.

15 DR. KANE: So costs are not all variable, and so  
16 you can have actually a very high fixed cost based, and all  
17 you really want to do then is maximize your revenue in any  
18 way possible. And I think that's where I'm having this sort  
19 of -- you know, that whole discussion about, oh, well, they  
20 wouldn't unbundle because it would be less efficient for  
21 them, maybe. But if they're paying a technician a salary  
22 and they're paying for the equipment on a fixed-cost basis,

1 then really what you want to do is maximize your revenue.  
2 And so then unbundling lets you maximize your revenue, and  
3 your cost structure does not change at all.

4           So I guess I'm having a little -- you know, it's  
5 nice to think we're getting efficient prices, but, you know,  
6 depending on how they structured their cost structure, the  
7 incentive could well be just to get as much revenue as you  
8 can for a certain level of fixed costs, in which case  
9 bundling, which lowers the revenue, will create an incentive  
10 to unbundle and make it less -- and I just think we ought to  
11 -- I'm all for bundling. I just think we ought to recognize  
12 that that's the potential incentive that needs to be perhaps  
13 monitored and, you know, maybe through patient surveys or  
14 something else, but I don't think we can assume that because  
15 we have somehow, you know, brought down that cost that the  
16 physician is not incurring -- not motivated to still ramp up  
17 -- unbundle those services to ramp up the revenue.

18           [Pause.]

19           MR. HACKBARTH: So Round 2, no further comments or  
20 questions on that?

21           DR. BAICKER: Just to follow up on what Nancy  
22 said, that all sounds like you have to get the prices right,

1 that if you bundle and you reduce them too much, you get  
2 this perverse incentive to have people come back more  
3 frequently; if you don't reduce the price enough, you're  
4 double paying for stuff, and that seems like a real  
5 challenge. But we're kind of sure that we're too far in one  
6 direction right now.

7 DR. BERENSON: Can I pick up on that comment?  
8 Just picking up on that comment, one reason later in the day  
9 when we're talking about getting real-time data to support  
10 the work assignments, we're using sort of rules of thumb for  
11 reductions, you know, a 50-percent reduction for the second  
12 surgery. That's another place where getting real-time data  
13 will inform getting the prices right rather than just  
14 relying on a somewhat arbitrary reduction, which I think is  
15 a first approximation, but it's the reason we need real-time  
16 data to get better estimates of work and practice expense so  
17 that we can actually make more valid decisions around this  
18 kind of an issue.

19 MR. HACKBARTH: And Nancy's point is well taken  
20 about the fixed versus variable costs and the like. That  
21 makes sense to me conceptually.

22 We also have to keep in mind, though, that in the

1 current system there are incentives, too, to do more, to  
2 have beneficiaries not only be subject to more visits, but  
3 also be subject to excess radiation and other concerns. I  
4 think this is consistent with what Kate was saying. We have  
5 reason to believe we are not at the optimal point right now  
6 in terms of utilization.

7 We're going to have to move ahead. We're running  
8 behind.

9 DR. BORMAN: Yeah, just a last comment. I think  
10 what you and Kate have just said in terms of what we're  
11 trying to narrow our view to right now is at least our  
12 perception based on available data relative to the relative  
13 mispricing and/or overall incorrect pricing. This is a  
14 world of users who are very bright people, and so we've  
15 already got a system where, despite good intentions, people  
16 have permuted it to other things. I don't think that we can  
17 create through a draft recommendation or all the wonderful  
18 text a circumstance that can't be permuted by a few folks in  
19 a particular way and, in terms of looking at your business,  
20 just as any business people are going to look to maximize  
21 their margin.

22 So I think that to get hung up on that piece at

1 this level by this group is probably not productive.

2 MR. HACKBARTH: Now let's move on to  
3 Recommendation 3. Questions or comments on 3?

4 MS. BEHROOZI: [off microphone].

5 MR. HACKBARTH: Okay. Number 3.

6 DR. CASTELLANOS: Again, I have a little concern  
7 about the definition of "other diagnostic tests." And I  
8 also have some concern about what you mean by -- is it going  
9 to be in the same session? Or if that person orders  
10 diagnostic tests for the next day, two days, three days down  
11 the pike, will that be included in that bundle?

12 My real concern here is not really for the  
13 specialist but predominantly for primary care. Primary care  
14 does a lot of the basic screening on diagnostic tests -- the  
15 CBC, blood tests, chest X-rays, EKGs. Welcome to Medicare,  
16 I mean, they have a whole battery of diagnostic tests they  
17 do.

18 I think it's going to have a huge impact to  
19 primary care, and we have always had a feeling on MedPAC  
20 that we -- I hate to use the words -- "want to protect the  
21 primary care doctor," and we do, for a lot of reasons. And  
22 I just don't know where you're going with the diagnostic

1 tests, not applying to specialists like myself but maybe Tom  
2 can fit in and peep in on this, because I think it's going  
3 to impact the primary care doctor more than anything else,  
4 and I don't want to do that unless we have to view.

5 MR. HACKBARTH: Here's my view on that, Ron.  
6 Certainly I don't want to do harm to primary care. I want  
7 to increase payments to primary care. However, I think  
8 there are right ways to do that and wrong ways to do it. I  
9 think we should try to price services accurately, and that's  
10 what these recommendations are about. They reflect --

11 DR. CASTELLANOS: I understand that.

12 MR. HACKBARTH: -- the actual work involved, and I  
13 think in this situation the work does change, there are  
14 economies in the work. If we want to increase payments for  
15 primary care, we ought to use much more direct mechanisms  
16 like primary care bonus or we ought to work, as Bob has  
17 repeatedly urged, on the basic structure of the relative  
18 values and not think about whether accurate pricing is going  
19 to reduce dollars at the margin to primary care. Let's keep  
20 our eye on the ball, price as accurately as possible for  
21 individual services, and achieve policy goals about  
22 redistribution through other more direct means.

1           We are on number 3 now. Further questions or  
2 comments?

3           DR. CASTELLANOS: Can you define that a little  
4 better [off microphone]?

5           MR. HACKBARTH: Oh, I'm sorry. The first part of  
6 the question.

7           MR. WINTER: What we're referring to here, these  
8 are diagnostic tests paid under the physician fee schedule,  
9 so it would things like cardiac stress tests, EKGs, anatomic  
10 pathology tests. It would not include tests that are paid  
11 under the clinical lab fee schedule, like urinalyses or CBC.  
12 A lot of, you know, basic tests are paid under the lab fee  
13 schedule. This would not be included here.

14          DR. CASTELLANOS: [off microphone] -- if they're  
15 not done in the same --

16          MR. WINTER: Right. So same session or not, this  
17 recommendation is not limited to tests that are ordered and  
18 performed on the same day as an E&M visit. We're assuming  
19 that through a prior E&M visit -- it might have been same  
20 day, it might have been a week or two beforehand -- the  
21 physician acquired certain information about the patient  
22 that makes it -- they've already acquired information about

1 their history and their symptoms and their medications, the  
2 indications for the test, and so, therefore, that portion of  
3 the pre-service phase of the payment for the test itself has  
4 already been accomplished or the physician already has this  
5 information, and so the payment for that, acquiring that  
6 information that's in the test, is duplicative, in some way  
7 duplicative. We're not giving the exact amount. We don't  
8 have the exact amount. But in some way we think it's  
9 duplicative.

10 DR. CASTELLANOS: Just to make it clear, I want to  
11 do what you do, Glenn. I want to make the prices right.  
12 There's no question. We just need to really clarify this.  
13 When we have things like that up, sometimes it can be very  
14 ambiguous.

15 MR. HACKBARTH: Okay. Are we ready to move on to  
16 Recommendation 4?

17 MS. BEHROOZI: So I waited, I was disciplined and  
18 waited until the end to kind of just make a real Round 2  
19 kind of comment. On all of it, Ariel, the work that you  
20 have done has been so great, and the first three, I think,  
21 recommendations really reflect a lot of very careful  
22 dissection of the way the fee-for-service payment system

1 could be made a little bit better. But, of course, we all  
2 want to get past that as quickly as possible, and to the  
3 extent that this reflects a desire to bundle or, you know,  
4 move in that direction, that's great. But it's also  
5 something that hopefully we can leave behind when we are in  
6 the world of ACOs and other kinds of payment systems.

7           It is really important to focus on imaging, and I  
8 really support all of the recommendations. I just want to  
9 highlight a statement that you make in the paper that  
10 greater use of imaging is associated with greater overall  
11 resource use. And, you know, in these times, when we can  
12 get lost in the weeds on each of the particulars,  
13 particularly in 1 through 3, it's really important to  
14 recognize that it's not just about, you know, the extra  
15 tests on a given day, but it's about the drive toward  
16 increasing utilization, not all of which is appropriate, as  
17 we know.

18           So what I really like about Recommendation 4 is  
19 that it recognizes that you can't always use the blunt  
20 instrument of payment policy to achieve your ends, that  
21 there are just some times when, because, you know, you have  
22 unintended consequences, you know, you clamp down and it

1 squishes out at the sides -- it doesn't go away, it just  
2 squishes out at the sides -- sometimes you really have to  
3 take some utilization out of the mix altogether. And I  
4 think that it is really important to do what is kind of  
5 obvious out there, you know, in the private sector has had  
6 some positive effect and to go for a prior authorization  
7 program.

8 DR. DEAN: Yeah, I would just echo the things that  
9 Mitra just said and you alluded to, Glenn. It would be nice  
10 if we could all of a sudden move to a system where the  
11 incentives were focused entirely on what is the value of  
12 this test to this individual patient. Clearly, the fee-for-  
13 service system introduces a bunch of perverse incentives  
14 that lead us to have to go through all these other  
15 exercises.

16 With regard to the prior authorization, as I've  
17 said before, you know, I have mixed feelings about that. I  
18 basically support the recommendation, but with some  
19 uneasiness about -- because having gone through some of the  
20 hassle factors that can be associated with these kinds of  
21 activities, they don't have to be. And I guess it depends  
22 so much on how the program is constructed and how the

1 activities are carried out.

2           The first concern is we keep talking about if they  
3 adhered to the guidelines as though guidelines were all set  
4 and that we had clear-cut indications for all these  
5 procedures. And, unfortunately, that just is not the state  
6 of the art, and I think we're too quick to assume that we do  
7 have clear indications, and the indication -- because the  
8 indications may well change depending on the individual  
9 patient, especially as we're dealing with elderly folks with  
10 multiple diagnoses. There's a lot of times there are trade-  
11 offs, that there are things that might well be indicated in  
12 one patient and for another patient with the same diagnosis  
13 is not indicated because of some other conflicting  
14 diagnosis. And I guess that's what I hesitate about. I  
15 think we need to move forward along this line, but we can't  
16 lose sight of how complex it can become when you get on the  
17 front lines and you have to decide whether or not something  
18 is truly indicated. And that's why I worry a little bit  
19 about as this gets implemented in a bureaucratic structure,  
20 whether that complexity will be -- will there be a  
21 sensitivity to that kind of complexity?

22           Secondly -- and this has come up in our other

1 discussions -- the issue of who are the large users does  
2 depend -- compared -- well, and I think the statement is  
3 compared to their peer group. As we have already mentioned,  
4 I'd just emphasize that we need to be careful about figuring  
5 out who that peer group is, because as we have said, just  
6 doing it by specialty is not nearly specific enough. And it  
7 may well be difficult, and, again, it gets back to some of  
8 the things I just said. So it's not a straightforward  
9 process by any means.

10           And I guess just to close, I'd say that because  
11 it's so complex, the quicker we can move to payment systems  
12 that eliminate the perverse incentives, the better off we  
13 are, because I'm not sure we're ever going to get this  
14 entirely right. I think it's a move in the right direction,  
15 but there's inevitably going to be hassle and mistakes and  
16 frustrations and all those things.

17           MS. HANSEN: I collectively support the  
18 recommendations. I'll just highlight what has been said and  
19 I think as an emphasis that the payment incentives  
20 ultimately are kind of the driving force of some change on a  
21 larger policy level, because all these discrete conditions  
22 that Tom mentioned are ones that are just very difficult to

1 do on this kind of large scale. So ultimately, you know,  
2 having lived with global payments for over 20 years, I do  
3 think that when you have that incentive in mind, the  
4 appropriateness components using evidence is more possible.

5           The last comment I'd make is relative to a comment  
6 that was brought up a little bit earlier about some of the  
7 changes that are occurring, whether it is by location but  
8 probably more significantly the change of employment of  
9 physicians and how that's going to affect many of the pieces  
10 of work that the Commission does, period. But I think that  
11 the ability to capture that in our work, which probably is  
12 already going on, but I've heard certainly, for example, the  
13 cardiology field that within a couple of years 80 percent of  
14 cardiologists will be somewhere employed in an environment.  
15 So those shifts are significant in each of the specialty  
16 areas as practice goes. I know that even in Northern  
17 California, you know, Kaiser hired ten orthopedic surgeons,  
18 you know, in one fell swoop. So there's a definite practice  
19 change that hopefully we as a Commission will start  
20 describing because I think that undergirds some of the  
21 shifting, and whether it's the private PIN number that  
22 people have and how do we capture that data, which is

1 something we brought up earlier. So I just hope that that  
2 would be a piece where the Commission will continue to start  
3 describing more quickly, because I think these changes are  
4 happening within these couple of years with great change.

5 Thanks.

6 DR. CHERNEW: [off microphone] first, I agree  
7 completely with Mitra said. What makes this different than  
8 just payment changes is payment changes hit everybody, and  
9 this allows some targeting. I think that's generally really  
10 important.

11 I'm supportive of the first three recommendations.  
12 I'm basically a little ambivalent about the fourth. I guess  
13 in the end I'll be supportive of it, but I'm not excited  
14 about it, I suppose. I have a few general questions about  
15 it that I think could be clarified in the chapter.

16 The first one is the chapter talks about this  
17 multi-step process where first you submit to CMS, then CMS  
18 figures out if you have a lot of inappropriate, and if you  
19 have inappropriate, then you go out to prior auth. The  
20 prior auth. could be done by CMS or a contractor. I think  
21 that in general you wouldn't want to have CMS develop its  
22 own set of guidelines to decide if you're inappropriate and

1 then a contractor decide a separate set of guidelines to  
2 determine if you're inappropriate. So I would encourage  
3 whatever process is going to be used at the end to figure  
4 out an appropriateness, that's the same set of criteria that  
5 you use to figure out if you meet the threshold one way or  
6 another. I think that's more efficient and clearer for  
7 everybody, and there is room for different guidelines.  
8 That's my first comment.

9 My second comment is -- it's a little bit of a  
10 comment, a little bit of a question. We've seen a lot and  
11 we'll see later things about practice pattern variation in  
12 general, and most of the places where I've known this is  
13 done, I think about it being done by an organization where  
14 they're doing it in their area. And I just don't know the  
15 answers to the following two questions:

16 How much variation is there geographically in  
17 practice patterns for imaging? I assume the answer is a lot  
18 because there just always seems to be, but I actually don't  
19 know that.

20 And assuming that's true, are we envisioning the  
21 standards being national? I'm assuming the answer to that  
22 is yes because I can't imagine guidelines that say, oh, in

1 Texas...

2           So I think one thing that makes this a challenge  
3 is to use evidence-based guidelines nationally, which I  
4 would be supportive of if you -- you know, I can't envision  
5 the argument against that. But that's going to have  
6 distributional consequences in ways that I haven't fully  
7 thought through based on where people are and what they're  
8 doing. And I think that requires some thought at least, not  
9 enough thought to make me say no, I don't think we should do  
10 this, but enough thought to make me say I should take up  
11 your time.

12           MS. UCCELLO: I'm going to support this  
13 recommendation, but a little less enthusiastically than  
14 maybe the others. I think my main concern is the  
15 administrative burden on CMS. Given the limited resources  
16 of CMS, I really think we need to make sure that they are  
17 targeting their efforts and resources most appropriately to  
18 get, you know, most effectively. And I don't think it's  
19 necessarily clear how pre-authorization compares to  
20 notification or to these decision support systems.

21           Nevertheless, I think given the evidence of  
22 overuse, prior authorization is an appropriate lever that we

1 can pursue, so I will support it.

2 MR. HACKBARTH: [off microphone] -- still on 4.

3 MR. GEORGE MILLER: Yeah, in general, I agree,  
4 like my colleagues, I support the recommendations and the  
5 comments that Michael made and Cori just made, certainly  
6 withstanding particularly with the resources for CMS, I'm a  
7 little concerned. But I would like to just expound that I  
8 think that part of this recommendation should deal with the  
9 education of the physician as well, particularly for those  
10 who may be high utilization users but there's no indication  
11 or measurement tool at this point in time. And what I'm  
12 concerned about is building bureaucracy to try to deal with  
13 an authorization where you may get the same effect if you do  
14 prior notification and the education component of that.

15 I do recall -- I think it was either Herb or Peter  
16 who said it -- than when the Joint Commission came with the  
17 tracer methodology, there was great learning versus the, my  
18 words "gotcha" mentality prior to tracer methodology and the  
19 fact that the surveys were done with an education component  
20 in mind to show exactly how it would be done.

21 So I think that that same theory could be used  
22 with the physicians, particularly what Ron described even in

1 his practice. He may have a high utilizer. They all may be  
2 appropriate. He may have a utilizer and that may not be  
3 appropriate. We may not tease that out. But if you have a  
4 prior notification you can do a better job in educating  
5 everyone and then see if there's a measured change, and if  
6 there's not then go to the authorization.

7           So I just wanted to push that theory in this  
8 recommendation to have part of an education or complete  
9 education program, because I think it would be less  
10 burdensome on CMS and the resources it would take to do a  
11 full-blown prior authorization program.

12           DR. CASTELLANOS: Okay. I'm going to take a lot  
13 of time, and I apologize. I am totally against this  
14 recommendation as written. I'm not against the policy of  
15 doing something in this vein, but I think what we're doing  
16 at this time is a tremendously blunt instrument to handle a  
17 problem.

18           Now, Ariel, you gave some statistics and you said  
19 -- you're right -- we had 2-percent growth in imaging last  
20 year. What was it the year before? It was 3.3 percent. So  
21 we went down in rate of growth. The time before that was  
22 3.8 percent. The total number of all services growth was

1 3.3 percent, and now you're complaining about 2 percent.

2           So what I'm saying is that, yes, we have a  
3 problem, but why hit it with this large blunt instrument  
4 when, in my opinion, we're not ready for this? Now, it has  
5 worked very well in the private sector, but I'm sure it  
6 wasn't started all in one step. And what I would like to  
7 see is a program where we do have pre-notification where  
8 everybody is notified on his or her resource use and  
9 appropriateness. And what happens if that person then does  
10 not respond appropriately by changing his or her pattern?  
11 Then go perhaps into a pre-notification process.

12           We're not ready for this. We're not ready for  
13 prime time. We have not established appropriate guidelines.  
14 We talked last month's session concerning this. There's a  
15 little bit in the chapter concerning how the American  
16 College of Cardiology and RBMs work together to establish  
17 this, but we don't have that yet.

18           So until we have something like that and we know  
19 what's appropriate and what's not appropriate, I think we're  
20 really way, way ahead of the game. You know, we're not even  
21 sure if this is going to be cost saving. There's no studies  
22 that say that. The radiology benefit managers of course are

1 going to tell you they're going to save it. You go out and  
2 buy a car, the Chevrolet company is going to say, oh, this  
3 is going to save you a lot of money by buying this. But we  
4 don't have any factual studies. There was a question -- and  
5 we can do this -- whether this has the authority to be able  
6 to do this.

7           There were a couple of other issues that you go  
8 into the text about or into the briefing material. You're  
9 going to exclude ACOs, which I think is a good idea. You're  
10 going to exclude the ER, which I think is a very good idea.  
11 But you're going to exclude inpatient hospitals. And then  
12 right next to that you have an article published in 2010  
13 saying that in a large urban hospital 26 percent of the  
14 cases done by primary care ordering were inappropriate. But  
15 you're going to exclude that.

16           Now, I work in the real world, and I'm dealing  
17 with a bunch of hospitalists. Now, that's an ongoing  
18 educational process for them, but I spend most of my time in  
19 these consults saying this isn't necessary, this isn't  
20 necessary, and this isn't necessary. But yet you're not  
21 even going to look at the hospital side where I think it can  
22 be a significant problem.

1           And on Bruce's point, 40 percent of the doctors  
2 today are employed by hospitals. Now, that doesn't mean  
3 these doctors are going to be done in the hospital. We're  
4 talking about inpatient.

5           So I guess my point really is we're not ready for  
6 this yet. We don't have the structure in place. We haven't  
7 even approached the specialty societies, and I've been  
8 asking to do this for several meetings that we should get  
9 the specialty societies to try to establish adequate  
10 criteria for inappropriateness. And in the next session,  
11 when we talk about that, I'm going to bring that up again,  
12 not just with the QIO issue but on all Medicare providers.

13           So what I would like to say at this time is that I  
14 don't think we're ready for this. I think this is going to  
15 be a tremendous hassle to the medical community. I think  
16 it's going to be a tremendous hassle to the patients. And  
17 until we can do it right the first time and not correct it,  
18 I think we're going to have a problem.

19           There was some discussion in the executive session  
20 about a pilot program, and I was enthusiastic about that  
21 because that is something we can massage, we can develop, we  
22 can improve and see where we stand. But to go out on this

1 at this time, in prime time, I think is going to be much too  
2 destructive both for the Medicare beneficiaries and for the  
3 practicing communities.

4 MR. HACKBARTH: I just want to pick up on a couple  
5 points, Ron, and I respect your opinion on the final  
6 recommendation and wouldn't try to persuade you otherwise,  
7 but there are a couple factual issues here.

8 On your first point about the slowing rate of  
9 growth in imaging, I think our data certainly show that the  
10 rate of growth has slowed. However, the question about  
11 whether the rate of imaging is appropriate has more to do  
12 with the level of spending rather than the trend in the rate  
13 of growth.

14 We have a slowing of the rate of growth after  
15 basically a decade of exceedingly rapid growth in imaging.  
16 So even if it has flattened out completely, we could well be  
17 -- in fact, I believe that we would be leveling off at a  
18 level of utilization that is well above what is appropriate  
19 for a high-quality, high-value practice. So the rate of  
20 growth, trends in the rate of growth are a bit of a red  
21 herring in terms of making a policy judgment on what to do  
22 about imaging payment.

1           And then the other point was a narrow one. I  
2 think the chapter refers to not covering through prior  
3 authorization inpatient hospital services. Is that correct?

4           MR. WINTER: Correct.

5           MR. HACKBARTH: Inpatient hospital services, as  
6 you know, are paid under a bundled payment rate. I agree  
7 with you that there may well be issues about appropriate  
8 utilization of imaging and other services within the  
9 hospital, but within the Medicare payment framework, the  
10 hospital has every incentive to try to address those issues  
11 within its organizational structure. What makes this  
12 different is that it's in a fee-for-service environment, and  
13 nobody has that incentive to carefully monitor appropriate  
14 utilization, so it is left to Medicare to do it.

15           DR. CASTELLANOS: Can I respond? You're right  
16 about the pricing. As far as the way it is in the  
17 inpatient, my concern is that the physician community --  
18 site of service, hospital, outpatient, wherever -- should  
19 practice the same quality of medicine and the same  
20 appropriateness. And if we don't apply it over the whole  
21 spectrum, I think we're missing a tremendous opportunity.

22           The second point about the increased use of

1 advanced imaging, I would like to see some data on that. I  
2 don't have that data. And if you think we --

3 MR. HACKBARTH: [off microphone] The data on  
4 what?

5 DR. CASTELLANOS: The inappropriate use of  
6 expensive data and when we talk about, you know, using the  
7 increased percentage of imaging, what percentage is really -  
8 - you know, I can see what's happening here because I have  
9 the data here. And, you know, the advanced imaging has gone  
10 down. So has the total imaging.

11 MR. HACKBARTH: Again, you're looking at growth  
12 rates.

13 DR. CASTELLANOS: We're looking at --

14 MR. HACKBARTH: Growth rates.

15 DR. MARK MILLER: Growth rates.

16 DR. CASTELLANOS: We're looking at physician fee  
17 schedule beneficiaries --

18 MR. HACKBARTH: And it's a table on the rate of  
19 growth in services --

20 DR. CASTELLANOS: It's our table. It's MedPAC's.

21 MR. HACKBARTH: Right. The rate of growth in  
22 services. That's -- I know what it says. It is the rate of

1 growth --

2 DR. CASTELLANOS: But the CAT scan has gone down.

3 MR. HACKBARTH: But it doesn't address the level  
4 of spending. Okay. We're going to have to --

5 DR. CASTELLANOS: Okay. Thank you.

6 MR. HACKBARTH: We probably won't persuade one  
7 another on this point. We need to move on.

8 DR. BERENSON: Okay. It's interesting to come  
9 after Ron for once.

10 I disagree with Ron's position. First let me  
11 comment where I have some sympathy with it and Tom's  
12 concerns that were more mildly expressed about whether CMS  
13 can do this.

14 As I was sitting here and reviewed the concerns  
15 about whether there's authority, I remembered that I  
16 actually was practicing when the PROs, I think in the second  
17 scope of work -- it may have been the third scope of work --  
18 did prior authorization for ten diagnoses, I believe it was,  
19 for hospitalization. It wasn't done very well. It was  
20 abandoned fairly quickly. And so I do have concerns that  
21 this would not work.

22 But I think having said that, this is an area

1 which has been well pioneered. I assume CMS would learn a  
2 lot from how it is being implemented. And I specifically  
3 disagree with your term "blunt instrument." We are putting  
4 some real criteria in here to have it be anything but a  
5 blunt instrument, and the issue is whether CMS can implement  
6 it that way. We are going to really target this where  
7 there's a problem.

8 I'm encouraged that we could target by the  
9 findings that physicians in the top decile of imaging, use  
10 for each modality accounted for over half of all the  
11 studies. Tom, you will probably never get a call  
12 challenging your decision. This will be focused. It has to  
13 be based on appropriateness criteria, but it's CMS' job  
14 ultimately to implement this and to meet with the specialty  
15 societies to get that right, not MedPAC's job. We're not an  
16 operating agency to do that. And, clearly, we are putting a  
17 high set of expectations on how this would be done, and it  
18 will take a while, and that is one of the concerns. If in  
19 the next few years imaging starts dropping and it becomes --  
20 I mean, I'm with Glenn. I'm not convinced that we don't  
21 have a serious problem of overimaging right now. But if in  
22 the couple years it will take to get this organized, you

1 know, the problem sort of disappears, well, good for  
2 everybody and maybe we don't have to proceed.

3 But then let me make my final point. I actually  
4 think starting here is a good place to start, but I would  
5 hope we actually don't finish prior authorization just on  
6 ambulatory imaging services or even in self-referred  
7 services. Ariel presented a couple of other areas that are  
8 being abused, clearly being abused.

9 There was a recent study in one of the major  
10 clinical journals on the fact that ICDs, cardiac  
11 defibrillators, 25 percent of the time now are being  
12 installed outside of clinical guidelines. I mean, they're  
13 really inappropriately being put into patients. I'm sure  
14 that a significant percentage of those actually are outside  
15 of the coverage with conditions criteria that CMS  
16 established, and established the registry. In fact, it's  
17 because there's a registry we actually know that 25 percent  
18 of the time these defibrillators are being implanted. It's  
19 an elective service. It's a very expensive service. It can  
20 cause serious harm to patients if it, in fact, is not  
21 indicated. And it seems to me the kind of service that CMS  
22 might want down the road after it gets its legs under it to

1 subject to prior authorization rather than somehow going  
2 after those 25 percent that have been inappropriate. It is  
3 much harder to pay and chase than it is to do prior  
4 authorization.

5           So I actually see this as an investment in some  
6 other activities. I would much rather have group practice  
7 ACOs in which they've got the incentive to do it themselves,  
8 be exempt from all of this, have an incentive to put in  
9 their own imaging criteria or their own mechanism for  
10 assuring that defibrillators were being appropriately  
11 implemented. But in the meantime, I think this is what  
12 we've got.

13           Then let me make then my really final point, that  
14 we have an ongoing problem with the fact that the  
15 administrative costs are in one bucket and the savings go  
16 into the mandatory spending bucket, and we are, in fact,  
17 sort of asking CMS to do something which they probably don't  
18 have the resources to do. They will have to contract for  
19 services. We are making them go through special hoops to  
20 make sure we are using evidence-based guidelines, that  
21 they're targeting. That will probably make it somewhat less  
22 efficient than if you were doing it. I don't know. But the

1 fact is they'll save -- I'm convinced this will save money  
2 for the trust fund. It will cost money on the  
3 administrative budget, and there's a disconnect there.

4 A few times in the past I've brought up the issue  
5 of whether in some circumstances -- there's one precedent in  
6 the fraud and abuse accounts, but whether we should consider  
7 broadening that precedent, so for areas like utilization  
8 management, we allow CMS to actually recoup money from the  
9 trust funds to support the activity that is saving them  
10 money, because otherwise this won't be done well, and so I  
11 just think we should come back to that issue again.

12 So either we need early on to demonstrate the  
13 return on investment and be able to go to Congress and say  
14 now you need to really adequately fund this, or we need some  
15 mechanism to permit CMS to keep some of the savings it  
16 achieves through this kind of a mechanism. But I think we  
17 need to proceed in this area.

18 [Pause.]

19 DR. KANE: Yeah, I'll try to be a lot briefer, but  
20 I agree with a lot of what Bob says. I think we need other  
21 tools like prior authorization because, frankly, I think  
22 this notion that there's a perfect price out there is

1 somewhat delusionary. And I think you can't possibly  
2 imagine all the different cost structures underlying the  
3 providers, you know, that don't reflect this average,  
4 wonderful 100-percent variable cost structure that the RBRVU  
5 system assumes.

6 I mean, you can have all the time estimates in the  
7 world, but the costs paying for those people don't go away  
8 just because they don't do that piece of work. So the  
9 incentive -- and especially if people become more salaried.  
10 The incentive to jack up your volume as long as your revenue  
11 increases by jacking up your volume is just unbelievably  
12 strong. And I think we're just deluding ourselves that  
13 somehow we can just get the right mix and, you know, 25  
14 percent lower RB -- I mean, we're deluding ourselves.

15 So I think you really need something where,  
16 particularly something like imaging which can damage people  
17 if they have too much of it, and because we know it is the  
18 kind of discretionary service that providers can do without,  
19 you know, soaking up a lot of their own time and still  
20 benefit from it really requires other tools than hoping that  
21 the payment system is going to fix it, because until we get  
22 into the ACO and much more global payment, it isn't. It's

1 just going to -- the more volume you get, the more revenue  
2 you get; that's just too strong an incentive no matter how  
3 perfectly you put the unit price.

4 I guess the only other thing I'd like to say about  
5 the prior authorization program and all the issues people  
6 have raised about CMS' challenges in implementing this is  
7 that this is the perfect opportunity to do something with  
8 the private sector. I mean, why do we need each payer to  
9 have their own investment in a prior authorization with all  
10 the investment that you have to do with the specialty  
11 societies and all the investment you have to do with the  
12 software? I mean, this is crazy to duplicate this for  
13 Medicare when we know the same services have to be  
14 duplicated in the private sector, and they're talking often  
15 about the same providers. So the providers are under five  
16 different prior authorization programs or, you know, imaging  
17 utilization programs, and to me that's where we really  
18 should be thinking about how do we develop public-private  
19 partnerships around regional prior authorization programs  
20 that address the delivery system, not by payer.

21 So, I mean, that's my only way to think about  
22 making prior -- and, you know, I don't know how complicated

1 that could possibly be, but to me, you know, you don't need  
2 16 different prior authorization programs for any geographic  
3 region. You need one. So that's my only way to make it  
4 more efficient, and I will -- but I do support all the  
5 recommendations. I just think the first three are a  
6 pipedream in hoping that's going to fix the real incentives  
7 here to provide more imaging. And the fourth one is the  
8 only real way to start getting at maybe a meaningful  
9 approach until we get to this much more effective payment  
10 system that we dream about that might happen in ten years.

11 MR. BUTLER: So people want to record their votes  
12 with and without enthusiasm, I think. I'll go on record and  
13 say I can support all with great enthusiasm, if that helps.

14 [Laughter.]

15 MR. BUTLER: Two specific points.

16 One, you cast in the beginning us maybe going  
17 after this as a self-referral issue versus a mispricing, and  
18 I very much am in favor of how you've landed on mispricing  
19 for two specific reasons. I think mispricing is at this  
20 point a more efficient way to get change done than, as we've  
21 discussed, prior authorization. The lag time in trying to  
22 make an impact -- it's just a more efficient way to get at

1 the issue. We don't know if it will work or not, but I  
2 think it's an important point that shouldn't escape us.

3           And the second is, as much as I, you know, could  
4 say some of this ownership stuff is really lousy and self-  
5 referral is bad, I think if we went after it aggressively,  
6 we actually may fragment at a time when we're trying to  
7 bundle. So I could look at orthopedics and say, you know,  
8 physical therapy is overused, yet in a bundled -- and not  
9 just an ACO world and episode of care, I might really want  
10 that physical therapy in the orthopedist's office as the most  
11 efficient, effective way of doing things. And if we had  
12 gotten too aggressive there, I think we might have actually  
13 fragmented at this point.

14           My last point is that your last slide actually is  
15 as important as some of the four recommendations. I don't  
16 think we're done with this, and the monitoring and the  
17 further, you know, understanding of these patterns is an  
18 important issue for us.

19           DR. STUART: I'll be brief. I support all four  
20 recommendations. I'd like to see some language in the  
21 chapter regarding budget neutrality and how that's done  
22 technically so that the reader will know when we say it,

1 will know what, in fact, is being recommended.

2 DR. BAICKER: I support all the recommendations.  
3 I'm quite sympathetic to the lack of knowledge about the  
4 best way to implement prior authorization. So to the extent  
5 that the language in the chapter can convey that the  
6 specifics are ideas and examples but that there are many  
7 different choices that need to be made to optimally  
8 implement it, I think that would be great.

9 MR. ARMSTRONG: I, too, specifically support all  
10 four of these, I guess with enthusiasm if we need to take a  
11 position on the enthusiasm scale.

12 I just would acknowledge that I'm not concerned  
13 about this approach. I think it's reasonable and focused in  
14 the right way and involves notification as well as -- this  
15 is around the fourth recommendation -- notification as well  
16 as prior authorization.

17 I think this also acknowledges to some of the  
18 points made about different -- a broader context within  
19 which payment gets made for these services. Payment  
20 structure is what we deal with here, but imaging utilization  
21 or ancillary utilization also is the product of a lot of  
22 other variables, like the culture of a medical practice and

1 the degree to which different specialists and others are  
2 working together and a lot of other things as well, which is  
3 why we should look forward to these conversations about how  
4 different ACO-type structures or other payment methodologies  
5 give us traction way beyond just pure payment changes.

6 So I'm enthusiastic in support of these  
7 recommendations, and I agree with Peter that we have a lot  
8 of work in front of us on these issues.

9 DR. BORMAN: I support the recommendations. I  
10 think there are opportunities for gain and there are  
11 opportunities for peril and things we can't foresee or  
12 things that we can and worry about. It will be incumbent on  
13 the stakeholders to respond appropriately to the draft  
14 regulations and for everyone to try and do their best to  
15 make these achieve the desired goal rather than offer  
16 opportunities for making things worse.

17 MR. HACKBARTH: So before we vote, Ariel, I wanted  
18 to thank you for your work on a particularly complex and  
19 controversial subject. We've been working on this set of  
20 issues now for at least a year and a half, I think two  
21 years. But who's counting, right, Ariel? Two years. And  
22 as a couple Commissioners have said, we're not yet to the

1 end of the journey, but perhaps at a significant stopping  
2 point along the way.

3 I do feel like these recommendations are the  
4 product of our collective work. Perhaps they are not  
5 perfect, but that's sort of the nature of the world in which  
6 we live. But we strive to take into account the views, the  
7 concerns, the ideas that you've expressed over these last  
8 couple years.

9 I absolutely would agree with Nancy's comment that  
10 trying to get the prices right is a difficult task and one  
11 that we'll inevitably fall short on, although I think we can  
12 get them righter than they are currently.

13 I have no illusions myself that even if we could  
14 make the prices perfect that that in and of itself would  
15 solve the issues around utilization. I do think we need to  
16 move with some urgency towards new payment systems, and I  
17 for one am, therefore, really excited that CMS has produced  
18 a proposed rule on ACOs. So long as, however, a large  
19 portion of our services are provided in a fee-for-service  
20 environment, trying to get the prices right, if only for  
21 fairness reasons in terms of distribution of income across  
22 physicians, is an important thing to do, although it's

1 always going to be difficult. And so long as we have fee-  
2 for-service, issues like prior authorization are going to  
3 come up when there are not other controls on utilization and  
4 we see evidence of significant problems. Hopefully we can  
5 get to a better world with a new payment system. We're not  
6 there yet. So thank you, Ariel, for your work on this.

7 It's time to vote, and so on Draft Recommendation  
8 1, all in favor of number 1, please raise your hand?

9 Opposed? Abstentions?

10 Okay, Draft Recommendation 2, all in favor?

11 Opposed? Abstentions?

12 Number 3, all in favor?

13 Opposed? Abstentions?

14 And Draft Recommendation 4 -- I've got to get rid  
15 of the "draft." This is the real thing. Recommendation 4,  
16 all in favor?

17 Opposed?

18 Abstentions?

19 Okay. Thank you very much.

20 [Pause.]

21 MR. HACKBARTH: So we are running a bit behind  
22 schedule, roughly a half-hour. Our next topic and our last

1 topic before lunch is "Enhancing Medicare's Technical  
2 Assistance and Oversight of Providers," and Anne will lead  
3 that presentation.

4 MS. MUTTI: Okay. This presentation continues our  
5 work on ways that Medicare can better encourage quality  
6 improvement and offers a package of draft recommendations  
7 for your consideration. As you will see, we have revised  
8 most of them based on your comments.

9 As we noted in February, we are considering  
10 changes to the current technical assistance and oversight  
11 policies for several reasons. First, by all accounts, the  
12 pace of quality improvement has been slow.

13 Second, the combination of newly enacted Medicare  
14 payment incentives for quality and the increasing number of  
15 quality improvement entities in the private sector creates  
16 an opportunity to rethink the way that Medicare supports  
17 technical assistance.

18 Third, improved technical assistance and oversight  
19 has the potential to address factors contributing to racial  
20 disparities in health care.

21 So first, a little context. To be clear, in this  
22 presentation, we are focusing on technical assistance and

1 Conditions of Participation, which are just a couple of the  
2 leverage points that Medicare has to induce quality  
3 improvement. Medicare's other major leverage points include  
4 payment policy, public disclosure, medical education  
5 funding, benefit design, and coverage policy. There are  
6 also a number of other Federal agencies involved in quality  
7 improvement, like the Agency for Health Research and  
8 Quality, the Centers for Disease Control, the Health  
9 Services Resources and Services Administration, among quite  
10 a few others.

11           So the focus today on technical assistance and  
12 oversight through the COPs should be understood as a piece  
13 of a much larger environment. Ideally, though, the levers  
14 are used in a way that are mutually reinforcing, and we have  
15 tried to design this package to reflect that.

16           Recent administration actions on quality  
17 improvement are also important to note as context. First,  
18 working within the confines of current law, CMS is in the  
19 process of finalizing the Statement of Work. That is the  
20 three-year contract that governs the work of the QIOs.  
21 Since our last meeting, they issued a draft for comment.  
22 The draft suggests a greater role for the QIOs in

1 encouraging providers to join learning networks or  
2 collaboratives, and many of these, the QIOs would be  
3 expected to create in order to address issues such as  
4 readmissions and complications.

5 In addition, the administration is concurrently  
6 pursuing statutory changes that would broaden the geographic  
7 scope of QIO contracts, eliminate the conflict of interest  
8 between beneficiary protection and quality improvement  
9 activities, and expand the pool of contractors eligible for  
10 QIO work, and these changes are similar to one of our draft  
11 recommendations.

12 Also since our last meeting, HHS has issued its  
13 national strategy for quality improvement in health care.  
14 It articulates broad aims and priorities and HHS plans to  
15 develop it over time, allowing for more input.

16 So now I will move on to reviewing the draft  
17 recommendations, and although I will discuss them one by  
18 one, the intent is that they are part of a package in which  
19 the components build upon one another.

20 The first draft recommendation would fundamentally  
21 change the QIO program. Currently, technical assistance  
22 funds go directly to the designated QIOs and it is incumbent

1 on them to reach out to providers and encourage improvement.  
2 Under this draft recommendation, the funds would instead go  
3 to the providers and communities directly, who would, in  
4 turn, use the grant money to purchase technical assistance  
5 from a qualified agent of their choice or they could also  
6 choose to participate in a learning collaborative. This  
7 change is intended to improve the engagement and culture  
8 change that needs to occur for quality improvement to take  
9 root.

10           And just to emphasize, the vision here is that  
11 assistance would be temporary for each provider or  
12 community. So although we recognize that improvement may  
13 not be immediately evident and organizational turnaround can  
14 take time, this assistance should not be considered  
15 indefinite.

16           In addition, providers should have some  
17 flexibility in how they use their resources so that they  
18 best meet the needs of the community. The incentive for  
19 technical assistance agents would no longer be to meet the  
20 generic terms of a CMS contract, but rather to be responsive  
21 to the specific needs of their clients, and those are the  
22 providers and communities.

1           Also, to facilitate the formation of this  
2 technical assistance market, CMS will likely need to create  
3 an online resource where providers can see their choice of  
4 qualified agents and evaluate their expertise and record of  
5 success.

6           A draft recommendation for your consideration is,  
7 therefore, the Congress should redesign the current QIO  
8 program to allow the Secretary to provide funding for time-  
9 limited technical assistance directly to providers and  
10 communities. The Congress should require the Secretary to  
11 develop an accountability structure to ensure these funds  
12 are used appropriately.

13           As for implications, spending would be constrained  
14 to no more than QIO program levels. And I just want to note  
15 that we recognize that this recommendation involves some new  
16 administrative requirements -- making grants, setting up a  
17 web-based marketplace, approving assistance agents. But the  
18 current program requires substantial resources and staff to  
19 manage and these could be redirected. Currently, nearly 50  
20 percent of the QIO budget goes to things like data  
21 processing, theme implementation, collaboration, and support  
22 contracts. So it seems that money is available for

1 redirection.

2           In terms of beneficiary and provider implications,  
3 to the extent that providers are responsive to the intent of  
4 the incentive, beneficiaries should receive improved care.  
5 Some providers would receive technical assistance funds  
6 directly.

7           So to be clear here, we are redistributing the  
8 funding from QIOs to providers and communities. Entities  
9 that are currently QIOs may still ultimately receive the  
10 money if the providers or communities choose to work with  
11 them, and they may be particularly successful with  
12 communities given their prior experience. But overall, the  
13 QIOs, who we have met with in the past several weeks, do not  
14 view these proposals positively.

15           Also, a note. As a time saver going forward, I  
16 will just note now that the spending and beneficiary and  
17 provider implications are fairly similar across all the  
18 recommendations, so I will not read them out each time.  
19 They will vary slightly, and that will be noted on the  
20 slide.

21           In the last decade, more organizations have gotten  
22 involved in spreading quality improvement, including

1 national quality organizations, professional associations,  
2 providers themselves, and regional health improvement  
3 collaborative organizations. Ideally, Medicare-sponsored  
4 technical assistance would draw upon some of their  
5 innovation and energy.

6 Under the current QIO program, however, a variety  
7 of requirements serve as barriers to entry for these  
8 organizations. So the second draft recommendation would  
9 remove these barriers with the goal of improving competition  
10 and harnessing the dynamism in the field.

11 One barrier is that QIOs must serve an entire  
12 State. Another well-noted barrier is that QIOs must be  
13 either a physician-sponsored or a physician-access  
14 organization, and these designations require specific  
15 thresholds for the number of physicians in the  
16 organization's ownership or membership and it serves to  
17 limit who can compete to be a QIO.

18 A third barrier is the requirement that QIOs also  
19 perform regulatory oversight, as well as field and  
20 investigate beneficiary complaints. This dual role creates  
21 some problems, but most importantly here, perhaps, is that  
22 it restricts the type of organization that will compete to

1 be a QIO.

2           So draft recommendation two is the Congress should  
3 authorize the Secretary to define criteria to qualify  
4 technical assistance agents so that a variety of entities  
5 can compete to assist providers and to provide community-  
6 level quality improvement. The Congress should remove  
7 requirements that the agents be physician-sponsored, serve a  
8 specific State, and have regulatory responsibilities.

9           And just to be clear, back on that recommendation,  
10 the intent is that the regulatory responsibilities,  
11 including fielding beneficiary complaints, would go to  
12 another entity. It certainly would not be dropped.

13           As you will recall, we also discussed at the last  
14 meeting the notion of making low-performing providers and  
15 communities a priority in funding technical assistance, and  
16 this has several advantages. First, it can help providers  
17 respond to new payment policies that hold providers  
18 accountable for poor outcomes, like hospital-acquired  
19 infections and readmissions. By directing resources to low-  
20 performing providers, we should at least partly allay  
21 concerns about holding providers accountable when they care  
22 for disadvantaged and challenging patient populations.

1           Second, because minorities tend to receive most of  
2 their care from a limited number of physicians and hospitals  
3 and those providers tend to have lower quality, focusing on  
4 low performers should help to address disparities in care.

5           Third, this type of focus should minimize the  
6 likelihood that public resources would displace equally  
7 effective private sector resources.

8           A key issue, of course, is how we measure low  
9 performance, and we do not specifically define it but  
10 discuss in the text of the chapter how it could include a  
11 variety of outcomes and process measures, including those  
12 that capture systemness. We also place a priority on  
13 providing assistance to communities because we might expect  
14 groups of providers and other stakeholders to be  
15 particularly effective in addressing local problems, like  
16 high rates of readmissions or avoidable ED visits when they  
17 work together.

18           And now John will pick up on a couple of questions  
19 related to this issue.

20           MR. RICHARDSON: As Anne noted, we have made  
21 revisions and refinements throughout the draft chapter and  
22 recommendations to reflect the Commission's discussion in

1 February, but here, we wanted to highlight a few specific  
2 issues that were raised related to the part of the next  
3 draft recommendation about giving priority to low-performing  
4 providers when providing technical assistance for quality  
5 improvement.

6           First, Cori, you asked if we had any information  
7 on whether the quality gap between low and high performers  
8 had changed over time. We reviewed the literature and found  
9 a 2010 study that compared changes in hospitals' performance  
10 from 2004 through 2006 on a set of process of care measures  
11 used for Hospital Compare and on a set of outcome measures,  
12 including 30-day mortality and readmission rates. The  
13 author stratified the hospitals into four groups, ranging  
14 from low to high performers at baseline, and found that on  
15 the process of care measures, the gaps between the highest  
16 and lowest performers narrowed by statistically significant  
17 amounts over the three-year period as the low performers  
18 improved more than the other groups. However, for the  
19 mortality and readmission rate measures, the greatest gains  
20 in most cases were made by the hospitals that started in the  
21 middle of the pack. That is, the low performers started  
22 with higher risk-adjusted mortality and readmission rates

1 and they did not improve as much as the mid-level  
2 performers.

3           Another study with the same lead author used the  
4 same data set to look at changes from 2004 to 2006, when  
5 hospitals were stratified on the basis of the percentage of  
6 their patients that were Medicaid beneficiaries. The  
7 authors used Medicaid patient share to define whether a  
8 hospital was a safety net provider or not. They found that  
9 hospitals with relatively high percentages of Medicaid  
10 patients tended to have smaller gains in process measure  
11 performance over the three-year period and that these safety  
12 net hospitals were less likely to be high performing over  
13 time than the non-safety net hospitals. We believe these  
14 results support the idea that giving the Secretary  
15 flexibility to target technical assistance to low performers  
16 has the potential to address known socioeconomic and racial  
17 disparities in the quality of care across hospitals.

18           This last study also addresses a question that  
19 Nancy raised, which was whether Medicaid patients could be  
20 included in the target population that would benefit from  
21 successful Medicare-funded technical assistance. The  
22 findings of the safety net hospital study I just cited

1 suggests that a technical assistance program with some  
2 degree of priority for hospitals with relatively low  
3 performance on Medicare quality measures would also improve  
4 the quality of care for the disproportionately higher  
5 percentages of Medicaid patients served by these safety net  
6 providers.

7           One other technical point related to Nancy's  
8 question is that the process of care measures used in  
9 Hospital Care are calculated from a sample of all the adult  
10 patients treated in the hospital, regardless of their  
11 insurance status. That is, the bulk of the measures that  
12 for the foreseeable future will be used to identify low-  
13 performing hospitals reflect the quality of care for  
14 Medicaid as well as Medicare patients.

15           I will now turn it back to Anne to present the  
16 draft recommendation.

17           MS. MUTTI: So draft recommendation three is the  
18 Secretary should make low-performing providers and  
19 community-level initiatives a high priority in allocating  
20 resources for technical assistance for quality improvement.

21           And to be clear here, the recommendation has been  
22 deliberately revised to allow high performers and mid-

1 performers to also receive assistance, particularly as they  
2 participate in collaboratives with low performers. This is  
3 in recognition of the value that is gained from having the  
4 full range of providers interact in problem solving.

5           Now, I will shift gears a bit and talk about how  
6 Medicare can stimulate quality improvement by reforming its  
7 Conditions of Participation, and these are the minimum  
8 standards that certain provider types are required to meet  
9 to participate in Medicare.

10           The COPs are currently largely structural  
11 requirements and have not been broadly updated for hospitals  
12 in particular in a long time. While the COPs require  
13 facilities to conduct what they call quality improvement  
14 activities, they do not require that providers adopt  
15 particular processes that are known to improve quality or  
16 require facilities to show improvement on outcomes measures  
17 over time. This seems like a missed opportunity and  
18 motivates the next draft recommendation to update the COPs.

19           We do not specify the exact requirements, but  
20 discuss some possibilities like requiring compliance with  
21 hand washing protocols, transmission of discharge  
22 instructions in a timely way, or compliance with the Joint

1 Commission's National Patient Safety Goals, things like  
2 checklists to avoid central line infections or time-outs  
3 before procedures. Another possibility is that the COPs  
4 require hospitals to demonstrate physician involvement in  
5 patient safety activities. These types of requirements  
6 could encourage more facilities to adopt a culture of  
7 quality improvement, something that is hard to directly  
8 mandate but appears essential.

9           In any case, another important aspect to note is  
10 that the requirements, that is the COPs themselves as well  
11 as any accompanying agency implementation guidance, should  
12 be evidence-based, allow for some flexibility so that  
13 providers can continue to innovate, and be developed through  
14 an open process.

15           So draft recommendation four is the Secretary  
16 should regularly update the Conditions of Participation so  
17 that the requirements incorporate and emphasize evidence-  
18 based measures of quality care.

19           The next draft recommendation addresses the  
20 concern that some providers are consistently delivering poor  
21 and unsafe care and are not investing adequately in quality  
22 improvement. Given the difficult issues raised by excluding

1 them from the program, they continue often to serve Medicare  
2 beneficiaries and minority beneficiaries disproportionately.  
3 There are some levers or tools CMS has to address these  
4 problems and promote remediation, and while they have  
5 potential, they are not widely used.

6           One of the tools is System Improvement Agreements,  
7 and they have been used with at least ten nursing homes and  
8 with seven transplant centers. These agreements accompany  
9 termination notices with delayed effective dates and are  
10 negotiated between CMS and the provider. In general, they  
11 require that the facilities do things like contract with an  
12 entity to perform a root cause analysis and develop an  
13 action plan, place funds in escrow to finance quality  
14 improvement, and hire an independent quality monitor who can  
15 verify implementation of the plan. So the point here of the  
16 SIAs, as they are called, is to turn these facilities  
17 around, not simply to penalize them.

18           GAO finds that these agreements have potential to  
19 improve performance of nursing homes even if the results to  
20 date are mixed. Four of the ten homes met the terms of the  
21 SIAs. Three others appear to be making progress. Among the  
22 seven transplant centers, three improved performance to be

1 within legal requirements. A couple of others are making  
2 progress.

3           So the recommendation language has changed since  
4 the earlier draft, moving away from creating more  
5 intermediate sanctions toward expanding interventions to  
6 promote systemic improvement, and perhaps our best model  
7 here is the SIAs. This recommendation urges Congress to  
8 formalize the authority for such interventions and direct  
9 the Secretary to expand their use, apply them to more and  
10 other types of providers as appropriate, recognizing that  
11 they have the potential to be a greater force for quality  
12 improvement. In addition, we note that the effectiveness of  
13 levers like SIAs may be enhanced if technical assistance  
14 grants were more available.

15           So draft recommendation five reads, the Congress  
16 should require the Secretary to expand interventions that  
17 promote systemic remediation of quality problems for  
18 persistently low-performing providers.

19           And lastly, to round out the package of  
20 recommendations, we have a final draft recommendation to  
21 publicly recognize the contributions of high performers who  
22 participate in collaboratives or play a mentoring role.

1 Their participation in peer-to-peer learning is key to  
2 improving quality of care systemwide and deserves  
3 recognition. Ideally, a recognition program would also  
4 encourage more to play this role.

5           So the language on draft recommendation six is the  
6 Secretary should establish a public recognition program for  
7 high-performing providers that participate in collaboratives  
8 or learning networks or otherwise act as mentors to improve  
9 the quality of lower performing providers. And I just  
10 wanted to note one clarification -- that I added one thing  
11 since it was sent to you in the mailing materials. We just  
12 added the words "high performing" in that second line, just  
13 to be a little bit more clear.

14           So with that, I will leave this summary slide with  
15 paraphrased versions of the draft recommendations on the  
16 screen for reference and look forward to your discussion.

17           MR. HACKBARTH: Thank you, Anne and John.

18           So round one clarifying questions, beginning on  
19 Karen's side. Any? Peter, and then Nancy.

20           MR. BUTLER: One question. When I read the  
21 chapter carefully, it says \$1.1 billion a year is what we  
22 spend on this, and there are 41 QIOs --

1 MS. MUTTI: One-point-one over three years. It is  
2 because it is over the statement of work --

3 MR. BUTLER: Okay. So that is not --

4 MS. MUTTI: -- which is a three-year contract.

5 MR. BUTLER: So it is --

6 MS. MUTTI: So it is more like \$300-plus million a  
7 year.

8 MR. BUTLER: And there are 41 --

9 MS. MUTTI: Right, and some of them have contracts  
10 in more than one State.

11 MR. BUTLER: Okay. So my math is something like  
12 \$7 or \$8 million per QIO per year, or something like that is  
13 the size of these things.

14 MS. MUTTI: I am trusting your math, yes.

15 MR. BUTLER: Yes --

16 MS. MUTTI: Your math is probably better than mine  
17 right now.

18 MR. BUTLER: I am just trying to get a sense of  
19 what the commitment is, because we talk about comparative  
20 effectiveness. Some of these other things that we spend  
21 money on or have -- I was just trying to get a sense.

22 MR. HACKBARTH: Good question. I assume that the

1 size of the contracts vary considerably based on the State,  
2 the population, the area covered, and what not.

3 MS. MUTTI: Mm-hmm.

4 MR. HACKBARTH: Nancy?

5 DR. KANE: I am just thinking about the  
6 relationship between changing the Conditions of  
7 Participation and incorporating quality in there and then  
8 thinking about, well, what is the remediation. Is the  
9 remediation meant to be if you -- no. Let us just say they  
10 have 25 measures of quality that get into this, or 65, as  
11 there might be. How does that -- what would that trigger if  
12 you are not good at, say, some subset of them? Would that  
13 trigger some kind of not full participation, or would that  
14 trigger remedial help, or -- I am just trying to understand  
15 how four and five might or might not relate, because  
16 Conditions of Participation is basically either you are a  
17 participant or you are not a participant.

18 MS. MUTTI: Right. Well, I think that four is  
19 meant to make the Conditions of Participation more  
20 meaningful, more current, up to date, so that it is not just  
21 looking at, you know, are the -- and I am sure it does more  
22 than this, but focusing on the cleanliness of the cafeteria

1 or the adequacy of the heating system and do you have the  
2 right supervisor in place here, but looks at some things  
3 that may resonate a little bit more with beneficiaries, like  
4 are you using checklists? Do you have a whole culture and  
5 processes in places that are designed to improve outcomes?

6           So by making those more meaningful and then  
7 enforcing those more meaningful COPs, if you happen to be  
8 low-performing, and this is over time, we are imagining, we  
9 have these agreements, something like the System Improvement  
10 Agreements that could be used to help say, it looks like you  
11 are having trouble. We need to turn this around. These are  
12 the kinds of things we need you to do, is to get some  
13 outside help and to have a plan.

14           And it is not something that we are expecting that  
15 is going to be done in 30 or 60 days, like current  
16 corrective action plans are, which we have heard act more as  
17 band-aids. People kind of make quick changes. This is  
18 expected to take a little longer and make more meaningful  
19 systemic change.

20           DR. KANE: I guess my main question is, is that  
21 the right tool, the COPs, only because, at some point, is  
22 the threat that you are going to revoke their participation

1 --

2 MS. MUTTI: Yes.

3 DR. KANE: -- that they are going to be revoked --

4 MS. MUTTI: Yes. In fact --

5 DR. KANE: -- as opposed to that they will go into  
6 the P4P -- I mean, I guess -- how bad do you have to be  
7 before you get revoked, is the --

8 MS. MUTTI: Yes. I mean, I guess that gets to  
9 another point of when we talk about what is low performers,  
10 and is it solely based on their adherence to the Conditions  
11 of Participation or do you also want to consider their  
12 performance on outcomes measures and other process measures  
13 that we have as part of P4P.

14 MR. HACKBARTH: As I think of it, Nancy, we are  
15 sort of working on two different vectors. One is to make  
16 the Conditions of Participation more meaningful and urge the  
17 Secretary to adopt some new approaches to improving the  
18 performance of those that are just sort of teetering above  
19 the absolute minimal level for participation in Medicare.  
20 And then there is another group of providers that may be  
21 well over the absolute minimum threshold, but are still,  
22 relatively speaking, low-performing providers, and we have a

1 series of recommendations that are targeted towards trying  
2 to help them elevate their performance. So they may not be  
3 at risk of losing their eligibility to participate in  
4 Medicare at all, but they are still not up to snuff.

5 DR. KANE: But those would be different metrics  
6 than, say, P4P, where actually we are lowering their revenue  
7 by virtue of their poor performance.

8 MR. HACKBARTH: Well, as I have come to think of  
9 this -- in fact, I think Herb has used the phrase from time  
10 to time about piling on, worry that with all of the new  
11 payment rules linked to performance, that there is a fear  
12 that the low-performing institutions can get locked in a  
13 position where they cannot get out. They are losing money.  
14 The resources available for quality improvement are  
15 diminishing, not expanding. And that is one of the reasons  
16 for saying, well, we think that there ought to be a  
17 particular focus of providing Federal resources to  
18 institutions and do so in a way where they can own it and  
19 then elevate their performance so we get out of the piling  
20 on phenomenon, or try to minimize it, at least.

21 Herb?

22 MR. KUHN: Just an observation about Glenn and

1 Nancy's comments. That's absolutely right. If you look at  
2 some of the new payment deliver models, they are the  
3 tournament-type model. So this does, I think, fit nicely to  
4 provide that support that is out there.

5 But Anne, just a couple of questions, one on the  
6 System Improvement Agreements. As you indicated, they have  
7 been used for long-term care facilities or nursing  
8 facilities and transplant centers, which for all intents and  
9 purposes are part of an acute care hospital. But as CMS has  
10 looked at those, they think there is enough portability in  
11 that tool that they could be used for all providers, that it  
12 is a functional tool for all providers.

13 MS. MUTTI: Yes, definitely. In our conversations  
14 with CMS staff, they indicated it would be worthwhile to  
15 expand it.

16 MR. KUHN: Okay. And the second question is, on  
17 the recommendation number two, where we talk about provide  
18 community-level improvement, one of the arguments I know the  
19 QIOs have made is that we have identified it as a barrier,  
20 but they have identified it as an enhancement, the fact that  
21 there are physician-sponsored organizations that are out  
22 there. And they believe that ties them tighter to the

1 community overall.

2           When we go with this kind of draft recommendation  
3 -- I guess maybe I am getting into round two, I am sorry --  
4 but how do we kind of keep that focus on community-based  
5 organizations on a go-forward basis? I think it is there,  
6 but I just want to make sure that we are continuing to have  
7 that emphasis on community-based organizations.

8           MS. MUTTI: So that community-based organizations  
9 would be available to be technical assistance agents, right?

10          MR. KUHN: [Off microphone.] Right.

11          MS. MUTTI: Well, we are envisioning that the  
12 Secretary would come up with the standards for what would be  
13 technical assistance agents, so certainly that could be one  
14 of the criteria, is that they reflect a community, a board  
15 or something like that where they reached into the community  
16 and have that input in framing the way they provide  
17 technical assistance.

18          MR. HACKBARTH: The way I think of it is that the  
19 QIOs can compete for these opportunities. Nobody is saying  
20 that they are ineligible. To the extent that the users of  
21 their services see their community ties as advantageous,  
22 that would be a reason why they may want to look to a QIO

1 for the assistance. If for the particular set of problems  
2 they are trying to solve they don't think that is an  
3 important consideration, then they can choose somebody else.

4 MR. KUHN: [Off microphone.] Thanks.

5 MR. HACKBARTH: Let the market work.

6 Ron, round one.

7 DR. CASTELLANOS: Actually, just two questions.

8 The first one I asked you last time. This is going to apply  
9 to all Medicare providers, is that correct, because we  
10 really are just focused predominately on QIOs and hospitals,  
11 but it will --

12 MS. MUTTI: Oh, right. The technical assistance  
13 would be available to all types of providers.

14 DR. CASTELLANOS: Good. And the second question  
15 is, you are really focusing on low performers. What  
16 happens, like in Peter's hospital, who I am sure is a very  
17 high performer? He needs some assistance on whatever issue.  
18 Would that be available to him, or is it just available to  
19 low performers?

20 MS. MUTTI: It would be available to high  
21 performers. We have recast the recommendation to be a bit  
22 more inclusive.

1 DR. CASTELLANOS: Thank you.

2 MR. GEORGE MILLER: First of all, I want to thank  
3 -- I thought this was a very good chapter and thank the  
4 staff for it putting together, particularly around the  
5 issues of health care disparities and addressing those  
6 issues. I think there was good research and I really  
7 appreciate that. I want to be very complimentary to the  
8 staff for that.

9 I will try to make sure it is around one question  
10 and a comment. Along the lines of health care disparities,  
11 you didn't talk about cultural competencies as part of that  
12 process. The recommendations were good, but I wonder -- and  
13 particularly to Ron's question about high performers --  
14 still, there are some minority populations that go to high-  
15 performing hospitals and the concern is they get the same  
16 quality of care, and the issue would be around cultural  
17 competencies, how to communicate with them and make sure  
18 they get that outstanding care. Again, great job with this,  
19 but I'm just wondering about that part of the issue.

20 MS. MUTTI: I mean, I think that we could add that  
21 point, that that might be a very valuable part of technical  
22 assistance, is to address cultural competencies.

1 MR. GEORGE MILLER: Okay. Thank you.

2 MS. UCCELLO: I just want to quickly thank you for  
3 looking into my question.

4 DR. CHERNEW: I just want to make sure I  
5 understand how recommendations one through three fit  
6 together. So the change for one is that now the money goes  
7 to the providers and communities as opposed to the -- and so  
8 I presume in order to get that money, the providers would  
9 have to submit an application or something to CMS. Is that  
10 the --

11 MS. MUTTI: Correct.

12 DR. CHERNEW: -- some discussion about there will  
13 be a process that CMS will have to set up. So you would  
14 have to essentially respond to an RFP to get some amount of  
15 money.

16 MS. MUTTI: Right. We, I think, are allowing that  
17 it's linked to number five, when you identify a provider  
18 that is persistently low performing and you want to pull  
19 them into one of these System Improvement Agreements, there  
20 may be -- it may be a little bit of a two-way street. It  
21 could be CMS coming to you and saying, we want you to make  
22 these kinds of changes --

1 DR. CHERNEW: Okay. So they could say, we want  
2 you to apply --

3 MS. MUTTI: There could be -- we're not totally  
4 directive on that, but I think we're allowing for a mix.

5 DR. CHERNEW: All right. And so then number two  
6 says, when you apply, you are going to have to write in an  
7 application what you're going to do with the money, and now  
8 you can spend that money on more organizations than just the  
9 QIO. So you could write, we're going to spend that money to  
10 do whatever.

11 So my first question to you is, what if you wrote,  
12 we're going to spend that money to buy a new IT system and  
13 we're going to solve the problem, but we're not going to go  
14 contract out with someone to tell us what to do. We know  
15 what to do. We just want to do this. Would that --

16 MS. MUTTI: Yes. We've talked about that  
17 internally and we're allowing for some -- that could happen.  
18 It could be legitimate. But there would definitely have to  
19 be protections in place.

20 DR. MARK MILLER: So internally, when we talked  
21 about it. But I just want to make one point, because I do  
22 think it connects to a question that's been asked a couple

1 of different times. There's a couple of different routes  
2 this could happen. I'm in my hospital. I'm having a bunch  
3 of readmission issues, and maybe I'm getting penalized and I  
4 think, I'm going to avail myself of this resource, try and  
5 turn this problem around. That's one way it could happen.

6 Focusing on five, say, or four and five, CMS could  
7 approach them and say, you know, you're having trouble with  
8 your COPs and I encourage you to avail yourself of this and  
9 start to get a turnaround going in your hospital. So  
10 there's two different doors, and I thought you were sort of  
11 asking that, and you seemed to be --

12 DR. CHERNEW: Right.

13 DR. MARK MILLER: That's not -- all right. Then  
14 the other point is this. I think that we would have to be  
15 very careful about -- and this, I think, links to the time-  
16 limited nature of the funding. So if somebody comes along  
17 and says, I know. I'm going to hire ten new staff and  
18 that's going to turn the problem around, a problem with that  
19 would be, well, wait a second. How do you support that  
20 after the funding --

21 DR. CHERNEW: Right. Right.

22 DR. MARK MILLER: -- so you wouldn't want to do

1 that. The IT thing came up in our conversations, and that  
2 falls in a funny space. Now, first of all, there's some  
3 other money out there to do that, the ARRA money, and you  
4 could sort of argue there's stuff going on there. But that  
5 falls in a funny space. I think the evaluation would have  
6 to be that this is truly related to the problem and actually  
7 can support the turnaround. I think the IT thing is a very  
8 difficult --

9 DR. CHERNEW: Right. So my real question,  
10 actually, to clarify, was the organization that makes the  
11 determination of all these funny things, where they fit or  
12 what you want to do with the money, actually in this process  
13 that you're setting up with one through three is CMS. So  
14 you apply to CMS and say, I have this problem of  
15 readmissions and I want to solve it and I want to do blah.  
16 So you write in and you could write whatever you wanted and  
17 CMS could judge that. And so they might make that --

18 DR. MARK MILLER: Well --

19 DR. CHERNEW: I'm just trying to figure out what  
20 the --

21 DR. MARK MILLER: -- presumably, there's some  
22 criteria, and I guess what I would say, more, I think, the

1 way we envision this is that what you're asking for is  
2 technical assistance for how to turn around your problem.  
3 So it may be that a consultant comes in and says to you,  
4 I've evaluated everything and it looks like an EHR --

5 DR. CHERNEW: Okay --

6 DR. MARK MILLER: -- would help you, which, you  
7 know, then --

8 DR. CHERNEW: Right, which is different than --

9 DR. MARK MILLER: -- then you've got to figure out  
10 --

11 DR. CHERNEW: -- buying EHR.

12 DR. MARK MILLER: Right.

13 DR. CHERNEW: I understand. So you want the money  
14 to go to figuring out which EHR, or whether you need an EHR,  
15 as opposed to buying the actual EHR. So I just --

16 DR. MARK MILLER: Yeah, and I'm trying to keep an  
17 eye on Anne as you're asking this question, but my sense is  
18 that the line is not as bright as, you know, this is in,  
19 this is out --

20 DR. CHERNEW: Right.

21 DR. MARK MILLER: -- we're sort of --

22 DR. CHERNEW: And CMS would decide.

1 DR. MARK MILLER: That's correct, but I think  
2 mostly what we're envisioning here is this notion of how  
3 does somebody get the expertise and technical assistance in-  
4 house --

5 DR. CHERNEW: Right.

6 DR. MARK MILLER: -- to figure out how to turn  
7 their operation around.

8 DR. CHERNEW: And I think--and so, my question on  
9 the third one. So you have these proposals or you have gone  
10 out and solicited them and the idea behind the  
11 Recommendation 3 is that in scoring your proposal -- in  
12 scoring -- so now you put in, they would wait where you were  
13 low -- but they wouldn't eliminate you if you were low  
14 performing but that would just be one of the criteria --

15 DR. MARK MILLER: Correct.

16 DR. CHERNEW: -- in the evaluation --

17 DR. MARK MILLER: Yes.

18 DR. CHERNEW: -- is what was your performance.

19 And that's just -- okay -- clear. Okay, so that was just  
20 the clear -- so, I'll save the follow up.

21 MS. HANSEN: On Slide 14 with the recommendation,  
22 the kind of improvement process that was described in the

1 SIA oftentimes, as you say, is not really a short 30- or 60-  
2 day type of thing. I've seen this operating out in the  
3 community and where resources camp in for probably a few  
4 months, per se. So I noted that the spending implications  
5 is that there's no direct spending implications, and I was  
6 just curious that if we open up the door wider for these  
7 kind of interventions, I was curious as to where the funding  
8 comes from, or is that the QIO money that has been  
9 designated.

10 MS. MUTTI: The SIAs themselves don't necessarily  
11 increase -- it doesn't require that Medicare spend more  
12 benefit money. It could require more administrative  
13 expenses as you negotiate these, and that is definitely a  
14 concern. I think here, we do see the opportunity for some  
15 connection with the QIO money in order to help these  
16 facilities get back on track -- to help cover those  
17 administrative costs. But we're also hoping that, as time  
18 goes on, the program could be streamlined and could require  
19 less administrative resources.

20 MS. HANSEN: Just on the surface of it, it just  
21 appears that if we are opening up the scope to all --  
22 somebody asked the question, is this all Medicare programs

1 per se -- it seems like it could be quite a larger "n" of  
2 activity, and that was just my question about TA money does  
3 cost quite a bit, so I was just curious --

4 MS. MUTTI: Right. I mean, currently, the SIAs  
5 don't come with TA money. So we are kind of saying, maybe  
6 it should coordinate a little bit with the new TA money that  
7 we're making available directly to providers. That could  
8 create some synergies there, and that money is already in  
9 the QIO program.

10 DR. DEAN: [Off microphone.] So if all of this  
11 was implemented, does that mean that there will be still a  
12 requirement to have some sort of agency overseeing quality  
13 status for Medicare beneficiaries, just not necessarily the  
14 QIOs as we currently envision them, or would there still be  
15 a QIO program, or --

16 MS. MUTTI: Right. I mean, there's still --  
17 there's the oversight, which is being sure that there's  
18 Conditions of Participation, and that's done by survey and  
19 accreditation organizations. But to the point about, okay,  
20 what happens to the QIOs now, right?

21 DR. DEAN: Mm-hmm.

22 MS. MUTTI: No, so that would mean that there's

1 not necessarily a standing QIO serving each State that has  
2 an office that goes out and says, hi, we're the QIO. Maybe  
3 you'd like to participate in one of our projects. So that  
4 infrastructure would be eliminated under this vision.

5 DR. DEAN: But there would be a requirement that  
6 some agent, some activity, or some entity be looking at  
7 these issues.

8 MS. MUTTI: Well, so the issues that the QIOs  
9 currently look at now, you know, they -- for technical  
10 assistance, they go around to providers, and depending on  
11 what their statement of work says, you know, we're working  
12 on readmissions, we're working on complications. You might  
13 want to participate with us. And so there would not be that  
14 dynamic.

15 Instead now -- and I think we're recognizing that  
16 since there's payment incentives in place, more providers  
17 might be a little bit more self-aware of their problems and  
18 more motivated to make a change. And for those that are  
19 struggling, we now have a resource where they don't have to  
20 be confined to just going to the one QIO in their State.  
21 They can look around and, you know, talk to other providers  
22 and say, wow, I think that this particular other

1 organization that's in the market, that's been serving  
2 private sector clients, has really something to offer to me  
3 and I want to avail myself of those and I can get Federal  
4 money to help avail myself of those resources.

5 DR. DEAN: Okay.

6 MS. MUTTI: The services.

7 MS. BEHROOZI: Yes, this is on draft -- it's on  
8 draft recommendation one, but it's sort of related to all of  
9 them. You refer in draft recommendation one to the fact  
10 that the funding -- yes, the funding can go directly to  
11 providers or communities, and actually in the text, I found  
12 the definition, I guess, of communities a little farther  
13 along, and the types of entities that it seems like -- I  
14 mean, maybe you should describe a little bit about the types  
15 of entities that you envision coming within the term  
16 "communities" there, because it sounds like some of them  
17 could also be the technical -- the community-based technical  
18 assistance agents. So it looks here like you're saying the  
19 money could go directly to them for their own activities,  
20 improving the health in their community, but they could also  
21 be the eventual recipient of funds through providers. Is  
22 that right, I guess is kind of my clarifying question.

1 MS. MUTTI: Yes. No, the definition of  
2 communities, I think, can be different for different people,  
3 and we tried to be fairly inclusive in our discussion of it  
4 so that you could have communities of providers in a  
5 specific town or county that wanted to take on a problem  
6 that they felt really overlapped with one another.

7 Readmissions is a good example, where, you know,  
8 if one of us tackles it but the rest don't, we still have a  
9 community problem. Perhaps we're best off coming together.  
10 And we also need to reach out to some of our patient  
11 stakeholder groups, you know, patient advocates. We want to  
12 reach out to county-funded services that would help address  
13 some other issues. So we're going to come to you as sort of  
14 a group. And maybe they come to CMS on their own and then  
15 they go into the market and pick their technical assistance  
16 agent, or maybe they come in tandem with their technical  
17 assistance agent and say, we already know who we want to  
18 help pull us all together, the great convener who really  
19 works with us well, and that could be one scenario, or maybe  
20 two scenarios there, really.

21 MS. BEHROOZI: So how could it be communities  
22 freestanding, kind of, I mean, not communities that you

1 wouldn't also call providers, like, for example, advocacy  
2 organizations or something. Would you envision that they  
3 could go directly to --

4 MS. MUTTI: Right. Now, I don't know how you want  
5 to handle that --

6 DR. MARK MILLER: I mean, I --

7 MS. MUTTI: -- we've talked about it a little bit  
8 --

9 DR. MARK MILLER: Yes, and I think what I would  
10 say is that I think more of the way we were thinking about  
11 this and trying to structure it is that the initiative comes  
12 from the entity that's trying to solve the problem, you  
13 know, and we've been using the term "providers" here, and  
14 certainly the scenarios that we talked about internally and  
15 that we've tried to put in the paper and describe here sort  
16 of act with the community as three hospitals and three  
17 nursing homes come together and say, we have a readmission  
18 problem. I'm approaching CMS, and as a community, we're  
19 going to try and solve this problem. And as Anne said,  
20 maybe they approach with a technical assistance agent in  
21 mind.

22 We didn't envision sort of a technical assistance

1 agent sort of approaching CMS and saying, okay, give me the  
2 money and I will approach this community. But you could  
3 imagine that actor going into the community and saying, why  
4 don't we get together and collective try and -- but we see -  
5 - I think we see the conduit coming through the providers  
6 actually taking the initiative, and part of the reason for  
7 that is I think the two things we're trying to articulate  
8 here is there's a specific problem they're trying to go  
9 after and there's a time limited period they're going to get  
10 resources to solve that problem. That's sort of the notion.  
11 And so we sort of thought that the conduit was the provider,  
12 or collections of providers. And if they pull other people  
13 in, fine, but --

14 MS. MUTTI: Because that builds in an  
15 accountability element that we might not have just with a  
16 community because the providers have an incentive and some  
17 accountability for being successful.

18 MR. HACKBARTH: So I had one clarifying question.  
19 In the chapter, on page 24, it says, "In 2010, JCHO lost its  
20 deeming status." Could you just say a bit about what the  
21 practical implications of that are?

22 MS. MUTTI: Okay. And feel free to jump in if I

1 don't quite get this right, but -- Herb, I'm thinking of, is  
2 knowledgeable on this. Prior to that time, the Joint  
3 Commission was, by statute, an organization that could  
4 develop its own standards and anybody that passed their  
5 accreditation process was automatically viewed as meeting  
6 the Conditions of Participation.

7           When they lost their deemed status, it meant that  
8 they just had to demonstrate to CMS that their accreditation  
9 standards did meet the Conditions of Participation and was  
10 fully aligned and that they wouldn't automatically be a  
11 chosen organization to be an accreditation entity. And so  
12 they've gone through that process where they've demonstrated  
13 to CMS, and I think there was some give and take as to, you  
14 know, you need to change these standards to be in compliance  
15 and they've met that and now do at -- I think sometimes  
16 deeming is used in two ways. Are you noticing that, too?

17           And so, now, yes, when you meet the accreditation  
18 standards, you are deemed to have meet the COPs, but they  
19 are no longer an entity that automatically has that  
20 privilege.

21           MR. HACKBARTH: Was this a statutory change?

22           MS. MUTTI: I believe it was, yes.

1           MR. HACKBARTH: Yes. So it used to be they were  
2 specifically named --

3           MS. MUTTI: Yes. Yes.

4           MR. HACKBARTH: -- in the statute, and that has  
5 been changed --

6           MS. MUTTI: Yes.

7           MR. HACKBARTH: -- but now they've gone through  
8 another channel to be able to basically certify hospitals  
9 meet the conditions.

10          MS. MUTTI: Correct. Correct.

11          MR. KUHN: And I think as a result of that now, we  
12 have three organizations that --

13          MS. MUTTI: We do.

14          MR. KUHN: -- accredit hospitals now, and I think  
15 the most recent one came online about a year, year and a  
16 half ago. So it's kind of opened up the process further.

17          MR. HACKBARTH: So, in a sense, it's sort of  
18 connected to this in that the potential accreditors have  
19 been opened up. It's more competitive as opposed to a  
20 monopoly situation.

21                 So for me -- this, too, is a subject that we've  
22 been talking about now for quite a few months. This is the

1 culmination of a number of discussions. To me, the two  
2 really big overriding ideas here are, one, the importance,  
3 in my view, of doing everything we can to lift the low-  
4 performing providers in the system, because as the research  
5 has shown, they have a disproportionate impact on racial and  
6 ethnic minorities, and if we want to do something meaningful  
7 on disparities, elevating low-performing providers could be  
8 a significant step, not an answer, but a significant step.

9           Then the other element is, as Herb has often  
10 pointed out, we are now moving into a new payment era where  
11 there are going to be payment penalties for low-performing  
12 providers, and if we just do that without anything else, we  
13 run the risk of driving these organizations into the ground  
14 and the racial and ethnic minorities will be  
15 disproportionately affected to the extent that happens. So  
16 we've got to make a particular effort now to try to marshal  
17 resources to try to elevate the low-performing providers.  
18 So that was one key thought for me.

19           The second is the world has changed a lot since  
20 the QIO program was enacted, or even more since the  
21 predecessor programs, you know, PSROs and the whole deal,  
22 were enacted, and there's a much more robust field of people

1 who have expertise in quality improvement that could help  
2 organizations. And given that, to have a federally-granted  
3 monopoly on this money just doesn't, to me, make any sense  
4 anymore.

5 And so for me, those are sort of the two big  
6 overriding issues here, and then the other pieces fit in the  
7 puzzle. So that's my round two comment, and now it's  
8 Karen's turn. Anything, Karen?

9 DR. BORMAN: [Off microphone.] I have no problem  
10 with the recommendations.

11 MR. HACKBARTH: Scott?

12 MR. ARMSTRONG: I also support all the  
13 recommendations. I did, though, just want to say, Glenn, I  
14 thought the way you summarized what we're trying to  
15 accomplish with these six recommendations was a nice  
16 synthesis. But one additional point I would want to make is  
17 that, particularly on the notion of making the funds to  
18 support these improvement efforts available to a broader  
19 range of organizations, I agree with that, but let's also  
20 just acknowledge that some of the QIOs are excellent and are  
21 doing fantastic work, and this does not mean that they won't  
22 continue to be actively involved in doing some excellent

1 work.

2 DR. BAICKER: I support the recommendations and I  
3 like the coupling of the extra help for low performers and  
4 the acknowledgement of high performers.

5 DR. STUART: I also support the recommendations,  
6 but I'd like to pick up very briefly on a point that Peter  
7 made in the first round, and that's kind of the arithmetic  
8 here. If you take \$300 million a year, roughly, as the  
9 budget and you divide it by 50 States, that works out to  
10 about \$6 million a State per year, and granted, it would not  
11 be equally distributed, but that's not a lot of money.

12 And one of the things that I'd want to be a little  
13 careful about here is that you take that little bit of money  
14 and you spread it around and you particularly go to a low-  
15 performing provider and the technical assistance says, well,  
16 you ought to do A, B, C, and D, and the provider says, well,  
17 I don't have any money to do that. I mean, this is -- so it  
18 strikes me that part of this needs to develop some  
19 understanding of the unmet need out there and whether this  
20 \$6 million a State per year is going to be anywhere  
21 sufficient to do that. And I recognize we don't have that  
22 information at hand, but I think it might enhance this to

1 say, all right. Well, this is a continuing process here  
2 that we're going to be coming back to, and having some kind  
3 of needs assessment, I think, is really important.

4 MR. BUTLER: So I think this is an example of a  
5 topic that is under the radar for a whole bunch of  
6 stakeholders in the industry, so I think the fact that we  
7 are making some really pretty bold recommendations is  
8 filling a void and helping move some things along that  
9 otherwise might not happen if it weren't for us. So that's  
10 the good side of what we're doing.

11 I still do -- and we're coming close to maybe kind  
12 of zero-basing this in terms of the approach, but not  
13 exactly. I'm not sure quality would go dramatically  
14 backwards if this went away. I'm not positive. And I'm not  
15 sure that this is exactly the right way to spend it. You  
16 could just as easily say, let's take the \$300 million and  
17 give \$1 million to 300 institutions that are financially --  
18 are the efficient providers that are performing well on the  
19 metrics but having financial troubles. Let's give them each  
20 a million dollars. That would make a big difference,  
21 anyway, and motivate people. That's an extreme.

22 But a less extreme suggestion, and as one who was

1 lukewarm on public recognition, I wouldn't discount giving,  
2 say, \$100,000 or something for high performers that need the  
3 money that fit into that category and say, wow, 100 grand is  
4 something that is real, and it would be a small part of this  
5 total spend, and they'd say, that means something to us.

6 MR. KUHN: Let me just kind of pick a little bit  
7 where Glenn stated, and I do think this is a good set of  
8 recommendations. You know, as we look at the new payment  
9 and deliver models, some could drive some provider into the  
10 basement and this is a way to kind of help them and give  
11 them some lift, and I think that's a very good way to go as  
12 we continue to move forward.

13 The other thing I like about this set of  
14 recommendations is it really does synch us up nicely with  
15 all the new payment delivery models that are out there.  
16 We've got to get the alignment of all these programs going  
17 and I think this does an exceptionally job in doing that.

18 The other part of this set of recommendations, we  
19 haven't talked about it much, but, you know, as we continue  
20 this movement on this quality journey -- and it is a  
21 journey. There's a destination out there somewhere,  
22 hopefully, but it's a long journey as we continue to move

1 forward -- is that in the past, a lot of the notion has  
2 been, let's just count and punish. Let's count the number  
3 of mistakes people made and let's punish them. Let's point  
4 fingers. Let's embarrass individuals. Let's find out who  
5 did wrong. And this continues that movement away from that  
6 kind of thinking that's out there. It's grounded in  
7 science, is what we're thinking about. It's better learning  
8 opportunities. It's better collaborations. It's better  
9 targeting, and I think this makes a lot of sense on a lot of  
10 reasons as we go forward.

11 I support all six of the recommendations. Two of  
12 them, I'd like to highlight specifically. One is  
13 recommendation number four, and that's the COPs, and I want  
14 to thank all the hard work since the last meeting. That one  
15 was just kind of a write-up before. Now it's moved into a  
16 full recommendation, and I think this is really powerful and  
17 really important. It's hard work for CMS to do this,  
18 there's no question about it. But again, I think, as we try  
19 to synch up the payment and delivery models with kind of the  
20 other functionalities of CMS, this is important for us to  
21 put out there.

22 And then, finally, I'd like to highlight

1 recommendation number five. I think the advancement and the  
2 conversation we have about the System Improvement Agreements  
3 here is very well done. I think this is a lot better than  
4 the conversation before on the intermediate sanctions.

5 Again, I felt like that was kind of the notion of let's kind  
6 of count who's making mistakes and kind of get at them. I  
7 think this is more uplifting and it's a better way to go.

8 So a good set of recommendations. I strongly  
9 support all of them.

10 DR. BERENSON: I want to talk about number four,  
11 if you could put that up a little bit. I have a couple of  
12 comments to make. There it is.

13 In the stuff you sent us, you sort of titled the  
14 section, "Update Conditions of Participation to Align Them  
15 With Current Quality Improvement Efforts," but then the  
16 proposal -- the recommendation was, update the Conditions of  
17 Participation so that requirements incorporate and emphasize  
18 evidence-based measures of quality care. Those two things  
19 are not the same and I want to make a couple of points about  
20 that.

21 You've got some very good examples of quality  
22 improvement efforts that need to happen that should be

1 incorporated into the Conditions of Participation, but  
2 aren't measured. I mean, specifically the one about getting  
3 physician participation in patient safety activities, it's  
4 not subject to the kind of a measurement that is in Hospital  
5 Compare. So I don't think quality improvement is equatable  
6 into performance measures. That's point number one.

7           And then more specifically, there's an increasing  
8 set of studies coming in that are beginning to show some  
9 skepticism about the ability of process measures, clinical  
10 process measures, to actually predict outcomes, and so I  
11 think we're being a little -- and, in fact, I want to refer  
12 -- in our letter to Don Berwick on the ACOs, we actually  
13 made a point of wanting to concentrate on outcome measures  
14 rather than just a whole raft of process measures, and I see  
15 that they've actually introduced 65 measures. I haven't  
16 been through the 65 yet to sort of form a judgment about  
17 them.

18           But I think maybe we're being a little  
19 inconsistent and maybe we're being a little too cavalier  
20 about saying, well, let's just throw in lots more Hospital  
21 Compare measures here. My point is not to make a final  
22 judgment on that. I would be very happy if instead of

1 calling this recommendation "performance measures" you use  
2 that original language, which was to incorporate more  
3 quality improvement, of which some of that might be around  
4 performance measures.

5           So I don't know whether you're getting my point.  
6 I'm more skeptical about the reliance on performance  
7 measures than I am about the need to incorporate quality  
8 improvement learnings into COPs and I'd like somehow that to  
9 be reflected.

10           MS. MUTTI: I can take a first stab at it, anyway.  
11 I think that maybe our language didn't do what it was  
12 intended to do, because what we were trying to do, we  
13 originally did have processes in place but we didn't feel  
14 that adequately captured the outcomes, the need -- you know,  
15 we would want to be measuring outcomes, also. So we put the  
16 language "evidence-based measures" in, and I think that at  
17 least I was thinking of them very broadly, that we weren't  
18 just talking about measures that were in Hospital Compare,  
19 but even if you wanted to incorporate into the COPs that  
20 hospitals should be involving physicians in their quality  
21 improvement, you would have to measure it in order to  
22 demonstrate -- so that maybe there was a -- I was thinking

1 of measures a little bit more broadly, you know, ultimately  
2 to --

3 DR. BERENSON: Yes.

4 MR. HACKBARTH: Yes. We have been struggling with  
5 this language, and I certainly haven't thought of it as what  
6 we mean here is Hospital Compare-type measures.

7 MS. MUTTI: Right.

8 MR. HACKBARTH: I think we're saying, or at least  
9 what I'm trying to say is we don't think that the Conditions  
10 of Participation should be focused exclusively on things  
11 like do you have a quality committee and do they keep  
12 minutes and are the appropriate executives on all of the  
13 right committees. We want to urge that the conditions start  
14 to take into account newer information about what actually  
15 drive quality improvement within organizations. And if  
16 there is evidence that a particular type of program works,  
17 you might say that's part of the Conditions of  
18 Participation, even though it doesn't lend itself to a  
19 quantitative measure. So --

20 DR. BERENSON: I would like to just capture that  
21 thought --

22 MR. HACKBARTH: Yes, so --

1 DR. BERENSON: -- in the language.

2 MR. HACKBARTH: -- proposed -- do you have  
3 language that you would prefer --

4 DR. BERENSON: I actually like the set-up for the  
5 chapter, which was to incorporate -- what does it say -- to  
6 align them with current quality improvement efforts. I  
7 mean, I actually thought that sort of captured -- I mean, we  
8 could say quality improvement and measurement efforts if we  
9 wanted to say that.

10 MR. HACKBARTH: Yes. Well, I think --

11 DR. MARK MILLER: I have one other shot at this,  
12 because I was taking your comment as to say that measures  
13 was a little bit wide of the mark and what we want here are  
14 -- I'm going to use some imprecise language -- in Conditions  
15 of Participation, incorporating tools, things that improve  
16 quality, and so what about language that says that  
17 requirements that incorporate and emphasize evidence -- I'm  
18 going to say this -- evidence-based methods of improving  
19 quality of care.

20 DR. BERENSON: [Off microphone.] That works --

21 MR. HACKBARTH: Okay.

22 DR. MARK MILLER: Because I got your point that

1 measures was sort of throwing you, and I definitely see it.  
2 And I think, whether we wrote it or not, this is what was in  
3 our heads in trying to capture your conversation --

4 DR. BERENSON: Yes. I mean, I thought the write-  
5 up was exactly right. It was just how it was labeled was my  
6 only real problem.

7 MR. KUHN: And for me, I think that works well,  
8 too, because I know I've used the example many times here,  
9 and I've got several others, but again, if you look at the  
10 discharge activity right now, you only have to provide the  
11 discharge information within 30 days after discharge. Well,  
12 with readmissions, ACOs, it ought to be almost -- it almost  
13 ought to be at the time of discharge. And so I think  
14 "methods" captures that versus a measure, and I think that  
15 makes good sense to me, too.

16 DR. CASTELLANOS: Two things. One, I support all  
17 the recommendations. Let me muddy the water a little bit on  
18 draft four, a different approach, and then give a real world  
19 example.

20 In the material that was distributed, you  
21 mentioned something about the National Practice Database and  
22 you talked about peer review and you implied that perhaps

1 hospitals need to monitor physicians as they are applying  
2 their practice appropriately in the hospital setting. Let  
3 me give you a real world setting.

4           For some reason, I came across on my desk in the  
5 throw-away journal from John Vendburg [phonetic] that -- and  
6 it's not a nice thing, but where I live in Fort Myers, that  
7 if you lived in Fort Myers, you had two to three times  
8 greater chance of having your knees replaced than if you  
9 lived in Miami. And that bothered me for three reasons.  
10 One, comparing us to Miami --

11           [Laughter.]

12           DR. CASTELLANOS: I can't believe anybody is worse  
13 than Miami.

14           [Laughter.]

15           DR. CASTELLANOS: Second of all, it was John  
16 Vendburg [phonetic]. And third of all, it was my hospital.

17           So I went to the hospital and I said, you know, we  
18 need to talk about this, not just about orthopedics, but  
19 about everything. It was kind of a blind wall.

20           And that's why I brought up the issues earlier on  
21 clarification. I really think we need -- I think we talked  
22 a little bit about appropriateness in the previous

1 discussion and we need to do that. We need to do that with  
2 this situation just as much as the other previous situation.  
3 But it's just an interesting tie-in.

4 MR. GEORGE MILLER: Yes, just briefly, because  
5 both Herb and Bob captured what I would say. I can support  
6 the recommendations. I also highlighted that same part that  
7 Ron just quoted about in the chapter. Again, I thought the  
8 chapter was well written except for that little paragraph  
9 that seemed to imply, and it may be the wording or the  
10 sensitivity I have to what is said about hospitals. But it  
11 does say it seems that hospitals, broadly, are not  
12 monitoring whether physicians are practicing appropriate  
13 medicine.

14 So the way I read this, it was implying that all  
15 hospitals are not doing it versus the example. You used two  
16 examples. So I would suggest we might want to think about  
17 modifying that language just not to imply every hospital.  
18 The six hospitals that I have been privileged to run, we had  
19 a very strong medical staff that got involved in peer  
20 review. We took appropriate measures most of the time when  
21 we had problems with inappropriate medicine that negatively  
22 impacted a patient, including doing all the things that --

1 quality measures to include in one of my hospitals we would  
2 bring actual patients who were harmed by our physicians to  
3 the board so they would report specifically so that the  
4 board members could see the impact of having negative  
5 outcomes to patients.

6 So some hospitals get it and are participating. I  
7 wouldn't disagree that maybe some don't, but this statement,  
8 in my opinion, was very broad. Very broad.

9 MS. UCCELLO: Well, first, my dad just got his  
10 knee replaced in Fort Myers --

11 [Laughter.]

12 MS. UCCELLO: He's doing very well.

13 DR. CASTELLANOS: You referred him to a good  
14 doctor.

15 MS. UCCELLO: He's doing very well.

16 [Laughter.]

17 MS. UCCELLO: In terms of the continuum of  
18 enthusiasm, I kind of want to highlight and say I  
19 particularly like -- I support all of these, but the idea of  
20 providing assistance at the community level, I think, is a  
21 really great thing. In the past couple of months, there  
22 have been two New Yorker articles that are kind of case

1 studies in looking at disadvantaged communities and how  
2 important it is to be able to coordinate not just across  
3 providers, but also to incorporate non-clinical assistance  
4 for these folks. So I think that's a really great step  
5 forward.

6 DR. CHERNEW: I have a comment about  
7 recommendation three, and that is the one about targeting  
8 the low-performing providers. So based on the questions I  
9 was asking before, I view that there's going to be, at least  
10 in a lot of cases, this sort of grant process. So you're  
11 trying to apply for the money. And I think the conceptually  
12 right thing to target is to target the organizations that  
13 can improve the most, which may not be the bad ones. And so  
14 if I saw a lot of, just to give you an example, a lot of  
15 low-volume open heart surgery providers, I'm not sure I'd  
16 want to target them to have better quality. I mean, I would  
17 say we shouldn't have a lot of low-volume open heart surgery  
18 providers.

19 So I would care in my criteria, do I want to  
20 support this low-volume provider? Are there a lot of other  
21 providers around, and if this provider went belly-up --  
22 because I don't view Medicare as sort of our job is to keep

1 you operating no matter what. But if it was a critical  
2 access or something like that, then I would care.

3           Secondly, I agree 100 percent with the notion --  
4 the motivation in the chapter for targeting low-volume  
5 provider is often, well, it will help with issues related to  
6 the providers that have a disproportionate share of  
7 minorities. So that's true, but I guess what I thought was,  
8 well, why don't we just put into the criteria for these  
9 grants or whatever they are, if you have a disproportionate  
10 share of minorities.

11           So I would look -- if that was my objective,  
12 getting about the objective of improving care for minorities  
13 through targeting low-volume providers, you would do better  
14 if you targeted providers that had a lot of potential to  
15 improve and served a disproportionate share of minorities.  
16 And, in fact, I might be able to make the case, although I  
17 haven't done the research, that if you let low-volume  
18 providers serving some communities go belly-up, those  
19 patients would be directed to higher-volume providers and  
20 get better care than they would get if they were just going  
21 to a low-performing provider that got a technical assistance  
22 grant.

1           So I don't disagree -- I mean, I think you could  
2 make a case that, well, there aren't a lot of providers  
3 there. These are very special providers. And so I don't  
4 know what the right answer is, but my general sense is all  
5 these things should be weighed in a CMS evaluation of a  
6 grant proposal as opposed to simply put in, "We care about  
7 low-performing providers." So if I was at CMS and I got a  
8 proposal, I had \$300 million and I was going to give them to  
9 providers -- which I like very much because the idea of  
10 figuring out the most efficient way to do it, I think it's  
11 best that the providers can choose -- I would want to look  
12 at what's the importance of the problem they're proposing to  
13 fix? What's the importance of their population? What are  
14 the alternatives that patients in their areas have? Should  
15 they be providing these services anyway? I think the  
16 disproportionate share of minorities, or more broadly, the  
17 impact that this would have on disparities, I think would be  
18 an important criteria for evaluating the grant.

19           But I see this recommendation as sort of a one-  
20 sided thing that indirectly gets at a goal that we support.  
21 So in the end, I'll vote for it, but I would say that I view  
22 it as much narrower than what I would really do if I were

1 saying, CMS has to come up with a criteria to evaluate who  
2 gets some of this \$300 million.

3 MR. GEORGE MILLER: Just quick. Michael, on your  
4 point, Parkland Hospital services a disproportionate number  
5 of minorities, but they do a great job. Dr. Ron Henderson -  
6 -

7 DR. CHERNEW: No, I agree, and if they could do a  
8 better -- so if they could do --

9 MR. GEORGE MILLER: They could do it better.

10 DR. CHERNEW: So I'm sure they could do a better  
11 job. I would rather send them the money, because they can  
12 do a better job, than to send money to another organization  
13 in their market that's a lot worse that won't improve with  
14 the money. In other words, I could do a better --

15 MR. GEORGE MILLER: Yes. I've got your point now.  
16 Okay.

17 DR. CHERNEW: I'm not saying I could do better for  
18 Parkland. I would have to see the application and compare  
19 it to the other application and decide. But it's not de  
20 facto clear to me that I don't want the money to go to the  
21 good provider to get better as opposed to the bad provider  
22 to get better, depending on details of the application.

1           MR. HACKBARTH: Mike raised a question, and I  
2 meant to ask during the clarifying round, in the Conditions  
3 of Participation, do they sometimes impose service-specific  
4 requirements, for example, on low volume of cardiac surgery?  
5 Are there standards that say you can't have a low-volume  
6 cardiac service or a low-volume transplant service?  
7 Transplants, I know, are --

8           MS. MUTTI: Transplant is different, right --

9           MR. HACKBARTH: What about non-transplant  
10 services?

11          MS. MUTTI: No, I don't believe they do.

12          MR. HACKBARTH: Okay. Jennie?

13          MS. HANSEN: Yes. I --

14          MS. MUTTI: Oh, wait. I stand corrected a little  
15 bit. I'm sorry. On that one question, apparently there are  
16 some other procedures that also have maybe a volume  
17 threshold. Okay.

18          MS. HANSEN: [Off microphone.]

19          DR. SOKOLOVSKY: [Off microphone.]

20          MS. MUTTI: Oh, for the coverage process. So  
21 maybe like bariatric, Joan, is that maybe one thing you're  
22 thinking of? Okay.

1 MS. HANSEN: Thank you. I think that the body of  
2 work that has evolved is really great. I would -- I  
3 definitely support this, and I think what I pick up from  
4 Mike's comments is that I think the directionality and the  
5 tone of support of making sure that we will have a closing  
6 of the gap of performance, you know, with this. But so it  
7 really is more the execution of the program that's going to  
8 be absolutely vital to be able to determine what the  
9 ultimate product of service is, because it could go out the  
10 way I think that Mark was saying, and yourself, to say,  
11 Mike, that if you really want the good quality of service  
12 and performer to kind of come together rather than the fact  
13 that we're saving every entity in communities --

14 DR. CHERNEW: Right. I said protecting an entity  
15 isn't high on my list of things to do if there's  
16 alternatives.

17 MS. HANSEN: Right, and I fully support that, as  
18 well.

19 And I think, also, just to reemphasize Scott's  
20 earlier point that we do know that even though the QIO  
21 program has operated this way forever based on its current  
22 statutory authority, that there are individual performing

1 QIOs that have done phenomenal kind of community  
2 relationship and quality work so that just knowing, to be  
3 reassured, that those same organizations would be subject to  
4 -- still be able to compete there.

5           And then, finally, the last, undergirding that so  
6 often that is brought up is to really emphasize on some of  
7 the communities that by circumstance are disadvantaged and  
8 that this is another way of kind of coming at it rather than  
9 thinking this is, quote, a "minority" issue. It is about a  
10 quality and access and performance issue. So it is a really  
11 nice way to frame this, so thank you.

12           DR. DEAN: Yes, I have a couple of concerns. I  
13 agree, I overall like the direction that these  
14 recommendations go and certainly support them. I do have a  
15 concern, and it sort of follows up on Mike's point, and  
16 maybe I don't totally understand how this would all play  
17 out, but it concerns me if this evolves into just strictly  
18 basically a grant program that relies on individual entities  
19 to seek assistance, because in many cases, the solution to  
20 some of the concerns we have is really a broader system  
21 community issue and is there anyone that -- any entity that  
22 is really looking at the bigger picture.

1           I am very familiar with a relatively small  
2 community that has two aggressively competing systems that  
3 are duplicating everything, and they probably do meet the  
4 basic thresholds, and yet I think there is tons of evidence  
5 that if we could force a little bit of cooperation and  
6 sharing and you take this procedure and I will take the  
7 other one, all the evidence would be that both the Medicare  
8 would be better off and probably the beneficiary would be  
9 better off. And yet if we rely on the individual programs  
10 to seek that assistance, I do not think that will ever  
11 happen.

12           So I am concerned about that as well as just the  
13 fact that there needs to be some entity, I would think, that  
14 is looking over the whole spectrum, because low-performing  
15 providers may or may not even be aware that they are low  
16 performing. And presumably, there will be something within  
17 the process to help to make them aware of that.

18           A couple of other just quick points. I mean, that  
19 is the biggest concern I would have. I would say that in  
20 the selection of these entities, whoever is going to provide  
21 this assistance, it really is important that they can prove  
22 that they have a credibility within the physician community

1 and that there is a relationship there, because if there  
2 isn't, you may well just run into all kinds of hostility.  
3 It's bad enough the way it currently exists, when you really  
4 do have physician organizations running these things. There  
5 is still a certain amount of hostility. And if you have a  
6 totally independent agency, they could have that  
7 credibility, but I think in the selection, that needs to be  
8 one thing that is looked at.

9           Finally, something we haven't talked about and  
10 that I think we need to be very careful about is as we look  
11 at performance criteria, a lot of your performance criteria  
12 is determined by which patients you take care of, and we  
13 want to be really careful that we don't introduce an  
14 incentive to have facilities encourage the people they can  
15 identify right at day one that are going to hurt their  
16 statistics, that they encourage them to go someplace else,  
17 because that can happen and it can happen in all sorts of  
18 subtle ways and we want to be sure that -- in fact, we have  
19 had a joke.

20           The fellow that is the medical director for the  
21 QIO in South Dakota actually still practices part-time just  
22 down the road from where I do and we have a running debate

1 that I'm going to send all my non-compliant diabetics to him  
2 and my statistics all of a sudden look much better and he'll  
3 have to hassle with those. I mean, you really can affect  
4 your statistics. I understand there are issues of risk  
5 adjustment and all that, but they are less than perfect.

6 MR. HACKBARTH: Yes, and that last issue, for  
7 sure, is a very important one. Obviously, it goes way  
8 beyond the immediate conversation, but broad issues and  
9 performance measurement and pay-for-performance and you  
10 could have unintended consequences if you don't do these  
11 things right.

12 DR. DEAN: Yes, just so we don't --

13 MR. HACKBARTH: I agree.

14 DR. DEAN: Be careful about the incentives that  
15 we're introducing, because they can have unintended  
16 consequences.

17 MR. HACKBARTH: Yes. I wanted to pick up in  
18 particular, though, on your comment about the community  
19 problems. We tried to take care to recognize that there are  
20 quality problems that reside within the four walls of an  
21 institution, for example, and then there are other quality  
22 problems that cross the boundaries of institutions, and

1 readmissions is often cited potentially as an example of the  
2 latter.

3 Yes, there are things that can be done within a  
4 hospital to reduce readmissions, but some of the causes may  
5 lay outside the hospital and would benefit from different  
6 providers working together to solve the problem. So we've  
7 taken care to recognize that there are those community-type  
8 problems and they may require a different type of technical  
9 assistance agent or a different process for selecting that  
10 agent. That may be an area where QIOs have a particular  
11 niche, given that they are already established within  
12 communities.

13 The specific example that you cited, though, of  
14 you have two competing hospitals that are duplicating  
15 services and that duplication is causing quality problems is  
16 a whole different kettle of fish. For them to get together  
17 and say, well, I will do A and you do B, on the face of it  
18 is an antitrust violation, and QIOs, no matter how they are  
19 formulated, are not going to address that specifically. So  
20 some sort of community problems, I think we can address  
21 through this type of technical assistance mechanism. Other  
22 types of community problems are probably beyond the reach.

1 DR. DEAN: But I don't think it's beyond the reach  
2 of at least thinking about it, that in many cases, you know,  
3 moving toward just a single provider of these really  
4 technical services makes all kinds of sense.

5 MR. HACKBARTH: It's beyond the scope of this  
6 conversation --

7 DR. DEAN: Yes. Okay.

8 MR. HACKBARTH: -- not that it is beyond the scope  
9 of reasonable discussion. It's just beyond the scope of  
10 this conversation.

11 Mitra?

12 MS. BEHROOZI: I'll try to be brief. I do think  
13 it's important in the paper to be clear -- to make it  
14 clearer that when you're talking about providers or  
15 communities that you really mean communities that include  
16 providers to be the recipients of the funds because of all  
17 the things that people have said here, and it kind of  
18 relates to the concern that I've expressed before that  
19 opening up that money or that pot of money to sort of  
20 market-based competition, there are downsides to that, too.  
21 There are risks to that, too. And so rather than saying  
22 more types of entities, not even provider-related, could be

1 competing for that money would just make it that much worse.

2 I also wanted to acknowledge what you describe  
3 about creating an online marketplace, you know, the kind of  
4 assistance that CMS would need to provide to make  
5 information available, because a market assumes a rather  
6 perfect state of information and the low-performing  
7 providers may not be the types to really be the best at that  
8 information, which then takes me to my favorite  
9 recommendation now, today, being number six.

10 I really like the way that came out -- Glenn, you  
11 and I talked about it -- that that reinforces the notion  
12 that it's not just high performers. They've got a lot of  
13 other star systems to be judged by. But it's really those  
14 who provide the big buddy kind of services to the low  
15 performers that may be sort of among the most reliable and  
16 truly community-building kinds of efforts.

17 MR. HACKBARTH: Okay. It's time to vote. So  
18 would you put up number one, please. All in favor of  
19 recommendation one, please raise your hand.

20 Opposed?

21 Abstentions?

22 Okay. Number two. All in favor of two?

1           Opposed?

2           Abstentions?

3           Number three. All in favor of three?

4           Opposed?

5           Abstentions?

6           And four. Mark, will you read the revised

7 version?

8           DR. MARK MILLER: This is my big moment.

9           MR. HACKBARTH: Right.

10          DR. MARK MILLER: Okay.

11          MR. HACKBARTH: Clear your throat.

12                   [Laughter.]

13          DR. MARK MILLER: All right. [Clearing throat.]

14          The Secretary should regularly update Conditions of  
15          Participation so that the requirements incorporate and  
16          emphasize evidence-based methods of improving quality of  
17          care. Does anybody want to hear it again?

18          MR. HACKBARTH: No, once was enough.

19                   [Laughter.]

20          MR. HACKBARTH: Okay. All in favor of that

21 reading?

22          Opposed?

1 Abstentions?

2 Number five. All in favor of number five?

3 Opposed?

4 That was just a belated lowering of your arm. You  
5 weren't opposed to it.

6 DR. CHERNEW: [Off microphone.] No, I'm not  
7 opposed.

8 MR. HACKBARTH: Okay. And number six. All in  
9 favor of number six?

10 Opposed?

11 Abstentions?

12 Okay. We are done. Thank you, Anne and John.  
13 Another long odyssey, if not complete, at least we're to a  
14 way station for now.

15 Okay. We'll now have a brief public comment  
16 period. The ground rules are no more than two minutes.  
17 When this light comes back on, that signifies the end of  
18 your two minutes, and please begin by identifying yourself  
19 and your organization.

20 And as always, I would remind people that this is  
21 not your only or even your best opportunity to provide input  
22 on MedPAC's work. Please avail yourself of the website,

1 where you can put comments, and also, of course, interact  
2 directly with our staff.

3 DR. ROWE: Thank you.

4 I'm Elizabeth Rowe, representing the Mid-America  
5 Neuroscience Institute in Lenexa, Kansas.

6 I'm comment in self-referral limitations and the  
7 tectonic shift of outpatient health care into the high-cost  
8 hospital environment, two related topics.

9 The mistaken policy efforts to curtail self-  
10 referral by clinical physicians are failing completely in  
11 their alleged mission to reduce health care costs. In  
12 Kansas City, the two major independent cardiology groups  
13 sold themselves to hospitals because the draconian cuts in  
14 the reimbursement made independent practice untenable.  
15 Thus, their services, now billed at hospital rates, will  
16 cost Medicare much more than they did before.

17 While attending the MedPAC meeting last month, I  
18 was shocked at the level of conviction here that self-  
19 referral of imaging significantly contributes to rising  
20 health care costs and must be curtailed. In an effort to  
21 discover the basis for this conviction, I have since  
22 reviewed the MedPAC record of transcripts and reports going

1 back to 2008. I've read the referenced studies and found  
2 them to be flawed and one-sided. I've also found missing  
3 any of the available references that dispute the premise  
4 that self-referral yields to overutilization, even though I  
5 understand that some have been presented to staff over the  
6 last two years.

7 I submitted some of the key missing references to  
8 staff a few weeks ago.

9 I also submitted a three-page discussion and  
10 critique of the specific studies referenced in the MedPAC  
11 record, which I hope that Commissioners will read.

12 One key study, by Baker, which was presented here  
13 in 2008 and published in December in *Health Affairs*, claimed  
14 that self-referring neurologists and orthopods increase  
15 their MRI orders after purchasing an MRI but Baker  
16 completely ignores all the MRIs pre-ordered by the referring  
17 physicians. So this study has nothing to say about  
18 utilization or costs.

19 Moreover, since his control group were likely  
20 hospital-based, the referring physicians were likely  
21 hospital-owned with incentives to pre-order MRIs, and those  
22 MRIs cost three times more than those ordered by the self-

1 referring physicians.

2 I have a letter in press at Health Affairs about  
3 this study.

4 The second key reference by Gazelle, a  
5 radiologist, is not about ownership, it's about the  
6 professional component. And it's not about self-referral  
7 because it counts same specialty referral as self-referral.  
8 Yet, it is cited as a key study opposing self-referral of  
9 imaging.

10 In conclusion, I hope MedPAC will take on the  
11 powerful policy forces that are driving up costs by forcing  
12 physicians into the welcoming arms of the big business  
13 conglomerates we call hospitals. This will ultimately limit  
14 access for the elderly and poor who rely on Medicare.

15 MS. DENNIS: Maureen Dennis. I represent the  
16 American College of Radiology. I now offer the following  
17 comments with respect to the presentation this morning.

18 So the first observation I would make is that the  
19 recommendations dealing with the mispricing of services may  
20 not get you where you think you want to go. So with respect  
21 to the technical component, the costs of self-referral are  
22 really in the TC -- that's the price of equipment, paying

1 for the tech, et cetera. And when that reduction has been  
2 applied to the technical component, imaging utilization has  
3 gone down but the rate of inappropriate self-referral of  
4 imaging continues to rise.

5 That is likely to also occur if this reduction is  
6 expanded on the professional component. So again, what you  
7 will see is that the utilization of appropriate imaging will  
8 go down but inappropriate self-referral will continue to  
9 rise.

10 Thank you.

11 MR. HACKBARTH: Okay. We are adjourned until 1:00  
12 p.m. Thank you.

13 [Whereupon, at 12:23 p.m., the meeting was  
14 adjourned, to reconvene at 1:00 p.m., this same day.]

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1 try to compare and contrast Medicare Advantage benefit  
2 design with the fee-for-service Medicare design. Then in  
3 response to other questions, Julie will present some numbers  
4 on financial burden on beneficiaries caused by Medicare  
5 cost-sharing and discuss some of the trade-offs between  
6 changes in the Medicare--possible Medicare deductibles and  
7 then an out-of-pocket cap. And then Joan is going to talk  
8 about a Medicare demonstration project that is encouraging  
9 beneficiaries to use high quality, efficient providers  
10 within fee-for-service Medicare.

11 Last time, I think Scott and Nancy and others were  
12 interested in how cost-sharing was structured in MA plans.  
13 We looked and it turns out that cost-sharing under MA plans  
14 tends to be very different than under fee-for-service  
15 Medicare. The major cost-sharing structures under Parts A  
16 and B are used by few MA plans. Only 1 percent of MA  
17 enrollees are in plans that charge the Part A hospital  
18 deductible of \$1,132 per spell of illness.

19 Instead, most plans charge per diem copayments  
20 ranging up to \$400 a day. Often the copayments are only  
21 charged on the first week or ten days of a stay. I  
22 calculated what cost-sharing would be for a hospital stay of

1 five days, which is the fee-for-service average stay, and  
2 found that cost-sharing averaged a little under the fee-for-  
3 service deductible. Now, for shorter stays of, say, three  
4 days, the cost-sharing would be substantially lower than  
5 under fee-for-service, and for longer stays of, say, ten  
6 days, plan cost-sharing could be substantially higher than  
7 under fee-for-service.

8           Moving on to physician services, under Part B of  
9 fee-for-service Medicare, beneficiaries must pay a \$162  
10 deductible per year and are charged 20 percent coinsurance  
11 for physician services. But almost all MA enrollees are in  
12 plans that charge flat copayments for physician services.  
13 Now, plans often differentiate between primary care visits  
14 and specialty care visits. For primary care visits,  
15 copayments average about \$12.50; and copayments for  
16 specialty care visits are a good bit higher, averaging  
17 almost \$30.00.

18           There are a couple of Part B service categories  
19 where the MA plans do tend to follow fee-for-service  
20 Medicare's 20 percent coinsurance structure. About 95  
21 percent of MA enrollees are in plans that charge coinsurance  
22 for durable medical equipment, and the second category here

1 is Part B drugs, which includes chemotherapy drugs, where  
2 about four out of five enrollees are in MA plans that charge  
3 20 percent coinsurance just like fee-for-service.

4           There are other differences in the Medicare  
5 benefits as well. While CMS has used various incentives to  
6 encourage MA plans to include an out-of-pocket cap over the  
7 years, for 2011, CMS did require that all plans have a cap  
8 of no more than \$6,700 for in-network and out-of-network  
9 Medicare-covered services. Plans may have lower caps and  
10 may also have a separate lower cap on in-network cost-  
11 sharing. Half of all enrollees have an in-network cap of  
12 \$3,400 or less.

13           In addition to the out-of-pocket cap, most plans  
14 enhance the Medicare-covered services by waiving the three-  
15 day hospital stay requirement that fee-for-service Medicare  
16 applies before qualifying beneficiaries for skilled nursing  
17 facility care. 95 percent of MA enrollees are in plans that  
18 waive that three-day stay requirement.

19           Now, unlike fee-for-service Medicare, MA plans  
20 have management techniques aside from cost-sharing at their  
21 disposal. Plans usually maintain provider networks and can  
22 use techniques such as prior authorization and utilization

1 review to influence service use. We found that 60 percent  
2 of enrollees are in plans that require the plan's medical  
3 director to approve the use of SNF services and a similar  
4 percentage were in plans that required the medical director  
5 to approve the use of home health services.

6 MS. LEE: At the last meeting, we had discussed  
7 how beneficiaries' financial burden varies by supplemental  
8 coverage income and the spending level. The general pattern  
9 was that among those spenders, beneficiaries with Medigap  
10 had the highest relative burden followed by Medicare only  
11 and ESI. Among high spenders, beneficiaries with Medicare  
12 only had the highest burden than Medigap and ESI.

13 We've updated the analysis with the 2007 data.  
14 The overall pattern is similar and this slide tries to  
15 unpack some of the numbers behind that pattern. As before,  
16 financial burden is defined as a percent of income spent on  
17 out-of-pocket and premiums. That means that there are four  
18 variables at play: Medicare spending, which determines the  
19 cost of sharing liability; out-of-pocket, which reflects the  
20 cost-sharing liability and supplemental coverage; premiums  
21 for Medicare and supplemental insurance; and income. You  
22 can see these four variables in that table by beneficiary

1 supplemental coverage categories.

2 In 2007, the median burden was 11 percent for  
3 Medicare-only, 15 percent for Medigap, and 1 percent for  
4 duals. Medicare-only beneficiaries were noticeably younger,  
5 had low Medicare spending, and low premiums. In contrast,  
6 Medigap beneficiaries had a much higher spending, about  
7 average out-of-pocket due to Medigap, but also high premiums  
8 because of Medigap.

9 To summarize in very imprecise, loose terms, the  
10 median burden among Medicare-only beneficiaries reflects  
11 that they are lower spending and premiums. The burden among  
12 ESI beneficiaries reflects that they are higher income. And  
13 the burden among Medigap beneficiaries reflects their high  
14 spending and premiums.

15 The Commission has been concerned with the  
16 potentially unlimited cost-sharing on the fee-for-service  
17 benefits, because the current cost-sharing rules don't  
18 provide a catastrophic limit. Out-of-pocket costs can be  
19 very high for some beneficiaries without supplemental  
20 coverage.

21 In our June report last year, we had asked the  
22 question, What would be the program costs of adding an out-

1 of-pocket cap to the fee-for-service benefit? Depending on  
2 the level of the cap, the increasing program cost was in the  
3 2 to 4 percent range. A corollary to that question is, what  
4 would be the combined deductible required to add an out-of-  
5 pocket cap, but hold the program spending constant? This  
6 table presents the results of that modeling exercise.

7           For example, look at the middle of that table,  
8 that third option down. For a \$5,000 out-of-pocket cap, we  
9 will need almost \$1,200 in a combined deductible for budget  
10 neutrality. Under this option, out-of-pocket costs would  
11 stay about the same for almost 60 percent of beneficiaries,  
12 but there would be a shift in out-of-pocket costs from  
13 beneficiaries with the high spending to those with the low  
14 spending.

15           For a third of beneficiaries, out-of-pocket costs  
16 would go up by about \$300, on average, and for 7 percent of  
17 beneficiaries out-of-pocket costs would go down by more than  
18 \$1,000, on average.

19           As we've seen previously, the vast majority of  
20 Medicare beneficiaries have supplemental coverage, which  
21 means the kind of changes in cost-sharing we discussed in  
22 the previous slide would not affect those beneficiaries if

1 their supplemental insurance wraps around the new cost-  
2 sharing rules.

3           Therefore, to preserve the effects of cost-  
4 sharing, many proposed changes to fee-for-service benefits  
5 often combine these type of changes in benefit design, the  
6 out-of-pocket cap plus a combined deductible with an option  
7 prohibiting first-dollar coverage in Medigap plans. Such  
8 proposals typically put an out-of-pocket cap in the \$5,000  
9 to \$6,000 range with a combined deductible around \$550 to  
10 \$600, and they also impose a uniform coinsurance of 20  
11 percent on all Medicare services including inpatient.

12           Instead of limiting how Medigap can fill in  
13 Medicare's cost-sharing, an alternative approach would be to  
14 levy an excise tax on Medigap policies. This approach would  
15 not prohibit Medigap from filling in all of Medicare's cost-  
16 sharing, but instead, charge the insurer for at least some  
17 of the added costs of Medicare to having such comprehensive  
18 coverage.

19           In general, any changes in Medicare fee-for-  
20 service benefits would also have implications for employer-  
21 sponsored supplemental coverage and Medicaid, as to how they  
22 can wrap around the Medicare benefits. Next, Joan will

1 discuss some other ideas for changing fee-for-service  
2 benefit design.

3 DR. SOKOLOVSKY: Last month we talked about some  
4 of the innovative benefit designs being used in the private  
5 sector. As you may recall, in our discussions with payers  
6 this year, we noted four broad categories of design  
7 strategies. The first one involves lower-end cost-sharing  
8 for high value services. For example, some employers have  
9 eliminated copayments for preventive services and for  
10 medications to control specific chronic conditions like  
11 diabetes.

12 Second, others talked about, although few have  
13 implemented, raising cost-sharing for low-value services.  
14 One example that is being used is reference pricing for  
15 brand drugs that have generic equivalents. Under reference  
16 pricing, an enrollee who wants a branded drug when a generic  
17 is available pays the full additional price of the branded  
18 drug.

19 Thirdly, some providers provide incentives for  
20 enrollees to see high-performing and low-cost providers.  
21 These examples are quite varied, ranging from different  
22 copays for primary care versus specialty care visits, to

1 varying copayments or lowering premiums for enrollees who  
2 use specific efficient providers.

3           Fourthly, some providers provide incentives for  
4 enrollees to adopt healthy behaviors, examples like  
5 exercise, quitting smoking, enrolling in disease management  
6 programs. In some cases, enrollees must meet agreed-upon  
7 goals to receive the incentive. No interviewee employed all  
8 four strategies, but no interviewee relied on a single  
9 strategy either.

10           One issue to consider with these innovative  
11 benefit designs is whether they can be implemented within  
12 fee-for-service Medicare. This month, I want to focus on  
13 one of these strategies which is currently being tested in a  
14 Medicare demonstration project, and that is, encouraging  
15 beneficiaries to use high quality, efficient providers  
16 within fee-for-service Medicare.

17           Within these demonstrations, beneficiaries who  
18 choose the designated provider face lower out-of-pocket  
19 costs or, in the case of the current demonstration, they  
20 receive rebates from Medicare if their providers produce  
21 Medicare savings.

22           The first project using this model was the

1 coronary-artery bypass graft, or CABG, demonstration, which  
2 ran from 1991 to 1996. This demonstration tested the  
3 effects of providing a bundled payment for hospitals and  
4 physicians for two particular cardiac procedures. Seven  
5 sites were chosen by competitive bidding on the basis of  
6 both quality and discounted prices.

7           It produced savings for the program, about 10  
8 percent of expected costs, and improved quality. Mortality  
9 rates for these seven sites declined even though they were  
10 at a very high rate to begin with. And beneficiaries saved  
11 money, reported high satisfaction with care. However, the  
12 sites did not increase market share as they had hoped.

13           The acute care episode, or ACE, demonstration  
14 began in 2009. It also consists of bundled payments for  
15 physician and hospital services treating patients needing  
16 specific orthopedic and cardiovascular services. Hospitals  
17 offered a discounted rate, but unlike the CABG demo,  
18 physicians received the full fee-for-service payment from  
19 the hospital that gets the bundled rate.

20           Sites were chosen by competitive bidding, but  
21 limited to Texas, Oklahoma, New Mexico, and Colorado. Both  
22 physicians and beneficiaries share in any savings generated.

1 Beneficiaries share 50 percent of Medicare savings up to the  
2 total cost of the annual Part B premium. Participating  
3 sites can market themselves as value-based care centers.

4           Two sites have reported preliminary results,  
5 although there has been no independent evaluation yet. Both  
6 hospitals report improved surgical quality and beneficiary  
7 satisfaction and savings. The main source of savings for  
8 the hospitals comes from increased bargaining power for  
9 devices, equipment, and supplies.

10           Physicians participating in the demo received a  
11 list of the prices of the different devices and supplies and  
12 were able to come to agree on using a selected number of  
13 these types. That gave the hospitals a lot more leverage  
14 negotiating prices for the particular devices.

15           One hospital reported that after nine months of  
16 the demo, joint replacement patients received an average of  
17 \$350 from Medicare. Similarly, a second hospital reported  
18 that it had saved \$4 million in device and supply savings in  
19 the first 18 months. Participating physicians shared gains  
20 of about \$560,000, and 2,000 patients received checks  
21 averaging \$300 per beneficiary.

22           One hospital reported substantial increases in the

1 volume of both the cardiology and orthopedic procedures  
2 covered in the demonstration. And as I said, there is no  
3 evaluation yet and it's not clear whether the increase has  
4 come from increased market share or an increase in the  
5 number of patients having these procedures.

6 To sum up, we have focused this presentation on  
7 issues within the Medicare fee-for-service benefit that  
8 might be addressed in the short term. You may want to  
9 discuss whether, in the short term, Medicare should modify  
10 the benefit design to rationalize cost-sharing services  
11 across Part A and B, and across silos.

12 Should it set an out-of-pocket limit to provide  
13 better protection for beneficiaries? Should it set some  
14 cost-sharing for all services? And if that's where you want  
15 to go, should limits be placed on the ability of  
16 supplemental coverage to cover all cost-sharing? And should  
17 there be nominal cost-sharing added after beneficiaries hit  
18 the out-of-pocket cap, as it's currently done under Part D?

19 Lastly, should Medicare incentivize efficient  
20 provider arrangements such as we've seen in the CABG and the  
21 ACE demonstrations? We, of course, will be happy to answer  
22 any questions and we look forward to your discussion.

1 MR. HACKBARTH: Okay. Thank you all. So let's  
2 see. Round 1 clarifying questions. Mitra, I think we're on  
3 your side this time. No? Clarifying questions? Cori.

4 MS. UCCELLO: For Slide 7, I'm confused of what  
5 that top line is, if there's no change.

6 MS. LEE: The first option is current law. It has  
7 no out-of-pocket cap under current law. So there's zero  
8 cap.

9 MS. UCCELLO: Oh, I'm sorry. And that would be --  
10 okay. So that 595 is just if we want to combine --

11 MS. LEE: If we wanted to combine the A and B  
12 deductibles.

13 MS. UCCELLO: Okay. I had something else, but I  
14 can't remember.

15 MR. HACKBARTH: Okay.

16 MR. GEORGE MILLER: Joan, on Slide 11, you  
17 indicated that, I believe, both categories increase volume,  
18 when you were talking about this slide. I think it was  
19 cardiology and orthopedics. Do you know the reason for the  
20 increase in volume? Was it because -- let me just ask the  
21 question. Do you know the reason for the increase in  
22 volume?

1 DR. SOKOLOVSKY: No. And as I said, there has  
2 been no independent evaluation. I did speak to CMS about it  
3 and they're aware of the possibilities and that's an  
4 important part of their evaluation to try to figure that  
5 out.

6 MR. GEORGE MILLER: Are there any theories of what  
7 were the drivers? Do you have any idea or we just have to  
8 wait? Okay. Thank you.

9 MR. HACKBARTH: Ron.

10 DR. CASTELLANOS: Just some definitions. On Slide  
11 3, you talk about high quality, lost cost provider. How do  
12 you define that?

13 DR. HARRISON: For the demo.

14 DR. CASTELLANOS: Slide 3, the last --

15 DR. SOKOLOVSKY: Oh, as far as the demonstration  
16 is concerned?

17 DR. CASTELLANOS: Yeah.

18 DR. SOKOLOVSKY: I would have to say that the  
19 criteria were different for the two demonstrations. In the  
20 CABG demonstration, it was a national demonstration, and the  
21 providers who applied to participate had to have achieved  
22 very high quality measurement goals, including survival

1 rate, and a number of other things. They had to be very  
2 much near the -- very much high quality, in that sense, in  
3 every way that we could measure those two procedures.

4 DR. CASTELLANOS: Okay.

5 DR. SOKOLOVSKY: The second demo is much more --  
6 it's limited, again, to those four states, and the  
7 participating providers had to demonstrate that they had  
8 quality improvement processes in place. They have to report  
9 many additional measures of quality going forward, but they  
10 didn't have to have a particular plateau in order to  
11 qualify. And the low cost is, in both cases, they're  
12 offering a discount.

13 DR. CASTELLANOS: Okay. On Slide 9, you want to  
14 incentivize enrollees to see high-performing or low-cost  
15 providers. Are you taking in consideration quality at all  
16 on these providers?

17 DR. SOKOLOVSKY: Yes, and again, the reason I used  
18 "or" is this is what private payers were doing and there was  
19 considerable variation on whether -- on how they ranked  
20 providers, how much quality played in versus costs. So  
21 there was not one answer to that.

22 DR. CASTELLANOS: So the low-cost providers would

1 still provide high-quality care?

2 DR. SOKOLOVSKY: Yes, in most of them but not all  
3 of them. In some of them, the emphasis was much more on low  
4 cost. In some of them, in fact, they didn't have to be low  
5 cost if they were very high quality. So I couldn't give one  
6 answer to that.

7 DR. CASTELLANOS: I guess my concern is that are  
8 we incentivizing patients just because of cost?

9 DR. MARK MILLER: It's clear that she's reporting  
10 what private sector people would know.

11 DR. CASTELLANOS: Yeah, I understand that.

12 DR. MARK MILLER: Right. So it's not a "we" here.  
13 She's explaining what they've done.

14 DR. CASTELLANOS: They, okay. And I guess the  
15 last one is on the last slide. How do you describe an  
16 efficient provider? Is there a definition on that?

17 DR. SOKOLOVSKY: When we use the term efficient,  
18 it means both high quality and --

19 DR. CASTELLANOS: Okay, thank you.

20 DR. BERENSON: I want to -- this is for Joan again  
21 on Number 11. I want to ask a couple more questions to  
22 follow up.

1 DR. SOKOLOVSKY: Great.

2 DR. BERENSON: It sounds like the success, one of  
3 the reasons, at least in your two cases where you've heard  
4 something back, is sort of getting the physicians and the  
5 hospitals together to agree on particular purchasing  
6 strategies, perhaps agreeing on which implant to go after or  
7 which stent, not have each doctor have his or her own sort  
8 of unique one. So to use some market leverage to reduce the  
9 prices of those things.

10 Now, that has been, for over a decade, sort of the  
11 goal of gain-sharing, where the hospitals wanted to be able  
12 to share savings with physicians for that very purpose and  
13 the Office of Inspector General sort of put cold water on  
14 that, basically saying that it would perhaps compromise  
15 quality by doing that.

16 So I guess my first question is, is there an  
17 inconsistency in the policies? Are the quality measures  
18 that are being used in this demo, would that make the  
19 inspector general happy? I mean, it would seem to be that  
20 it's an easier strategy to just permit some kind of gain-  
21 sharing rather than having to actually bundle the payments.

22 So I guess my question is about sort of the

1 consistency of sort of Federal statements in this area.

2 DR. SOKOLOVSKY: Well, that's a good question, but  
3 probably not one that I can answer in terms of the happiness  
4 of the inspector general. But both of these sites were very  
5 clear that that was the source of the savings, that's the  
6 money -- and they also said that one of the reasons that it  
7 worked was because they didn't say to the physicians, You  
8 have to use this particular implant. It was very much a  
9 collaboration among the physicians.

10 MR. HACKBARTH: So could you refresh our  
11 collective recollection, Joan, on the status of gain-  
12 sharing? So my recollection was that eventually, the  
13 inspector general put out some rules or guidance that said,  
14 Well, under certain circumstances, it may be okay. There  
15 was also a demonstration project that was begun, and then I  
16 think at one point, stopped due to court action. And then I  
17 think there has also been some legislative deliberation on a  
18 gain-sharing provision. Could you just give us a summary of  
19 where all that stands?

20 DR. SOKOLOVSKY: I really wish I could. I never  
21 even -- I'm probably not the right person to do that. I  
22 know basically what you've said I know is true and I can't

1 really go beyond that.

2 MR. HACKBARTH: Can anybody on the staff?

3 DR. MATHEWS: We're going to see if we can find  
4 Ariel. He should be able to address the question.

5 DR. MARK MILLER: He's the one, also, who keeps  
6 track of the gain-sharing, and I do also recall the  
7 demonstration. Well, we'll get this fact, but I also want  
8 to draw the policy logic together in a minute.

9 MR. HACKBARTH: So, Ariel, my question was, if we  
10 could get sort of a brief summary of where the idea of gain-  
11 sharing stands. There are a few different activities that  
12 I'm vaguely aware of. One is the inspector general's  
13 involvement, which I think ultimately led to the creation of  
14 some sort of safe harbor rules on gain-sharing that might be  
15 permissible. And then there was a demonstration project  
16 that's sort of been on again/off again due to litigation.  
17 And then there's also been some legislative activity. Can  
18 you sort of give us a quick synopsis of where it stands?

19 MR. WINTER: Thank you. So we'll start first with  
20 the OIG advisory opinions. Let me back up a bit actually  
21 and talk about the gain-sharing demonstration that CMS is  
22 working on with a coalition of New Jersey hospitals, which

1 was halted by a circuit court decision which said it  
2 violated the civil monetary penalty provision, which  
3 prohibits hospitals from giving physicians financial  
4 incentives, et cetera. Okay. So that was stopped.

5           After that, CMS did issue several advisory  
6 opinions approving specific arrangements between specific  
7 hospitals and physician groups to allow gain-sharing related  
8 to reducing use of unnecessary drugs and supplies or  
9 standardizing devices, that sort of thing. But those  
10 advisory opinions only applied to those arrangements.

11           MR. HACKBARTH: Right.

12           MR. WINTER: I think there have been 11 all told,  
13 all together. In the statute, I think it was either MMA or  
14 one of the ones after that explicitly approved or directed  
15 the Secretary to create a gain-sharing demonstration within  
16 Medicare and what CMS did is they actually created two gain-  
17 sharing demonstrations. One was on -- looked at sort of  
18 shorter term outcomes on like 30 or 60 days savings in the  
19 hospitalization and maybe 30 days mortality, that sort of  
20 thing.

21           Then there was another demonstration which  
22 included broader health care systems and looked at longer

1 term trends. I think they've selected participants for both  
2 demonstrations. I'm not aware of any -- so they're  
3 underway, but I'm not aware of any evaluation that's been  
4 done yet. And I think they're still underway. I don't  
5 think they've completed yet. So that's sort of the status  
6 as far as I know.

7 MR. HACKBARTH: Great. Thank you.

8 DR. BERENSON: Can I continue?

9 MR. HACKBARTH: Yeah, sure.

10 DR. BERENSON: The second part of my question,  
11 Joan -- and thank you very much, Ariel, for that answer --  
12 has to do also with the ACE's demo, the concern about  
13 increasing volume when you put the docs and the hospitals  
14 together that at least, theoretically, in a fee-for-service  
15 world, they now have aligned incentives. One to be more  
16 efficient within a bundle, but two, to also market the hell  
17 out of a bundle to provide a -- do we know if in the design  
18 of the demo that the centers that got awarded had to come in  
19 with some protections around appropriateness? I mean, this  
20 is Ron's issue, around appropriateness. Some sort of  
21 process or structural protections that the CMS would have  
22 that they actually were going to be interventions when

1 appropriate so that the design itself would try to correct  
2 for this potential volume increase?

3 DR. SOKOLOVSKY: They are looking in terms of  
4 having -- for these particular DRGs, reporting about 30  
5 quality measures for each one to help them keep track of it,  
6 but I don't believe that in advance they were planning to --  
7 because, in fact, they were working the opposite way. One  
8 of the problems with the CABG demo that the sites identified  
9 was that CMS didn't help them market. So, in fact, CMS is  
10 going out of their way to help market these demos.

11 DR. BERENSON: So -- okay. I guess my point is  
12 that it would an absolutely important parameter to be  
13 evaluating, is what has happened to the volume of services  
14 in the marketplace? I mean, are we having a shift of the  
15 same number or are we actually having a total increase in  
16 the number of services as a focus factory has been created,  
17 in essence? I mean, that's my concern about -- I mean, I'd  
18 like a lot of episode bundles around acute events, but my  
19 concern is around the appropriateness issue and how to keep  
20 some management control over that incentive.

21 DR. SOKOLOVSKY: And I did talk to CMS about this  
22 issue yesterday and they did say they were very aware of it

1 and they were very concerned and it would be one of the  
2 focuses of the evaluation.

3 MR. HACKBARTH: I'm going to pick up on your first  
4 comment, Bob, and sort of flag a particular aspect of it.  
5 As you point out, there are things that we can do to bundle  
6 services, create incentives for providers to be more  
7 efficient, create an opportunity for physicians and  
8 hospitals to work together to reduce costs.

9 Now, one of the features of the demos is to bring  
10 the beneficiary into that activity as well. So in addition  
11 to there being an incentive for the providers to produce  
12 each unit as efficiently as possible, there's also an  
13 opportunity to gain market share, to the extent that savings  
14 can be passed onto the beneficiary, a piece of the  
15 efficiency gain.

16 I know you know that, but I'm just trying to draw  
17 a distinction here. Broadly speaking, our focus on this  
18 topic is how do we bring the beneficiary into the  
19 efficiency-seeking activity. Herb.

20 MR. KUHN: And on that notion of the beneficiary,  
21 you indicated, Joan, on the ACE demo that beneficiary  
22 satisfaction was up. Was that driven by -- was that from

1 focus groups or is there a cap survey? Where was that  
2 information from?

3 DR. SOKOLOVSKY: Remember, there is no evaluation  
4 yet. This is the hospital, but the hospital did survey  
5 their patients and their patients reported both high  
6 satisfaction and also reported -- and again, it's up to you  
7 how much weight you want to lend to this. It's not  
8 independently verified. But they said they did not choose  
9 the hospital because of the potential for the rebate, but  
10 they were -- the fact that it was listed as a value-based  
11 care center, that there was a third party identifying this,  
12 was an important reason for their choice.

13 MR. KUHN: And on that a little bit more, talking  
14 in response to Bob's question about CMS notifying or making  
15 aware of these centers or these individual hospitals or  
16 health systems that were part of the demonstration, for  
17 beneficiaries, was that through a beneficiary mailing? Was  
18 that a posting to the CMS website? How was that  
19 notification transmitted?

20 DR. SOKOLOVSKY: As far as I know, the  
21 beneficiaries were not contacted individually. It was the  
22 hospital that was able to market itself to beneficiaries,

1 and the physicians to be able to market to their patients.

2 DR. KANE: Yeah, for the -- on the paper that  
3 accompanies this, could I just ask a question? I don't know  
4 if you have it. It's on Page 23. You have a table and I  
5 guess I'm trying to make sure I understand it. It's the  
6 Table 4 on average cost-sharing liability and out-of-pocket  
7 spending by type of supplemental coverage. At the bottom,  
8 you say premiums. I'll give you a minute to find it.

9 MS. LEE: Yes.

10 DR. KANE: At the bottom, it says premiums. And  
11 it says first health insurance. Does that mean just the  
12 supplemental?

13 MS. LEE: That's correct, private insurance.

14 DR. KANE: So this is just the supplemental health  
15 insurance. Then is that supposed to be out-of-pocket or the  
16 total value of the health insurance?

17 MS. LEE: It's the premiums for the private  
18 supplemental insurance.

19 DR. KANE: So it might not be out-of-pocket if the  
20 employer, for instance, is paying for the employer-  
21 sponsored?

22 MS. LEE: This is what beneficiaries are paying,

1    yeah.  The beneficiaries' share of the premiums.

2                   DR. KANE:  Oh, okay.  So it isn't the premium.  
3    It's the beneficiary's share towards that.

4                   MS. LEE:  Exactly.  What a beneficiary is paying.

5                   DR. KANE:  Okay.  Because that's why then it's a  
6    big difference because the Medigap is twice as expensive.  
7    But you're saying that's because the employer is probably  
8    subsidizing?

9                   MS. LEE:  Exactly.

10                  DR. KANE:  Although then you also see -- yeah, the  
11    costs are quite -- but the costs up at the top are quite a  
12    bit less as well for employer-sponsored people.  It's \$2,000  
13    less, \$6,900 versus \$9,000.

14                  MS. LEE:  There is a difference between those two  
15    groups in average spending.

16                  DR. KANE:  But the premium is probably -- you  
17    can't tell because it's probably cost share, because there's  
18    a contribution from the employer.

19                  MS. LEE:  We would not know exactly what employers  
20    would be subsidizing.

21                  DR. KANE:  And then in the last line, it says  
22    Medicare and health insurance.  Does that mean the Part B

1 premium or what does that mean?

2 MS. LEE: That's mostly Part B. Some people have  
3 a Part A premium, so those will be included. But it will be  
4 mostly Part B premiums.

5 DR. KANE: And not D?

6 MS. LEE: These are just for A and B services, so  
7 it excludes Part D.

8 DR. KANE: Okay, great. Thank you.

9 MR. BUTLER: So on Slide 6, I'm still making sure  
10 I understand the basic premise, and that is in the left-hand  
11 column under Medicare only, because there is no supplemental  
12 coverage, unlike the right-hand columns, we've got lower  
13 utilization. And when you get the first-dollar coverage or  
14 something closer to it on the right-hand side, spending is  
15 greater, right?

16 MS. LEE: Medicare only also, spending is lower  
17 because we have younger people in that group.

18 MR. BUTLER: Okay.

19 MS. LEE: So it's partly the age --

20 MR. BUTLER: Not risk-adjusted, it's not risk-  
21 adjusted. But still, I think --

22 MS. LEE: That's correct.

1           MR. BUTLER: -- our basic idea is that that  
2 population still is more cost-effective than the others.  
3 That's why we're looking at the issue.

4           MS. LEE: Exactly. Part of that lower spending  
5 will reflect the lower utilization due to not having  
6 supplemental coverage.

7           MR. BUTLER: Okay. So if that's the case, and  
8 it's adjust for age, you would think in that population you  
9 would be able to tell the utilization within there for the  
10 things that are price sensitive and so much more luxury  
11 items versus, say, inpatient care which would be inelastic.  
12 Do we look at different patterns of utilization occurring  
13 within the Medicare-only? Not just a lower amount, but is  
14 the lower utilization in the areas you would expect because  
15 they have greater out-of-pocket expenses? Do we know that?

16           DR. MARK MILLER: This is -- we have gone through  
17 this and I'm looking at the three and thinking either Scott  
18 or Joan --

19           DR. SOKOLOVSKY: In the paper, we discuss the work  
20 that Chris Hogan did for us a number of years ago, and I  
21 can't remember the numbers offhand, but inpatient emergency  
22 room use, inelastic, no particular difference. The main

1 difference was physician visits.

2 DR. MARK MILLER: And so, it does go the way you  
3 think.

4 MR. BUTLER: Yeah, I thought we had done that. I  
5 just couldn't find it in any of the tables.

6 DR. MARK MILLER: And we can make sure this gets  
7 back in front of you. We also wrote this up in detail in  
8 June 2010 -- or it was earlier than that?

9 DR. SOKOLOVSKY: 2009.

10 DR. MARK MILLER: 2009? Okay. And we can make  
11 sure that you have that.

12 DR. STUART: Just a quick point on this slide  
13 since it's up. These numbers are different from the numbers  
14 on Table 4 that Nancy was talking about.

15 MS. LEE: It reflects a slightly different sample  
16 because we were looking at the relative spending levels. We  
17 restricted the sample to people who are enrolled in Part A  
18 and B portfolios.

19 DR. STUART: All right. So they're slightly  
20 different. On the Medicare side over here, there's a little  
21 problem with the arithmetic. It looks like the median  
22 burden is going to be around 7.5 percent, but my -- if the

1 OOP in premium really is \$787, that seems pretty high. Why  
2 would somebody on Medicare have that high out-of-pocket --  
3 well, they wouldn't have premiums, so it would be all out-  
4 of-pocket.

5 MS. LEE: The categories are not totally clean by  
6 the beneficiaries, by supplemental coverage. We assign them  
7 according to the number of months, but they can have  
8 multiple coverages.

9 DR. STUART: Okay. The problem with the MCBS?

10 MS. LEE: Yeah.

11 DR. STUART: And then lastly, this particular  
12 table doesn't include Medicare Advantage.

13 MS. LEE: That's correct.

14 DR. STUART: And I actually have questions about  
15 Medicare Advantage, if we could go back to Slide 4. Now, in  
16 your discussion, you treat Medicare Advantage as something  
17 extra from Medicare-only. So there's Medicare-only and then  
18 there's Medicare Advantage. And the text box in the chapter  
19 as well as the points that you made suggest that in most  
20 cases, it's probably more generous than Medicare; although  
21 in some cases, it might not be more generous than Medicare.

22 And my question is, is there any secondary market

1 for people who are in MA plans that may not be as generous?  
2 Or are there enhanced plans that MA programs can offer so  
3 that you get even lower cost-sharing than you might from an  
4 unenhanced plan? Do you know anything about this?

5 DR. HARRISON: There's all different plan designs,  
6 and in fact, there are some plans that we call rebate plans  
7 where they will actually rebate part or all of your Part B  
8 premium. So there is sort of a cash back for some plans.

9 DR. STUART: Would this be the same organization  
10 would offer a series --

11 DR. HARRISON: Yes.

12 DR. STUART: -- of programs so you've got the  
13 Platinum Plan and the Gold Plan --

14 DR. HARRISON: And that's what they're called  
15 often.

16 DR. STUART: -- and then the Iron Plan. I didn't  
17 see any of that discussed in the chapter, and it might be  
18 interesting to lay that out because the way it's set up  
19 here, it's as if anybody in MA just has MA and it looks like  
20 they've got a lot more choice.

21 DR. HARRISON: Well, I was just trying to show  
22 what a typical plan was like --

1 DR. STUART: Yeah, okay.

2 DR. HARRISON: -- what they behave like. But  
3 there are different levels.

4 DR. STUART: And to get back, I guess, to the  
5 relevance of this, how many people who are in MA are in the  
6 platinum version as opposed to the plastic version?

7 DR. HARRISON: [Shakes head.]

8 DR. KANE: Don't know.

9 DR. BAICKER: Going back to Slide 6, I thought  
10 this was a really interesting array and you talked in the  
11 text about the fact that people may be responding to the  
12 copayments in a way that affects consumption of different  
13 services, you called it the insurance affect or I might call  
14 it a moral hazard.

15 What I wasn't sure you had tried to measure, and  
16 wondered if you could, is the insurance value of the product  
17 they're buying in that insurance is not only paying out an  
18 average amount, but it's protecting you from variability of  
19 unknown future expenses.

20 So part of what you're buying with these premiums  
21 is protection against the risk of potentially very high  
22 expenses. You can try to price that out by looking at the

1 distribution of costs that a typical beneficiary might face,  
2 given uncertain medical expenses, and put a value on that  
3 reduction in variability.

4 I wonder if that -- how much of that -- how much  
5 of the difference in the people with supplemental coverage  
6 expenses can be attributed to a reduction in variance, not  
7 just a change in the mean? That wasn't meant to be a  
8 rhetorical question.

9 DR. MARK MILLER: I was gathering that. I think  
10 what you're probably getting here is -- and I would like to  
11 do this, too, is maybe we could huddle on this question,  
12 because you're asking if we can calculate something and I  
13 suspect there's a bit of a cold start as we all think  
14 through the data set, the properties of the data set, and  
15 our ability to do it.

16 Now, Julie, if you know the answer to the  
17 question, you should feel free to say it right at this  
18 point. But my sense is, we need to back up, because I  
19 definitely understood the question. I don't understand  
20 whether we can answer it. Now, I gave you some time to  
21 think through some stuff, so you're up.

22 MS. LEE: So that is correct, that the numbers

1 that are on the slide, they definitely do not reflect the  
2 value that beneficiaries get in the insurance protection.  
3 There's the literature that kind of look at the riskiness of  
4 the elderly seem to suggest that they are highly risk  
5 covered. So they are going to put relatively high premiums  
6 on that protection.

7 As to the question of whether we can actually  
8 estimate how much of that high premium, extra premium that  
9 beneficiaries are paying is reflecting that extra utility  
10 that they drive. I actually am not sure we can do that with  
11 the given data sources.

12 DR. MARK MILLER: [Off microphone.]

13 MR. HACKBARTH: Okay. Ready for Round 2. Mitra.

14 MS. BEHROOZI: This is so interesting and there's  
15 so much to think about and talk about and think about other  
16 ways of looking at some of the questions that they material  
17 raises. The whole issue removing the out-of-pocket --  
18 setting an out-of-pocket cap, you know, removing the  
19 catastrophic liability from the beneficiaries and shifting  
20 that to the front end by way of a combined deductible, that  
21 might be a good thing to do, or eliminating the catastrophic  
22 exposure is a good thing to do. I mean, I think it's a good

1 thing to do.

2           But doing that, paying for it, by putting it all  
3 up front in a deductible, I think doesn't really belong in  
4 kind of the analysis that we're doing about trying to  
5 encourage beneficiaries to make better decisions about high  
6 value and low value care. When there's an up front  
7 deductible that applies to all services, that doesn't  
8 distinguish between high value and low value care.

9           It just doesn't seem consistent with the rest of  
10 the discussion that we have, that the chapter goes into and  
11 the analysis that you've done and all the interviews that  
12 you did, Joan, with payers trying to find ways to drive  
13 value. Deductibles are the crudest -- I still don't get  
14 what the point is except to shift costs, I mean, generally  
15 in the world.

16           I don't just mean here in this discussion. Nobody  
17 can really articulate for me the policy value of  
18 deductibles. They neither act like premiums where people  
19 choose certainty, they choose to pay more in premiums to  
20 protect themselves from both variability and catastrophic  
21 costs, nor are they associated with being able to make good  
22 choices about what's valuable to a beneficiary.

1           So if we want to talk about eliminating the  
2 catastrophic exposure and paying for it some other way, I'd  
3 really like us to look at other ways. You suggested an  
4 excise tax on Medigap plans. Of course, that then finds its  
5 way into the premium, the same way that coverage of the  
6 deductible would find its way into the premium.

7           There are other ways to do it, too. You could  
8 just add it to the Part B premium and then let people buy  
9 policies that -- or join MA plans or engage in other  
10 behaviors that help them reduce the cost of the Part B  
11 premium. There are just a lot of ways to do that. I really  
12 think deductibles are not consistent. It's moving backward.  
13 It's not moving forward in terms of creativity and  
14 progressiveness around benefit design.

15           So that's about deductibles. I think I've made  
16 clear how I feel about copayments. The same dollar cost  
17 across the board means different things to different people  
18 according to their income status and -- I've said many times  
19 -- dual eligibility, eligibility for Medicaid is not co-  
20 extensive with low income.

21           You have a lot of references in the paper, I think  
22 particularly, Joan, in the panel that you did, where it's

1 clear that there will be more avoidance of appropriate care  
2 by people at the lower end of the income spectrum, or people  
3 who feel like maybe they have a lot of dependents to take  
4 care or high rent or whatever, their income isn't  
5 necessarily at a threshold that you would obviously say is  
6 low, but they think they can't afford the cost of that  
7 service.

8           So I think it is progressive design to try to  
9 apply costs in a way that will discourage low-value care, so  
10 that does mean copayments or exposing people to the full  
11 cost of a low-value service when a high-value service is  
12 available, reference pricing, as you said, being a good  
13 example of that.

14           But I also think it's important to make sure that  
15 when you're talking about that, that there are options for  
16 people to avoid those costs like reference pricing, you  
17 know, making it free or very low cost to get the high value  
18 service, or joining a Medicare Select plan where there is a  
19 narrow network that costs Medicare less, or one of a number  
20 of different types of Medicare Advantage plans where  
21 people's costs will be lower.

22           As you said, there are many different benefit

1 designs, and they can choose where they want to either  
2 expose themselves to risk or expose themselves to management  
3 techniques or limited choices, and not necessarily say  
4 everybody has to pay -- going back to an earlier discussion  
5 -- \$100 or \$150 for an episode of home health care use  
6 because it will have different impacts on different people  
7 and it's too crude a tool to do what we want, which is drive  
8 high-value utilization and discourage low-value utilization.

9 MR. HACKBARTH: So let me just try to tease out a  
10 couple different points that I hear you making, Mitra. One  
11 is that although you personally would value improved  
12 catastrophic coverage, how that's financed really matters a  
13 lot to you because of different distributive implications  
14 and the like.

15 Now, for any given beneficiary, how the affect of  
16 a big increase in the front end deductible, you know,  
17 combined A and B deductible at a high level, how they would  
18 experience that front end cost will be a function of their  
19 supplemental coverage. And so, they can choose a  
20 supplemental coverage that uses deductibles as a feature.  
21 Some people may welcome that. Or they could choose a  
22 supplemental plan that has much smaller copays and pay a

1 higher premium for it. Or they could choose a supplemental  
2 policy that has no cost-sharing at all and pay still a  
3 higher premium than that.

4 So that the point I'm trying to make is that even  
5 if Medicare were to say, Well, we're going to pay for  
6 catastrophic with a front end deductible, that's sort of the  
7 beginning of the tale as opposed to the end of the story.  
8 Exactly what the distributive implications are will be  
9 influenced by the array of private plan options that people  
10 could choose.

11 MS. BEHROOZI: Except that the people who are  
12 really exposed to the catastrophic potential costs are the  
13 ones, for the most part, without supplementary coverage,  
14 right, supplemental coverage. And so they are the ones who  
15 will experience the deductible up front, and it's that 10  
16 percent of people.

17 MR. HACKBARTH: Although to the extent that  
18 they're experiencing catastrophic costs, even without  
19 supplemental coverage, they would be among the big winners  
20 from a restructuring the Medicare benefit package.

21 MS. BEHROOZI: But of that 10 percent that don't  
22 have Medicare coverage, I don't know the numbers, but I'm

1 sure that far more of them would experience the deductible  
2 than would realize the benefit of the catastrophic coverage.

3 MR. HACKBARTH: Oh, yeah, absolutely.

4 MS. BEHROOZI: So all of those people who face  
5 that deductible before they can use any services, hopefully  
6 they're all young and healthy, but they have Medicare  
7 spending. So there's going to be a lot of appropriate care  
8 that they're going to forego. All of them will be risk of  
9 that.

10 DR. MARK MILLER: But even absent the catastrophic  
11 discussion, the other nature of this discussion is, is we've  
12 got these two very different deductibles that exist in  
13 Medicare, 1,200 bucks and a couple hundred on the other  
14 side, and there's sort of that that formed some of this  
15 thinking, too. I mean, even if you didn't change the  
16 absolute dollar amount that anybody's facing under current  
17 law, is there some reason to discuss rationalizing, at  
18 least, who's hitting that?

19 MS. BEHROOZI: Yeah, but if somebody doesn't have  
20 a hospitalization during the year and they have to pay a  
21 combined deductible, they're going to face higher costs than  
22 they do now.

1 DR. MARK MILLER: Absolutely.

2 MS. BEHROOZI: I guess there was some rationale  
3 when the two different deductibles were put in place.

4 DR. MARK MILLER: I was trying to speak to your  
5 point for the person who faces the deductible, because the  
6 person who faces the A deductible is headed to the hospital  
7 and they have to incur that.

8 MR. HACKBARTH: Would you put Slide 12, the  
9 questions that you had posed for us? This is such a big and  
10 complicated topic. As we go through Round 2, if we can try  
11 to address ourselves to the questions, I think it will help  
12 us figure out how to get to the next step in this  
13 conversation.

14 Mitra, let me give you a chance, either now or at  
15 the end, if there are some things specific you want to say  
16 on these questions.

17 MS. BEHROOZI: I feel like a lot of what I said  
18 addressed a lot of the points. I think maybe -- I mean,  
19 yes, I think rationalizing cost-sharing is important, but  
20 how you do it matters. I've expressed some opinions about  
21 what I think is rational to me, anyway. Better financial  
22 protections, yes, on catastrophic. Some cost-sharing for

1 all services, yes, with, as I said, the option to avoid the  
2 costs by not -- well, sorry. I wonder how that's going to  
3 look in the transcript.

4 No. I guess the answer to that is no, I would  
5 like there to be some plan designs or networks or something  
6 where there is management as a substitute for cost-sharing  
7 in all cases.

8 DR. MARK MILLER: So that's the last bullet.

9 MS. BEHROOZI: Actually, that's three. That's the  
10 third bullet in the first section, set some cost-sharing for  
11 all services.

12 DR. MARK MILLER: No. You're saying you would  
13 prefer that the beneficiary, instead of that, have the  
14 ability to go into a set of providers that are more tightly  
15 managed and perhaps reduce their cost-sharing that way?

16 MS. BEHROOZI: Yeah, yes. I mean, provider or  
17 payer is what I think of doing the management, you know,  
18 like an MA plan I don't think of as a provider, but if  
19 you're including that in provider, then yes.

20 DR. MARK MILLER: I am.

21 MS. BEHROOZI: Okay. Then yes. I guess --

22 MR. HACKBARTH: What about the second major

1 bullet, should limits be placed on ability of supplemental  
2 coverage to cover all cost-sharing?

3 MS. BEHROOZI: That, I think, is related to what  
4 we were just saying, that there should be some types of plan  
5 designs that are allowed to use management instead of cost-  
6 sharing. I don't have the faith in cost-sharing that it  
7 always has to be present. So it's one or the other and you  
8 have to accept the management narrow network, or you face  
9 cost-sharing for all services except preventive services  
10 under the PPACA.

11 MR. HACKBARTH: Okay, thanks. Tom.

12 DR. DEAN: In general, I agree with most of the  
13 concerns that Mitra just raised. I'll be very brief. I was  
14 saying at lunchtime that I have really been struck how cost-  
15 sharing can really lead people to some, what I believe, are  
16 inappropriate decisions in that so often, I will recommend a  
17 service and the criteria for the decision is, does Medicare  
18 pay for it? Regardless of what, at least I see, the value  
19 of the service to be.

20 And coming from people who clearly have the  
21 resources. It's not an issue of them not being able to do  
22 it, but it just -- I'm troubled and, you know, it isn't all

1 the time, but I'm troubled how frequent -- it's almost a  
2 knee-jerk reaction. If it's covered, it's fine. If it's  
3 not covered, nope, can't do it.

4 So I think we need to be very careful about this.  
5 In theory, these things make a lot of sense, but on a  
6 practical level, they sometimes just don't bring about the  
7 decision-making we'd like.

8 MR. HACKBARTH: I'm not sure what the implication  
9 of that is. And so, does that mean there should never be  
10 cost-sharing or that there should always be cost-sharing?  
11 I'm not sure which way it should cut.

12 DR. DEAN: I'm as confused as you are.

13 [Laughter.]

14 MS. HANSEN: Before I get to the last page, I'd  
15 like to go back some more to Chart Number 6, or Page Number  
16 6, and it has to do with the -- I really like how it's  
17 arrayed relative to the A and B and the out-of-pocket and  
18 premiums relative to the income. I wonder whether we have  
19 the capacity with this to kind of separate out the different  
20 age cohorts, because this is an average of all 65 and older.

21 MS. LEE: Actually, average of all Medicare  
22 beneficiaries. It includes under 65.

1 MS. HANSEN: Includes under 65. So I wonder  
2 whether or not there's a break-out possible of the different  
3 segments or whether that's too complicated.

4 MS. LEE: It thins out each age cell pretty  
5 quickly.

6 MS. HANSEN: Right.

7 MS. LEE: So if we are adding, in addition to the  
8 three variables and then the overlaying age cohort on the  
9 top of that, then the sample becomes pretty thin

10 MS. HANSEN: It does? And I appreciate that that  
11 probably will occur. I'm thinking more kind of  
12 prospectively, that as the population continues to grow in  
13 those older age cohorts, for future purposes, I think the  
14 ability to track that -- because the income level is quite  
15 different for the average 85 and above to the 65 to 74  
16 population. And so, the percentage of out-of-pocket  
17 expenditure will be relative to those differences, even  
18 within each one of these silos.

19 The reason I think about that, that the benefit  
20 design side of it is that the cost-sharing side of it will  
21 be that much more significant for people whose income, net  
22 income, annual income is going to be lower over time, even

1 if they're only a -- if they're on the Medicare-only side.  
2 So at the moment it reflects possibly the younger  
3 population.

4           People who might not be able to afford  
5 supplemental insurance over time will fall into this  
6 category. So I think, again, the precious dollars that  
7 people have to spend to make choices will, you know,  
8 possibly be at greater risk just because in the meantime,  
9 right now even filing bankruptcies is highest in this older  
10 age group due to medical costs.

11           So going back to the last page here, I think this  
12 whole sense of rationalizing, all these concepts make total  
13 first-level sense on this. So I always use the income  
14 benchmark and I appreciate the extra chart, by the way, that  
15 the staff put -- the national chart that some of us have in  
16 color of the 12 United States groups. They show income as a  
17 factor of the country.

18           But going back to this point, I'd really like to  
19 jump back down to the last major bullet about incentivizing  
20 beneficiaries to see efficient providers. I definitely  
21 believe in that being a way, if we could shape behavior so  
22 that it's theoretically a win-win. My only concern is back

1 to an earlier conversation we had about quality improvement  
2 and the QIOs helping providers become more effective.

3           If there are not that many efficient providers at  
4 this point, there's going to be a limited opportunity to  
5 have places what you can be kind of guided towards. So I  
6 think it's both the behavior here, but the context of what  
7 you have to choose from as to whether or not, you know,  
8 there are physicians to choose or hospital systems that you  
9 can choose. Some communities may not have that choice right  
10 now.

11           MR. HACKBARTH: So Jennie, any thoughts on the  
12 issue of there being limits on the ability of supplemental  
13 coverage to cover all cost-sharing

14           MS. HANSEN: Back to that essential question, I'm  
15 leaning toward the fact of yes, there should be some limits  
16 to full cost-sharing entirely. I must say that that's  
17 asterisked by an article that I sent you all, an article  
18 that pointed out that even when there was no cost-sharing,  
19 sometimes beneficiaries won't get these free preventive  
20 services. So I don't know what that one tells us.

21           MR. HACKBARTH: This was the RAND study --

22           MS. HANSEN: The RAND study.

1 MR. HACKBARTH: -- that was recently published?

2 MS. HANSEN: Yeah. So I don't know whether then -  
3 - you know, my thinking that we should have some degree of  
4 cost-sharing, whether it's something nominal like a couple  
5 of dollars, just so that people are aware they're getting  
6 services, but that article certainly gave me a little bit  
7 more of a pause.

8 MR. HACKBARTH: Mike.

9 DR. CHERNEW: So, I'm going to try and be quick,  
10 not by saying a few things, just by saying it quickly. So  
11 first let me, my view of MA plans --

12 MR. HACKBARTH: You're off to a slow start.

13 DR. CHERNEW: I know.

14 [Laughter.]

15 DR. CHERNEW: My view of MA plans is they were  
16 traditionally the organization that avoided cost-sharing and  
17 tried to manage things through management and other tools.  
18 So having the fee-for-service system benefit designed  
19 juxtaposed against MA is the way you would allow people to  
20 say, I don't want to be managed through money; I want to be  
21 managed through these other tools.

22 In fact, now that we have ACOs and a bunch of

1 other things, there's even more opportunity to begin to do  
2 that. So that's sort of in response to Mitra's comments.  
3 As some of you may know, I spend a lot of time thinking  
4 about this in benefit design, and so in answering these, I  
5 think very clearly the most important thing is to  
6 rationalize cost-sharing, but I think that encompasses  
7 providing better financial protection to beneficiaries,  
8 setting some cost-sharing, not for all services, but at  
9 least for current services that we don't have.

10           So I think we should place limits on the ability  
11 of supplemental coverage to cover all cost-sharing, and I  
12 think that in general, I support using incentives to send  
13 Medicare beneficiaries to efficient providers, but remember,  
14 in a fixed-price world, you have to think about exactly the  
15 set up like the ACE demonstration is different than just  
16 saying, Oh, you're efficient, because the efficient ones are  
17 just getting paid the same amount. They don't have a lower  
18 price. We have to think that. So that's my sort of broad  
19 answer to these.

20           Regarding the general set of how -- so the real  
21 question is, what does rationalization mean, because we  
22 don't want to irrationalize cost-sharing. And so, I think

1 rationalization basically means we have to recognize some  
2 problems with cost-sharing, many of which have been  
3 mentioned.

4           One is, people don't do the right thing, (a) when  
5 it's free, and they do -- if you charge them more, they  
6 don't just cut out the bad things. They cut out the good  
7 things and you have to understand why. I was cited in the  
8 chapter, and I agree, too much cost-sharing can lead to  
9 disparities. With the chapter.

10           [Laughter.]

11           DR. CHERNEW: The chapter said it causes  
12 disparities. I agree with that. I'm glad that --

13           MR. GEORGE MILLER: And they quoted you.

14           DR. CHERNEW: Right.

15           [Laughter.]

16           DR. CHERNEW: So you have to worry about that. I  
17 also think -- it's going to just go longer.

18           [Laughter.]

19           DR. CHERNEW: I also think you have to worry about  
20 some other problems like adverse selection if you give  
21 people a lot of choices. So it's really -- that's not said  
22 much in the chapter. I think we have to worry about

1 cognitive problems. It's very easy to talk about how well  
2 the markets will work if we just make people pay, but if you  
3 look at some of the people that are deciding, there's all  
4 kinds of evidence that there's this sort of cognitive  
5 problem.

6           So the tightrope that I'm trying to walk is, I'm a  
7 big believer that we have to do a better job of designing  
8 the benefit package and allowing consumers to vote with  
9 their feet about what they want and to have incentives in  
10 the right place. But we can't do that with a blind notion  
11 that the markets are just going to work perfectly and people  
12 will just always do the right things. So it's a lot harder  
13 to rationalize.

14           I do think there are some places where we can do  
15 better than we're doing now, and so I think the bar should  
16 be, if we were to do this, is it better than it is now, and  
17 I think having some cost-sharing for a lot of current  
18 services would be better.

19           And I think -- so I have a few specific things  
20 about the employer stuff in the chapter that I just want to  
21 say. The first one is, there's a strange tone in places  
22 where sometimes it's sort of a lit review and sometimes it's

1 not quite a lit review. So, for example, there's a few  
2 things in the chapter that make it sound like there's not  
3 really a response to cost-sharing. And then there's the  
4 cite for this one Commission study that shows there's a huge  
5 potential financial gain if you have cost-sharing.

6           So the earlier stuff that was critiqued -- it's  
7 like the adverse selection potential and how those studies  
8 went, but it never really says how the study you did -- I  
9 believe and the chapter cites, which I agree with, that the  
10 RAND health insurance is a pretty good sense of what the  
11 elasticity estimates would be, and I think the chapter  
12 should go on noting that there will be behavioral changes if  
13 we charge people for stuff. We know loosely what the  
14 magnitudes might be, and some of those behavioral changes  
15 will be good and some of them will be bad.

16           I guess the last thing, I held back my Round 1  
17 question so I'm going to ask it loosely now, which is, you  
18 talked about the quality measures. So, what are the typical  
19 quality measures when they're doing these various types of  
20 programs like you say, some people go to high-performing?  
21 Are they typically process measures, the ones I've seen? I  
22 know you said there were some cost ones, but the other

1 quality ones, are they often process-type measures?

2 DR. SOKOLOVSKY: The cost -- well, I guess I'm not  
3 quite sure what you're asking. To get into it in the  
4 demonstration or the measures that they now have to report?

5 DR. CHERNEW: In the ACE demonstration, but also  
6 in all of the other work on efficient providers and how you  
7 would identify an efficient provider, which there was a lot  
8 of discussion in the chapter about.

9 DR. SOKOLOVSKY: Most of the discussion in the  
10 chapter comes from the interviews, and the way in which they  
11 identified efficient providers varied by employer. And  
12 again, sometimes it was totally on quality, sometimes it was  
13 totally on cost, and sometimes it was cost and quality.

14 DR. CHERNEW: But the quality measures that you  
15 used, I think, the ones that I'm familiar with, are  
16 generally process measures. They're like, did you get an  
17 eye exam if you have diabetes, or did you get a -- a lot of  
18 the HEDIS measures, they tend to be process measures.

19 The only reason I say that is, there's some  
20 language in the chapter that makes it sound like, Well, we  
21 can't figure out what high-value services, but I think in  
22 almost everything we have done, we can't identify all the

1 high-value services, but almost all the time when we use the  
2 word, this is high quality, they're efficient, we're  
3 actually using quality measures that are actually things  
4 that we want to encourage people to do.

5           And so, I think there are measures for -- not  
6 comprehensively, but I think there are measures that you  
7 could use for identifying what's high quality, and if you  
8 can identify low quality, what I think we typically see  
9 going on in the world is everybody's raising copays anyway.  
10 So instead of saying, We're going to raise copays extra for,  
11 pick some imaging service just to keep the theme of the day  
12 going through.

13           Instead of saying, We're going to pick this  
14 imaging service, instead, people will say, We're just going  
15 to raise copays 5 percent. So that's a way of raising  
16 copays to align incentives systematically even though you're  
17 going to get it wrong.

18           DR. SOKOLOVSKY: I think just -- and I'll need to  
19 make it clear in the chapter -- although there were  
20 differences in how you measured high value, there was a lot  
21 more consensus about that and it did turn on that.

22           DR. CHERNEW: Right.

1 DR. SOKOLOVSKY: It was the low value where it was  
2 much harder to get.

3 DR. CHERNEW: Right. To pick particular ones.

4 DR. SOKOLOVSKY: Yeah.

5 DR. CHERNEW: But oftentimes, the alternative is,  
6 All right, we can't pick particular ones. We want to  
7 protect the high-value ones, so we're going to raise it for  
8 everything that's not in the high-value bin.

9 DR. SOKOLOVSKY: Yes.

10 DR. CHERNEW: And that could allow you to hit  
11 whatever financial goal you want. And I guess the last  
12 cautionary thing I'll say is, I would be very wary of  
13 following the evaluation that employers do to tell you the  
14 impact of their programs, because I've seen too many cases  
15 where the employers tell you how wonderful it is for this,  
16 that, and the other thing. And then when I've actually seen  
17 the evaluations, it's not just, Oh, they didn't get the  
18 standard errors right. It's more that the basic message is  
19 just wrong. There's some discussion about, you know, the  
20 employer did this in their report.

21 And you were very good in the presentation to  
22 point out, with a lot of caution, and I do think it's

1 important, not just for, you know, Medicare, we randomize  
2 people into this and we do all this evaluation, but when the  
3 chapter is written, the employers report this. Sometimes,  
4 although you don't say it, sometimes it seems as if we're  
5 endorsing that was the effect. And I'm a little more  
6 cautious. Thank you.

7 MR. HACKBARTH: I want to just throw out one  
8 additional thought to give people an opportunity to react to  
9 it as we go around. Implicit in my mind, and I want to make  
10 it explicit and get people to react to it, is that when we  
11 talk about rationalizing cost-sharing, my goal is not to  
12 reduce Medicare outlays in the first instance. So I'm not  
13 trying to reduce the actuarial value of the benefit package.

14 My own personal view is that the actuarial value  
15 of Medicare's benefit package is already pretty skimpy, and  
16 unlike employers that may have a rich benefit package and  
17 they're starting to introduce cost-sharing just to get that  
18 first order reduction in costs, I don't think that's really  
19 appropriate in Medicare given how skimpy the benefit package  
20 is already.

21 So when I think about changing the cost-sharing  
22 structure, I'm more focused on, you know, the distributive

1   burden and allocating it in a way that makes more sense is  
2   fairer.  So that's one goal.

3                   And then in addition, when I think about the  
4   possibility of saying Medigap policies cannot fill in all  
5   cost-sharing, my goal, again, would not be to reduce the  
6   Medicare line in the budget, but perhaps by changing  
7   utilization patterns, free up dollars that can be used to  
8   enrich the benefit package elsewhere.  So that's just how  
9   I'm thinking about it.  I welcome people to agree or  
10  disagree with that, but I wanted to make that explicit and  
11  give people a chance --

12                   DR. CHERNEW:  [Off microphone.]

13                   MR. HACKBARTH:  Yes.

14                   MS. UCCELLO:  Briefly, I agree with your  
15  description of the rationalization.  I mean, that makes  
16  sense to me.  I think that's needed.  And also, catastrophic  
17  protection, I think, is something to pursue and I'll get  
18  back to it in a minute.

19                   With respect to setting cost-sharing for all  
20  services, and also, should we allow supplemental coverage to  
21  cover everything, it seems to me that if there are things  
22  that we think people shouldn't have to pay -- that are high

1 value, that are helpful to people that are steering them  
2 toward more effective use of care, that should be for  
3 everybody, not just the people with supplemental coverage.

4 So the supplemental coverage should not cover all  
5 cost-sharing. So I would put the things that we think are  
6 high value, cover all of it for everybody.

7 Going back, kind of building on something Mitra  
8 said about how to kind of fund the catastrophic, if we pay  
9 for it solely through the deductible, then it's just hitting  
10 the people who have spending. On Table 3, it says 40  
11 percent of beneficiaries have spending below \$500. So  
12 that's a pretty big share who probably aren't going to get  
13 hit by this.

14 If we somehow can build it into a premium, then  
15 it's spread across everybody. But my question then is, the  
16 premium is just for Part B. It seems like this would be the  
17 case, but is most of the reason that people have high costs  
18 due to the Part B services than the Part A? It seemed like  
19 that would be the case.

20 MR. HACKBARTH: So your question, Cori, is for  
21 those who have catastrophically high costs, what proportion  
22 would come from Part B services as opposed to Part A?

1 DR. MARK MILLER: Yeah. I would have -- question?  
2 Well, I gave you a little air cover. I mean, I would have  
3 thought that -- and I'm basing this on some of our  
4 conversations of what happens when you change the structure;  
5 that a lot of the people who are hitting the catastrophic  
6 cap are having hospitalizations.

7 MS. UCCELLO: I think they're having  
8 hospitalizations, but their out-of-pocket spending --

9 DR. MARK MILLER: Oh, I see what you're saying.

10 MS. UCCELLO: -- yeah. Where is their high out-  
11 of-pocket spending coming from? And that seems to be Part  
12 B, right? So that, I think, supports the funding of it from  
13 the Part B premium versus trying to find a way to have it  
14 funded by everything.

15 MR. HACKBARTH: I understand what you're saying,  
16 although funding it through the Part B premium means it's a  
17 flat amount regardless of -- well, not even -- you can't  
18 even say that anymore -- regardless of income. But it has a  
19 different distributive impact if you fund it through Part B  
20 premium as opposed as through the payroll tax.

21 MS. UCCELLO: Yes, yes, right. But it was just  
22 one other thing to think about, how to kind of spread that

1 around.

2 MR. HACKBARTH: Right. George, Round 2 comment?

3 MR. GEORGE MILLER: Yeah. I'm going to try to  
4 make this succinct, but I want to start with Michael's  
5 comment that we can do better than we are currently doing,  
6 and I want to quote him from the chapter concerning the  
7 issue about low-income beneficiaries, and I would imagine  
8 that would include dual eligibles are certainly price  
9 sensitive -- price sensitive for increasing costs and may  
10 contribute to health care disparities.

11 With that said, then looking at your discussion  
12 questions, I want to frame it around -- discussion around  
13 those two issues. I think Michael was quoted and he quoted  
14 himself when he said he agreed with the chapter.

15 The first issue is, as a first priority, should  
16 Medicare deal with costs, rationalize cost-sharing, and I  
17 would say yes. But again, I want to emphasize that I would  
18 be concerned about low-income and then dual eligibles from  
19 the price sensitive standpoint of that cost-sharing.

20 And it seems to me that the discussion about the  
21 demonstration project where you can align the incentive of  
22 all the providers and the beneficiaries in the cost-sharing

1 or gain-sharing would be a better approach, in the fact that  
2 even the beneficiaries get back, as the demonstration said,  
3 50 percent of their savings up to their annual Part B  
4 premium. I think that has some attraction and makes some  
5 sense.

6 I void that against Tom's comments that even those  
7 who could afford, if Medicare did not pay for it, they seem  
8 to not select that, and those, according to Tom, were folks  
9 who could afford to pay for it. Then you've got the issue  
10 of low-income and dual eligibles who would be faced with  
11 that same issue who can't afford to pay for it.

12 So for the most part, for the discussion, I can  
13 support the recommendations here, the short-term question  
14 issues that we're talking about. Yes, there should be some  
15 cost-sharing for all services with the caveat about low-  
16 income and dual eligible beneficiaries, as Jennie would  
17 certainly raise the issue.

18 And we certainly should incentivize beneficiaries  
19 to see efficient providers, but again, as Ron would ask,  
20 what's that definition, and make sure we can appropriately  
21 move folks into the most cost-efficient provider.

22 And I want to quote the New York example where --

1 I think it was last month, where minority beneficiaries were  
2 bypassing a better provider going to a low provider, and I  
3 wonder what the reason for that is, familiarity, if it was  
4 competencies or communication issues, that they felt more  
5 comfortable? And so, we need to explore those issues as  
6 well. Thank you.

7 MR. HACKBARTH: Ron.

8 DR. CASTELLANOS: Thank you. I live in the real  
9 world and I'd like to focus on the real world and that's the  
10 beneficiary.

11 MR. HACKBARTH: But you're in Washington now.

12 DR. CASTELLANOS: I'm not sure this is the real  
13 world, I've got to tell you. I'd like to focus a little bit  
14 on the real world of the beneficiary. You know, we're  
15 struggling ourselves to try to work out what is best. Now,  
16 my experience for Part D, where the patients had multiple  
17 decisions, they were just unable to make any clear decision  
18 themselves.

19 So if we're going to do something, we really need  
20 to look at it also from the beneficiary's perspective where  
21 they can understand. Now, what Tom was saying, and it's the  
22 same thing I say and I'm sure Karen will say, the consumer

1 or the beneficiary looks at cost. They really look at cost.  
2 Whether they have insurance or whether they have to come  
3 out-of-pocket or what, the ultimate decision is, What is it  
4 going to cost me, does insurance cover it, and is it worth  
5 me doing this?

6 As far as cost savings go, as far as cost-sharing  
7 goes, I think we really need -- based on the RAND study, and  
8 that's the only experience I have and what I read, that  
9 gives a good behavioral response, but we have to protect the  
10 low-income and the minority patient. And I think we can do  
11 that.

12 So I'm really for cost-sharing to encourage high  
13 quality procedures. I'm for it to try to prevent the  
14 unnecessary procedures. Catastrophic protection is  
15 extremely important. I see this every day in my practice  
16 where people go in bankruptcy.

17 In my community, 25 percent of the bankruptcies  
18 are due to health care. Now, some of these may not be  
19 Medicare patients, they may be private, but 25 percent of  
20 the bankruptcies in my community are related to health  
21 costs. So I think we do need to do something from a society  
22 viewpoint to help protect catastrophic problems.

1           Should Medicare incentivize beneficiaries to see  
2 more efficient providers? I mean, that's a no-brainer. Of  
3 course. But these have to be efficient providers that  
4 provide high-quality and low-cost care.

5           MR. HACKBARTH: Bob, just a note on the time. We  
6 are now just at the allotted time for this topic, so  
7 anything we do beyond this point we're taking out of future  
8 agenda items.

9           DR. BERENSON: All right. I'll try to be quick.  
10 Picking up on what Ron said, I think we need to provide  
11 better financial protection to beneficiaries and people  
12 should not go bankrupt because Medicare has an inadequate  
13 benefit package. Part of the goal then, in my view, is if  
14 we rationalize cost-sharing and provide a catastrophic  
15 coverage, that people won't feel the need to have to go buy  
16 what is not very efficiently provided, Medigap insurance,  
17 that people would be willing to actually pay the first-  
18 dollar cost-sharing without filling in with supplemental.

19           Whether we have to place limits on the ability to  
20 supplemental, I guess I would like to not go there unless I  
21 was convinced that that had to be done in order to prevent  
22 the costs to the program from first-dollar coverage. So I

1 would hope we could improve the benefit package such that  
2 people wouldn't feel the need to do that. But I would  
3 consider that. I'm intrigued by the idea of an excise tax,  
4 also, as an alternative.

5 I guess the final piece on, set some cost-sharing  
6 for all services, I would say set some cost-sharing for all  
7 benefit categories. I mean, we shouldn't have these  
8 anomalies for home health and hospice on the one hand, and  
9 then after a certain number of days, for SNF it's very  
10 large. Within benefit categories, then we should try to see  
11 if value-based models can work.

12 There might be particular services within a  
13 benefit category that we have such confidence is high value,  
14 like prevention we've done, that you would waive cost-  
15 sharing for those particular ones. I think we're way off  
16 from being able to, with any granularity, identify services  
17 that are high value or low value. Home health is usually  
18 high value and sometimes it's low value.

19 So I think we do have to rely, to some extent, on  
20 pruder approaches that sort of rely on the individual to  
21 make the choices. But to the extent that we can move in  
22 that direction, we should, and we should also try to

1     incentivize beneficiaries to see efficient providers.

2             DR. KANE: I think the readings made me just think  
3     that rationalizing cost-sharing is an incredible difficult  
4     thing to do because the rationale for appropriateness is  
5     specific to the individual and not the service. I just  
6     think that's -- you know, that's just a long road. Maybe we  
7     can get there someday, kind of like finding the perfect  
8     price, but I think it would be more useful to put our  
9     energies into something that has a quicker payoff.

10            I certainly think that better financial protection  
11    to beneficiaries is incredibly attractive, and I agree with  
12    Bob. I think if we had that, maybe people would stop buying  
13    inefficient Medigap policies or would 20 percent go for just  
14    the marketing expense?

15            I think maybe the other -- and that's one reason,  
16    actually, the whole idea of putting it into Part B is not a  
17    bad one because then people get that coverage and then they  
18    don't have to pay the 20 percent for the marketing if they  
19    think that's enough. If the reason that people are buying  
20    Medigap now is to get that financial protection of that from  
21    out-of-pocket costs.

22            So I just think that really focusing on the

1 financial protection, minimizing the catastrophic potential  
2 is really worth spending time on. The other cost-sharing  
3 pieces, I just think there's too much -- it's too specific  
4 to the beneficiary in their situation for any broad policy  
5 to be made at the Medicare national level.

6           And if we can't put the better financial  
7 protection into the Part B premium, which I know has all  
8 kinds of issues now since only a few people are paying any  
9 increase in that, the other way to think about it is to say,  
10 Let's tie getting an out-of-pocket cap to joining an ACO or  
11 a medical home, thereby pushing people into that bottom  
12 category should Medicare incentivize beneficiaries. Yeah,  
13 let's incentivize into going to medical homes and ACOs and  
14 behave themselves within that context and, you know, try to  
15 stay -- play the game that we're trying to get the providers  
16 to play.

17           And in return, they get out-of-pocket limits,  
18 which is kind of what managed care does. I mean, first of  
19 all, they have to have an out-of-pocket limit. I think I  
20 heard that 3,000 was kind of what most of them were at --  
21 maybe I didn't hear that because I'm deaf in one ear, but  
22 anyway, 6,700, whatever it is, you know, they're doing that

1 in managed care now.

2           So it sounds like it's doable to have an out-of-  
3 pocket limit, but people have to accept some level of  
4 responsibility to be in a more efficient network and not go  
5 crazy, you know, seeing a specialist every time their nose  
6 itches.

7           So I would say take the financial protection and  
8 tie it to going into medical home, ACO, and then the other  
9 stuff will fall into place much more than if we spend  
10 hundreds of hours trying to figure out how to structure  
11 high-value cost-sharing which I think is really, really  
12 tough, and the private sector, obviously, hasn't figured it  
13 out yet and they've been experimenting with it for a long  
14 time.

15           MR. BUTLER: Said less elegantly, but more  
16 efficiently. I think I agree with most of the consensus of  
17 the group and that is, rationalization of cost-sharing, I  
18 think particularly if you look in the transcript as you  
19 described it, Glenn, is good. The financial protection as  
20 Bob described it, I think, is good, and others. The cost-  
21 sharing shouldn't be across every service. Of course, we  
22 want to have some limits on supplemental coverage.

1 Otherwise, we're not really changing much because 90 percent  
2 of the people have supplemental coverage.

3           Where I may differ is on incentivizing on  
4 inefficient providers. I think at the ACO or the Medicare  
5 Advantage, as stated by Nancy, yes, I think it's just a  
6 question of prioritization, and I think if we do a bunch of  
7 coronary artery bypasses and things like that, you just  
8 don't get very far very fast with a lot of effort.

9           The overall should be on the basic structure of  
10 how you do the copays, deductibles, et cetera, and probably  
11 less initial prioritization on steering to specific  
12 providers for specific services, which can be pretty labor-  
13 intensive without the yield, except for a pilot in Ft. Myers  
14 for a knee replacement.

15           DR. STUART: I'll go along with that. I obviously  
16 agree very broadly with what's been said here. I'm a little  
17 more optimistic than Nancy about being able to devise value-  
18 based designs that are going to, on average, do us well.  
19 It's true that every service can have different impacts on  
20 different patients. What we don't know is just how broad  
21 that heterogeneity is, and I think it's probably overstated  
22 in many cases. So I'd still like to go down that line.

1           I'd also like to point out one thing, that we're a  
2 little inconsistent in terms of incentivizing beneficiaries  
3 to see efficient providers. Everybody says that that's a  
4 no-brainer, but remember, when we looked at the overpayment  
5 of MA plans, we said, Well, it costs 117 percent of what the  
6 fee-for-service costs in MA plans. Well, another way to  
7 think about that is while we're incentivizing beneficiaries  
8 to choose these managed care plans and then, as Mike said,  
9 well, then they're subject to this management.

10           So I think we have to be a little careful about  
11 being consistent in our message here, and particularly when  
12 we've got these new programs coming online with ACOs and  
13 medical homes. We might end up in the same place that we  
14 ended up with this MA overpayment issue. So we need to know  
15 what we're getting when we do the incentivizing.

16           MR. HACKBARTH: On this issue of rewarding  
17 beneficiaries for going to efficient providers, keep in mind  
18 that the model of ACO in the proposed rule, the model of  
19 medical home that's being used in demonstration,  
20 beneficiaries retain their freedom of choice.

21           So they're not locking themselves into an  
22 efficient delivery system for which you can say, Oh, there's

1 a lower cost. Some are going of the use it exclusively,  
2 some are going to go in and out, so we're sort of combining  
3 insurance concepts with care delivery concepts in a way that  
4 doesn't entirely match up. Kate.

5 DR. BAICKER: I think setting cost-sharing for  
6 some or all services is clearly subsumed within  
7 rationalizing cost-sharing, and in some ways, part of  
8 incentivizing beneficiaries to see efficient providers is as  
9 well. On the cost dimension, if the cost-sharing is  
10 rationalized, that pushes people towards lower cost  
11 conditioned on value. People need ways to be able to  
12 evaluate quality and you may need to juice that a bit to  
13 drive people not just based on cost, but based on a trade-  
14 off of cost and quality.

15 I think it all goes back, in some ways, to  
16 providing better financial protections, because I think the  
17 real draw to the Medigap plans that undermine the cost-  
18 sharing is that they provide these backstops that the main  
19 benefit really should provide. It's hard for me to  
20 understand why we would have a main Medicare benefit that  
21 does not have catastrophic backstops.

22 So if you fix that, then it would be less of a

1 blow to amend the Medigap policies because you would already  
2 have that backstop. I would urge us to remember that  
3 financial protection in all of the discussions.

4           When I look at Table 6, which I think was on Slide  
5 7, looking at how beneficiaries would be better or worse off  
6 in terms of out-of-pocket plans -- in terms of out-of-pocket  
7 spending, if they were in a plan with a catastrophic  
8 backstop, that's ignoring, in some sense -- there's nothing  
9 wrong with this, but I'd like to layer on the fact that  
10 they're also getting a benefit of the catastrophic backstop  
11 even if they don't end up using it.

12           So even though most beneficiaries don't end up  
13 hitting the catastrophic backstop, that doesn't mean it  
14 wasn't of value to them. And so, you want to take that into  
15 account. You may look a little worse off in terms of out-  
16 of-pocket spending this year, but it could have been a  
17 disaster and you were protected from that. So let's build  
18 that into whether people are worse off or not when thinking  
19 about the effect of moving from one plan to the other.

20           DR. MARK MILLER: To your insurance value point  
21 from --

22           DR. BAICKER: Yeah. I'm a one-trick pony.

1 DR. MARK MILLER: No, I didn't mean that.

2 [Laughter.]

3 MR. ARMSTRONG: But I think it's a really good  
4 point.

5 DR. BAICKER: If you're only going to have one  
6 joke.

7 MR. ARMSTRONG: We want to have a good one.

8 First, just a few points. First, I think this is  
9 really a very important topic for MedPAC to be focusing its  
10 attention on and I'm glad that this is -- we're basically  
11 affirming that we're going to be going forward with this  
12 work in the year ahead.

13 In particular, we have acknowledged in a couple of  
14 our last meetings that we really want to complement all the  
15 time we spend looking at payment policy to providers with  
16 policy around incentives directly to the beneficiaries, and  
17 I think the value of our products will be much enhanced if  
18 we're really looking at both levels and really thinking  
19 about this at both levels.

20 I also have to admit, the more I learn about the  
21 benefits in this fee-for-service plan, I am amazed more  
22 people don't join Medicare Advantage plans, and the fact

1 that 90 percent of people in fee-for-service feel compelled  
2 to either buy a Medigap plan or benefit from the plan  
3 through their employer, to me, says we really need to be  
4 looking at these benefits as this is proposed that we do.

5           If you look at Slide 12, the questions, I would  
6 agree we should be looking at the various ways in which  
7 we've talked about rationalizing cost-sharing. You know,  
8 one point I would make, though, is that I think there are  
9 some services where there should not be cost-sharing for,  
10 whether it's prevention or generic drugs or any visits that  
11 are scheduled visits for patients with chronic illness.

12           So I assume that that's really what we mean, that  
13 we wouldn't necessarily cost share for everything, but we  
14 would rationalize that. And then in particular, I also  
15 would agree that there are powerful opportunities for us to  
16 look at, incentives to change, through cost-sharing, the  
17 behavior of patients relative to different kinds of  
18 providers: Higher cost shares for specialists, lower for  
19 primary care, or even different networks.

20           And then finally, I live in a world where it's  
21 really not an insurance product if there isn't a cap on out-  
22 of-pocket costs, and that Medicare Advantage plans that we

1 have, have \$3,000 out-of-pocket limits, and so we just  
2 really have to be talking about that.

3 DR. BORMAN: As I listen to the conversation, I  
4 think I see us having something of a problem of dichotomous  
5 thinking about this a little bit. In one respect, a lot of  
6 what we talk about is sort of at a strategic, plan-wide,  
7 somewhat depersonalized level in terms of population  
8 behaviors and that sort of thing.

9 But then at times, we all find ourselves thinking  
10 about that favorite geriatric relative that we know, some  
11 descriptive clinical circumstance for those of us that are  
12 health care providers, or whatever, and we come down to the  
13 individual and we can't, at the end, make policy that serves  
14 both perfectly.

15 And, Glenn, I support what you've said about  
16 removing this conversation from the background monetary  
17 issues, although at the end of the day, I think we have to  
18 remain cognizant that whatever we set up may, in fact,  
19 ratchet back as we try to deal with our national fiscal  
20 plight, but that's not the work of this Commission.

21 So I think that we have a couple of confounding  
22 factors, one of which is that the value to any given

1 individual of a health care service changes over time  
2 depending on what you're sick with when. And so, it's not a  
3 static thing to which we can say, This has value forever, I  
4 don't think. I don't find that my patients can do that, and  
5 I think that's partly the message you've heard from Tom's  
6 conversation with his patients.

7           And I think that in my view, and it's a biologic  
8 population, so it's not like managing widgets and there will  
9 always be some funny outliers, there will unpredictable  
10 things in terms of the evolution of disease and treatment  
11 that we just can't control and not all of our patients'  
12 illnesses are controllable and modifiable by them.

13           And so, we have a dichotomous population. Some  
14 have illnesses that they could have impacted, and we should  
15 incentivize their ability to impact, but some people have  
16 things happen to them that were absolutely outside their  
17 control, and to manage all that in one system is very  
18 difficult. So to get this down to crisp up, where can we  
19 rationally go with this?

20           I would just say a couple of things. Number one,  
21 I'm not sure that I'm smart enough, or any group is smart  
22 enough to say, This is clearly high value for the next 50

1 years for everybody. I personally would try and move that  
2 instead into an arena where there's perhaps some cost-  
3 sharing, albeit small, for everything, because you as the  
4 individual in the end have to make a value judgment about  
5 your situation over the time frame that you can predict.  
6 And maybe some small level that relates to everything, in  
7 the end, may be the most fair. I don't know.

8 I think in terms of ability of supplemental  
9 coverage to cover everything, I think yes, to a point. If I  
10 have the means and want to buy the Cadillac supplemental  
11 coverage, if I still view that I need it after we fix the  
12 background, I should still have that ability to do that.  
13 You can make it be a huge premium with some kind of extra  
14 tax on it or something, but I don't think that should go  
15 away if you can afford it and if you judge that you want to  
16 have it.

17 I think not to do that is an unfair thing to do.  
18 And we're already sort of getting into the equity business  
19 in the program by virtue of the unearned income tax that's  
20 in the Affordable Care Act by the fact that we have the  
21 premium tiering relating to when you got in the program and  
22 your income. So there's sort of already things happening in

1 that regard, and so I do think we shouldn't totally take  
2 away somebody's ability to buy that protection if indeed  
3 they want to buy it.

4 In terms of incentivizing beneficiaries to see  
5 efficient providers, I think in theory, it's a no-brainer,  
6 as has been said. I think the devil is in the details about  
7 what's efficient and what's appropriate, as Ron is  
8 constantly reminding us, a propriety here. And I think it's  
9 yes but, and I think we're a long way from knowing what that  
10 definition is.

11 MR. HACKBARTH: This is a really difficult,  
12 complex subject to deal with and it's sort of multi-  
13 dimensional, so we'll need to think real hard about how to  
14 structure our next conversation. We're sort of up at a very  
15 abstract level trying to wrestle with it, and I think it may  
16 be good if the next time we talk about it we can have some  
17 more concrete alternatives as a way of just sort of getting  
18 people to react, I like this, don't like that. So we'll  
19 think about that.

20 Even though it's a difficult conversation, a  
21 complex issue to deal with, I think it is very important  
22 that we wrestle with it for the reasons that Scott was

1 saying. The country has a really serious problem with the  
2 budget in general, with Medicare costs in particular, and  
3 the problem gets bigger as time goes on.

4           And so, in dealing with that, we need to use all  
5 available tools and opportunities. We spend a lot of time  
6 talking about the right updates and putting pressure on unit  
7 prices. I think that's part of what we need to do. The  
8 conversation we're going to have in just a few minutes is  
9 about getting relative values right and getting the signals  
10 that we send to be more accurate than they are now. That's  
11 also part of the solution.

12           And part of it is also new payment methods, ACOs,  
13 medical homes, that change the incentives for care delivery.  
14 But the fourth part, I think, of the solution, as it were,  
15 needs to be, how can we fairly, appropriately bring  
16 beneficiaries into the effort to make the system more  
17 efficient. And if we just work on the payment side of it  
18 and ignore the beneficiaries, I don't think we're doing the  
19 best job that we can, and I don't think we will be as  
20 successful.

21           Now, it is very tricky, for all the reasons that  
22 have been discussed today, to figure out how to engage

1 beneficiaries constructively in seeking out lower cost, high  
2 value care, but it's a well-placed effort, I think. Thank  
3 you all, and obviously more on this in the future.

4           So our next topic is improving the accuracy of  
5 payments to physicians and other health professionals. So,  
6 Kevin, are you leading the way?

7           DR. HAYES: Yes. Our topic, as you said, Glenn,  
8 is improving the accuracy of payments to physicians and  
9 other health professionals. It is a follow-up to a session  
10 you had at your meeting last October. Since then, we have  
11 worked with two contractors and have developed the issue  
12 further for your discussion today and for the June report.

13           As you know, the payment system for these services  
14 is Medicare's Physician Fee Schedule. It replaced a payment  
15 system that was based on charges and one believed to be  
16 inflationary and inequitable. The fee schedule is designed  
17 to account for differences among services and use of three  
18 types of resources: The work of the practitioner, practice  
19 expense, and professional liability insurance.

20           Commissioners have expressed concerns about this  
21 payment system. One is that it is vulnerable to mispricing,  
22 and two, it does not account for the relative effects of

1 different services on clinical outcomes. On this latter  
2 point, you asked us to do some research and ask private  
3 plans, integrated delivery systems, and others whether they  
4 have developed innovative approaches to paying for  
5 practitioner services, approaches that could be considered  
6 for Medicare.

7           So the way we have organized this presentation is  
8 that, first, Ariel will describe our work with a contractor  
9 on payment innovations. Then we will switch to mispricing  
10 and I will describe work by another contractor and some  
11 options you may wish to consider on that topic.

12           Ariel?

13           MR. WINTER: So as Kevin said, we contracted with  
14 the University of Minnesota to examine alternative  
15 approaches to valuing physician services being used by  
16 health plans, integrated delivery systems, and medical  
17 groups. The findings from this contract may help inform the  
18 Commission's work in improving the Physician Fee Schedule.

19           The contractor conducted structured interviews  
20 with leaders of 24 organizations. Fifteen were selected  
21 from across the United States and nine were from the  
22 Minneapolis-St. Paul market, and the researchers focused on

1 this market because there is significant experimentation  
2 with new payment mechanisms going on there. Because the  
3 organizations in the study were not randomly selected, the  
4 payment methods that they used do not necessarily reflect  
5 the prevalence of these approaches nationally.

6           So this slide summarizes the key findings from the  
7 interviews with the 15 organizations from across the United  
8 States. The most common physician compensation model within  
9 provider groups is based on the number of Medicare work RVUs  
10 provided by physicians combined with a target compensation  
11 amount. This target amount is usually linked to  
12 compensation for physicians in the same market and  
13 specialty. A small share of physician compensation is  
14 usually based on quality metrics, such as patient  
15 satisfaction, process measures, and outcome measures. Non-  
16 physician practitioners are generally paid on a salary  
17 basis.

18           The contractor did not find evidence that plans or  
19 providers have developed alternative approaches to valuing  
20 individual physician services, such as basing the relative  
21 weight of a service on its clinical value for patients.  
22 However, there are examples of collaborative efforts between

1 plans and provider groups to test innovative arrangements,  
2 such as medical homes, shared savings models, and pay-for-  
3 performance. Some of these efforts have been in existence  
4 for several years, whereas others are still in the  
5 discussion phase or in a pilot phase.

6 The motivation for these experiments is  
7 dissatisfaction with the fee-for-service payment system and  
8 a desire by health care providers to get an experience with  
9 ACO models that may become more prevalent in the future.

10 This slide is the key findings from the interviews  
11 with the organizations in the Minneapolis-St. Paul market.  
12 All of the plans and most of the integrated delivery systems  
13 in this market are developing or have implemented shared  
14 savings arrangements. In these models, the delivery system  
15 shares with the plan in the overall savings they can achieve  
16 for their patients relative to a negotiated target, assuming  
17 that quality goals are met. These approaches are based on  
18 total cost of care. In other words, they cover both  
19 physician and hospital spending.

20 The interview respondents identified patient  
21 attribution and data sharing between plans and providers as  
22 key issues. The high level of patient loyalty to specific

1 delivery systems in this market made it easier to attribute  
2 patients.

3           There are several factors that have contributed to  
4 the high level of innovation in this market. There is the  
5 history of collaboration among plans and providers in  
6 quality measurement and improvement. There is the presence  
7 of large integrated delivery systems. And there has also  
8 been encouragement and support from the public sector and a  
9 large organized employer group.

10           Because the shared savings contracts are still in  
11 their infancy, respondents were not yet able to share much  
12 empirical evidence about their effectiveness, and now I'll  
13 turn things back over to Kevin.

14           DR. HAYES: All right, and we will continue now  
15 with some issues having to do with mispricing. And we note  
16 here that CMS is planning to validate the fee schedule's  
17 relative value units.

18           The history on this is that, first, there have  
19 been concerns about the process for establishing relative  
20 values in the Fee Schedule. In 2006, for example, the  
21 Commission made a series of recommendations for improving  
22 the valuation process. In addition, contract research for

1 CMS and the Assistant Secretary for Planning and Evaluation  
2 has raised questions about the accuracy of the fee  
3 schedule's relative values. They depend on estimates of the  
4 amount of time that a practitioner typically spends when  
5 furnishing each service, and the research has shown that  
6 some of the estimates are likely too high.

7           And, as Ariel discussed this morning, there's  
8 GAO's results on efficiencies that arise when multiple  
9 services are furnished during a single encounter. Those  
10 results have implications for the pricing of services  
11 generally, but for the time estimates, too.

12           So there is evidence of mispricing and concerns  
13 about the time estimates in particular.

14           The validation process that CMS is now planning  
15 could be a step toward addressing these concerns. It would  
16 fulfill a requirement in the Patient Protection and  
17 Affordable Care Act. The law requires the Secretary to  
18 establish a process to include a sampling of services that  
19 meet criteria, criteria such as rapid volume growth, and  
20 criteria that services are potentially misvalued.

21           As part of the validation process, the law gives  
22 the Secretary the authority to make appropriate adjustments

1 to the RVUs for practitioner work. CMS sees validation of  
2 RVUs as a new requirement and one that would complement the  
3 ongoing efforts of the RUC.

4 As discussed at the October meeting, the fee  
5 schedule's time estimates are very important in determining  
6 RVUs. Depending on the type of service, the estimates  
7 explain from 72 percent to 90 percent of variation in the  
8 RVUs for practitioner work.

9 If the goal is to ensure the accuracy of these  
10 RVUs, it seems fair to say that it is necessary to ensure  
11 the accuracy of the time estimates. The estimates have  
12 their origins primarily in surveys conducted by physician  
13 specialty societies. The Commission's concern has been that  
14 the specialty societies and their members have a financial  
15 stake in the process.

16 To consider options for validating the fee  
17 schedule's time estimates and collecting objective time  
18 data, the Commission contracted with RTI International for a  
19 study to address two topics: One, are time data currently  
20 available from accessible sources; and two, what is the  
21 feasibility of collecting time data from practices and other  
22 facilities where practitioners work.

1           The project is continuing, but the primary  
2 findings are, one, with surgical services as a possible  
3 exception, we have not yet found sources of readily  
4 available data for this purpose.

5           Two, it appears that a data collection activity  
6 dedicated to collecting time data will be necessary. For  
7 that, the contractor is conducting interviews with  
8 representatives of integrated delivery systems and multi-  
9 specialty group practices. From what we have learned so  
10 far, time data exists within practices, but some assembly of  
11 data from different systems will be required. For example,  
12 time per service could come from electronic health records  
13 and from patient scheduling systems. Then it would be  
14 necessary to integrate these data with billing codes.  
15 However, billing codes may need to come from another system,  
16 the billing system. This issue of billing codes is  
17 important because the fee schedule's time estimates are  
18 specific to each code.

19           As you can see, collecting objective time data  
20 would require an organized effort. Voluntary surveys are  
21 one option. The problem with surveys, though, for a purpose  
22 such as this is that, historically, they have had low

1 response rates. Response rates of 20 percent or less are  
2 not uncommon.

3           Alternatively, participation could be mandatory  
4 for all, not unlike the cost reports submitted by  
5 institutional providers. While mandatory participation  
6 would overcome the problem of low response, it would require  
7 a change in regulation. In addition, the administrative  
8 burden on practitioners could be a problem, depending on the  
9 level of detail required.

10           To avoid the difficulties of voluntary surveys and  
11 mandatory cost reports, a different approach could be for  
12 CMS to collect data on a recurring basis from a cohort of  
13 practices and other facilities where practitioners work.  
14 Participation would be required among those selected. The  
15 cohort would be representative of all specialties and types  
16 of practitioners. However, the data collection could target  
17 specific types of practices, such as those that are more  
18 efficient than others. Clearly, such an activity would put  
19 demands on resources, both at CMS and practices  
20 participating.

21           Collecting data from a cohort of practices would  
22 present a number of issues. We list some of them here.

1 What number of participants would be required? Would it be  
2 necessary to compensate practices, and so on.

3 But let me draw your attention to the last two  
4 items on this list, the levels of data collection and  
5 estimation of time per service. With levels of data  
6 collection, there's a question of whether to collect time  
7 data at the level of each billing code or whether it's  
8 sufficient to collect the data at the level of the  
9 practitioner. It's a kind of trade-off. Collecting data at  
10 the level of the billing code has its advantages, but the  
11 difficulty is that it would put the heaviest demands on  
12 practices in terms of having to integrate data from multiple  
13 systems, their electronic health records, billing systems,  
14 and so on.

15 Alternatively, the data could be collected at the  
16 level of the practitioner. Here, the data collected would  
17 be limited to the volume of services by billing code for  
18 some interval, say a week, and the practitioner's total  
19 hours worked during that time period. Clearly, collecting  
20 practitioner-level data could reduce the burden for  
21 practices. However, it would then be necessary to conduct a  
22 statistical analysis of the data to answer questions about

1 the validity of the current time estimates and perhaps to  
2 develop new estimates. So these are some of the issues you  
3 might want to consider on this.

4 And that concludes our presentation. We look  
5 forward to your discussion of the points raised, in  
6 particular, your comments on the alterative approaches to  
7 valuing practitioner services, the ones that Ariel  
8 presented, and also your thoughts on next steps on  
9 validating time data. Thank you.

10 MR. HACKBARTH: All right. Let's see, round one  
11 clarifying questions. I can't remember. I think we're on  
12 your side this time, Karen.

13 DR. BORMAN: Could you just reconfirm for me that  
14 time, in addition to being the driver here, remains a  
15 significant number in generating the practice expense value,  
16 as well?

17 DR. HAYES: Yes, it does. It's -- there are two  
18 distinctions. There are two types of costs identified for  
19 purposes of practice expense. There are the direct costs  
20 associated with -- that are directly attributable to a  
21 service, things like staff and equipment use for a  
22 particular service. But then there is a category called

1 indirect costs, and so these would be the kinds of costs  
2 that are not readily identifiable as due to furnishing a  
3 specific service. This would be stuff like rent, reception,  
4 and all that kind of activity. And so it's with the  
5 indirects that the time data become important, because it's  
6 partly a function of the work RVUs, so it's kind of  
7 indirectly a function of the time estimates, but also in  
8 terms of the allocation of time of practice costs by  
9 physician specialty is also contingent on time.

10 DR. BORMAN: But also, for example, in the  
11 estimate of clinical staff time, for example, also often  
12 goes back to the physician time plus some increment, so it  
13 also factors into the direct expense if I recall correctly.  
14 So is that -- that's all captured in indirect, including  
15 clinical staff, clinical labor?

16 MR. WINTER: The non-physician clinical labor is  
17 part of the direct practice expense --

18 DR. BORMAN: Right, the direct. That's what I  
19 said. So it's in the direct --

20 MR. WINTER: It's in the direct, right.

21 DR. BORMAN: It impacts --

22 MR. WINTER: That's the non-physician clinical

1 staff time.

2 DR. BORMAN: Right. Okay. So it's important for  
3 a lot of reasons in addition -- [Off microphone.]

4 MR. BUTLER: So we're seeking a solution to what  
5 is an ill-defined problem, in my head a little bit. Why are  
6 we worried about accurate prices? Is it a little bit of  
7 the, do we want to make sure that there is the right supply  
8 available, which could be a longer-term question of making  
9 sure that certain specialties are reimbursed the right way.  
10 Is it a shorter-term, we are doing too much of one thing and  
11 not enough of another in the prices? Or are we just trying  
12 to make sure that the costs, the prices reflect the costs of  
13 providing the service? I'm just -- you know, a little bit  
14 more help on the definition of the problem that we're trying  
15 to solve here in the short run.

16 DR. HAYES: Sure, and it's, to an extent, kind of  
17 all of the above. I mean, the concern about pricing has to  
18 do partly with its effects perhaps on the volume of  
19 services, and the Commission has said that rapid growth in  
20 volume of services could be attributable, at least in part,  
21 to mispricing of services. So that's one consideration.

22 But also in discussions about the future of the

1 practitioner workforce, there's also been a connection made  
2 to the implications of mispricing for that, for what you  
3 might call the passive devaluation of some services.  
4 Services such as, we'll say, evaluation and management  
5 services are not so amenable to changes in the amount of  
6 time required because of technological advances and so on,  
7 whereas other services would be more subject to innovations,  
8 technological advances that might reduce the amount of time  
9 required.

10           So to the extent that those two problems, those  
11 two kind of categories of services are split, one specialty  
12 versus another, you could then see some skewing of  
13 incentives or compensation and so on. And so, as I say, it  
14 comes down to an issue of workforce over the longer term.

15           MR. HACKBARTH: I don't disagree with anything  
16 that Kevin said, but I want to add to it. I think this is a  
17 really important question that Peter has asked.

18           So our method of paying physicians now is based on  
19 the concept of a resource-based relative value scale, so  
20 what we're trying to do is estimate the resources that go  
21 into producing individual services and match our payments as  
22 best we can to the resources required to produce the

1 services, and the resources are practice expense and  
2 professional liability and the work involved by the  
3 physician or other practitioner.

4           But the concept is match payments, the prices for  
5 services to the cost of producing the services. As we've  
6 often noted in our discussions here, that's not the only way  
7 you may think about how to determine the appropriate price  
8 for services. In fact, in competitive markets, other things  
9 come into play, like shortages of supply and prices adjust  
10 to attract new people or new entrants into a marketplace.  
11 So you could imagine that even if our prices exactly match  
12 input costs for different services, that you want to  
13 introduce on another vector, another plain, considerations  
14 of supply. Still another possibility is the value of the  
15 service to the individual patient or to the broader hospital  
16 system, and we often talk about primary care as being  
17 particularly valuable.

18           Those last two sets of considerations, supply and  
19 value, are external to the physician payment system that we  
20 use, the resource-based relative value scale. This  
21 conversation is primarily focused on how can we better do  
22 estimates to calculate the relative values. There are other

1 conversations that we have that more directly attack the  
2 issues of supply and value. But it's important to keep them  
3 straight, which we're talking about at any given point in  
4 time.

5           Now, I agree with what Kevin said. If you don't  
6 have the prices well matched to the cost of production, you  
7 can create incentives for either over-production or under-  
8 production, or in the long run, you can affect the decisions  
9 of new physicians, whether to go into a specialty or not.  
10 Those are sort of second-order effects of mismatching prices  
11 to resource costs.

12           MR. BUTLER: [Off microphone.] So are you saying  
13 we're focusing on improvement in the RVUs primarily, right?

14           MR. HACKBARTH: [Off microphone.]

15           MR. BUTLER: Which may have relatively little to  
16 do, ultimately, with pricing. It could have little to do.

17           MR. HACKBARTH: [Off microphone.] In a subsequent  
18 conversation, we could, and, in fact --

19           [Fire alarm sounding.]

20           MR. HACKBARTH: I guess that means the emergency  
21 is over. The fire department is very efficient. They come  
22 and douse the flames.

1 [Laughter.]

2 MR. HACKBARTH: So let me stop, and Bob, I know  
3 you've got thoughts on this.

4 DR. BERENSON: Yes. No, I agree with what Glenn  
5 said, but I think it's going to take us a much longer time  
6 to work through issues around how does setting prices affect  
7 supply decisions, you know, career decisions that medical  
8 students and residents make or find a consensus about what  
9 services are undervalued in the sense of what beneficiaries  
10 would benefit from.

11 So I think this drill is about getting prices  
12 closer to the resource costs. I mean, I agree with Nancy.  
13 We can't get it perfect. But this is a narrower drill, that  
14 there are distortions that currently exist such that -- I'll  
15 just quote a medical group administrator I interviewed last  
16 year who said that, "You're telling me that under the RBRVS  
17 that a full-time orthopedist working full out is getting  
18 16,000 work RVUs and a full-time family physician working  
19 full out is getting 7,000 RVUs. I have trouble managing a  
20 medical group with those kinds of variations."

21 And I guess the final point I make is until we  
22 have a different way of doing it, the inputs to bundled

1 payments or even to some extent the capitated or global  
2 payments, the building blocks are these relative values and  
3 DRG values, et cetera. So it just -- I mean, so there's a  
4 lot of reasons it affects the mix of services that  
5 beneficiaries get and probably the dynamics in the system  
6 and career decisions, although we have much less grounds for  
7 that, I guess is what I'd say.

8 MR. HACKBARTH: [Off microphone.] Round one  
9 clarifying questions?

10 DR. KANE: Yes, just a quick one. I read through  
11 it quickly and I'm not sure I picked up. Are we  
12 considering, when we want to look at time per HCPC or  
13 whatever, are we talking about the average time or the  
14 efficient time, and have we tried to alter the way we pick?  
15 If we end up sort of sampling, which sounds like the only  
16 feasible way, is there going to be some effort to identify  
17 the most efficient --

18 [Fire alarm sounding.]

19 DR. HAYES: The response is that it can be  
20 efficient or it can be the average. I think that's a kind  
21 of a judgment call, a decision about how to execute this  
22 kind of thing. If it were to be the efficient one, there's

1 still some work to be done to define what efficient means in  
2 this kind of context, but it would seem doable. This is  
3 flexible enough to accommodate either one.

4 MR. KUHN: Yes, Kevin, a question about the levels  
5 of data collection that you shared with us earlier, either  
6 at the practitioner level or at the billing code level.  
7 When the RUC currently reviews codes and goes through their  
8 process, how is the data presented to them and how are they  
9 reviewing it now?

10 DR. HAYES: [Off microphone.] How are they what -  
11 -

12 MR. KUHN: Yes. How is it presented to them now  
13 by -- I assume the various specialty societies bring codes  
14 forward and so they have times in there. So is it at the  
15 practitioner level? Is it at the billing code level? How  
16 are they now currently reviewing time?

17 DR. HAYES: It's at the billing code level. This  
18 is a kind of code-by-code review process and so a specialty  
19 society would present, you know, their time estimates, their  
20 recommendation for a relative value unit for a service, and  
21 then there would be some deliberation among the RUC members  
22 and then a recommendation agreed upon, voted upon by the

1 RUC, and that's what goes to CMS.

2 MR. KUHN: And is that data generally collected  
3 through a survey, or how is it collected now by the  
4 specialty societies?

5 DR. HAYES: Yes. It's collected via survey --  
6 [Fire alarm sounding.]

7 DR. HAYES: It's a survey conducted by the  
8 specialty societies and brought forward to the RUC.

9 MR. KUHN: And then one additional question. On  
10 those surveys, is that a standard format survey that they  
11 have to meet certain criteria, and if so, who sets that  
12 criteria for that survey right now?

13 DR. HAYES: It's a standard format adopted by the  
14 RUC and used, you know, uniformly by all the specialties.

15 DR. BERENSON: Yes, two round one questions. I  
16 just wanted to --

17 [Fire alarm announcement sounding.]

18 DR. BERENSON: I wanted to pick up on Karen's  
19 important issue around the multiplier effect on time and  
20 work. Recently, I think the RUC put up on its website some  
21 results of its work, that when CMS has adopted  
22 recommendations in the fee schedule, that suggests that

1 they've actually produced a fair amount of redistribution,  
2 up to about \$400 million in reduced work, and suggesting  
3 that that -- and then finding that that produced almost \$1.2  
4 billion of savings for redistribution because the practice  
5 expense savings were almost twice as much. I mean, does  
6 that basically -- can I infer from that that the multiplier  
7 effect is that dramatic? Have you had a chance to look at  
8 that, and -- I guess that's my question.

9 DR. HAYES: Yes. I would say that it's worth --  
10 we have looked at it in kind of a cursory way, and indeed,  
11 there have been some redistributions of dollars because of  
12 changes in practice expense RVUs. It's kind of difficult to  
13 pin that down, to pin that number down. And then I would  
14 also urge some caution about whether those practice expense  
15 changes are kind of a ripple effect, if you will, from the  
16 work changes, or whether they are changes that have happened  
17 because of, say, new survey data for practice expense. The  
18 Physician Practice Information Survey is, of course, being -  
19 - the data from that have become available. The practice  
20 expense RVUs based on that survey are being transitioned  
21 into use right now. So it could be that some of that -- I'd  
22 have to nail this down, and I'll get back to you on this,

1 but some of those savings for practice expense could be due  
2 to that --

3 DR. BERENSON: Okay.

4 DR. HAYES: -- than not.

5 DR. BERENSON: All right. I think that would be  
6 important to understand sort of the magnitude of this sort  
7 of spillover effect on getting time and work more accurate.

8 My second question has to do with Slide 6, where  
9 you've talked about the validation provision within the ACA.  
10 I'm aware that CMS in their proposed rule last year asked  
11 for comments on whether to engage in time and motion  
12 studies, and I guess got some discouraging feedback, that  
13 professionals don't like to do time and motion studies or  
14 something, and that sounds pretty resource-intensive. I  
15 guess, do you have any idea whether CMS is also looking at  
16 this issue of feasibility of using administrative data  
17 sources, or are we the ones who are sort of doing that, I  
18 guess is my question.

19 DR. HAYES: Well, on the matter of time and motion  
20 studies, you're correct that they did ask about this, and  
21 the comments back were -- how to characterize them -- they  
22 were not as negative as you might have thought, but there

1 was caution expressed, ample caution expressed about doing  
2 anything, whether it's time and motion studies or whatever,  
3 that's too narrowly focused, that concentrates on, say, one  
4 specialty or one type of service. The point that was made  
5 was that, whatever you do, it needs to pretty much apply  
6 across the board for the fee schedule.

7           Also on time and motion studies, I will mention  
8 that RTI in their work for us has been asking about this,  
9 about the potential for time and motion studies, and from  
10 minimal kind of interviews, what we have learned is that  
11 they are done in some cases, but they're very specific.  
12 They're done for very specific problems. Say we have a  
13 facility that's very much oriented on quality improvement,  
14 on these so-called lean production systems. They would do  
15 time and motion studies to deal with a specific, say, issue  
16 of patient safety. But that's pretty much as far as it  
17 goes. And no one that we've been able to find actually goes  
18 so far as to link the results of those studies to, say, the  
19 billing codes and such.

20           DR. BERENSON: And I guess, I mean, more  
21 specifically on my question, do you know if CMS is also  
22 looking at this administrative feasibility of administrative

1 data?

2 DR. HAYES: I don't know that for a fact. They  
3 have solicited comments on this and received a number of  
4 them and report back in the final rule that they are  
5 continuing to look into the matter, but they weren't  
6 specific about exactly what their activities are in this  
7 area.

8 DR. CASTELLANOS: Yes, I think this is important  
9 work, also. You know, the work value is time, which is the  
10 predominant one, but it's also intensity, and I haven't  
11 heard anybody talk about, are we going to be looking at the  
12 intensity, because time's intensity is the work value.

13 DR. HAYES: Yes. Well, we have looked at -- we  
14 have considered the issue of intensity, and if you look at  
15 Slide 7, you will see that we have tried to measure the  
16 importance of the time estimates relative to intensity as  
17 determinants of the fee schedule's relative values for  
18 practitioner work, and what we have found is that the time  
19 is really the most important factor. If you look at the  
20 correlations between the amount of time it takes and the  
21 RVUs that are set for a service, the time, you know, is  
22 very, very highly correlated. It does a lot to explain why

1 the RVU for a service is high or low.

2           So the focus here has been on the time estimates,  
3 on trying to come up with a source for validating that, and  
4 the thought would be that if we can nail that, then you've  
5 got a good metric against which you can do some analysis of  
6 intensity. You can then take the work RVU, divide it by an  
7 accurate time estimate, and now you've got a measure of  
8 intensity, of work per unit of time, which will be a very  
9 useful thing to have. So we kind of see this as time focus  
10 initially and then there's the stronger potential to go at  
11 intensity.

12           DR. CASTELLANOS: I agree with you. I think time  
13 is the most important. But intensity changes just like time  
14 changes when you do a procedure. It becomes common and it's  
15 not as hard to do and it becomes common sense. So I think,  
16 as time goes, I think we need to look at that, also.

17           MR. GEORGE MILLER: Yes, just quickly. Is it your  
18 thought in defining an efficient provider we need to get  
19 this part of the work done first and then try to define  
20 efficient provider, or can you define efficient provider now  
21 and then try to work backwards into the appropriate time?

22           DR. HAYES: Yes, that's an interesting question.

1 I would say that what would be useful here would be some  
2 research on what might constitute an efficient practice, and  
3 if you could get some consensus about those results and  
4 about their utility for work of this sort, you might be able  
5 to say on the front end, okay, we know enough about what  
6 makes an efficient practice. We want to go out and get some  
7 time data from those practices of that sort. If we could  
8 define them and conduct a data collection activity centered  
9 around that, it would be feasible to do this. But the first  
10 step is, as I say, yes.

11 MR. GEORGE MILLER: It would make it easier, I  
12 think, to do this modeling.

13 MR. HACKBARTH: Kevin, isn't a key question what  
14 unit of production you use to define efficiency? So a given  
15 practice may be very efficient in producing, say, a mid-  
16 level E&M visit, and so if that's the unit of measure, you  
17 may go to this set of practices to determine whether that's  
18 efficient. You may have another practice which is more  
19 efficient in terms of total costs but has a very different  
20 production system for producing mid-level office visits and  
21 they may look inefficient on that. And so you have to  
22 define efficiency and what you're trying to produce.

1           Cori, Mike, Jennie, Tom, clarifying questions,  
2   Mitra? No clarifying questions. Okay. Round two, and let  
3   me just do a time check here. We are at 3:26, so we're  
4   already about ten minutes overdue on this one, so as people  
5   make their round two comments, if you would, please be very  
6   crisp so we can not take too much time out of other topics.  
7   I'd appreciate it. Karen?

8           DR. BORMAN: I think that in addition to the issue  
9   about the perfect price, we have to recognize there's  
10  probably not the perfect data set, and so we have to decide  
11  how good a data set will get us at least some way down this  
12  road.

13           I think as Kevin alluded to, and Ariel, if I'm  
14  correct, what you're alluding to about the surgical data is  
15  the NIS-Quick data [phonetic]. It is a data set that was  
16  collected for another purpose, but as a part of it has code-  
17  specific time-associated data. I think the experience --  
18  and Bob may have an insight into this -- from the  
19  development of the RBRVS would suggest that when  
20  practitioners know the purpose of the data collection, there  
21  is something of an incentive to potentially influence the  
22  system or certainly perhaps taint the measurements, and I

1 don't mean that as surgeons that we're pure in that or  
2 impure in that. I think it is true, and I think as  
3 specialties were surveyed through the Harvard process, it  
4 became apparent as the values got higher and higher that the  
5 people learned the process. I mean, they're smart people.  
6 They learn the process.

7           So I would encourage that a criterion of the data  
8 sets perhaps should be that to the extent that we can find  
9 ones that were collected for at least additional purposes  
10 and not solely for this purpose, they may, in fact, have  
11 enhanced validity.

12           The other thing that I think was in the chapter  
13 that you guys sort of alluded to in the difficulty of the  
14 collection is that it's very difficult to -- you know, a  
15 given service is believed to have three pieces, a pre-  
16 service, a post-service, and then the actual delivery of the  
17 encounter face-to-face with the patient, and whether that  
18 encounter is an operation, an office visit, or whatever. It  
19 is because efficiency demands that you multi-task, whether  
20 it is while you are with one person or doing a lot of things  
21 about different people going on at one time, it is very  
22 difficult to get to that very micro level, and I think that

1 the information you provided suggests that it may be nigh  
2 unto impossible. And I personally would not want us to  
3 waste a lot of time trying to get at that.

4 I think the more macro work back, and accepting  
5 that the statistical inferences may not be as perfect as  
6 going to somebody's office and watching it, I just think we  
7 could be making the perfect time set well after everybody in  
8 this room is dead. And so I think if we really do want to  
9 try and enhance some of the accuracy of the times, we need  
10 to look for some good data collections and good criteria and  
11 move forward and do them, because I think that's the only  
12 way we're going to make progress in this area.

13 And I would urge us to consider, albeit this is  
14 more about the work thing, that the estimates of some of the  
15 other times, like clinical staff time, might also have some  
16 question about their validity, and if there's a process in  
17 the data sets that we identified, to also perhaps revalidate  
18 those, that there could be value to doing that. There are  
19 some services where the clinical staff time is two and three  
20 times the actual service encounter, which may be true for  
21 some services. It's a little hard to believe that it's true  
22 for all.

1           And then at the end of the day, if the conclusion  
2 is, yes, they're all inflated times, then maybe it kind of  
3 doesn't matter, so that is, I guess, maybe one of the  
4 research questions to answer, is if we decide they're  
5 inflated, we can't get a perfect data set or even something  
6 close, do we have consistent inflation in the methodology  
7 and do we just have to learn to live with that piece in the  
8 background as we take the data forward. So I think those  
9 would be important.

10           MR. BUTLER: Just a quick reaffirmation of the  
11 Minnesota findings, and that is it's not just the payment  
12 accuracy. Most of us that have big group practices, this is  
13 the foundation and how we're compensating and incentivizing,  
14 along with, increasingly, quality metrics and the rest. So  
15 to get it right is not unimportant. Often, we'll pay very  
16 different from what we actually collect in terms of the RVUs  
17 based on payer mix, so it's an important topic.

18           DR. KANE: I think I asked this before, too, but  
19 are there codes for which the private sector has just  
20 decided they're so far off that they've negotiated a  
21 different, you know, substantially -- if you were to look at  
22 how their RBRVS system was, was it substantial -- I mean,

1 I'm just wondering if there is some signal for where you  
2 should be spending your time and adjusting, rather than just  
3 going across the board. But other than that, it's a tough  
4 task. I think Bill Hsiao switched to designing single payer  
5 systems because that's easier.

6 MR. WINTER: We couldn't find any examples where  
7 plans had -- plans that generally pay on a fee-for-service  
8 basis, where they altered their fees, you know, set their  
9 fees differently than Medicare, or when we looked within  
10 practices, how they compensate employed physicians, it's  
11 usually based on a combination of the Medicare work RVUs and  
12 a salary basis. They did not adjust Medicare work RVUs. We  
13 tried to find examples, worked very hard, found maybe one  
14 limited example of a plan, but it's generally shifting away  
15 from Medicare RVUs to pay its providers. So, really, no  
16 examples.

17 And what one respondent said, and this quote will  
18 be in the final report, is that we found Medicare work RVUs  
19 are the least bad option we have for paying physicians. So  
20 they recognize in many cases the limitations, but they have  
21 not developed alternatives.

22 MR. HACKBARTH: But John Bertko used to say that

1 what they will do, of course, is use a different conversion  
2 factor. So they'll use Medicare's RVUs and have a different  
3 conversion factor. And in some markets, they may have a  
4 separate conversion factor for a given specialty out of  
5 necessity, because there's a very powerful single specialty  
6 group that's merged and basically the only way they can get  
7 them in is to have a special conversion factor for them.  
8 But they use the Medicare RVUs as sort of the core  
9 infrastructure, is what John always used to tell me.

10 MR. KUHN: The area, as we continue to look at  
11 this issue, the area I was interested in is the notion of do  
12 we have to collect data on all CPT codes out there, and I  
13 think some of the information you put in the paper is going  
14 to be very helpful as we go forward, the fact that about 460  
15 codes account for about 90 percent of the spend in the fee  
16 schedule and about something a little south of 300 codes are  
17 the ones that represent over 10,000 services per year. So  
18 as we go forward, I think that will be helpful to help us  
19 kind of in a narrowing process here so we don't overwhelm  
20 the system as we think about this.

21 DR. BERENSON: I will say a few things. One is  
22 that this is -- I continue to believe this is very important

1 work and you guys are making progress. We should just  
2 remember that the -- we do not have a terrific system now  
3 for estimating time. It's one that has a lot of bias. I  
4 think the RUC does a decent job at challenging some of the  
5 specialty societies who come up with completely implausible  
6 time estimates, but they really have no basis. So I'm  
7 concerned that even though the RUC is doing a very nice job  
8 and CMS in reviewing a whole bunch of services, and in the  
9 last year generating \$1.2 billion for redistribution, that  
10 maybe some of the revaluations should have been  
11 significantly more.

12           And so, Ariel, this morning, you presented data  
13 that on that echo, when they combined three separate echoes  
14 that are always performed together into one, in fact, the  
15 new valuation is marginally lower, I mean, is essentially  
16 the same, has a time of over 30 minutes as we talked about,  
17 and in my view doesn't pass face validity as being correct.  
18 Obviously, there are some cardiologists who will disagree  
19 with me, but I have seen echocardiograms being the  
20 professional work associated with those and I don't believe  
21 it takes 31 minutes or whatever it takes any more than I  
22 believe that the EKG interpretation, which is currently in

1 the system at five minutes or seven minutes, depending on  
2 which one you use, is anywhere close to the reality of a few  
3 seconds at this point with automated EKGs that show up on  
4 your desktop with an interpretation and all the doctor has  
5 to do is say, yes, that's right.

6           So I think, in fact, the work that we're embarking  
7 on could improve the RUC's work rather than be seen as a  
8 threat to the RUC's work. The RUC could be the entity that  
9 takes the time data and uses it and does, Ron, what I think  
10 only a professional group can do, is address the intensity  
11 across services. There is no gold standard for that, and I  
12 think we have to rely on professionals, but I don't think  
13 they have to make up the time data. I think we could, with  
14 CMS ultimately doing it, clearly, through some  
15 administrative mechanism, get the time data. If the RUC is  
16 wedded to their current way of doing it, which is based on  
17 reviewing 30 doctors who know what the game is, what their  
18 estimates are, then we would have to have a different  
19 process, it seems to me. So I think that remains to be  
20 seen.

21           We need to come up with something feasible. The  
22 perfect should not be the enemy of the good. Right now, we

1 have a system that I don't think works very well and I think  
2 we should, as Karen suggested, try to figure out something  
3 practical that is better. If it got plugged into the RUC  
4 process, then clearly a specialty society could come forward  
5 and say, well, you got it wrong and here's why. There would  
6 still be an opportunity for correcting what came out of some  
7 administrative collection process, but the burden would now  
8 be shifted. Rather than the RUC trying to show that the  
9 specialty society was cooking the numbers, intentionally or  
10 inadvertently, that burden would now be on the specialty  
11 society to say why it is that this administrative data that  
12 came from six or eight or ten multi-specialty group  
13 practices and a few other practices was wrong, and I think  
14 that would be a great improvement to the process.

15 I don't remember if I said this up front, but we  
16 are spending close to \$70 billion just in Medicare on  
17 physician payments and we should at least be basing them on  
18 some real data. I mean, we need -- so that is my final  
19 point, is it will cost some money, I assume, to collect this  
20 administrative data, and once we have a proposal for how to  
21 do it, I think CMS needs the resources to go contract to get  
22 it.

1           One advantage to the current method is that the  
2 specialists are providing free labor to CMS, but they have  
3 an interest in doing so, a self-interest in doing so. This  
4 would not be free and I think we would need to put some kind  
5 of parameters of administrative costs that would be required  
6 to collect this data, but I encourage you to keep working.  
7 You're doing -- it's a good start and I think it is not  
8 going to turn around next year, but I think over time this  
9 is the right way to be going.

10           DR. MARK MILLER: [Off microphone.] Can I get you  
11 just to say one more thing? So you're very clear on there's  
12 a problem that the RUC is not going -- at least as the  
13 current process is, they are not going to correct it, and  
14 very much an encouragement there should be another effort to  
15 gather this information. In an attempt to tease out  
16 questions on that, there was a slide on surveys, mandatory  
17 versus recruiting from a cohort of practices. Did you have  
18 any views on the direction to collect the data?

19           DR. BERENSON: I think I would be going to places  
20 that have automated data systems. The closer some of them  
21 have to CPT-level assignment of time, the better, but if  
22 that doesn't exist, then somehow backing into the allocation

1 to the CPT codes, but through administrative data. So if  
2 that means it's a somewhat skewed population of practices,  
3 we're talking about large multi-specialty groups with  
4 sophisticated data systems and they're the only ones who can  
5 do it, then I would take that, put it into a process where  
6 there is an opportunity for pointing out that, well, it's  
7 different for a solo doctor and here's why. Maybe the EKG  
8 is more than three seconds. Maybe it's a minute if you  
9 don't have an electronic health system.

10 But I think we don't make it so complex in terms  
11 of having representativeness from every kind of a practice  
12 that it makes it infeasible. I would be concentrating on  
13 practices, hospitals that have data systems that can be used  
14 to produce this kind of data and then present what the  
15 potential error might be because they are unique practices.

16 MR. HACKBARTH: So the way that you've expressed  
17 it to me before, Bob, is that you would go to a subset of  
18 practices that have the systems that allow the information  
19 to be collected efficiently, and then you could allow people  
20 to rebut the presumption. There would be a presumption in  
21 favor of this being the accurate measurement, but if people  
22 can produce persuasive information that it is not accurate

1 in certain circumstances, the door would be open to that,  
2 but you'd have to come with --

3 DR. BERENSON: Yes. I mean, it could even be -- I  
4 don't know exactly how it would work out. The RUC would  
5 continue asking the 30 doctors to submit their time data.  
6 Here's now a new database. The RUC has both of them and  
7 there is an engagement. CMS obviously is not obligated to -  
8 - I mean, I'm not endorsing that. I'm saying there are a  
9 number of different ways in which you could permit some, you  
10 know, the profession, the specialty societies to absolutely  
11 have input into the process, but they don't get to sort of  
12 put all of the words on the blank page first. There's  
13 another database, which I assume over time will get better  
14 and better.

15 And I know that there are some people on the RUC  
16 who have wanted to have this kind of information outside of  
17 relying on specialty societies and others who think that  
18 their current way is the right way. I think consulting with  
19 the RUC as to how to make this work within their process  
20 would be a useful thing. My first choice would be to have  
21 the RUC use this objective time data within their processes,  
22 have CMS do what it normally does, is review the RUC

1 recommendations. If the RUC doesn't want to use objective  
2 time data, then there might need to be a different system.

3 DR. CASTELLANOS: Let me just clarify a couple of  
4 things so I'm not misunderstood. I totally agree that we  
5 need to look at time. We need to look at it on a new  
6 perspective. There's just no question we need to do that.

7 I just think we need just to give a more balanced  
8 opinion of the RUC, not that I -- I guess Karen is probably  
9 the best person to talk about the RUC. She was head of the  
10 CPT Committee and she can give you more information as to  
11 their workings and that. I had the opportunity to go down  
12 after Barbara Levy invited us last spring and I was very  
13 prejudiced towards the RUC, towards the Wall Street Journal  
14 article, et cetera. I thought they were very professional.  
15 I thought it was a tremendous amount of work they were  
16 doing. I really was interested in the extent of their  
17 importance of the cross-specialty discussions and the  
18 enormous push-back that I saw.

19 Bob, I just want to -- you recognize there's a  
20 problem, and Mark, you asked Bob, there's a problem but they  
21 don't want to do anything about it. I don't think that's  
22 real fair, because I think the RUC has tried to do something

1 about it, because I brought these questions to them when I  
2 was there. I think they made every effort in their  
3 abilities to do it, but perhaps they don't have the  
4 abilities or are not looking at the right thing.

5 I don't want to leave here now thinking that the  
6 RUC has not tried to do something. I think they have  
7 provided a good service, and Bob, I appreciate you went from  
8 decent to very good and I appreciate those adjectives --

9 [Laughter.]

10 DR. CASTELLANOS: -- but I don't want to throw the  
11 baby out in the bathwater. I don't want anybody to leave  
12 here thinking that the RUC has not tried. I didn't say they  
13 have succeeded.

14 DR. BERENSON: Point of privilege. I mean, good,  
15 decent -- I mean, I gave him great credit for having a lot  
16 of activity, for producing a substantial amount of  
17 redistribution. I'm just saying I think there might even --  
18 with more tools, they could even do better, but I'm being  
19 pretty positive here.

20 DR. CHERNEW: I'm very wary of these time-motion-  
21 type studies. I want to go on record as saying that. And I  
22 actually think, although I couldn't right now tell you how

1 to do it, there probably is some operations researcher  
2 somewhere who, if you knew the amount of time worked and you  
3 knew the set of codes billed and in a big enough sample, you  
4 could statistically try and sort this out without trying to  
5 observe exactly how much time would be spent on things, and  
6 you'd have to make assumptions on the case mix  
7 heterogeneity. But I think compared to survey stuff or  
8 time-motion stuff or those types of things, it's fraught  
9 with a whole series of errors and it would take a lot of  
10 thought to think how to do it the other way, but I'm  
11 convinced you could get a better statistical estimate using  
12 sort of macro data and statistics than trying to send  
13 someone with a clipboard and stopwatch.

14 MR. HACKBARTH: You would include in that drawing  
15 information from administrative systems the way Bob --

16 DR. CHERNEW: No, that's how I would do it.

17 MR. HACKBARTH: Okay.

18 DR. CHERNEW: The only thing you need to know is  
19 what you billed for and how long the people were working,  
20 and maybe some of the other resources, maybe some case-mix  
21 stuff --

22 DR. BAICKER: And you'd want to know what share of

1 their time was devoted to Medicare beneficiaries versus  
2 other patients.

3 DR. CHERNEW: Well, again, that depends on whether  
4 or not you want to know overall everything that they billed  
5 for everybody, which is a separate issue. So, yes, you'd  
6 have to sort that out, because obviously you need to know  
7 that in the amount of time for Medicare --

8 DR. BAICKER: I was thinking just for the  
9 denominator.

10 MR. HACKBARTH: Jennie?

11 MS. HANSEN: Yes. This is more of a question  
12 relative to, you know, besides the large database, is there  
13 a methodology being looked at, and this might be for you  
14 folks as well as with Bob, about when it comes from the  
15 beneficiary multi-morbid perspective, are there factors of  
16 waiting for looking at people who might be dealing with, you  
17 know, eight comorbidities and things like that. So my  
18 purpose in asking this is to just make sure that, over time,  
19 these more complex people that may take a lot of time but  
20 also have clinical complexity will get seen and have the  
21 clinicians paid for appropriately here.

22 DR. HAYES: Well, I'll just say that the purpose

1 of what we're talking about here is to get more accurate  
2 time estimates and to try and do the best we can within the  
3 constraints of this kind of a payment system, to do the best  
4 job possible to account for the complexity of the patient.

5 I would also point out that there are within the  
6 payment system provisions for the unusual cases, for the  
7 beneficiaries who, say, take an extra amount of time. Now,  
8 there's all kinds of controversy about how well the payment  
9 system accommodates those special cases, but there is some  
10 provision for that.

11 But anyway, in any case, I just come back to the  
12 original point that I tried to make, which is that we're  
13 trying to just do the best we can with what we've got here  
14 and so the time data seem to be part of the answer.

15 DR. DEAN: Yes. I'm very conflicted about this.  
16 I understand that we need this kind of a tool. I am also  
17 deeply cynical about how effective the current one is and  
18 how it fails to in any way account for at least my time.  
19 And I understand that the specialty I am in is probably --  
20 it fits least well. If you're doing a lot of well-defined  
21 procedures, which I'm not, I suspect that there is a chance  
22 that this could work. But right now, for instance, if I sew

1 up a simple laceration or take off a little skin cancer,  
2 I'll get paid probably three times as much as if I spend 45  
3 minutes with the patient that Jennie just described. It  
4 really, you know, makes you very cynical about the whole  
5 structure.

6 But I understand for the reasons Peter mentioned  
7 and so forth that we need some kind of a tool, but there's  
8 so much variability between individual physicians. There's  
9 experience, what kind of support staff you have, what the  
10 patient's idiosyncracies are. I mean, you can go on for a  
11 long time. I'm just not sure that we can ever get it right,  
12 although I understand there's a need to try.

13 MR. HACKBARTH: And this actually links to our  
14 next conversation. I don't think you need to try to get it  
15 all -- address all of those issues through the resource-  
16 based relative value scale. This is the point I was trying  
17 to make in response to Peter. This conversation is a narrow  
18 one within the construct of a resource-based relative value  
19 scale. How do we make it as accurate as possible?

20 Then, separate from that, we may wish to change  
21 how we pay physicians, use new methods, or establish  
22 bonuses, other mechanisms to better address the sort of

1 issues that you're raising.

2 DR. DEAN: I think the comment that you made  
3 earlier about, you know, this bases everything on input  
4 costs. It has no relationship to value --

5 MR. HACKBARTH: Value --

6 DR. DEAN: -- and that's, to me, where the real  
7 problem is.

8 MR. HACKBARTH: Right. And so we'll turn to that  
9 in just a second. Mitra? I think that was round two,  
10 wasn't it?

11 DR. MARK MILLER: Can I just add one thing?

12 MR. HACKBARTH: Yes.

13 DR. MARK MILLER: I also want both the  
14 Commissioners and the public to know that when we have these  
15 conversations, it isn't without any knowledge of the RUC.  
16 Kevin regularly goes to the RUC meetings and engages in the  
17 process and follows the process, or at least he tells me --  
18 he disappears for a few days and says that's what he's  
19 doing.

20 [Laughter.]

21 DR. MARK MILLER: The other thing I would say, and  
22 there's something of an interaction here that works like

1 this. I think the RUC has taken actions over the last few  
2 years, but I also would remind this Commission -- some of  
3 you weren't here -- it was a few years back that we started  
4 looking at the RUC and that, I think, had some role in the  
5 RUC sort of changing.

6 And so I think there is a kind of a symbiotic  
7 relationship or a conflict relationship, whichever way you  
8 want to think about it, in order to get the best out of both  
9 sides, our work and their work. So I just don't want you to  
10 think that we're doing it completely oblivious to what  
11 actually goes on there. We do try and engage and pay  
12 attention to what they're up to.

13 MR. HACKBARTH: Okay. Thank you, Kevin and Ariel.  
14 More on this later.

15 Our next topic is the SGR system.

16 Okay, whenever you're ready.

17 MS. BOCCUTI: Okay, I'll get started. So as most  
18 of you know, policymakers face an extremely difficult  
19 challenge regarding Medicare's future fees for physician  
20 services. Under current law, Medicare's fees for these  
21 services are projected to decline more than 30 percent over  
22 the next several years under the SGR.

1           So we're going to start with a short summary of  
2 the Commission's assessment of the SGR system. Then we're  
3 going to review a series of discussion questions and some of  
4 the issues that you want to consider for each of them. And  
5 then given the complexity of this issue, we're going to  
6 really try to keep our presentation short and maximize your  
7 time for discussing the direction that MedPAC wants to take  
8 in the world on this area.

9           So on this slide, we've got a very brief review of  
10 MedPAC's assessment of the SGR. It was, of course,  
11 summarized, or this is summarized from previous discussions  
12 over the last couple years and years before that. Also, as  
13 you recall, we included this, a more detailed version of  
14 this assessment in the recent March report.

15           So first, there are several widely held criticisms  
16 and flaws of the SGR system. A main flaw is its inability  
17 to differentiate updates by provider. It neither rewards  
18 specific physicians who restrain unnecessary volume growth  
19 nor penalizes those who contribute most to volume increases.

20           Another problem is that the SGR is strictly  
21 budgetary. It has no tools to counter the volume incentives  
22 that are inherent in the fee-for-service system or to

1 improve quality.

2           And in addition to these systemic flaws, there's  
3 widespread agreement that the updates that the SGR formula  
4 has called for are problematic; that is, large unrealistic  
5 payment cuts loom in the future under current law, and these  
6 cuts threaten provider willingness to serve beneficiaries.  
7 Also, the temporary stop-gap fixes that have been  
8 implemented in recent years have created uncertainty,  
9 frustration and financial problems for medical practices,  
10 and additionally they add significant burden to CMS's claims  
11 processing activities.

12           And then a third issue surrounding SGR  
13 discussions, of course, is that eliminating the SGR cuts  
14 translates to a minimum CBO score of about \$300 billion, and  
15 that's just for a freeze in payments for the next 10 years.  
16 So this high score carries two critical, but somewhat  
17 circular, issues. The high score makes elimination of the  
18 SGR extremely difficult, but each year that the SGR remains  
19 in place and its fee cuts are overridden the score for  
20 replacing it gets higher and the prescribed fee cuts get  
21 larger.

22           So with that very brief summary statement, we're

1 going to start with framing the series of questions for you  
2 to consider when we discuss the SGR alternatives.

3 So at the broadest level the first question is:  
4 Should the SGR system be eliminated or modified?

5 And if you answer yes to either elimination or  
6 modification, then the next question is: What alternative  
7 mechanism -- or really I think it should be pluralized  
8 there. What alternative mechanism or mechanisms will  
9 determine Medicare payments for fee schedule services?

10 So would it include a new expenditure target  
11 system, or does elimination of the SGR present an  
12 opportunity to institute a contingent package of tradeoffs  
13 which would include modest, but stable, updates?

14 And of course, these, those two options that are  
15 those bullets there aren't necessary mutually exclusive.

16 So following from that previous slide, we ask:  
17 Should another expenditure target system replace the SGR?  
18 We list here some general points about expenditure target  
19 systems that MedPAC has made in previous discussions.

20 So first, expenditure target systems are designed  
21 to constrain price growth, but their effect on total  
22 spending or volume here is really less direct. Nonetheless,

1 expenditure target systems, by design, do regularly alert  
2 policymakers of spending growth, and they require  
3 significant congressional action to override them. As the  
4 Commission has stated repeatedly though, expenditure target  
5 systems in their starkest form are not a mechanism necessary  
6 for improving care delivery. And finally, expenditure  
7 targets that are narrowly applied to a single sector, such  
8 as the fee schedule payments in the SGR, offer no spending  
9 flexibility across provider sectors.

10           So in general, expenditure target systems are  
11 formulaic, and thus, they have several parameters to  
12 consider.

13           So how would the parameters of a new expenditure  
14 target system be defined? The first overarching design  
15 element for an expenditure system is its scope. By that, I  
16 mean would it apply to the fee schedule only, as it's done  
17 in the SGR like I said, or would it be expanded to Parts A  
18 and B or to all of Medicare?

19           Next question, what would the spending growth  
20 targets be? In the SGR, it's based on GDP. But some have  
21 suggested GDP+1 or MEI, or there could be a specified  
22 percentage of growth.

1           A third parameter to talk about is what would the  
2 updates be if spending was at or below the target. In the  
3 SGR, for example, it's MEI -- so in the MEI, when services  
4 are supposed to get an MEI update if the cumulative spending  
5 is equal to or below the target. Another possibility for  
6 the updates would be a predetermined amount like 1 percent  
7 when spending is at or below the target.

8           A fourth parameter is to what degree would the  
9 system cumulate differences across years. The SGR is fully  
10 cumulative, so it's designed to recoup any and all spending  
11 over the target. In contrast, the system prior to the SGR  
12 set the rates annually, so it did not require recoupment  
13 across multiple years. Some have suggested that there's a  
14 possibility for a partial recoupment.

15           Moving on to a fifth parameter, would the targets  
16 and the resulting updates vary by certain factors? The SGR  
17 has one national target. In contrast, some proposals have  
18 explored different targets and updates, say, by geographic  
19 area or by types of service.

20           And then finally, would there be an allowance for  
21 selected entities to be exempt from an expenditure target  
22 system? And we've talked before about the possibility of

1 participants in ACOs or medical homes, particularly ones  
2 that are subject to other kinds of performance risks, could  
3 be exempt from expenditure target policies.

4           So now I'm going to switch away from the  
5 expenditure target discussion for a moment and talk about  
6 something that was discussed at the last meeting, and that's  
7 the concept that eliminating the SGR offers an opportunity  
8 for gaining other system improvements. In other words,  
9 alleviating the looming SGR cuts could be contingent on a  
10 set of tradeoffs that could have goals of improving the  
11 stability of future payments and also aligning incentives  
12 with improvements for high quality and efficient care.

13           You discuss several options in the package of  
14 tradeoffs including limited future updates starting in 2012.  
15 That is fairly modest, but stable, updates for several years  
16 head.

17           And a second option is a major realignment of this  
18 fee schedule. This effect or, excuse me, this effort of the  
19 major realignment would have a goal of enhancing overall  
20 value of nonprocedural services and balancing per hour  
21 compensation across specialties.

22           A third component in this contingent tradeoff list

1 could allow for service-specific fee increases or decreases.  
2 In this scenario, the Secretary could make changes to fees  
3 for individual services. She could make these decisions  
4 based on CMS validation activities, and that goes to the  
5 presentation that, or the session right before with Kevin.  
6 Although that's not really listed on the slide, I think we  
7 could consider that in this realm. But also she could make  
8 these individual changes based on advice from the RUC or a  
9 Secretary's expert panel. A question for discussion then is  
10 whether or not these service-specific adjustments would be  
11 budget neutral.

12 And then there's a final bullet on the slide that  
13 is really there for a placeholder for other ideas that you  
14 might want to discuss today, some of which may have been  
15 brought up at the last meeting.

16 Okay, so as you painfully know, maybe because I've  
17 been telling you so many times, eliminating the SGR's future  
18 cuts carries a very high budgetary score. At a minimum,  
19 like I said, it's \$300 billion over 10 years. And although  
20 Congress has the ability to apply what's called directed  
21 score-keeping to legislation, which is basically telling CBO  
22 how to score a bill, that option is essentially a

1 congressional prerogative. So we're going to focus here on  
2 this slide with potential areas for finding scoring offsets.

3 First, we could focus on Medicare spending  
4 reductions to offset the high score. Unfortunately though,  
5 it's extremely difficult to find this amount in Medicare  
6 spending reductions. Most recently, in our March report,  
7 the Commission did recommend lower updates in several  
8 sectors, but that is really just a start, or it doesn't go  
9 to the \$300 billion when I say "start."

10 And then the other option is to think beyond  
11 Medicare, to include all federal spending and revenue. The  
12 concept here is to widen the pool of options that are  
13 available for offsetting the score.

14 And of course, these two options don't need to be  
15 mutually exclusive.

16 Before we get to the final slide, there's one  
17 point that the Commission has raised in several meetings and  
18 in our recent March report. And that's that in the interim,  
19 while determining what to do with the SGR, should there be a  
20 minimum period of time for which overriding updates should  
21 apply, say, for a minimum of one year?

22 The shorter updates that occurred in recent years

1 were, as I said, extremely problematic on many fronts. They  
2 undermine the confidence of providers and patients. They  
3 threaten Medicare's reputation, and they burden CMS's claims  
4 processing activities.

5           And finally, on this last slide, for your  
6 discussion we've summarized the framework of questions that  
7 I just ran through. And as Glenn mentioned, our immediate  
8 goal is to be able to give some sense of the Commission's  
9 direction on these considerations. We're not necessary  
10 concentrating on details and specifics for each time, but  
11 really we're trying to chart, or this discussion will chart  
12 a general course for the Commission's future work.

13           Thank you.

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

15           In the interest of time, I think what we'll do is  
16 just have one round on this topic, and what I'd like to do  
17 is kick that off, repeat a little bit of what Cristina said.  
18 My goal is to give you something to react to in terms of a  
19 potential direction for it, and I'm going to try to maybe  
20 put some sharp edges on it with the specific intent of  
21 getting you to say I agree that or I disagree with that.

22           And I'm trying to help create the outline at least

1 of what our message is in our June report. You'll recall  
2 last time I said that the process that I envision is that in  
3 our June report we'll discuss the SGR and hopefully point in  
4 a broad direction, if not a detailed one. Over the course  
5 of the summer including at our July retreat, we'll talk  
6 about it in more detail, more concrete options.

7           Assuming all of that goes well, I would envision  
8 that we would have draft recommendations for discussion at  
9 our September meeting, and if that goes well, then  
10 potentially final votes in October. And I mean to emphasize  
11 if that all goes well. This is a difficult topic, and so  
12 I'm not sure we can assume that all will go well, but that  
13 is certainly the objective, is to find a consensus on a very  
14 difficult and controversial issue.

15           So I'm going to go through some sort of summary  
16 statements about SGR based on my own ideas and things I've  
17 heard commissioners say in the past, and I want you to react  
18 to these during the discussion.

19           The first point is that SGR and mechanism like it,  
20 formulaic across-the-board changes in unit prices based on  
21 what's happening with total expenditures, mechanisms of that  
22 sort do not create incentives for the efficient delivery of

1 care. In fact, arguably, they create perverse incentives  
2 for people to respond to impending future reductions in  
3 payment by increasing volume, or alternatively, they have  
4 inequitable effects by falling more harshly on some types of  
5 physicians than others. Physicians who can readily increase  
6 the volume and intensity of their service are hurt less by  
7 them, whereas specialties that are more constrained in those  
8 opportunities bear the brunt of the cuts.

9           So the basic mechanism of, by formula, linking  
10 unit price increases updates each year to volume, total  
11 volume of services or total expenditures is a flawed,  
12 inherently flawed mechanism.

13           A corollary of that is that if in fact we want to  
14 create appropriate incentives for physicians and other  
15 practitioners to focus on producing high value care, the  
16 best possible quality with the lowest possible cost, we have  
17 to change the payment system at the level of the individual  
18 provider. We can't accomplish that goal through some sort  
19 of overlay of the fee-for-service system. So we need to  
20 advance the work on medical homes and ACOs and bundling, et  
21 cetera, if we want to change the incentives that  
22 practitioners face as they care for patients, and we want to

1 do so in an equitable way.

2           Now that's not to say that SGR has been totally  
3 without benefit. There are people, including maybe some  
4 present members and certainly some past members of this  
5 Commission, who have said that if nothing else the benefit  
6 of SGR has been to create a mechanism that has applied  
7 pressure, that has held the annual updates to levels, lower  
8 levels than they would have otherwise been and some savings  
9 have resulted from that. I'm sort of agnostic on whether we  
10 have in fact saved money or not, but let's stipulate for the  
11 sake of discussion that that's correct.

12           My concern -- you've heard me say this before --  
13 is that even if we assume that updates have been lower the  
14 price that we're paying for that may go up precipitously.  
15 The recurring crises about whether we're going to have very  
16 large cuts in Medicare's fees to physicians I think are  
17 taking a toll on physician, and potentially beneficiary,  
18 confidence in the program. So even if we are getting  
19 modestly lower updates than we otherwise would have gotten,  
20 we're running increasingly large risks to get that benefit.

21           There are other ways. If in fact our goal is, and  
22 it must be, to constrain updates in physician fees, I would

1 argue that at this point in time, especially in the current  
2 budget context, there are other mechanisms that can  
3 accomplish the goal of holding down updates without having  
4 this complex and threatening mechanism as the vehicle for  
5 doing that.

6           If, for example, there were just legislated zero  
7 updates for a period of 3 years and no more than 1 percent  
8 for the next 7 years in the 10-year budget horizon, that in  
9 and of itself in the current budget context would apply lots  
10 of pressure on Congress to keep the updates low. We don't  
11 need to threaten, in other words, 25 percent reductions to  
12 get low updates, especially in this fiscal context.

13           Now if we were, if the Congress were -- it's  
14 ultimately, of course, their decision. If the Congress were  
15 to repeal SGR, it seems to me that that also presents an  
16 opportunity, an opportunity to make some changes in  
17 physician payment that otherwise might be difficult to pull  
18 off.

19           Why is it an opportunity? Well, certainly, there  
20 is strong interest in the physician community in getting rid  
21 of SGR, and it may be an opportunity to say well, in  
22 exchange for getting SGR some other things have to happen.

1           And so one of the tasks I think that we ought to  
2 undertake during the next several months is to think about  
3 what that exchange might be, what changes would we want to  
4 see as part of an SGR repeal package. One example might be,  
5 as I said a minute ago, to have a legislated baseline that  
6 provides for low updates into the future.

7           A second element in my view might be a significant  
8 redistribution of payments among physicians. So now I want  
9 to link this conversation to the one we just had. The  
10 previous conversation is how do we make our estimates of  
11 relative values as accurate as possible. Here, I'm  
12 suggesting, as I responded to you, Tom, that in addition to  
13 that we may wish to make some other changes in the payment  
14 system that redistribute money within the system.

15           The existing primary care bonus that was enacted  
16 as part of PPACA is an example of that sort of outside of  
17 the RBRVS system let's change the distribution of dollars.  
18 As you know, there was a temporary 10 percent increase  
19 enacted in PPACA. Potentially, you could make that number  
20 bigger or you could even include in the package a change in  
21 method of payment for primary care. I'm not necessarily  
22 proposing those things at this point, but I'm using them as

1 illustrations.

2           Now let me turn to the very difficult problem of  
3 the budget score on this. I don't think that there are,  
4 within the Medicare program, offsets for a \$300 billion-plus  
5 budget score over 10 years, particularly on the heels of  
6 significant legislative changes have happened as part of  
7 PPACA that cumulatively over 10 years are scored at \$500  
8 billion plus savings. So we would be talking about \$300-  
9 plus billion beyond the \$500 billion in PPACA, and I don't  
10 know where that kind of money is going to come from in  
11 Medicare.

12           Having said that, I think it's possible that there  
13 could be some offsets, just not of the order of magnitude of  
14 \$300 billion. In fact, our March report recommendations, if  
15 you take all of them, aside from the physician update  
16 recommendation which has a big cost to it because of SGR, if  
17 you take all of the others, the net savings is about \$20  
18 billion over 5 years. So you know, that's a contribution,  
19 but it's hardly filling the entire hole.

20           To get really a significant contribution towards  
21 \$300 billion, I think it's clear that any proposals would  
22 have to have a broadbased effect. We're not talking about

1 doing targeted things that add up to \$300 billion. You'd  
2 have to have a broad cut that affects virtually all  
3 providers and potentially involves beneficiaries and  
4 Medicare Advantage plans as well if you're really going to  
5 try to approach something like \$300 billion.

6           Again, I'm not advocating that, but I think that's  
7 the reality of the dollar situation. You're not going to  
8 find targeted well thought-out proposals that are going to  
9 add up to \$300 billion.

10           So at the end of the day, my view, and I said this  
11 in response to a question at the Ways and Means Committee  
12 hearing on the March report, is that I think it's very  
13 likely that we're going to end up spending more than the SGR  
14 baseline. And I think really the question for the Congress  
15 is not whether we're going to end up spending more but how  
16 we end up spending more. The path that we've been on these  
17 last five, six, seven years is well, we spend more than SGR,  
18 but we do it through last-minute rescue operations that  
19 forestall large cuts, and we basically plow more money into  
20 the existing payment system that people have a lot of  
21 frustrations with.

22           I think because of the increasing risk that we're

1 running with SGR, we may be at the point of saying we've got  
2 to get on a different track. Spend more, hopefully not  
3 \$300-and-some billion more, but we're going to spend more.  
4 But let's do it in a way that is more strategic, that for  
5 example, redistributes dollars within the physician payment  
6 system in a way that shores up our primary care system or at  
7 least slows the erosion of it, et cetera.

8           So I have a couple goals here. I promised that a  
9 couple of these things would be pointed, and so one notion I  
10 want to get you to react to very specifically is that if you  
11 go back through Cristina's slides the first several are  
12 about ways that we might modify SGR. Frankly, my own view  
13 is that's not where we ought to be spending our time,  
14 thinking about how to change the targets or make them  
15 noncumulative, or creating margins of error around the  
16 numbers.

17           The basic mechanism of linking unit price  
18 increases updates to aggregate expenditures, it's a flawed  
19 mechanism. Let's recognize that.

20           It's not just unproductive; in important ways,  
21 it's counterproductive. Let's be clear about that and say  
22 the path that we envision involves getting rid of that kind

1 of mechanism, not just altering it. So that's one thing I  
2 want your reaction to.

3 A second point, which is sort of less big-picture,  
4 but I think very important in the near future, is that to  
5 make a clear statement to the Congress about the risks that  
6 we see in these recurring SGR crises and have a clear  
7 statement urging them if it can't be repealed, modified  
8 immediately, that extensions, the rescue plans should be of  
9 at least one year in duration to minimize the disruption to  
10 the program.

11 So those are two things, particular things I'd  
12 like you to react to, and I'm going to stop there and open  
13 it up for discussion.

14 And Mitra, I think we're on your side first.

15 MS. BEHROOZI: Yeah, I was scared of going first  
16 because there was so much to react to, but thank you for  
17 sort of putting out a focus for the discussion.

18 On the second one first, in the interim, should  
19 there be a minimum duration of time for which the updates  
20 should apply, but as I recall it -- I might have this  
21 backwards. But the first time that I was aware of there  
22 being this crisis around the SGR update it wasn't so much

1 the duration for which the fix happened. It was when it  
2 happened. Or more recently actually, I guess, that was also  
3 an issue. Right? It was a short one, but it came a month  
4 late. Right?

5           So if we're going to say that, I think we also  
6 have to say that it has to be before the cut goes into  
7 effect, right, though I recognize that's the most political  
8 of all sort of things that we could be sort of sticking our  
9 finger into. So I don't know how much they care what we  
10 think about that, given the realities of Congress's task  
11 there. You know.

12           MR. HACKBARTH: In fact, I think they recognize  
13 the problem of the 11th hour rescue. I know that some of  
14 the committees are gearing up now to work on this and  
15 potentially have hearings, and their goal is to resolve this  
16 before the last minute. Now whether that will happen or not  
17 obviously involves a lot of factors.

18           MS. BEHROOZI: On the bigger topic, yes, I agree.  
19 I don't think that having this formulaic approach for a lot  
20 of the reasons that you said makes a lot of sense, and part  
21 of it is related to our own experience, struggling with  
22 funding deficiencies in the various -- we have different

1 plans for different groups of workers, and when we have --  
2 recently, we've been facing funding crises in all of those  
3 pots of money where we had to provide benefits for workers,  
4 and we have to come up with different solutions for how to  
5 tighten things up, change the benefit design, whatever. We  
6 have to come up with what makes sense at that point in time  
7 based on evidence development, based on experiments being  
8 tried elsewhere, that kind of thing. So that's another  
9 factor that I would kind of throw in, why it doesn't make  
10 sense to say there's one way to fix it when we're spending  
11 too much.

12 I do think that it's important to have some kind  
13 of a measure of when things are getting out of hand. I mean  
14 when we're projected to run out of money in 12 months, in  
15 our pots of money, that's a clear signal that we have to do  
16 something. So it seems worthwhile to still have some kind  
17 of measure out there of what you think spending should not,  
18 what spending growth should not, exceed. But that's overall  
19 throughout the whole program because you need to have all  
20 the levers everywhere to be able to deal with that.

21 And I think that maybe what I'm talking about,  
22 starting to sound a little bit like the IPAB, that there is

1 some measure, that there is some threshold at which  
2 something has to happen because I also realize that if you  
3 just say well, it shouldn't cost more than X and then it  
4 goes back to Congress to come up with it, then it's subject  
5 to the same kind of political potential stalemate that you  
6 have around the SGR itself.

7 As to the scoring, I get that's the way it is.  
8 That's the way the rules are written. But it's also a  
9 political choice.

10 As you said, Glenn, you can elect to look in  
11 Medicare for that \$300 billion or you can elect to leave  
12 Afghanistan a couple months early, or something like that,  
13 and find the same \$300 billion elsewhere. And there are  
14 other more politically volatile things that I won't even  
15 mention.

16 But we're MedPAC. You know. I feel like we  
17 really need to recommend the best thing for Medicare  
18 spending and hope that they will do the right thing when it  
19 comes to the scoring and finding, figuring out how to pay  
20 for the right thing.

21 DR. DEAN: First of all, thanks for again bringing  
22 this up. I realize the Commission has talked about it a

1 number of times. But I have the same sense that you do,  
2 Glenn, that the environment is getting worse and that the  
3 hostility within the physician community is increasing and  
4 that it really is a problem that has to be fixed.

5 I don't believe this formula can be fixed. I  
6 think it needs to be repealed. I do think that for some of  
7 the reasons that Mitra mentioned, that some sort of  
8 expenditure targets in different sectors may be useful just  
9 as a monitoring system to alert us to when there are certain  
10 sectors that are growing faster than we anticipated, not  
11 that it dictates a response, but it calls our attention to  
12 where we are.

13 And in terms of if there's going to be a short-  
14 term fix, should it be at least a year? Absolutely.

15 MS. HANSEN: For the first one, more simply is I  
16 think yes, a minimum of a year at this point because of all  
17 the reasons cited.

18 I think the relative, the model of at this point,  
19 since I fully agree that tinkering with the existing SGR  
20 doesn't make sense. So I would move on the side of really  
21 saying what is the get-for if we end up doing this.

22 And I think in some ways -- I know this is not the

1 MedPAC role, but I think certainly my thinking goes to  
2 thinking of the legislative responsibility of those who  
3 govern to say what part of our GDP belongs in health care  
4 and what is a reasonable rate of inflation that should go,  
5 and then comparing it to other first-world countries that  
6 seem to get outputs that are seemingly more outcomes-driven  
7 in terms of quality.

8           So if we then back it into Medicare itself, the  
9 ability to have all of our providers move toward producing  
10 outputs and outcomes that are more value-based and more  
11 evidence-based toward the results, that may include both  
12 medical, which is what Medicare does do, but increasingly  
13 develop a method to understand the chronicity and the  
14 prevention to chronicity of using, say, things that are more  
15 perhaps touching other sectors, like CDC's work or AHRQ's  
16 work in terms of prevention and managing disease, so that  
17 what expenditures we have are going to be better distributed  
18 in terms of prevention that is primary, secondary and  
19 tertiary, so that we mitigate the use of tertiary.

20           So it's a very -- you know. We're talking about  
21 if we're going to change it that drastically in terms of  
22 being bold, let's look at using our medical resources under

1 Medicare, knowing what the population looks like and how  
2 then we potentially shape the value system.

3           There's one slide here about whether you start  
4 scoring it. Let me just quickly get to it here. I'm sorry.  
5 It's whether -- it was the second option that we had about  
6 how you might even have a redistribution to achieve the kind  
7 of outputs that you want for a Medicare population society.

8           So again, it was -- I am so apologetic.

9           MR. HACKBARTH: [Off microphone.] While you look  
10 that up, Jennie, Mike?

11          MS. HANSEN: Sure.

12          DR. CHERNEW: So I agree completely with your  
13 analysis.

14          MS. HANSEN: Seven. Sorry.

15          DR. CHERNEW: Do you want to finish?

16          MS. HANSEN: No, that's it.

17          DR. CHERNEW: So if I understand correctly, the  
18 current is for two, roughly two years from now? In other  
19 words, the current fix expires when?

20          MR. HACKBARTH: [Off microphone.] At the end of  
21 this calendar year.

22          DR. CHERNEW: Oh, so it's only basically --

1 MR. HACKBARTH: [Off microphone.] One year.

2 DR. CASTELLANOS: [Off microphone.] Nine months.

3 DR. CHERNEW: Right. So I think -- yeah. So then  
4 I would say we need at least a one year and probably a  
5 longer fix, and I'd like to think we'll have maybe one more  
6 fix in us, one more temporary fix in us before a longer fix.  
7 But in any case, I think it's important to say we need  
8 longer fixes as a general rule to the extent that we're in  
9 this place.

10 I guess my general views are if the problem is --  
11 accepting your analysis that you can't tie -- because of the  
12 vast number of providers, you can't tie the aggregate volume  
13 increase to fees. I think the first way to think of it is  
14 if you think volume is what the problem is we should do  
15 something that attacks volume.

16 So find the places where volume is going up and  
17 make someone say is it appropriate, is it not appropriate,  
18 how do you deal with it, what do you put in place would be  
19 the first thing that I would generically say although I  
20 still think that is a patchwork solution towards moving to a  
21 more sensible way from the fee-for-service system. And so I  
22 would be guided in this whole debate by what can we do to

1 move away from the fee-for-service system towards other  
2 systems.

3           So a few general comments about this. First one  
4 is I do think it's very important to rebase across the fees  
5 although, again, view that as a patchwork thing.

6           I think it's important that as we go through all  
7 the savings of our recommendations we try and capture those  
8 savings instead of just make it budget neutral and stick it  
9 back in the physician system some other place. In other  
10 words, even if it's small potatoes, I think it's worth  
11 trying to capture some of those things.

12           I think we have to give some serious thought when  
13 we have our broader benefit design discussion about taking  
14 some of those savings out in order to protect the fee  
15 schedule one way or another. The funny thing is it's very  
16 easy to get agreement, and I would agree that we want  
17 catastrophic coverage, but I think we can't put money back  
18 in through the benefit design and then back in through the  
19 fee schedule. So I think we need to think about benefit  
20 design and the role of patients in how we manage the use and  
21 what patients pay.

22           And I think we might get -- for example, if we

1 eliminated first dollar co-pays, which we were discussing  
2 before, I don't know how much money is there. But if we  
3 were to save that money, I would consider using that money  
4 in other ways in the fee schedule as opposed to throwing it  
5 back. So there might be other places as we go through where  
6 there's more money on the table.

7 I think, going forward, getting something like a  
8 flat update is useful. Or, even a flat update minus some  
9 small productivity thing as we've put in for all the other  
10 providers, I think we might be able to live with over some  
11 intermediate point in time although, again, that will  
12 eventually explode.

13 And so we need to find some way to have this safe  
14 harbor in ACOs, or whatever it is, so we can get a hold of  
15 paying providers in a more comprehensive way and paying the  
16 providers right instead of treating it like we're all in one  
17 huge physician group from coast to coast. And I think if we  
18 can [sic] get the payment right in the broader sort of ACO  
19 or MA world that will make this debate a lot more difficult.

20 And obviously I'm with Mitra. The scoring is just  
21 a fiction, and so it's just ridiculous. And having a  
22 broader debate about how to get around the fact that you

1 have to recognize something you know is there is important.

2 And if we could bring more money in through either  
3 taxes or through some other way, that's a reasonable thing  
4 to do. But I think again I agree with Mitra that as MedPAC  
5 I don't think it's up to us to make broad fiscal  
6 recommendations.

7 MS. UCCELLO: Just generally, I agree with much of  
8 what you said.

9 I know at the last meeting I had made a point that  
10 I was maybe not -- that some of these modification things  
11 were growing on me, but I was thinking about that.

12 MR. HACKBARTH: [Inaudible.]

13 [Laughter.]

14 MS. UCCELLO: But I was almost thinking of it in  
15 the absence of the ability to really just get rid of it  
16 altogether. But that, I mean I think I am persuaded by  
17 this. You know. It's time that we need to bite the bullet  
18 here and any impact that it may have had in the past of  
19 holding down updates. Like you say, there may be other ways  
20 to do that, and it's time for a sharp change.

21 MR. GEORGE MILLER: Yes, also I want to echo that  
22 I certainly appreciate, Glenn, the way you framed the whole

1 discussion and put it in an appropriate context.

2           So going down the list, yes, I believe that the  
3 SGR system should be eliminated. I think this is an  
4 opportunity for a transformational change, and with that I  
5 would agree that -- and I think Jennie used the term -- what  
6 you get for it. We should tie things into quality and  
7 quality outcomes, deal with what -- my words, of course --  
8 are health care disparities in that issue and tie that in as  
9 part of that quality issue, certainly get value for what  
10 we're doing and certainly do it in a way that's education  
11 and positive, that this will benefit the entire system. And  
12 then we can certainly deal with the issues that Michael  
13 talked about with benefit design and the role of the  
14 patients.

15           And I would also agree that it should be no less  
16 than one year. We certainly have to establish credibility  
17 within the physician community. It is very, very troubling  
18 as you've already illuminated, and Ron and Tom and Karen and  
19 the others. It is a major issue, and so I would support  
20 those things taking place.

21           DR. CASTELLANOS: Yes, I would agree to eliminate  
22 the SGR for the reasons you said, Glenn. I don't think I

1 need to comment on that.

2 Do I want another target? No.

3 What are other options? Maybe some limited future  
4 updates.

5 I'm really looking forward to hearing Dr. Bruce  
6 Hamory tomorrow from Geisinger Clinic. My understanding,  
7 they pay a salary, and then they pay for outcomes and  
8 quality. I'd like to see what his approach has been, and  
9 I'm going to ask him that. I know it's rural, but I'm going  
10 to ask him that.

11 I think we need to get -- you know. Start paying  
12 for quality and outcomes. Look at the ACO. Look at the  
13 medical homes. Look at the bundling. Look at a lot of the  
14 things that we've been talking about over the last four or  
15 five years.

16 What options do we have to get rid of the budget  
17 score? Simply write it off. Congress has no problems  
18 writing off bad debt from the World Bank or other countries.  
19 Why don't we start doing something for ourselves and our  
20 society?

21 You know Congress was the one that increased the  
22 payment rates without touching the targets. So I would just

1 write it off if we could.

2 As far as the duration of time, just what George  
3 said, we need some stability in the medical community. And  
4 I would do multiple years, not months, not one year, but  
5 multiple years. This has caused such a dissension in the  
6 medical community.

7 Again, I'm repeating something I've said over and  
8 over. It's like a broken record. I'm a small businessman.  
9 I run a small business. Now Tom and Karen don't; they work  
10 for company. But I run a small business with 90 employees.

11 And what do I have to do? If I'm not in business  
12 today, I can't take care of them.

13 So what has this forced me to do? It's forced me  
14 to look at other avenues of income. I'm just like any other  
15 businessman.

16 So we really need to stop that behavior and do  
17 what is appropriate.

18 MR. HACKBARTH: Bob, can I just pick up on Ron's  
19 first point about different payment systems?

20 I think there has been a hope that well, when we  
21 get rid of SGR, we can substitute new payment systems that  
22 create better incentives, and obviously that would be ideal.

1 The problem though is that we've got a mismatch in our  
2 timelines.

3 I am an optimist about our ability to move away  
4 from fee-for-service and develop new payment methods that  
5 improve incentives, but as we've often discussed before, the  
6 rate-limiting factor in that evolution is the care delivery  
7 system needs to change and organize to be able to receive  
8 new payment mechanisms like ACOs. And that's going to take  
9 some time, and now I fear that we are sort of out of time in  
10 the SGR game.

11 So we could, however, and this is the point I  
12 wanted to emphasize, is that we could think about to link  
13 the transition at least a little bit and say that among the  
14 benefits of moving into ACO is a different payment rate on  
15 the underlying physician services. So it's sort of an added  
16 inducement to try to accelerate the care delivery  
17 reorganization process.

18 So I just wanted to flag that as a possible idea.

19 DR. BERENSON: Just a few comments. One, I'm  
20 onboard. The SGR needs to be abandoned, and in a moment  
21 I'll say why I now think we should not try to replace it  
22 with a different mechanism that uses a formula, but I'll

1 come back to that in a second.

2 I think Mitra's and Mike's point is very  
3 important, that we can't deal with 300-plus billions of  
4 dollars. It's a fiscal decision for the country. There's  
5 now a proposal on the table that's in the multi-trillions of  
6 dollars of savings. In that kind of a context, you can deal  
7 with an SGR overhang, and that's not anything we're going to  
8 be doing.

9 We need to try to buy off as much time as we can.  
10 A year, two years would be great. I assume we won't get  
11 further than that to keep the pressure, as Ron and everybody  
12 has said. It is undermining Medicare's credibility with  
13 physicians and other providers. It provides a cloud over  
14 the program, and we need to move it down. We need to buy as  
15 much time as possible. So that actually -- you know.

16 The kinds of numbers you were referring to, \$20  
17 billion over 5, is the kind of number that can buy you some  
18 time. Twenty billion over five is beginning, is something  
19 real over ten, but it's not in that ballpark.

20 Physician payment, physician fee schedules are a  
21 little different from virtually all of the other payment  
22 systems in Medicare, which at least have some element of

1 prospective payment and some incentives for efficiency.  
2 There are none in a fee schedule. There is some rationale  
3 for -- I mean what we see is volume growth and some ability  
4 to deal with it.

5 I have, over time, been mildly attracted to a type  
6 of service approach but ultimately have decided that if it  
7 still says we're going to now reduce all imaging services by  
8 X percent to hit a target, that's formulaic, treats  
9 appropriate imaging values the same as inappropriate imaging  
10 values, and similarly for other services. It does have  
11 perverse incentives to just use a formulaic we're going to  
12 cut everybody equally.

13 But I do think there might be some logic in  
14 establishing a target for spending in the physician fee  
15 schedule and giving some discretion to the Secretary to  
16 figure out how to achieve it by targeting particular  
17 services, which in the Secretary's judgment can be where the  
18 prices can be reduced without harming beneficiaries.

19 Some work I was involved with a couple years ago  
20 with RAND in which we asked, using the RAND technique of  
21 asking clinical experts to tell us why certain services were  
22 fast growing; they were high spending and fast growing in

1 the physician fee schedule. Was it because of clinical  
2 breakthroughs or epidemiologic changes, or something to do  
3 with payment incentives?

4           And it was a process that actually helped us sort  
5 out in which cases it actually was clinical. There was a  
6 real reason for this volume increase. And in other cases,  
7 at least the experts we talked to simply said this is  
8 because the payments are too generous and people have  
9 figured out how to take advantage of it, and there are many,  
10 too many of these services being provided.

11           I think one could think about that kind of a  
12 process to support the Secretary to sort of target areas  
13 where if you need to make a target you can decide you're  
14 going to reduce some payments, or generate comparative  
15 effectiveness studies.

16           One of those areas, I'll be very specific, the  
17 epidemic of injections into the spine that are taking place  
18 with very murky evidence of what the indications are -- a  
19 perception, at least the people we interviewed, that they  
20 were very generously paid. It may be that in a refined  
21 time-based RBRVS process we would identify those being  
22 overpaid. But it also could be that it would generate, if

1 CER works, an NIH study which would actually give us the  
2 kind of information we need as to whether we should be even  
3 covering some of those services in the first place.

4           So I think that there -- and I'm not making this  
5 as a recommendation today, but I think we should think about  
6 whether there is any role for having a target which is not  
7 implemented through formula but is a forcing action of some  
8 kind to the Secretary to look for ways to live within that  
9 target.

10           MR. HACKBARTH: So can I just link Bob's  
11 suggestion to some other conversations that we've had today?  
12 Our previous session was talking about refining the relative  
13 values; that is a budget-neutral, redistributive exercise.  
14 What Bob is proposing here is that there be some targeted  
15 effort to reduce fees for identified overpaid services and  
16 do it in a non-budget-neutral way.

17           We had talked briefly this morning, Bruce, about  
18 exploring that avenue.

19           One of the concerns I think all of us have about  
20 the redistribution mechanism is that these are politically  
21 difficult things to do, and secretaries don't like to  
22 redistribute a lot of money for no budget savings. There's

1 a lot of pain for relatively little gain, and so the concept  
2 that we're trying to think through is could you use a target  
3 to sort of nudge that process along and potentially achieve  
4 some budget savings for it.

5 So it's very much in its embryonic phase. Whether  
6 we can figure out how to make it work, it raises a host of  
7 issues that need to be thought through carefully, but it's  
8 worth examining.

9 MR. KUHN: I would agree with that assessment,  
10 that it's worth examining. In fact, as many of these  
11 concepts that we can examine, we need to keep them all very  
12 much in play.

13 But I'm just going to join the chorus with  
14 everybody else. It's a flawed system. It doesn't work.  
15 It's got to go as we move forward.

16 But I think, as Glenn said at the outset, that  
17 there's got to be tradeoffs here as we continue to move  
18 forward.

19 And I think per the conversation we had this  
20 morning about quality health care, the way we were thinking  
21 on that one in terms of synching that up where we want the  
22 program to be five, ten years down the road. I think the

1 same kind of thought pattern has to go here as we think  
2 about the opportunities of the integration with ACOs,  
3 medical homes, other things out there.

4           And I think importantly, a chance to really  
5 rethink about primary care and how to kind of drive more  
6 activity and move that in that direction. When we look at  
7 the dwindling numbers of individuals in primary care, the  
8 age of that population of practitioners out there, a chance  
9 that we can use this policy to help move that forward is  
10 going to be pretty critical for us. So I think that's a  
11 part and will be an important part of the conversation.

12           The other issue that you've laid out, Glenn, that  
13 is of length of time, of course. I mean a year at a  
14 minimum, longer than that if possible.

15           But the other aspect of that that we have to think  
16 about too is what this has done at CMS and ultimately their  
17 contractors, the Medicare administrative contractors. With  
18 the number of overrides we've had over the last couple  
19 years, I think CMS has done a terrific job of holding claims  
20 with their contractors to minimize disruptions. And where  
21 they have gone past the 14-day minimum payment floor, CMS  
22 has taken it upon themselves to reprocess those claims.

1 It's been very expensive.

2           And as Bob was talking about this morning, there  
3 are kind of two different funds that CMS gets. They get  
4 their operational funds, and then there are the programmatic  
5 funds. That's eating away at operational funds. That  
6 shouldn't occur. That's out there. And so by holding those  
7 claims, reprocessing them, I think that's taken some of the  
8 sting from physicians, so they didn't have to do it  
9 themselves. But it's very costly for the government in more  
10 ways than we realize too.

11           DR. KANE: Yeah, well, this is -- I mean it's an  
12 impossible subject. But I guess I early on thought this is  
13 a volume problem; we should be coming up with volume  
14 solutions rather than price solutions.

15           And I think I mentioned this last time, that maybe  
16 we should look at have a three-year solution and then  
17 hopefully, once you sort of save money for three years,  
18 you've had time to rethink where you're going. I think even  
19 a one-year solution isn't going to do you much. It's a lot  
20 of work just to gear up to implement any solution -- so a  
21 three or four, or you earn your way out of the bad solution.

22           And the three-year solution shouldn't be pretty

1 because you want people to head off into the right  
2 direction, want to be in an ACO or a medical home and have a  
3 global payment. In high volume areas, you withhold 30  
4 percent of the fees, and if they do better than expected  
5 they get a little bit back. Have it be like the old  
6 withholds used to be where you only got it back if you hit  
7 your target.

8           So at least you're not saying it's a 30 percent  
9 cut. You're saying you'll get it back if you keep your  
10 volume to the level of the national bottom quartile, or  
11 something, something impossible probably.

12           I mean I think we have to just set something in  
13 place for -- not me because it's not me, but three to five  
14 years of something that's pretty dramatic and say we have to  
15 take this seriously. This isn't -- you know. It's a flaw,  
16 that part of this flaw has given us enormous volume  
17 increases that are not easily -- I think as Bob was saying,  
18 not all well explained by clinical need. If you can  
19 highlight those as well as the geographic, that's even  
20 better. I don't know what's feasible technically.

21           I mean you can even put -- you could even say  
22 we're going to incentivize Medicare patients to get all

1 their most expensive elective surgery in India. Pay them to  
2 go. It's much cheaper. People are going to Mexico for  
3 their dental care. You know, \$200 versus \$2,000. I mean  
4 there are ways we could really nail costs for three years if  
5 we really had to. It wouldn't be popular, but there is no  
6 popular solution.

7           So I don't know whether the right thing to do is  
8 say for the next three to five years let's just find ways to  
9 cut costs that will minimize harm to beneficiaries and  
10 signal that this is not sustainable, so that people get off  
11 their complacency and stop moaning that it's all government,  
12 bad government, and just say wow, we've got to do something  
13 about this because the system is really falling apart.

14           Otherwise, yeah, it would be nice if we could just  
15 say well, eliminate the tax cuts, but that's not in our  
16 domain. So you know. End the war in Afghanistan. Those  
17 are all nice, but that's just not in our domain.

18           If people really want us to come up with a  
19 solution, I think we should just say here's 3 to 5 years of  
20 ways to keep costs \$20 billion below what they would  
21 otherwise be. You pick. None of them are good. But  
22 meanwhile, the goal is by the year 6 to 10 people are moving

1 into these much better payment systems.

2 So anyway, good luck, everybody.

3 [Laughter.]

4 MR. BUTLER: So I think your strongest argument,  
5 which I know you agree with, is that the model doesn't make  
6 any sense. You know. You can't take one for the team at  
7 the national level. You can't even do it within a four-  
8 person office sometimes.

9 And I think you should reiterate it applies not  
10 only to Part B spending but any of the components of  
11 Medicare. It just doesn't align individual behavior.

12 So now if I get bolder in thinking though, I think  
13 Congress, if I were them, and I don't plan to be, I'd think  
14 they'd expect or would think that MedPAC can begin to grow  
15 to be something in between what it is today and what IPAB  
16 would do. And I think they want to see a set of  
17 recommendations that addresses the national spending a  
18 little bit more than just the unit prices that we do in  
19 March and some reform ideas that we put on the table in  
20 June.

21 So in a way, this is just a thought, on the spot  
22 kind of, but if you took what we do in March and more

1 explicitly said: Okay, here are the contributions that the  
2 unit prices are making, and we're also making some other  
3 recommendations. And here are the contributions on the  
4 volume side we think these are making. And by the way, here  
5 is the aggregate spending for this service.

6 Just to put it in front of them and say this is  
7 the aggregate Part A hospital, this is the hospice. And  
8 assemble it in a way that kind of draws more attention to  
9 the aggregate spending for each of the services we're making  
10 recommendations on as well as the volume recommendations.

11 And then I realize you get to episodes or ACOs,  
12 and they cross silos, but there may be a clever way to kind  
13 of being to more explicitly say what those are contributing  
14 to the national spending. And you're somehow getting closer  
15 to kind of us taking responsibility for the total budget as  
16 opposed to just the unit pricing.

17 And really, if you were to start over, you  
18 probably wouldn't say well, we were so fixated on this March  
19 and June report, and what's in one and what's in the other.  
20 Now we're redefining what our congressional responsibility  
21 is. I realize that, but if I were to think out of the box I  
22 would try to go a little more in that direction, if that

1 makes sense.

2 DR. STUART: I really like Ron's terminology.

3 Let's write it off.

4 And the reason I say that is that I think there  
5 are two issues here. Glenn, you said well, there's no way  
6 that Medicare is going to be able to come up with cost  
7 savings equal to \$300 billion over 10 years. It's actually  
8 worse than that because this thing grows. And the \$300  
9 billion is based upon a flat, you know, is based upon no  
10 increase, and we know there are going to be increases. So  
11 writing it off is the realistic thing to do.

12 Now the irony is that it's going to be easier to  
13 write it off the bigger it gets because then it's going to  
14 become obvious that there is no solution that is going to  
15 handle that particular thing. Now that doesn't make the  
16 debt go away. It just simply means that we have to be  
17 realistic about what the long-term debt is.

18 And if you look at the actuaries', at the  
19 trustees' report, you know they've got two lines. One that  
20 says current law, and the other one says well, let's bite  
21 the SGR bullet and just recognize that the debt is there.

22 I guess I like the idea of these contingent

1 tradeoffs, but I'd do that really quickly because I think if  
2 we go too much longer on this people are going to say:  
3 Well, you know, there's no contingency here. We're just  
4 going to have to write it off anyway. And so what are we  
5 giving up?

6           So then we get back into the question of having  
7 some realistic ways of constraining growth, and I don't have  
8 answers to that, but I really look forward the conversations  
9 that we're going to have around. And I'd just separate  
10 those two issues. I'd write off the SGR, have a realistic  
11 debt estimate and then really pay attention to constraining  
12 growth.

13           DR. BAICKER: Yeah, I think we're all agreed that  
14 the behavioral response one might hope for in physicians,  
15 where they foresee a drop in prices so they rein in their  
16 volume, is not going to operate at the aggregate level.  
17 There's just a mismatch between individual choices and then  
18 the effect on payments through this aggregate system. So it  
19 fails on that front.

20           And then the question is did it succeed -- and  
21 this is a rhetorical question. Did it succeed on the fiscal  
22 discipline front of exerting a cudgel because it keeps

1 getting worse and worse?

2           So there's a strong incentive to fix it now, and  
3 we've seen the patchwork solutions. And the counterfactual  
4 of what would it have looked like in the absence of the SGR,  
5 we're just not sure. It's possible that it could have been  
6 much, much worse.

7           But on the other hand, there's this real cost in  
8 provider uncertainty that we know is an increasing burden as  
9 the cycle gets shorter and shorter.

10           And I'd argue there's another cost in terms of  
11 successful budgeting in that when forced to forecast things  
12 based on a known fiction it distorts the estimates of the  
13 costs and budgetary score of all the other things that we  
14 talk about that interact with the physician system. And  
15 then there are alternative policy baselines that assume that  
16 the SGR doesn't hold any -- it really just muddies the  
17 water, and I think ties our hands, or hampers our ability to  
18 do accurate forecasting and planning across the program.

19           So those are two real costs that come at a  
20 potential benefit of exerting some impossible to measure  
21 fiscal discipline. It doesn't seem like that's a great --  
22 that it's been very successful on either of the measures.

1 So I would be happy to see it changed along those lines.

2 MR. ARMSTRONG: Glenn, just briefly, I would  
3 affirm that we should write it off, or whatever it is we do,  
4 and look to design a different system.

5 I think your points about the timing and how our  
6 timing and the realities of our national budget -- I don't  
7 know how to reconcile that -- as well as some of our other  
8 agendas should be thought through.

9 At least a one-year update, but you know, I think  
10 a one-year is short. And I think we ought to ask whether it  
11 makes more sense to look more like 18 to 24 months, frankly.

12 And then finally, redundant to many points made,  
13 but I would just affirm too that to the degree this sets us  
14 up to look at ways of applying to this part of our payment  
15 policy. A lot of the concepts that we've been talking about  
16 in these other agendas, like breaking down the silos between  
17 different parts of a care system that should work more like  
18 a system and focusing on population health and maybe  
19 investing more aggressively in some of these areas because  
20 we know there's a return that accrues in other parts of our  
21 system, to the degree we can use this to really think in  
22 those terms, I think it would be potentially very, very

1 valuable.

2 DR. BORMAN: I would agree with the groundswell  
3 for elimination of the SGR. I think the point that was made  
4 by some folks who used be here a lot, that it was sort of  
5 linking it to the common man, if you will, through the GDP,  
6 the average taxpayer, the worker who had to increase his or  
7 her productivity, was a well-intentioned idea. But I think  
8 that the nature, as has been pointed out, doesn't get to the  
9 individual to make that point. And the formulaic nature of  
10 it prevents it from being useful.

11 Medical practice is changing every day and at a  
12 pace like change in all of our society, that's accelerating,  
13 and the change in medical practice will outpace the ability  
14 to update any formula that we create. So I would agree with  
15 Bob. I've moved away some from thinking about other  
16 formulas just because I think this horse -- as a colleague  
17 of mine says, this train has left the station.

18 And there are so many things that we'd like to do  
19 that I'm not sure we can even do, given the way that people  
20 practice coming out of medical school and residency now. So  
21 I think that formulas are not going to get us anywhere.

22 I do believe that a minimum of two years may be in

1 fact better because I think about the effects on the VA  
2 health care system, for example, by a one-year appropriation  
3 process. And while this isn't exactly the same thing, it  
4 gives me great pause to think about a system having to  
5 recalibrate even on an annual basis when the stakes are so  
6 high.

7 I think Mitra's point actually, about ensuring  
8 that the renewal comes in a timely fashion as opposed to the  
9 crisis, is absolutely important. So for example, a two-year  
10 system in which the renewal is six months before the  
11 expiration might in fact start to get us there.

12 I think in terms of some of the tradeoffs that  
13 it's time for the physician community to go back and  
14 actively work, and it's an unpopular message. And I have  
15 taken some potshots, and I'm sure Ron and Tom have as well,  
16 about one of the tradeoffs here is physicians can no longer  
17 ignore being fiscally accountable, at least to some degree.

18 I would argue that we're not the only people who  
19 are fiscally accountable, but that we need to undertake some  
20 fiscal accountability and that we have been insular about  
21 this, and we need to do better. And that should be one of  
22 the -- philosophically, there's a tradeoff.

1           I do think that another potential tradeoff on the  
2 tradeoff list is trying to push more quickly even for more  
3 limited electronic solutions. I think that things that save  
4 money that don't take a lot of nurturing and fooling with  
5 are better. And I think if we just had a simple system  
6 where you knew right away that the patient you're seeing  
7 just had a CBC two days ago, or a chest x-ray three weeks  
8 ago, would be a huge advantage.

9           And can we not devise some flash drive or CD or  
10 something that somebody takes with them out of every visit  
11 that at least starts to reap those savings as opposed to  
12 waiting for the perfect compliant electronic system? I'm  
13 not sure, but that's a place that's almost automated savings  
14 if we could make it work by eliminating those duplications.

15           And then my last point would be that I think  
16 there's -- as we've highlighted in the benefit design  
17 discussion, I think also while we take it to the physician  
18 community to say let's be more fiscally accountable, we  
19 need, our beneficiaries need to understand better what their  
20 benefits are. Whether it's that simple little table about  
21 deductibles and co-insurance, whether it's the public  
22 service announcements, that there's one a night that is

1 about home health and what your deductible and co-pay, or  
2 whatever, there's got to be a way to utilize various  
3 communications, media to get those messages out there better  
4 because ignorance on the part of our beneficiaries is also  
5 hurting the system in a very tangible way.

6 So I think that there are things to be undertaken  
7 by everybody, but I think that the elimination and at least  
8 a two-year time horizon for one or two cycles is probably a  
9 reasonable way to go.

10 MR. HACKBARTH: Cristina, Kevin, anything you want  
11 to say or ask?

12 MS. BOCCUTI: No. It's good discussion.

13 MR. HACKBARTH: Okay. Mark? Good.

14 Okay. Thank you and more on this soon.

15 So we are to our last presentation of the day on  
16 private sector payment rates for physician and hospital  
17 services.

18 MR. ZARABOZO: Good afternoon. In the interest of  
19 time, July and I are going to try to do this very quickly,  
20 so we'll be deleting a lot of information that we otherwise  
21 would have presented.

22 MR. HACKBARTH: Yes, and thank you, Carlos and

1 Julie, for helping us with our time crunch. We appreciate  
2 it.

3 MR. ZARABOZO: We are here to discuss the work  
4 we've been doing on private sector payment rates. The last  
5 presentation on this topic was in November. Today we'll  
6 provide additional information on variation in physician  
7 payments across areas and by type of service.

8 In addition, we'll present our preliminary  
9 findings on the variation in private sector hospital  
10 payments across areas, and we'll illustrate a possible  
11 method for looking at variation in hospital payments within  
12 a given area. All of our results continue to be preliminary  
13 and subject to change.

14 This slide serves as a reminder of why we have  
15 undertaken an examination of private payer rates. Our  
16 results so far have been consistent with the literature and  
17 with other studies of private payer rates. Generally, each  
18 study shows wide variation in payments across areas and  
19 within areas, even after adjusting for factors such as case-  
20 mix and differing costs in an area.

21 Our eventual goal is to understand the causes for  
22 this variation, and from a Medicare point of view, if

1 private payer prices are viewed as a reference point for  
2 determining an appropriate level of Medicare payments, what  
3 should the relationship be between private sector rates and  
4 Medicare rates? The answer depends on what the private  
5 sector price is and how that price was arrived at.

6 If, for example, the source of variation in  
7 private payments is the market power of insurers or  
8 providers, what does this mean for Medicare payment policy?

9 This is the outline of our presentation, which  
10 we'll skip, and we'll just do directly to telling you what  
11 we found.

12 We'll begin by looking at a slide that shows one  
13 way of looking at the variation in payment rates across  
14 areas. To review our methodology, for physician services we  
15 use a market basket of services that includes the majority  
16 of services, and we determined payments by HCPCS, adjusted  
17 by a geographic adjustment factor in each area.

18 This gives us a relative index for each area. On  
19 the left half of this slide under physician payments, you  
20 see that the index values range from 0.73 to 2.2. That is,  
21 the area with the lowest value has prices that are 73  
22 percent of the national average level of payments, and the

1 2.2 area has prices that are 220 percent of the national  
2 average.

3           These two index values show that the area with the  
4 highest payment rates at 2.2 has payments that are 3 times  
5 the lowest area at 0.73. If you remove the lowest and  
6 highest index values for physician services, the ratio of  
7 the highest to lowest remains close to 3, at 2.8.

8           For hospital services, we see that after removing  
9 the single highest and lowest index value, there is a four-  
10 fold difference between the lowest and highest payments.  
11 The methodology that we use to arrive at average hospital  
12 payments in an area yields a severity-adjusted, wage index-  
13 adjusted average per stay payment in each area that is  
14 compared to the adjusted national average across all  
15 metropolitan areas.

16           You will note that we provide results for only 344  
17 metropolitan areas for hospital payments while we show 432  
18 metro areas for physician payments. For the hospital side,  
19 although we start with 432 areas, we only used areas in  
20 which there were over 200 hospital stays. The number 432  
21 exceeds the number of metropolitan statistical areas in the  
22 United States because we are separating out metropolitan

1 divisions and we are dividing up multi-state metropolitan  
2 statistical areas into single state portions of such areas.  
3 We're also excluding Maryland from the data as an all-payer  
4 state for hospital services.

5           In November, you saw a slide like this one showing  
6 the variation in physician payments across areas. Here  
7 we're showing the same data but weighted by the overall  
8 population in an area. The highest bar in this bar graph  
9 shows that about 30 percent of the population in  
10 metropolitan areas resides in areas where the payment rates  
11 for physician services are between 95 and 105 percent of the  
12 national average. There are no areas below 0.7 and 11  
13 percent of the population is in areas where the index value  
14 is greater than or equal to 1.2 -- that is, payments at or  
15 above 120 percent of the national average level of payments.

16           The last figure, 11 percent, contrasts with the  
17 hospital results where we see that 16 percent of the  
18 population resides in areas in which hospital payments are  
19 at or over 120 percent of the national average payment level  
20 compared to the 11 percent for physician services.

21           Here we see also that a little over 25 percent of  
22 the population resides in areas in which hospital payments

1 are in the 95- to 105-percent range, a smaller share than we  
2 saw for physicians at 30 percent in the preceding slide.

3 As indicated in the preceding slide showing the  
4 distribution of relative payments across areas, some areas  
5 have relatively high hospital payment rates or high  
6 physician payment rates and some areas have low rates. Here  
7 we show that the two do not always travel together; that is,  
8 an area with high hospital payments can have low physician  
9 payments, for example, or vice versa.

10 This is a collapsed version of a table in your  
11 mailing material that included a greater number of  
12 intervals, but this table illustrates the general points.

13 On the diagonal in the dark-shaded boxes, you see  
14 areas in which both the physician payment levels and the  
15 hospital payment levels are in the same general range, which  
16 is a total of 41 percent of areas and 45 percent of the  
17 population.

18 With respect to other types of areas, comparing  
19 the low end and the high end of payments, it is more likely  
20 that both physician and hospital payments are low in an  
21 area, which is the under 90 percent, the first dark-shaded  
22 area, as opposed to both being high, which is the lower

1 right-hand corner where 8 percent of the areas and 5 percent  
2 of the population are areas where both the hospitals and  
3 physicians are relatively high payment areas.

4           This slide provides information about the  
5 variation in physician payments based on our examination of  
6 the data by type of service. Among the services with the  
7 highest variation are endoscopy, lab tests, and imaging for  
8 heart conditions. We see the lowest variation in  
9 anesthesia, offices visits, and influenza immunizations.  
10 For endoscopy-bronchoscopy, the area at the 90th percentile  
11 of the average payments has payments that are almost 4 times  
12 as high as those in the area of the 10th percentile of  
13 average payments. In the case of the administration of the  
14 flu vaccine, the ratio is less than 1.5. However, as we  
15 noted in the mailing material, there can still be very high  
16 payments in flu vaccine administration in some areas in  
17 spite of the small variation across the country.

18           This slide is a revised version of the variation  
19 in physician payments that we presented the last time we  
20 talked about private payer issues. The slide shows PPO  
21 payment rates for a mid-level office visit in different  
22 markets along with the number of claims in each area for the

1 service. Each area has at least 25,000 claims for the HCPCS  
2 code.

3 We've also checked the data against other data to  
4 ensure that this represents differences in payments across  
5 providers rather than only differences because there are  
6 multiple insurers. The data for the markets that we show  
7 here are consistent with what we know about these markets.

8 In Miami, for example, the first area shown, where  
9 physicians are less likely to practice in large groups, we  
10 see that payments are relatively low in general, and the  
11 median payment is quite low. Boston has a somewhat higher  
12 median payment with wide variation, and Milwaukee has a very  
13 high median payment with some degree of variation.

14 Among the markets shown, the greatest variation is  
15 in the San Jose area, even though it is the area with the  
16 fewest claims for this service among the areas shown.

17 The next slide that we will display presents new  
18 information that was not including in your mailing material.  
19 However, before proceeding to the next slide, we should talk  
20 about the nature of the data that we are using. Our data  
21 are claims data for the year 2008 from MarketScan, a product  
22 of Thomson Reuters. It is a data set containing claims data

1 of primarily self-insured plans from insurers and  
2 administrators voluntarily providing data. The contributing  
3 entities can vary from one year to another. We do not know  
4 the identity of the contributing insurers and  
5 administrators, and we also do not know the identity of the  
6 providers. This makes it difficult to determine the extent  
7 of intra-area variation.

8           We noted in the mailing material that the data are  
9 geographically skewed towards the South, a point that we  
10 discussed in connection with the distribution of HMO claims  
11 in the data as compared to the distribution of HMO  
12 enrollment in some states. Therefore, we may have an issue  
13 as to whether or not we have a representative sample of  
14 claims in each area that we look at.

15           In this slide we're using one possible method of  
16 showing potential intra-market -- that is, within market  
17 variation in payment rates for a specific inpatient hospital  
18 service using the DRG for major lower extremity joint  
19 replacement, one of the most common procedures in the  
20 private payer data.

21           We took the top ten metropolitan areas and numbers  
22 of such procedures, and we are displaying four of the areas

1 here. Looking at the specific DRG is somewhat similar to  
2 looking at a particular HCPCS code, as we did in the  
3 preceding slide on physician payments. However, it is not  
4 exactly the same because HCPCS codes are universally used  
5 for physician payment. While the DRG-based payment is one  
6 possible arrangement that can exist between a hospital and  
7 an insurer, other possible arrangements include per diem  
8 payments or discounts off of charges, for example.

9           With that caveat and with our caveat about whether  
10 we have a representative sample in each geographic area,  
11 this slide shows the extent of variation between markets and  
12 across markets in the payment for this service. The highest  
13 median payment is for the Virginia portion of the  
14 Washington, D.C., metropolitan area, with the other areas  
15 having lower medians that are closer to each other.  
16 However, the widest range of payments is in Los Angeles and  
17 Chicago. Although we've stated several caveats, these  
18 dollar figures are internally consistent with the overall  
19 MarketScan data in that the average national payment for  
20 this DRG is about \$22,000 across metropolitan areas. Given  
21 the level of the DRG weight for this particular DRG, the  
22 \$22,000 figure is also consistent with the figure that we

1 included in the mailing material as the national average  
2 adjusted per discharge payment for all discharges across  
3 metropolitan areas.

4           It is likely that a couple of our Commissioners  
5 have intimate knowledge of one or two of these hospital  
6 markets and can comment on whether these data are consistent  
7 with their knowledge of the markets.

8           We are continuing to check our data for anomalies,  
9 and we intend to sort out the limitations in the data that  
10 we talked about, such as which areas may have non-  
11 representative samples based on the number of covered lives  
12 including in the MarketScan data in each geographic area.

13           We invite your comments on our methodology and the  
14 issues that we have raised. The next major task in our work  
15 is to gather information about the market conditions in each  
16 geographic area and examine the relationship between market  
17 factors and payment rates and spending, including using a  
18 case study approach to look more carefully at specific  
19 areas.

20           Thank you and we look forward to your questions.  
21 And I cleared this with Mark already: We will only take  
22 questions that can be answered yes, no, or no opinion.

1 [Laughter.]

2 MR. HACKBARTH: Okay. In the interest of time,  
3 we'll do just one round again. Let me start with a  
4 clarifying question. Would you put up Slide 9, please? I'm  
5 just trying to wrap my mind around this. Let's focus on  
6 Boston. Of these markets, it's the one I'm most familiar  
7 with, although my knowledge is dated. So the n here is  
8 37,300. That's 37,000 claims for --

9 MR. ZARABOZO: For this particular HCPCS, mid-  
10 level.

11 MR. HACKBARTH: Yes, this particular service.

12 MR. ZARABOZO: 99214.

13 MR. HACKBARTH: And then we have a distribution of  
14 the payment rates for that particular service indicated by  
15 the yellow line. Now, there aren't that many different  
16 insurers in Boston.

17 MR. ZARABOZO: Well, see, that's one of our points  
18 here, that we believe this shows variation among providers  
19 in the payments that they received, which, of course, is  
20 also what the attorney general showed about Boston. You  
21 have a lot of variation.

22 DR. KANE: [off microphone] In Boston they could

1 show you the variation within one insurer across providers,  
2 so that is very -- and it was pretty significant.

3 MR. HACKBARTH: And so this particular one, this  
4 particular graph captures the variation in the payment  
5 rates, which is a function of both the number of different  
6 providers and the different rates for each provider and the  
7 number of insurers.

8 MR. ZARABOZO: That's correct.

9 MR. HACKBARTH: A combination of the two.

10 MR. ZARABOZO: But, again, we believe a lot of  
11 this, looking at some other data, is due to variation among  
12 providers.

13 MR. HACKBARTH: Providers. Yeah, okay. Got it.

14 So, let's see. Which side are we on to start?

15 DR. BORMAN: It's a very elegant analysis. I'm  
16 not smart enough to question you about it, Carlos

17 MR. HACKBARTH: Okay.

18 MR. ARMSTRONG: So I'm not smart enough to avoid  
19 asking probably a dumb question, but on page 52 of the  
20 report, you show --

21 MR. ZARABOZO: Do we have 52 pages?

22 MR. ARMSTRONG: I'm sorry. Page 22.

1 DR. BORMAN: Good beginning.

2 MR. ARMSTRONG: I'm easily overwhelmed with small  
3 numbers, actually.

4 [Laughter.]

5 MR. ARMSTRONG: But I look at this, and if I read  
6 it correctly, my sense is that private insurers are paying a  
7 lot in markets that I tend to think of as being low-cost  
8 Medicare markets, and the inverse. Am I crazy or is there  
9 some reason for seeing that?

10 MR. ZARABOZO: I'll answer the "am I crazy" first,  
11 and I have no opinion on that.

12 [Laughter.]

13 MR. ARMSTRONG: Thank you. Good answer.

14 MR. ZARABOZO: But, no, you're correct, this is --  
15 in fact, I think Mike has looked at this, the inverse sort  
16 of relationship between -- these are the low Medicare  
17 utilization areas. They are also, as -- this is what we're  
18 showing. It's also what the GAO showed based on the 2001  
19 data, that, for example, Wisconsin, a lot of areas in  
20 Wisconsin are very high. Unit prices is what we're talking  
21 -- again, we're talking unit prices here.

22 MR. ARMSTRONG: And so part of the work that we're

1 teeing up to go forward would be to try to understand why  
2 that is. Is that correct?

3 MR. ZARABOZO: Right.

4 MR. ARMSTRONG: Okay.

5 DR. BAICKER: I had a quick question on Slide 7  
6 and the corresponding table. I had a hard time looking at  
7 that, integrating what I would expect to see if there were a  
8 high correlation versus a low correlation given that the cut  
9 points are somewhat arbitrary, not uniform across. So it  
10 would be nice to see it in a way that it's easier to --

11 MR. ZARABOZO: Yeah, the mailing material has --

12 DR. BAICKER: Had thinner slices, but non--

13 MR. ZARABOZO: Right, thinner slices.

14 DR. BAICKER: But they weren't populated in  
15 uniform ways. You could have a summary slide that showed  
16 the correlations in different quartiles versus the spending  
17 percentiles which don't slice the distribution evenly. I  
18 just had a harder time doing the math to figure out what I  
19 should expect to see if there were no correlation versus yes  
20 correlation, how I'd expect the percentiles to be  
21 distributed given that the distribution wasn't sliced in  
22 uniform tranches.

1           MR. HACKBARTH: [off microphone] yes/no/no opinion  
2 question for the economists in the group to address as we go  
3 around. Is this pattern of prices consistent with the  
4 existence of a competitive marketplace for these services?

5           DR. MARK MILLER: Not so easy, huh?

6           [Laughter.]

7           DR. CHERNEW: It depends what you think about the  
8 input price variation. So what you haven't done here is you  
9 don't have like the weight --

10          MR. HACKBARTH: Focus on the intra-market  
11 variation.

12          DR. CHERNEW: So the intra-market variation part  
13 generally would not be, unless you thought there were big  
14 quality differences or you thought there was a lot of noise  
15 in the data, because you could -- how you measure the  
16 prices, there's going to be -- a lot of this is going to be  
17 noise in there, and so you have to decide how much of it's  
18 really noise and how much of it's quality and heterogeneity  
19 of things. But the obvious general answer is this is  
20 awfully big to try and explain it away with those kind of  
21 explanations.

22          DR. BAICKER: But then the --

1 MR. HACKBARTH: [off microphone].

2 DR. CHERNEW: This is a longer discussion that is  
3 probably more dull, but in the claims data, you could have  
4 five claims for the same service, and then it turns out one  
5 was a reconciliation claim, and so you don't -- I don't know  
6 how you've dealt with all that yet, but in our data, for  
7 example, we find huge amounts of noise because it's not just  
8 one claims that's just clear, oh, that was the MRI.

9 DR. BAICKER: And also, you want to distinguish  
10 between competitive markets on the provider side versus the  
11 insurer side. There are two different problems floating  
12 around in these markets.

13 MR. HACKBARTH: Focused on the provider side.

14 DR. STUART: But that doesn't lead to an  
15 expectation of heterogeneity in terms of hospitals versus  
16 physicians. I think this is what you're suggesting. Would  
17 you expect in competitive markets that you would have -- you  
18 know, that they'd be below the mean or the median and in  
19 noncompetitive markets they'd be above the median? But  
20 there's no particular reason to presume, and we don't know -  
21 - and I think this is what Carlos is suggesting as his next  
22 step, is do we have a measure of competitiveness that looks

1 at both physicians and hospitals?

2 MR. HACKBARTH: I want to totally disrupt the  
3 flow. You will have another shot when we get around to you.

4 MR. BUTLER: Two questions. One, not from this,  
5 but the stunning thing when I read the chapter was the  
6 California, which did take into account the costs, the input  
7 prices, if you will, and showed a \$5,000 difference per cost  
8 per stay compared to the rest of the nation. I'm curious  
9 why you didn't put that up here. That was such a major  
10 deviation. I would just...

11 MR. ZARABOZO: No reason.

12 MR. BUTLER: Okay.

13 [Laughter.]

14 MR. BUTLER: All right. Then go back to Slide 10,  
15 which gets close to home. And I liked your qualifier. I  
16 thought I was listening to a drug ad on TV on the side  
17 effects. You know, be wary of this and that.

18 [Laughter.]

19 MR. BUTLER: I had a little bit of the same  
20 question now. Is it a weak insurer that is that top tenth -  
21 - you know, you say, in my market, yeah, they're those  
22 insurers that are hanging on. There are some that just, you

1 know, almost billed charges. And I know the answer is --  
2 it's more of a provider variation than insurance variation.

3 MR. ZARABOZO: Well, see, we're still not sure,  
4 particularly on the hospital side. We're kind of just  
5 starting to look at the hospital data in this manner. So  
6 we're not sure exactly what is happening here.

7 MR. BUTLER: It would be nice to have kind of a  
8 consolidation index or something like that for insurers and  
9 providers and somehow compare it to prices, so that if you  
10 have, say, a Blue Cross plan that has two-thirds of the  
11 market, or whatever it is, you know, does that have an  
12 impact or not?

13 MR. ZARABOZO: Which is exactly what we intend to  
14 do.

15 MR. BUTLER: That's where you're headed, okay.

16 The other is would your guess be that the mean --  
17 you know, it would be either good to see the percentiles or  
18 the means as well, because, you know, I could say, well, in  
19 Los Angeles the top decile's way out there, but if the mean  
20 is still sitting down below everybody else, you know, you'd  
21 say, well, I don't know. A totally different conclusion.

22 MR. ZARABOZO: I have the means. I don't have the

1 wherewithal, though. No, the Chicago mean is \$24,000, the  
2 wage index adjusted; Los Angeles, \$23,300.

3 MR. BUTLER: Because those two pull up about the  
4 D.C. area, and --

5 MR. ZARABOZO: Yes, D.C., Virginia. The mean in  
6 D.C. is \$24,400. So the means are very close except in  
7 Seattle, where it's \$20,500.

8 MR. BUTLER: But who wants to go there, Scott.

9 [Laughter.]

10 MR. BUTLER: All right.

11 DR. KANE: I guess one of the things that might be  
12 hard when you try to measure market power is that it's not  
13 just consolidation. There can be brand issues, so --

14 MR. ZARABOZO: Which we mention in the mailing  
15 material about --

16 DR. KANE: Yeah, I guess I'm getting to how do you  
17 measure that. I think case studies or getting to know a  
18 market pretty deeply is the only way that you could figure  
19 that out. Anyway, this does not -- none of this is  
20 surprising to me, of course, but -- and didn't we have a  
21 study earlier that said something like 60 percent of MSAs  
22 had non-competitive markets by some metric? There was some

1 -- and leading up to some of this, we had some earlier stuff  
2 about the level of competition among markets, and we  
3 basically found that they were pretty highly consolidated  
4 and increasingly consolidating over time. So, you know, we  
5 know these markets aren't wildly competitive.

6           Then there's all these other ways hospitals  
7 distinguish themselves perfectly logically around their --  
8 you know, whatever they advertise and whatever their brand  
9 is. So I think you can assume these aren't the most  
10 competitive markets that you've ever seen. And I don't know  
11 how much -- I'm not sure where you want to go with it,  
12 though, I guess is one question, is that you want to say  
13 that the hospitals are able to raise their prices to  
14 wherever they want, some of them? I mean, I'm not sure  
15 where you're going with this in terms of what are the  
16 implications for Medicare.

17           MR. HACKBARTH: Yeah, well, in fact, that's what  
18 I'm trying to get people to address and think about. Step  
19 one for me is to characterize what we found, and then step  
20 two would be to say, okay, what are the policy options for  
21 dealing with what we've found. And I'm not an economist,  
22 but this doesn't look like my Econ. 101 textbook description

1 of what a competitive market looks like.

2 Now, surely there may be some data issues, some  
3 noise issues, and I'm not qualified to comment on that. But  
4 I suspect that this is, you know, the flashing light that  
5 says, hey, policies that are based on the premise of  
6 competitive markets of these services, don't assume that,  
7 and so we then need to think about what policies to deal  
8 with non-competitive markets.

9 DR. KANE: Okay, so -- I'm sorry. Go ahead,  
10 Peter.

11 MR. BUTLER: I can't resist. Chicago, a quick  
12 comment. It's incredibly competitive. There are a hundred  
13 hospitals. The largest market share is like 13 percent. So  
14 the consolidation -- it could be the brand that gets the  
15 prices, but that doesn't mean it's not competitive. It's  
16 just -- it's on a different --

17 DR. KANE: It's on different attributes than cost.

18 MR. BUTLER: Different attributes than we're  
19 talking about.

20 DR. KANE: Yeah, and I think that's what -- it's  
21 on different attributes than cost.

22 DR. STUART: Really quick, the Health System

1 Change work in some but not all of these areas I think is  
2 something you really want to look at. That's going to give  
3 you a nice comparison of some of the competitive issues and  
4 how those have changed over time. And so it might be useful  
5 to look at those regions.

6 DR. KANE: Say in Boston, it's not just the  
7 hospitals' position, but it's how many primary care docs  
8 that also controls. So we have a couple systems that really  
9 control. You have to take their prices because you can't go  
10 without their doctors. So there is this joint physician-  
11 hospital effect that you have to put together, and that's  
12 why I think, you know, you're going to be better off with  
13 sort of case studies than trying --

14 DR. STUART: You've got some of that in Ginsburg's  
15 work [off microphone].

16 DR. KANE: You've got it everywhere, yeah -- I  
17 mean, so it's not just the hospitals separately from the  
18 docs. If you have a controlling market share in the  
19 physicians, particularly the ones with the primary care  
20 docs, you can dictate a lot of your prices because,  
21 otherwise, patients don't have access to the most -- you  
22 can't get access to most of the primary care docs. So I

1 think it's just hard to define, you know, where the nature  
2 of the non-competitiveness is coming from.

3 DR. BERENSON: Yeah, maybe I missed it in your  
4 oral presentation. I can't find it in the written. I'm  
5 just asking a sort of methodologic issue or just an issue  
6 about MarketScan. It talks about primarily self-insured  
7 employer plans. I guess my question is: How representative  
8 across hospitals -- let's pick hospitals in this one --  
9 would those discharges be? I mean, do we think that they  
10 are sort of representing the range of hospital stays in the  
11 market? Or are they skewed towards a certain -- I guess I  
12 don't know what this median means. You know what I'm  
13 saying, what I'm asking?

14 MR. ZARABOZO: Yeah. I'm not sure about that  
15 issue, whether self-insured employers might be different in  
16 some way than -- I kind of think not because it's through  
17 the insurers --

18 DR. BERENSON: So we think this is as good as we  
19 can get, is sort of a median for all the admissions in that  
20 community?

21 MR. ZARABOZO: Well, yeah -- no, and what we're  
22 looking at, we're trying to look at probably is how many

1 covered lives are we talking about in the MarketScan data  
2 compared to the number of insured people under 65 in a given  
3 area. So we're trying to get a feel for whether it could be  
4 considered representative or not in that market.

5 DR. STUART: Just really quick, they're big  
6 employers, and they tend to be national employers. And so  
7 to the extent that if you look at an area that is where the  
8 employment is primarily in smaller firms, then it's going to  
9 be less representative.

10 DR. BERENSON: Yeah, I mean, the point I guess I'd  
11 make -- I mean, you made reference to the HSC studies. I  
12 did the one on Los Angeles, and I would have thought the --  
13 well, there's huge variations that I witnessed in prices in  
14 Los Angeles, but I don't know to what extent this is -- I'm  
15 surprised that it's that low given what I know about the  
16 market, that the median is that low. So I don't know that  
17 you have the answer, but an issue is how representative of  
18 the market is the MarketScan data.

19 MR. ZARABOZO: Yeah, and, again, the average is  
20 like two other areas.

21 DR. BERENSON: Yeah. And the other thing I have,  
22 just to make the point, you emphasize on the physician side

1 that we define payment rate as the allowed payment for a  
2 particular service by a plan. That's not necessarily what  
3 the payment is to the physician who's able to be out of  
4 network and is balance billing, right?

5 MR. ZARABOZO: Right, but it looks like we see  
6 very little balance billing going on. Most of the claims  
7 that we see are shown as network claims.

8 DR. BERENSON: Oh, is that right?

9 MR. ZARABOZO: Yeah.

10 DR. BERENSON: Because I was trying to explain why  
11 Bethesda, Maryland, Arlington, Alexandria, and Washington  
12 are showing up as seemingly the least -- the lowest level of  
13 payment, and I also know there's a lot of out-of-network  
14 care going on here. But you don't think that's going on,  
15 that there's low fee schedules but maybe high actually  
16 payments to physicians.

17 MR. ZARABOZO: We don't seem to be seeing that. I  
18 mean, I would have expected that actually for the Washington  
19 market just on my personal experience in the Washington  
20 market.

21 DR. BERENSON: Yeah, no, exactly. So, okay, you  
22 don't think this data is being distorted by a growing number

1 of docs who go out of network. You think this is in  
2 network. Most of the services --

3 MR. ZARABOZO: It appears to be mostly in network,  
4 yeah.

5 DR. BERENSON: Okay. I appreciate that. Thanks.

6 DR. MARK MILLER: Just one that if [off  
7 microphone] it's out of network, it would have been caught  
8 by this data?

9 MR. ZARABOZO: Yes, it would be shown as out of  
10 network. It would be paid as an out-of-network claim, and  
11 so we would only show the insurer payment. The balance  
12 billing we would not be including if the numbers were in  
13 here. So some of the --

14 DR. BERENSON: So what kind of rates do you see of  
15 out-of-network -- I mean, sort of ball park. Is it in the  
16 5- to 10-percent range or the 20-percent range?

17 MR. ZARABOZO: I can't tell you.

18 DR. CASTELLANOS: Slide 9, please. We're going to  
19 focus in on Miami for a second. Unfortunately, I live 125  
20 miles from Miami -- or maybe fortunately. I had talked to  
21 John Bertko about this. Miami is a very heavily penetrated  
22 PPO market, and it has an excess amount of physicians. So

1 when they're talking about fees, they're negotiating  
2 contract fees somewhere around 80 or 78 percent of the  
3 Medicare fee.

4           Now, let me give you some reasons about what's  
5 happened. Obviously, they came across to our coast and  
6 wanted to give me 78 percent, and they said, "Take it or  
7 leave it." What did the physician do? I joined a large  
8 integrated group. And if they want to have my contract, now  
9 they have to pay the large integrated contract. And the  
10 group that I have controls the radiation therapy. I don't  
11 own radiation therapy. But if they want that person in that  
12 pool, they have to pay my rates. So that's a thing that  
13 physicians do. Okay? But this is what the insurance  
14 company does, and you can see the consolidation. What  
15 happens is -- I mean, they're big guys, and even John Bertko  
16 agreed it to me. He said, "Yeah, if we can pay 78 percent,  
17 that's what we're going to do. We're not going to pay them  
18 100 percent."

19           Now, there's another point I wanted to make.  
20 Since there's such low reimbursement in Miami, I'm not  
21 saying it does, but does that account perhaps for some of  
22 the unusual behavior we see there?

1 [Pause.]

2 You know, I'm just mentioning it. That's all.  
3 I'm not suggesting that.

4 Now, the other one that I -- one other point. We  
5 talked about knees in Fort Myers and knees in Miami, and we  
6 said, okay, why is there such a discrepancy? Because it's  
7 really the same age group, same -- and, I mean, the reason  
8 is that I think that in a managed care program those  
9 orthopedic patients never get to the orthopod. They're  
10 treated predominantly by the medical doctor and treated  
11 conservatively, as in Fort Myers perhaps they get to the  
12 orthopedic doctor. That was just a -- you know, we tried to  
13 look at what the heck is going on, and that was one of the -  
14 - one of the orthopods mentioned that to me.

15 MR. GEORGE MILLER: Yes, on the same slide, my  
16 question is: Could you differentiate or tell if during the  
17 stratification if the hospitals were part of a system they  
18 got the higher payments or, conversely, if they were part of  
19 a GPO? Did you do that type of analysis?

20 MR. ZARABOZO: We are not able to identify the  
21 provider.

22 MR. GEORGE MILLER: Okay. All right. SO there's

1 no way to tell -- okay. You answered that question.

2 Then on the physician, I guess I know the answer  
3 to that question as well.

4 MR. ZARABOZO: The only way would be to look at an  
5 area where we are certain that, you know, if, for example,  
6 there's only one system in a area, like an MSA, let's say,  
7 then we know yes, it's a one-system situation based just on  
8 the area that the claims are coming from.

9 MR. GEORGE MILLER: Well, this data seems to me,  
10 at least to me, to refute the argument that a hospital  
11 system and the market could determine the price with this  
12 wide variation. They're so dominant they could determine  
13 the price from a --

14 MR. HACKBARTH: Determine their price [off  
15 microphone] and then the others that are weaker --

16 MR. GEORGE MILLER: Well, we don't know that  
17 because -- how large this data is, that if they're able to -  
18 - because they are part of a system to determine the price  
19 from the insurer and beat the insurer up and get a larger  
20 price. At least from this data the way I'm reading the  
21 data.

22 MR. HACKBARTH: I'm not sure I'm following,

1 George. So there's variation.

2 MR. GEORGE MILLER: Right.

3 MR. HACKBARTH: Some are getting high prices, some  
4 are getting low prices. The fact that there is variation is  
5 consistent with the hypothesis that those with market power  
6 can exact a higher price than others. It doesn't prove the  
7 hypothesis, but it's consistent with that hypothesis.

8 MR. GEORGE MILLER: It doesn't prove it.

9 DR. BERENSON: Yeah, and a related point is at  
10 least in our findings at Health System Change, multi-  
11 hospital systems are actually crossing geographic areas.  
12 They're using -- I mean, like Sutter Health, which we wrote  
13 about, has 27 hospitals, but not, you know, one or two  
14 within San Francisco. They're using a strategy that gives  
15 them an ability to negotiate high across markets. And so  
16 that's not a traditional sort of market power consolidation  
17 antitrust issue, but it is a negotiating strategy.

18 MR. GEORGE MILLER: I would agree. I was at three  
19 different systems in Texas, and the one that I was in in one  
20 particular city, because of the power of the system, I got  
21 much better prices than when I was a small independent. And  
22 the insurance said, "This is what we're going to pay" -- the

1 insurer said, "This is what we're going to pay. Take it or  
2 leave it, or we can ship all of your patients 60 miles  
3 away."

4 DR. CHERNEW: A few quick things. The first one  
5 is there's measures of hospital competition which are  
6 generally easy to construct, although this discussion we  
7 just had illustrates they're still hard to construct. But  
8 at least you can measure hospitals by system using AHA data.  
9 It doesn't say anything about competition in the market. I  
10 will say that competition is kind of a loose word. We  
11 really mean market structure. And who knows how they  
12 behave? So the theory, you know, you could have a lot of  
13 providers and have them collude or have them compete. But,  
14 in general, a competitive market would suggest that any  
15 price variation was explained by some quality variation  
16 where quality could be broadly defined. Clinical quality,  
17 you care about the reputation so that is one, tell my  
18 friends that I went to whatever hospital, or amenity quality  
19 or locational quality, or there's some other thing that  
20 describes the price variation in that there's some sort of  
21 competition.

22 My general view based on other things like the

1 attorney general's report is you don't have to look at this  
2 data to infer that there's not a lot of competition in the  
3 classic economic sense across the markets, and I think this  
4 confirms that.

5           The second point I would say is related to the  
6 question that Bob was asking about this. In the data, a lot  
7 of these weak insurers aren't in there. This is large firms  
8 that have sort of big administrative -- so this is not a  
9 small insurer in the individual market and now I'm being  
10 charged a really high price. This is mostly I'm a large  
11 firm, I have an administrative services contract with  
12 probably a big insurer that has a PPO. That generally is  
13 what I think would be in here, although I'm not sure that's  
14 completely what's in here.

15           MR. HACKBARTH: Some of it may be attributable to  
16 large national firms, but only having a small number of  
17 employees in the market. So it's a big company, but they  
18 don't have much leverage in that market because it's --

19           DR. CHERNEW: Yeah, but they would usually  
20 leverage off of the leverage of who is their admin -- so say  
21 you were using Aetna as your -- right. It would be Aetna's  
22 leverage because you would be using their network and their

1 prices. And even if you only had a relatively small number  
2 of people in that market, if Aetna had a lot of other people  
3 in the market and their PPO, it would typically be their  
4 leverage.

5 MR. HACKBARTH: Right

6 DR. CHERNEW: That's how it would generally work.  
7 But I think that to answer the question, there's going to be  
8 a ton of noise in this for just data claims noise, non-  
9 generalizable data noise. So if the point was to make sort  
10 of -- whenever you put a number up there, like Milwaukee, or  
11 pick Miami, you know, I don't think it's coincidental that  
12 Peter picked Chicago and, you know, when Glenn mentioned  
13 Boston, Nancy jumped in, and Ron mentions Miami right away.  
14 It's very difficult to look at a particular one, so you  
15 could learn from case studies, I agree completely. But the  
16 advantage of this is to look systematically across all of  
17 them and understand patterns in the data. And I do think  
18 the value is to come to some conclusion about the  
19 determinants of how prices vary. It may be related to  
20 Medicare or Medicaid prices or a whole series of other  
21 things. And that does tell us -- not directly it doesn't  
22 drive policy, but I do think it tells us something about how

1 we will feel later when we think about, say, competitive  
2 strategies and what happens if we make -- you know, if we  
3 unleash the power of millions of Medicare beneficiaries to  
4 get the right care, that type of phrasing of what you think  
5 would happen does rely on competition. You wouldn't want to  
6 say we're going to release the power of a ton of people to  
7 get the right care rates always, you know? So there are  
8 competition issues, and I do think this speaks to it, but I  
9 think it's very hard to put up a report card because of all  
10 the data problems and say look how much higher the prices  
11 are in this city versus that city. But I do believe the  
12 general empirical regularities are probably telling you  
13 something despite the noise, and the within-market variation  
14 I think is much, much noisier than the between-market  
15 variation, although the between-market variation also has  
16 problems because you might not have all the hospitals in  
17 there, they might not be equally weighted, there might be a  
18 small set of employers, so it might be the employers in Los  
19 Angeles or a certain type of employer, and they have  
20 different things. There's case-mix issues here, so maybe an  
21 employer is paying a higher price because of the case-mix  
22 thing that's going on.

1           So there's all kinds of issues, but I think the  
2 general pictures are informative, if not definitive.

3           MR. HACKBARTH: I think a question for us, which I  
4 am absolutely not the right person to answer, is, you know,  
5 how far to go down this track of mining the data, analyzing  
6 the data, cutting it different ways, pursuing that path, not  
7 versus but the other path is the case study work that Health  
8 System Change has done, Bob and Paul Ginsburg's work. You  
9 know, there's a pretty clear picture, I think, developing.  
10 In fact, you also talk to insurers and you hear the same  
11 thing that, boy, these markets are working in a different  
12 way that isn't necessarily competitive as the term is  
13 usually understood. You know, how far do we have to go to  
14 document that reality?

15           DR. CHERNEW: Right [off microphone].

16           MR. HACKBARTH: Yeah.

17           DR. CHERNEW: I agree with that, so I think this  
18 is useful and a lot can be learned in doing this. But if  
19 you have -- obviously there's a lot of other things that  
20 people could do, and so I find this interesting work, as you  
21 know, for a bunch of reasons, and I think you guys have done  
22 a very good job. And I'm surprised how much I learned

1 knowing this well, even when I sit here and listen to what  
2 you've done. So I think that part is great, and I think  
3 MedPAC has a level of authority that's useful, so I think  
4 that's useful. But I wouldn't go and do this as a broad --  
5 you know, you're going to get what you need out of the work  
6 that you're doing, and I would definitely recommend  
7 continuing to push forward. You know, I'm not sure how much  
8 further I would go beyond what you've outlined your next  
9 steps were.

10 DR. MARK MILLER: We've had these conversations,  
11 this exact conversation internally, and part of it is we  
12 want to keep putting things in front of you and getting  
13 reactions, and particularly if you have some specialized  
14 expertise, by bending this data, and so here's the way the  
15 conversation goes. When we started this -- and, Peter, you  
16 know, this is just your exchange a minute ago, is the idea  
17 could you construct this data set, feel that the data is  
18 relatively stable, let's pretend we're at that point, and  
19 then start asking the question of could you measure  
20 consolidation and provider strength and insurer strength  
21 using various metrics, you know, the standard consolidation  
22 measures but also things like are there ways to look at

1 things like branding and that type of thing.

2 In a perfect world, you would have 400, 300-plus  
3 observations, have a gigantic regression, and go, look,  
4 these kinds of measures of consolidation seem to move prices  
5 by this much. But if the data turn out to be too noisy to  
6 do that and the difficulty of how do I capture branding  
7 instead of consolidation, then the retreat -- and, of  
8 course, their argument was we should do this because this  
9 involves site visits, and they could go out of the office --  
10 was to say, Do you go through the data identifying this is  
11 what I think Mike is saying in so many words? There are  
12 eight patterns, six patterns, and it will not be as clean as  
13 that, but just for the sake of discussion, eight patterns,  
14 and then those are the markets that you go to, do the case  
15 study, and come back and say, okay, I talked to everybody  
16 with red hair and everybody with black hair and here's what  
17 we found.

18 And so I think we're pushing the data out to get  
19 your reaction, and if it collapses and we can't do the  
20 gigantic regression, which, you know, we may not, then we do  
21 the case study approach.

22 DR. CHERNEW: But if you do just the case studies

1 and didn't do any of this work at all, then we'd go around  
2 the table and people would say, yeah, but that's one place  
3 and people just said it and you took a sample of folks. So  
4 I actually really do believe, as you said, there is some  
5 real value in being able to blend some of this work, as  
6 imperfect as it is, some of the case studies, as imperfect  
7 as it is, to come up with a conclusion, which, again, I  
8 don't think you are going to want to hang your hat on. We  
9 need to go into -- you don't want to go over to Justice and  
10 say, look, there's something wrong in Milwaukee, or whatever  
11 it happens to be. But I do when we have discussions about  
12 payment, ACOs, competitive strategies, I think the  
13 collection of evidence that you're building will end up  
14 being invaluable towards guiding that discussion because a  
15 lot of what's going to go on, I think, as we go forward, is  
16 going to have to do with a fundamental belief about how well  
17 you -- and I mean us collectively -- think markets can work  
18 in certain policy options. And my experience has been there  
19 is a wide variation in people's beliefs about that subject,  
20 some of which is informed by data and some of which is  
21 informed by something about their childhood. And so the  
22 data side is useful.

1           MS. BEHROOZI: It's late and we all want to go  
2 home. I'm really tired and in over my head, but I can't  
3 stop myself, mostly because of something Mike said. It  
4 figures.

5           Talking about how employers who are getting their  
6 benefits through an insurer might end up paying more, in a  
7 lot of cases, I mean, we rent networks, right? And those  
8 networks may have bargaining power with providers, but I  
9 don't know that we've talked about this. There's also the  
10 thing about how they can pass along their costs. That's  
11 another factor. We find that mostly the networks that we  
12 contract with don't have a lot of incentive to control the  
13 prices that they're paying providers because the people who  
14 come to them, like us, are unable to directly contract  
15 because we don't have enough density. And, yeah, they want  
16 to maximize their profit, but they can also pass along the  
17 extra cost to us.

18           So when you see them paying a higher rate, they  
19 may very well be the biggest game in town and they could  
20 squeeze the provider for a tighter rate, but they don't have  
21 a lot of incentive to. And that might be changing, as  
22 employers, as people, you know, the exchanges, whatever,

1 start collecting the purchasing power of those who are  
2 purchasing insurance. But the market power of the insurance  
3 company cuts two ways, and one of the examples that I'm  
4 thinking of is Maine, where there's like really dominant  
5 insurers, and I don't see them anywhere on the list of, you  
6 know, below 90th percentile or whatever. But we do know --  
7 I mean, I know from the SEIU experience that those workers  
8 who are covered by those policies in Maine are worried about  
9 the tax threshold under PPACA because their policies are so  
10 expensive because of the insurer market power. So it seems  
11 to have cut that direction, not against the providers. So  
12 that might be a reason to actually look at a market and say  
13 here is a market where you have, you know, provider  
14 concentration or you have insurer concentration and let's  
15 see what's happen here, rather than just using the data to  
16 draw you to a conclusion about the concentration because it  
17 might not actually play out that way.

18 DR. CHERNEW: And, remember, the Blues have had  
19 historically relationships with providers and there's  
20 nonprofit/for-profit issues going on. So there's a lot you  
21 could do if you really wanted to understand all that's going  
22 on in particular areas.

1           MR. HACKBARTH: Well, you know, I have a strong  
2 sense that this is a really important topic, and I see it  
3 lurking just beneath the surface or maybe even poking its  
4 head above the surface in a number of key policy areas: you  
5 know, that market power is a key issue related to whether  
6 there's cost shifting and the degree of cost shifting;  
7 market power is a big point of conversation around ACOs,  
8 where you hear private insurers and employer purchasers, you  
9 know, really reacting nervously to that because their  
10 experience is these markets are already concentrated and  
11 they're having difficulty dealing with powerful providers  
12 and even more of that is frightening to them.

13           It's an issue that lurks just beneath the surface  
14 in all schemes, whether it's PPACA or in premium support in  
15 Medicare that depend on competition among private plans to  
16 hold down costs. So this is really important stuff to  
17 understand, but it's really hard at the same time. So  
18 that's my last word.

19           Thank you, Carlos and Julie, and we will now have  
20 our public comment period.

21           So before you begin, let me just review the rules.  
22 Please begin by identifying yourself and your organization

1 and keep your comments to no more than two minutes. When  
2 this red light comes back on, that will signify the end of  
3 your two minutes.

4 MR. ZANETTI: Okay. My name is Cole Zanetti. I'm  
5 a fourth-year medical student from Texas, and I'm  
6 representing AACOM.

7 I have two things I just wanted to ask a question  
8 about. I wanted to get the opinion and how the Committee  
9 also intends on addressing issues of monitoring supply-  
10 sensitive care variation and also providing incentives for  
11 shared decision-making models of care and how that ties into  
12 potential payment models.

13 MR. HACKBARTH: So if you want to engage in a  
14 conversation about those issues, what I'd suggest that you  
15 be in contact with our staff and do it that way. Okay?

16 MR. ZANETTI: Okay. Thank you.

17 MR. HACKBARTH: We welcome your interest.

18 DR. MARK MILLER: Yeah, we do welcome that.

19 Ariel, can you make sure that he gets your card?

20

21 MS. MCILRATH: Sharon McIlrath. I'll make it  
22 quick.

1           Just because the \$731 million that came up in the  
2 context of the redistribution from the RUC, that is, a lot  
3 of is when they look at the work values they also then are  
4 looking again at what practice expense is built in. So if  
5 something previously took a fluoroscopy room and now that's  
6 mobile, then the equipment, that price changes in the  
7 practice's expense. So some of it is money that just flowed  
8 automatically due to the work value changes, but a lot of it  
9 is where they actually relooked at something.

10           And then to say also that the RUC is happy to look  
11 at any time data that anybody comes up with. For several  
12 years now, they have a subcommittee that has looked at  
13 criteria for what the time data would need to look at, or  
14 look like. It's not as easy as you might think. There are  
15 a lot of the things that are done so infrequently that there  
16 is no way you can find the people that do them unless you go  
17 through the specialties.

18           So what they have tried to do, and what maybe you  
19 may have other suggestions for ways to do this part of it,  
20 but they have tried to standardize a lot of things, so that  
21 when the specialty comes in there's a pre-service package,  
22 and everybody, that's what you get. I mean you can make an

1 appeal that you get something different than that, but  
2 that's already set in stone. So that takes a lot of the  
3 variation out of it.

4           There's a lot of back and forth. It is hard for  
5 somebody to come in now, much harder than it used to be, and  
6 argue for something that most people wouldn't think was  
7 reasonable.

8           And then the other thing is that because you  
9 really will have to limit the number of things that you're  
10 looking at, because you just can't go out and find them all  
11 in some random survey, you might want to be thinking of some  
12 generic things that you would want to look at, such things  
13 as Dr. Berenson mentioned where something has become  
14 automated over time. And certainly, the RUC staff would be  
15 and the members would be happy to talk to people about that.

16           And then finally, I just want to get on my horse  
17 here about the budget neutrality again. If you are going to  
18 have something that's left as the residue of the SGR and  
19 you're going to talk about having the Secretary take all the  
20 screens that the RUC is already taking, like whatever is  
21 growing fast, go back and look at new technology, all of  
22 those things, and then you have the Secretary competing for

1 that money as savings to the RUC trying to redistribute it  
2 within the system, I think at the very least you need to  
3 remember that the system is budget neutral at the top too.

4           So yes, you can have a law and regulation piece  
5 that is built in there where you try to recognize the things  
6 that have, built in, raised the expenditures, that  
7 physicians had no control over. But you better include  
8 coverage decisions on a lot of things that didn't get  
9 included in the SGR because if you have new coverage for  
10 macular degeneration and you expect the system to simply  
11 absorb that -- but then you want to take all the savings  
12 that somebody finds where okay, now something can be done  
13 more quickly than it used to be done and so we could  
14 probably reduce the value on that, but you're not going to  
15 let it be redistributed -- you're just constantly pushing  
16 down the system and expecting it to absorb everything.

17           MR. HACKBARTH: All right. Thank you, and we're  
18 adjourned until tomorrow morning at 8:30.

19           [Whereupon, at 5:59 p.m., the meeting was  
20 recessed, to reconvene at 8:30 a.m. on Friday, April 8,  
21 2011.]

22

## MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

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

Friday, April 8, 2011  
8:35 a.m.

COMMISSIONERS PRESENT:  
GLENN M. HACKBARTH, JD, Chair  
ROBERT BERENSON, MD, FACP, Vice Chair  
SCOTT ARMSTRONG, MBA  
KATHERINE BAICKER, PhD  
MITRA BEHROOZI, JD  
PETER W. BUTLER, MHSA  
RONALD D. CASTELLANOS, MD  
MICHAEL CHERNEW, PhD  
THOMAS M. DEAN, MD  
JENNIE CHIN HANSEN, RN, MSN, FAAN  
NANCY M. KANE, DBA  
HERB B. KUHN  
GEORGE N. MILLER, JR., MHSA  
BRUCE STUART, PhD  
CORI UCCELLO, FSA, MAAA, MPP

AGENDA	PAGE
Rural patient care systems	
- Jeff Stensland, Adaeze Akamigbo	3
- Dr. Bruce Hamory, Executive Vice President/ Managing Partner, Geisinger Consulting Sources	8
- Jim Long, Chief Executive Officer of West River Health Services, Hettinger, North Dakota	26
Public comment	89

1 P R O C E E D I N G S [8:35 a.m.]

2 MR. HACKBARTH: So our first session today, we  
3 have two guests on rural patient care systems. Jeff, will  
4 you do the introductions?

5 DR. STENSLAND: Sure.

6 Good morning. As you know, MedPAC is in the  
7 middle of a Congressionally mandated study of rural health  
8 care. Over the next year, we'll be discussing access to  
9 care, quality of care, as well as Medicare payments and  
10 costs. The study is due in June of 2012.

11 Today we are lucky to have two leaders in rural  
12 health care organizations to come speak with us. But before  
13 I introduce them, I want to clarify a question from our 2011  
14 discussion of access in rural areas and volumes of services  
15 in rural areas.

16 In February, we showed you this slide, and it  
17 indicated that urban areas had 10.1 office visits per  
18 beneficiary and there was a similar level in rural areas.  
19 This is true for micropolitan areas, which are counties with  
20 a town of 10,000, and for less populated rural areas,  
21 including those that are adjacent to an urban area or even  
22 rural counties that are not adjacent to an urban area and do

1 not have a town of 10,000.

2           Service volumes are even similar for frontier  
3 counties, which we define as an area with a population  
4 density of six or fewer people per square mile. While  
5 there's wide regional variation, the rural and urban service  
6 volumes were similar.

7           However, there was a concern at the meeting that a  
8 mean of 10 visits per beneficiary sounded quite high. And  
9 you also asked whether some of the outliers possibly were  
10 driving the mean upward. So today we bring you a breakdown  
11 of the distribution of visits.

12           As we show on this slide, the median is slightly  
13 lower the mean at between seven and eight visits per person,  
14 but the distribution is very similar across urban, rural,  
15 and even frontier areas. Finally, a median of eight visits  
16 and a mean of 10 may still appear large, so we made a few  
17 comparisons and found our numbers were similar to the  
18 literature. For example, Mia Pham, in a 2007 New England  
19 Journal article, found that among patients in her sample,  
20 beneficiaries saw a median of seven physicians in 2,000.  
21 This is seven different physicians, which could easily  
22 equate to 10 visits.

1           Leighton Chan, in a 2006 Journal of Rural Health  
2 study of five states found an average of between nine and 10  
3 claims per beneficiary. Dr. Chan did not include rural  
4 health or FQHC visits, so his numbers may slightly  
5 underestimate the full volume of rural beneficiary visits.

6           More recently, there's an IOM panel looking at  
7 regional variation, as led by Joe Newhouse. Last month,  
8 they released CMS data on E&M visits for the over-65  
9 population. They found an average of 12 E&M service events  
10 per person per year. Their number is slightly different  
11 than ours because, again, they didn't include RHC or FQHC  
12 visits. But they did include visits in the hospital and  
13 visits in nursing homes. That's why maybe they're at 12 and  
14 we're at 10.

15           So that's a long way of saying that if you look at  
16 the literature or the recent IOM work, you'll see similar  
17 levels of physicians visits per capita that we show in our  
18 data.

19           So we've talked about the level of care and the  
20 volume of visits in rural areas but the real point of  
21 today's meeting is to learn from some folks on the ground  
22 who are leading the effort to serve rural beneficiaries.

1 This is really a follow to our discussion at least  
2 February's meeting. In February, some of you asked us how  
3 large systems reach out into rural areas.

4 We are lucky enough to have Bruce Hamory share his  
5 experiences with us. Dr. Hamory leads Geisinger's efforts  
6 to extend its innovations in health care delivery and  
7 payments to other groups and health systems. Prior to his  
8 current physician, Dr. Hamory was Geisinger's systems chief  
9 medical officer for 10 years, where he led the growth of a  
10 535 physician multispecialty group practice into a 750  
11 physician multispecialty group practice in 40 locations  
12 serving 41 counties and three Geisinger hospitals in rural  
13 Pennsylvania. He will talk about how his system serves the  
14 Medicare beneficiaries in the hills of Pennsylvania.

15 But not all rural health care is delivered by  
16 large systems. Much of the good care in rural areas is  
17 provided by smaller organizations. Today we are also  
18 fortunate enough to have Jim Long from Hettinger, North  
19 Dakota. Mr. Long is a CPA, a hospital administrator and CEO  
20 of the West River Health Services, which is an integrated  
21 physician practice, hospital, and EMS service in  
22 Southwestern North Dakota.

1           Jim has a long history of serving his community  
2 and was kind enough to host the MedPAC staff when we went  
3 out to visit him a couple of years ago. We were very  
4 impressed with his ability to serve a wide geographic area  
5 with a small, cohesive medical staff of 23 providers,  
6 including physician assistants and nurse practitioners.

7           So intentionally, we brought you leaders from two  
8 very different systems today to talk to you about how they  
9 serve their communities. Mr. Long has about 23 providers  
10 who operate out of Hettinger, North Dakota, a town of 1,300  
11 people. In contrast, Dr. Hamory's Geisinger system has more  
12 than 1,300 people on its clinical staff. So in terms of  
13 scale, they're very different.

14           But in terms of important aspects, I think they're  
15 similar. They're both integrated organizations. They both  
16 have tightly coordinated physician staffs, hospitals, and  
17 even emergency transportation to the hospital.

18           And I think what's very important is they both  
19 have a strategy for serving their communities and a cohesive  
20 system for executing that strategy. Those are two  
21 characteristics that aren't universal.

22           After Dr. Hamory and Mr. Long give their

1 presentations, we will have an hour for discussion. So now I  
2 will turn it over to the speakers.

3 Dr. Hamory, will you lead us off?

4 DR. HAMORY: Good morning. I want to thank the  
5 Commissioners for the opportunity to talk a little bit about  
6 how Geisinger has, over the last 12 years, really worked to  
7 develop a systematic regional approach to the delivery of  
8 health care that, believe it or not, does not depend on  
9 owning all the pieces. It does depend on concerted effort,  
10 some planning, and a very robust IT system, as I will show  
11 you.

12 So just briefly, the outline, a little bit about  
13 Geisinger so you understand who we are, a brief discussion  
14 of the geography and demographics, a little bit about how we  
15 support rural hospitals, use of IT, telemedicine,  
16 coordination of care, an example of an ST segment MI program  
17 that allows us to helicopter people in from considerable  
18 differences and still achieve a first medical contact to  
19 balloon time of under 90 minutes. And then a couple of the  
20 high level implications for this.

21 So we always start with a slide, Mrs. Geisinger  
22 founded our organization 97 years ago and she told the first

1 physician, Dr. Foss there on the right, to make her hospital  
2 at that time the best. But she put in her deed of trust  
3 that the purpose was to care for the working man and his  
4 family. And so we have taken that for a number of years to  
5 mean devote attention to population-based health care. In  
6 fact, Dr. Foss, in his I think second annual report to the  
7 board in about 1916, reported that at that time Geisinger  
8 had served patients from every county in Pennsylvania.

9           This is our conceptual set up. We have provider  
10 facilities. Our largest, Geisinger Medical Center, which is  
11 now almost 500 beds, is located in a town of 5,000 people.  
12 We employ 7,500 people at that location. We have 350  
13 physicians, outpatient and inpatient, at that facility in a  
14 county of 17,000 people. So about one doctor for every 48  
15 residents of the county. That does not include 350  
16 residents and fellows in training.

17           Up in a more urban area, in the Scranton/Wilkes-  
18 Barre area, we have a smaller hospital, Geisinger Wyoming  
19 Valley. And then, as you see below that, a chemical  
20 dependency treatment center, ambulatory surgery. We are  
21 doing currently almost 50,000 admissions to both hospitals,  
22 a combined total of about 100,000 emergency room visits, and

1 so forth.

2           Physician group is now 860 physicians with just  
3 under 500 nurse practitioners and PAs. We run 37 primary  
4 care sites. They range in size from one doc in a PA to 19  
5 physicians and five or six nurse practitioners and PAs.  
6 They are located in towns that range from about 700  
7 residents up to a place like State College that has, without  
8 the university, probably 20,000 and with Penn State probably  
9 close to 60,000.

10           You see the outpatient visits. We are fortunate  
11 in that, as part of our organization, we have a health plan,  
12 Geisinger Health Plan. That health plan is currently a  
13 little over 260,000 members, of which almost 50,000 are  
14 Medicare Advantage patients.

15           They also have an extensive network of many  
16 contracted non-Geisinger doctors, 110 non-Geisinger  
17 hospitals. And so we have an area of overlap which my  
18 chief, Dr. Steele, calls the sweet spot in which the group  
19 practice and our hospitals provide care -- 28 percent of  
20 their care comes from the health plan, 28 percent of our  
21 business. We care for about 50 percent of the health plan's  
22 patients.

1           So we have about 130,000 people for whom we have  
2 complete clinical and financial data. We know all their  
3 care. And so, based on that number, we can do estimates of  
4 efficiency and cost reduction and all that.

5           In addition, we participated in the PGP demo for  
6 five years and will be part of the going forward of that.

7           We have invested heavily in an electronic health  
8 record, beginning in 1996, fully integrated, available  
9 everywhere our doctors work, including the roughly 25  
10 specialty outreach sites that occur in doctor's offices and  
11 smaller hospitals throughout the region. It has a major  
12 patient portal and I will tell you the rate of use of that  
13 portal is just as frequent among our Medicare beneficiaries  
14 as it is among our 30-year-old ladies. Age does not appear  
15 to be a factor in that.

16           We allow about 2,600 non-Geisinger physicians  
17 read-only access into that, with patient permission, and  
18 only for the patient's records for whom they have cared and  
19 referred to us.

20           For the last five years, I'll show you some data  
21 on a regional health information exchange which has used  
22 AHRQ money to establish and been facilitated by FCC grants

1 to improve fiber optic cable access to smaller hospitals and  
2 clinics. And so we are very grateful to our Federal  
3 Government for those opportunities.

4 In addition, in the last year-and-a-half, we have  
5 begun an electronic ICU program, initially served our two  
6 hospitals and is now extended to some other, smaller  
7 hospitals as a way to permit them to retain appropriate  
8 patients in their facilities without the usually Friday  
9 afternoon transfers to Geisinger when the surgeon or the  
10 internist who is managing their care wants to go out of  
11 town.

12 We have been awarded a Beacon Community, and I'll  
13 show you a minute about that, and a lot of recognition.

14 This is the IT history. I'm not going to go into  
15 it. It basically shows the different phases.

16 I will just mention, off to the right, that a data  
17 warehouse, which combines clinical data, financial data from  
18 both the providers and the health plan, has been a major  
19 enabler of our ability to rapidly identify patients in need  
20 of care, diabetics, women who have not had a mammogram  
21 within a relevant period. For example, a year-and-a-half  
22 ago we identified 100,000 patient who had not had a tetanus

1 shot in 10 years. That's fixed. We use it as a way to get  
2 our immunization rates for flu and pneumococcal vaccine in  
3 our high risk elderly up to about 85 percent by pulling them  
4 in.

5 This is our geography. Philadelphia is down to  
6 the right, Pittsburgh off to the left. This is a  
7 mountainous area. We are in the middle of the Appalachian  
8 Mountains and the Poconos. You see, in yellow the various  
9 primary care sites, in red -- and the yellow also means that  
10 they are up on primary medical home. All 35 of our primary  
11 care sites are accredited as Level 3 medical homes by NCQA.

12 This service area is approximately 21,000 square  
13 miles, the area outlined in white is the provider area. It  
14 has a population of 2.3 million, of which 405,000 are  
15 Medicare beneficiaries, 422,00 are Medicaid recipients. We  
16 serve, you know, a number of those people. Overall, about  
17 one-third of the residents in our service area see a  
18 Geisinger doctor every year. So we believe we can have a  
19 substantial impact on population health.

20 We work with three major hubs, two of which are  
21 hospitals. There are two stars off to the right, Geisinger  
22 Wyoming Valley or GWV; and Geisinger South Wilkes-Barre, or

1 GSWB. That South Wilkes-Barre site has now been converted  
2 to an ambulatory center and an outpatient surgery unit  
3 because it is five miles away from GWV. So we've  
4 consolidated, closed some beds, and done more  
5 regionalization there.

6           This is the Keystone Health Information Exchange  
7 Network in yellow. The Beacon community is immediately  
8 around Geisinger. It's five counties. That is committed to  
9 reducing the proportion of Medicare beneficiaries admitted  
10 for congestive failure and readmitted. The other red dots  
11 are other hospitals in Pennsylvania. You can see the  
12 sparseness of the dots in our area. We have no counties  
13 that meet a frontier designation. We have several that are  
14 designated as rural, and only a few that would meet the  
15 designation of being in an around a metropolitan area.  
16 Wilkes-Barre/Scranton standard metropolitan statistical area  
17 is about 1.1 million, I think.

18           This shows KeyHIE. Basically, this information  
19 exchange includes data from 10 hospitals -- only two are  
20 ours -- 15 other organizations that include other hospitals,  
21 private clinics, skilled care and home health agencies, and  
22 long-term care.

1           The goals are here, to provide clinical  
2 information in a timely way, eliminate duplication, analyze  
3 data to identify gaps in care, as I've mentioned, and  
4 provide interoperability of data between the various systems  
5 that these organizations use.

6           Telemedicine, I think you have heard testimony on  
7 before. We have begun to use this fairly extensively, and  
8 particularly in the middle two bullets: integration of  
9 clinical data to support telemedicine, and to facilitate  
10 consultation between primary care doctors and specialists.

11           The barriers you know about. The services are  
12 generally not covered by payers, including you all. We  
13 recognize that all payers are concerned about cost control  
14 for non-face-to-face visits and physician billing.

15           However, I would comment that, at least in our  
16 place, in our state, there is a requirement for a doctor at  
17 each end. That does not help this. If you can have a PA or  
18 a nurse practitioner, who is a competent clinician, at the  
19 referring end, and a physician at the receiving end, that  
20 would assist this process. Our state is not a major  
21 advocate for telemedicine at this time which, with the new  
22 administration, will probably remain true.

1           So we believe, as my boss has said, that we are  
2 there to provide best care closest to home. Our goal is not  
3 -- not, to bring everybody into a Geisinger hospital. Our  
4 physicians admit to 15 small hospitals that are not  
5 Geisinger and they account, in the aggregate, for 10,566  
6 admissions last year, in many of those hospitals 50 to 60  
7 percent of total admissions, and a significant volume of  
8 surgery and deliveries. So the goal is to keep the care out  
9 if it can be done safety.

10           Now as a side note, we have also been party to  
11 closing a hospital that we thought was dangerous and  
12 ultimately the state agreed. So there is some element of  
13 maintaining standard of care here.

14           These are the telehealth services we provide:  
15 TeleEcho for children, 23 off-campus sites, immediately  
16 review of trauma CT to four other hospitals, immediate  
17 review by moving images to the neurologist or neurosurgeon's  
18 home, for CT monitoring for stroke. It allows a decision as  
19 to whether or not the patient can be managed with a protocol  
20 at the local facility or needs to be transferred to  
21 Geisinger for urgent intervention, either neurosurgical or  
22 interventional radiology.

1           External maternal fetal monitoring, we do have a  
2 Level 3 nursery and three or four maternal fetal medicine  
3 people. TeleEEG, TeleUltrasound, TeleEcho, and now e-ICU,  
4 which extends to two non-Geisinger hospitals and there are  
5 several more in negotiation for that. And that, you know,  
6 that is a billed service. Many of the rest of these are  
7 supported at the local hospital end by their technical fees  
8 and at our end by the professional fee.

9           I will tell you that a substantial amount of the  
10 stroke business, for example, does not result in a transfer  
11 to Geisinger.

12           These are the pediatric sub-specialty services  
13 that are provided off our campus. Our pediatric sub-  
14 specialists ride a circuit to 10 outlying sites, doctor's  
15 offices and smaller hospitals. I still don't understand how  
16 our chief of pediatrics gets them on the road. We have  
17 eight pediatric neurologists and eight pediatric GI people  
18 and six pediatric cardiologists, and on and on. And they  
19 ride a circuit. They will spend sometimes three or three-  
20 and-a-half hours getting out to a place to see a full clinic  
21 of patients in that subspecialty who need attention but  
22 don't need to have mom pack everybody in the car and drive

1 three-and-a-half hours to see us.

2           These are the medical specialties provided onsite  
3 at smaller organizations or smaller institutions. And we  
4 provide hospitalist services. The two top there, GMC and  
5 GWV, are our own institutions. The two others, one is in  
6 State College. The other is in a smaller town south of  
7 State College. We provide the hospitalist services under  
8 contract which allows, at least at Lewistown, that hospital  
9 to retain primary care doctors who do not want to be on call  
10 at night for hospital patients.

11           We provide OB/GYN services, do deliveries at four  
12 non-Geisinger hospitals, and have continued to do GYN  
13 surgery of certain types at hospitals where they have closed  
14 their obstetric units because of low volumes and high  
15 malpractice. That business has been moved either to  
16 Geisinger or a larger facility. What we've done is have our  
17 GYN folks go out there and do surgery, where it can be done  
18 safely, as a way to support the economics of that hospital.

19           Surgery, we do these kinds of things at other  
20 hospitals, similar principle.

21           Our lab people provide backup support to 50 sites,  
22 I think they are all hospitals, in our area for specialized

1 testing, things other than routine chemistries. We are  
2 currently doing telepathology between both our hospitals and  
3 for one rural, non-Geisinger hospital where, with the  
4 current technology, our pathologist can read the surgical  
5 slides to make sure somebody has gotten the margins clear  
6 for breast cancer biopsy, for example, or a lump removal.  
7 And that, we believe, will extend.

8           Coumadin Clinic, we've been running for a number  
9 of years six sites where we have pharmacist-managed  
10 protocols for patients on Coumadin which, as you know, is a  
11 dangerous drug. They have spectacular results, very low  
12 rates of complication, very high rates of compliance of the  
13 patient. I have been a beneficiary of those services myself  
14 and can tell you it works very well.

15           I will tell you, nobody wants to pay for that  
16 service and hopefully, as the new anticoagulants come into  
17 more widespread use it may not be that dangerous, that need  
18 may go away. But for now, that's an issue. We've  
19 maintained that because it does improve patient care, it is  
20 a benefit for our communities and our staff. Doctors do not  
21 manage Coumadin well, as the literature would say.

22           The STEMI Program, which I want to spend a minute

1 on, is a regional program started by our cardiology groups  
2 and our emergency medicine people based on a program that I  
3 think Abbott Northwestern in Minneapolis put out. The goal  
4 is to reduce the first medical contact to balloon time to  
5 less than 90 minutes, which is the national standard for  
6 patient hitting the emergency room to cath lab and balloon  
7 dilated in the coronary artery. The cardiology people  
8 basically say every minute is more myocardium.

9           So this was done by creating a network of  
10 hospitals and trained EMTs so that if an ambulance that goes  
11 out into a community or a farm, when they do an EKG, if they  
12 see ST segment elevation, they can call from the ambulance  
13 to our transport center -- and we have five helicopters out  
14 and around. I'll show you where they are in a minute. That  
15 helicopter will meet that ambulance either at the nearest  
16 hospital or the nearest high school football field, pick the  
17 patient up and bring them to Geisinger, one of our  
18 hospitals. When the helicopter is dispatched, the cath team  
19 comes in, they're called. So they generally have a  
20 helicopter flight -- if it's a near pickup from outside and  
21 comes in, maybe half an hour, 35 minutes. And the cath team  
22 literally meets the patient at the helicopter pad, and I'll

1 show you the times.

2           So this is the network, the heart in the middle is  
3 Geisinger Medical Center, right on the bank of the  
4 Susquehanna River, high up enough that we don't get flooded,  
5 by the way. And then the red dots are where the four  
6 outlying helicopters are found. You see in the blue, that's  
7 a 15 minute flight time each way. In the red it's about a  
8 23 minute. So if you're in State College and somebody has  
9 to be picked up around there, it might take you under an  
10 hour to get out a little from State College, do the pickup,  
11 and get back.

12           The numbers that you have on your slides are  
13 incorrect, and I apologize for that. I had a correction  
14 come in from one of the cardiologists who runs this. These  
15 are the correct numbers. What I want to show you is that  
16 over this several years, the time for pickup to balloon at  
17 Geisinger has improved from just under three hours to under  
18 90 minutes. And 52 percent of all those patients met a 90-  
19 minute goal in the most recent calendar year. National  
20 databases generally cite 10 to 20 percent of patients, from  
21 the time they hit the emergency room door to balloon  
22 dilated, about 10 to 20 percent of patients hit that.

1           So you see, even if you're helicoptered in, we're  
2 better than that. And if you come directly to our ED which,  
3 of course, is a smaller area, generally about a 20 mile  
4 radius, that percent is 95 percent. Town of 5,000 people.  
5 Now, big medical center, right? Lot of people. And I think  
6 that's a problem in that one of the smaller hospitals has an  
7 interventional cath lab but the technician that staffs that  
8 lives 40 miles away, so their response times are not nearly  
9 this rapid.

10           This is data from our health plan that compares  
11 the HEDIS criteria in 2009, so standard assessment, standard  
12 data, of our clinic mainly in purple there in the middle  
13 column, versus the panel physicians in terms of the use --  
14 this demonstrates the use of teams, primary medical home,  
15 IT. The point is that health plan, in 2009, was number  
16 three in the national Medicare rankings and number seven or  
17 eight in the commercial. So well-ranked health plan in  
18 virtually every category, the group practice is  
19 statistically significantly higher than the community  
20 physicians the overall area, largely related to systems of  
21 care and reliability in care delivery.

22           Medical home, which we run in 35 -- in our primary

1 care sites, eight non-Geisinger practices. 14 percent  
2 decrease in total discharges for Medicare beneficiaries, 22  
3 percent total Medicare decrease in Medicare readmissions, 7  
4 percent sustained decrease in cost trend, 95 percent  
5 confidence intervals are now minus 3 percent to minus 12  
6 percent. That data will be published. It's for your  
7 internal use. I would not cite it yet. The statisticians  
8 are massaging but they've analyzed it two different ways and  
9 they say it comes out the same.

10 So we think the implications are that an  
11 integrated motivated delivery system can support rural  
12 health care and can do it in a beneficial, meaningful way,  
13 deliver high quality care in combination with hospitals that  
14 are in the community and not owned and doctors who are not  
15 employed.

16 Many of the small rural hospitals in our area will  
17 need to reconfigure and repurpose. They are all losing  
18 money, all of them. And some, because of the ability of  
19 transportation and the lack of ability to recruit doctors  
20 into those communities. The biggest problem we've got in  
21 our area is that, according to the physician relicensure  
22 data about three years ago, at that time 30 percent of the

1 non-Geisinger primary care doctors in our area were already  
2 over 62. So if the stock market keeps going up, we have a  
3 real public health problem.

4 Now as you see, Geisinger has been very  
5 successful. We recruited 25 primary care folks last year.  
6 We are able to recruit and to continue to provide services.  
7 But we are not going to be able to recruit enough or fast  
8 enough to replace 30 percent of the primary care doctors in  
9 35 counties. It won't happen.

10 So we're going to have to rely more on mid-level  
11 practitioners who support primary care physicians. And we  
12 have systematically tried to go down a path of divulging  
13 care from the doctor to the nurse practitioner, to the  
14 medical assistant, use protocols, use electronic reminders  
15 and monitoring, and have the doctor focus on the patient and  
16 family relationship and interaction and the difficult  
17 diagnostic and treatment decisions.

18 If you just have to write prescription refills, I  
19 mean we can do a lot of that electronically and send it to  
20 the pharmacy. If you need to manage hypertension or even  
21 simple congestive failure, a nurse or PA can do that with a  
22 protocol, and do.

1           But the hospitals probably will need to repurpose  
2 into emergency rooms, ambulatory surgical units, maybe a few  
3 beds for observation or perhaps an urgent deliver, although  
4 as you know changes in obstetrical care -- not pertinent to  
5 Medicare, of course, have meant that you can now predict  
6 which kids are going to need pediatric heart surgery,  
7 pediatric surgery of some other kind. And those deliveries  
8 are now elective and scheduled. So the day, when I trained,  
9 of somebody being helicoptered into Denton Cooley or Dr.  
10 Debakey or somebody with an unknown congenital heart defect  
11 are basically gone.

12           Last, a robust interactive health information  
13 network is essential for this. I think that one of the  
14 things that we're grateful about is that countries  
15 recognized this in terms of its investment. It will need to  
16 be continually supported by payment because one of the  
17 things we've learned, that I suspect many of you know, is  
18 that this is not plumbing. You do not put this in and walk  
19 away from it. It requires maintenance. It requires  
20 upgrading. The state of medical knowledge changes and needs  
21 to be put into that. Physicians and nurses need to review  
22 current practice and improve it. So it is a continuous

1 process. It takes energy. It takes time.

2 So with that, I appreciate the attention of the  
3 Commissioners and opportunity to present.

4 Thank you.

5 MR. LONG: Good morning. I might need a little  
6 help with your machine here first.

7 DR. STENSLAND: Get you to the show here.

8 MR. LONG: Thank you. Well, the Geisinger system  
9 is very impressive, and what I really appreciate, it sounds  
10 like they are staying true to their mission.

11 This is a much smaller version, but this is the  
12 service area that we serve, and what I really want you to  
13 pay attention to is looking at the populations of the  
14 counties and the distances. We are definitely not a suburb.  
15 We are not a bedroom community. We are 150 miles from the  
16 closest urban center with a whopping population of 61,000.  
17 Our home base is 1,300 in our city and 2,200 for our county,  
18 and the kind of potato-shaped area there is our service  
19 area, which is about 25,000 square miles and maybe has  
20 20,000 people in it, probably less, so less than one person  
21 per square mile. When people talk about rural and frontier,  
22 frontier is even considered six people per square mile. We

1 consider ourselves wilderness.

2 [Laughter.]

3 DR. HARMORY: No trees, but wilderness.

4 MR. LONG: Yes, we're a little short on trees,  
5 too.

6 And here is just kind of recapping those -- when  
7 we were looking at it, the map was kind of busy, is the  
8 distances and the populations to different locations. For  
9 example, obstetrics, if we weren't there, there would be  
10 about a 200-mile gap at least on one direction and 300-mile  
11 gap the other direction to the next obstetric provider.

12 This is our home community. Hettinger is 1,300.  
13 Our home county is 2,200. This is where it started, and as  
14 your comment about trees, I don't see any.

15 [Laughter.]

16 MR. LONG: Then I threw in this just for a little  
17 historical. Our community has existed in the 1920s as we  
18 are today, typical, proud rural people enjoying the  
19 Midwestern way of life. We are really known for our  
20 pheasants. North Dakota is the second highest producer of  
21 pheasants for hunting of the nation. And this is the other  
22 thing we are known for. It is a little cold and a little

1 snowy in our neck of the woods.

2           Our organization, we are a hospital. We have a  
3 25-bed critical access hospital. We have ICU and  
4 obstetrics. We deliver about 100 babies a year, and one of  
5 our doctors has delivered in excess of 5,000 babies and we  
6 think he's between 5,500 and 6,000 at the present, and he's  
7 soon to retire. Medical clinics, six medical clinics of  
8 which five of them are Rural Health Clinics. Then we have a  
9 foot and ankle clinic for podiatry and an eye clinic for  
10 optometrists.

11           We also are closely connected to a Federally  
12 Qualified Health Center out of Isabel, South Dakota, and so  
13 our medical staff supervises those mid-levels in four  
14 locations and that's -- two of the locations are -- well,  
15 one is 50, one is 75, one is 100, and the other is 120 miles  
16 away from us. We also provide staffing to two family  
17 planning clinics in the area that are operated by the  
18 Community Action Program.

19           We operate the EMS service that serves the  
20 residents of Adams County, plus we provide intercepts for  
21 area ambulances and both ambulance units and first responder  
22 units. Our physicians serve as the medical advisors to all

1 but one of those area services.

2 And so I just want to really make the point is  
3 that there is some concern about CAHs and close with  
4 ambulances and competitors. We have no competitors. We all  
5 work together. I cringe at the day that any of those close,  
6 because who is going to cover it? That's a difficult  
7 question.

8 We also operate a nursing home with skilled beds  
9 as well as basic care beds, assisted living unit. Our home  
10 health agency had to close because we could not make it  
11 under the Federal reimbursement system, but we do have the  
12 option under Rural Health Clinics for a visiting nurse  
13 program, so that's what we've installed as the option, and  
14 so when it comes to home care, we have probably a 100-mile  
15 stretch in our area that we can't reach and no other home  
16 care services reach, as well. So it's just not available.  
17 We operate a home medical equipment service. We have a  
18 wellness center.

19 And my number there where I said that we believe  
20 we meet 80 percent of our patient needs for 50 percent of  
21 the dollars was back when we had a health network. We  
22 contracted with Blue Cross-Blue Shield. We had a tertiary

1 care system as a subcontractor to us, and so we had good  
2 numbers on the total health care dollars of those patients,  
3 and that's where I got the 80 and 20 and 50-50 at the time.  
4 Since that time, that tertiary center decided they didn't  
5 want to be a subcontractor, they were going to be the prime  
6 contractor, and so I don't have that quite as readily  
7 available as I did before.

8 I talked about our medical staff. As you can see,  
9 primary care-driven system, with probably right in saying  
10 that 30 percent of our medical staff are approaching  
11 retirement and recruiting is a bear. This is the people,  
12 and as you can tell, there are some youngsters in the group  
13 and there are some oldsters in the group, so a blend, and  
14 we've kind of recruited from all over. Initially when the  
15 practice was in its early years, they were all through the  
16 University of North Dakota, but no more. We are about --  
17 about a third, I would say, is University of North Dakota  
18 and the rest of them, we've recruited from elsewhere,  
19 including one from Canada.

20 This is the hospital as was originally constructed  
21 in 1950. It had 26 beds on the upper level and the lower  
22 level was the nursing home and other support services. The

1 back wing was the emergency room and a little surgery room.

2 By the late 1960s, you can see it's developed to  
3 be a fair amount different. By that time, the beds have  
4 been expanded with that additional wing to a total of 46  
5 beds, and on the upper right is the clinic building, and  
6 that was the start of moving the system to being more  
7 integrated. The nursing home beds were given up and a  
8 facility was constructed up above. That's the top-level  
9 facility. I have a laser. I was not using it because I was  
10 scared of getting it in somebody's eyes. But as you're  
11 pointing that way, maybe I can -- but the nursing home is  
12 right up in there, and the clinic is up there, and then  
13 that's the addition where added the additional beds and also  
14 a new surgery area in the lower level of that.

15 And, of course, the interesting thing about the --  
16 we had the nursing home, is in order to -- there was only 16  
17 beds in the lower level and moved up there. That was an 88-  
18 bed facility that was constructed and it was by another  
19 provider, so it was no longer integrated to the system. And  
20 then three years ago, we bought it back, so now it is  
21 integrated as well as the clinic is all integrated to our  
22 system now.

1           And this is the facility as it existed after an  
2 1982 project, which was supposed to work us a little bit  
3 more towards more ambulatory care as well as really updating  
4 those patient rooms that were built in 1950, which, as you  
5 would imagine, do not meet current standards.

6           And then here we've just recently completed our  
7 project, really worked to push the ambulatory care model.  
8 This is the new addition right in all this area here, and  
9 then a remodeling on the lower level of the existing  
10 building as well as other areas, too, as to put the high-  
11 traffic services all within easy walking distance, all on  
12 one level, at the ease for our elderly patients, which is  
13 the bulk of our patient population.

14           We are quite proud. Our addition cost \$9 million  
15 and I thought, what a horrible, terrible amount of money to  
16 spend. But as I have compared with other facilities and  
17 they said, well, they went with a replacement facility and  
18 have spent \$50 and \$60 million, I think that we just got a  
19 heck of a deal.

20           What makes me proud and thankful -- we have a very  
21 supportive community, proud to support a staff. We have  
22 what I consider is a high level of care in a very rural

1 environment. Give a little plug to Dr. Gerry Sailer, the  
2 physician who came in the early 1960s who really helped  
3 orchestrate and was the visionary for creating our medical  
4 system. And, of course, I'm proud of the organization and  
5 the opportunity to be part of it. And I think it's quite  
6 incredible, what the organization has been able to do in a  
7 very small community by committed and dedicated people.

8 I have things that keep me awake at night. I fear  
9 that primary care is being eliminated, and it's really  
10 through our medical schools, is that doctors are saying,  
11 well, I can go into primary care and, hmm, I don't make much  
12 money. I go just a few more years, man alive, that's the  
13 big bucks, and they are just bypassing primary care right  
14 and left. I'm happy to hear that even the large systems are  
15 having a heck of a time recruiting primary care physicians  
16 because we are really having a devil of a time.

17 And I worry, as I had mentioned earlier in a slide  
18 about we are providing 80 percent of the care for 50 percent  
19 of the dollars, well, if the subspecialty care was 20  
20 percent and taking over 50, what if it becomes 100 percent?  
21 Is that going to be 300 or 400 percent cost? So I worry  
22 about where it's going.

1           And I fear that the government believes that  
2 primary care physicians can be replaced with mid-levels, and  
3 I appreciated the comment that says, well, increasing the  
4 use of mid-levels but still understanding they still need to  
5 be supervised by a physician. They don't have the same  
6 level of education and training.

7           And then elimination of programs and services in  
8 rural communities because they can't operate like in an  
9 urban center, and I gave the example earlier of home health,  
10 is that in rural areas, home health agencies are closing  
11 everywhere because too many distances involved. We can't  
12 see as many people in a short period of time.

13           And, of course, I fear on emergency medical  
14 services, about them closing. What will happen? Whose  
15 responsibility if, like in our area, 50 miles away, an  
16 ambulance service closes. Who picks up the slack and how do  
17 they pick up the slack? To just cover it from Hettinger is  
18 not a good option. If you've got the golden hour, it's  
19 going to take that long before you even get there. You need  
20 people there. You need volunteers, and it has to be a  
21 volunteer-based system because with our sparse populations,  
22 you can't employ and have a for-profit-run system in those

1 areas.

2 I also worry that the EHR Meaningful Use  
3 Incentives established in the Electronic Health Record won't  
4 really be there, that it will be portioned out, saying that  
5 at our Critical Access Hospitals, well, this portion has to  
6 do with Rural Health Clinics. That's not covered. This  
7 part has to do with the Visiting Nurse Program. That's not  
8 covered. This has to do with the just straight clinic part.  
9 This part has to do with obstetrics and we don't have any  
10 obstetrics. So by the time it's done, we have already \$3  
11 million invested in our computer systems. We are figuring  
12 that we will invest another \$2 million by the time we're  
13 done, and it will all come down and says, well, here's a  
14 couple hundred thousand dollars as incentive. So I'm  
15 worried about how those, quote, "Meaningful Use Incentives"  
16 are actually going to be applied and it's difficult to get  
17 an answer.

18 And I fear of becoming a trap line eliminated by a  
19 large subspecialty-driven urban health system, and that's  
20 really not because they are bad people, but it just means  
21 that our locally-controlled primary care model can't  
22 survive, and I think that would be unfortunate.

1           And I fear that our country's medical system will  
2 lose its purpose and mission for health care, and I think  
3 the prospective payment system was large in making a lot of  
4 systems think like a business, like make profit, high  
5 profit, and I think that focus was wrong.

6           And, of course, like everybody else, I worry about  
7 our growing national debt. What I'd like to see Congress  
8 do, I'd like to see a payment system to pay fairly and don't  
9 make some segments highly lucrative and other things not  
10 feasible, and I'll give an example. Under the DRG-PPS  
11 system, I felt that primary care kept getting cut at the  
12 expense of growing other services. I think we should reward  
13 quality and cost-effective providers, and too often, the  
14 system rewards those who have been taking advantage of the  
15 system. I just read recently the proposal on the  
16 Accountable Care Organizations and it says, well, you would  
17 use your existing as the base and then as you improved it,  
18 get more. It says, well, that's fine if you are a high-  
19 cost, low-quality system because now under that system  
20 you'll get paid even more. Now, if you are already a low-  
21 cost, high-quality system, it's like, oh, okay. Well, thank  
22 you. So it doesn't really reward quality and cost-effective

1 providers.

2           And then, of course, on the EMS issue is that this  
3 thing in the regulations that think in frontier areas that  
4 we have competing ambulances needs to be forgotten. That  
5 CAH ambulance 35-mile restriction has to be removed or at  
6 least modified to say if it's within 35 miles of an urban or  
7 for-profit ambulance. Then, I would agree.

8           And I would also like Congress to understand that  
9 true Rural Access Hospitals do not have an economic  
10 advantage and they are not profitable. The numbers of the  
11 CAHs in North Dakota are dismal, and if you think about it,  
12 if 75 percent of your business, the best you can do is break  
13 even -- the best -- now, that's because Medicare reimburses  
14 101 percent of recognized and allowable costs, eliminating  
15 such things as, well, patient telephones are not necessary.  
16 Patient TVs are not necessary. Fundraising services are, of  
17 course, not part of the model. Other items that they  
18 subtract -- advertising. We advertise that we're putting on  
19 a wellness class, we're putting on diabetes education.  
20 That's marketing. That's not allowable. So if the best you  
21 can do on 75 percent of your business is break even, and  
22 then you have a typical ten percent of charity and bad

1 debts, is that you have 15 percent where you're trying to  
2 come out ahead on.

3 I think I'd like to see Congress support the  
4 training of primary care physicians and support continuation  
5 of primary care services, especially in rural areas, and for  
6 them to consider the United Kingdom model for development of  
7 subspecialists. It may sound crazy to you to have a primary  
8 care, or a potential specialty physician spend five years in  
9 primary care before they would even be eligible to get  
10 accepted into a subspecialty program, but I think it would  
11 be great service not only to them and the patient to really  
12 understand the primary care before they went to another  
13 level.

14 So I'd like to see the clearer incentives and  
15 financial assistance of getting Critical Access Hospitals to  
16 meaningful use, including the Rural Health Clinics. Protect  
17 access of the care for geographically remote Americans. I  
18 say Congress understands remote, sparsely populated,  
19 frontier and wilderness in Alaska. Well, I believe that  
20 very similar situations exist in the Lower 48 and I believe  
21 we are proof. In fact, I put on here the note about when  
22 the National Rural Health Association had a convention in

1 Alaska and many of the people took tours and came back and  
2 said, you won't believe it, but there are people that live  
3 50 and 100 miles away and there's no hospital for those  
4 distances, and so they come to that community where the  
5 hospital is at and they stay there until their baby is born  
6 before they can go home. Isn't that incredible? And I  
7 thought, you should come to North Dakota. It's the same  
8 thing. We have the same thing in our area, as well.

9           So here, I just leave it with my map again, kind  
10 of showing you those great distances. Like I said, the  
11 obstetrics, if we weren't providing, is that huge  
12 differences there. You're talking pretty much 300 miles  
13 across throughout the entire works to get to the next OB  
14 provider if we weren't there. And so we have great open  
15 spaces and it's tough out there.

16           So with that, I'll leave with just one little  
17 cartoon. I probably shouldn't do this one. It says, "Let's  
18 leave California, you said. I can't stand the earthquakes,  
19 you said. I'm tired of the traffic. I can't stand the  
20 pollution. Well, at least in California, it isn't 70 below  
21 zero." Well, that's really an exaggeration. Unlike, as  
22 some people think we are the frozen tundra, and that's not

1 true, we typically have about a week to two weeks where it's  
2 below zero. But the picture where it shows the post office  
3 box or the mailbox and says "The Plains" and you look and  
4 there's one house and you don't see anything else, that's  
5 true. We've got a lot of distance between light bulbs.

6 So with that, I end my presentation. Thank you.

7 MR. HACKBARTH: Well, thank you, both of you, for  
8 really terrific presentations.

9 So what we do is we'll go around the table and  
10 give each Commissioner a chance to ask a question, and if  
11 time permits, we'll go around some more. I'm going to take  
12 the prerogative of asking the first question, and Jim, it's  
13 for you. I'm trying to understand a little bit better the  
14 issues in physician recruitment and what the issues are for  
15 physicians.

16 So I'm trying to get a feel for how much of it is  
17 money, versus issues of lifestyle, versus issues of going to  
18 a community where there may be issues about call coverage.  
19 Can you help me just sort of understand what the barriers  
20 are, and obviously of particular interest is to what extent  
21 they can be addressed through our lever, which is payment  
22 policy, as opposed to there are conditions that are really

1 beyond the issue of Medicare payment.

2 MR. LONG: Okay. It's pretty much all those  
3 things, but I'll kind of hit the high ones. Really,  
4 regarding call volume or call responsibility, we do compete  
5 and that is somewhat of a negative, but we are one of the  
6 lucky ones when it comes to most rurals. Most rurals have  
7 maybe two or three physicians on their staff, and so by the  
8 sharing of call is very burdensome for them. With our  
9 number of providers, we, at least, have a reasonable call  
10 schedule, so it's attractive from that standpoint if they  
11 are interested in the rural lifestyle.

12 When it comes to money, as I mentioned with our  
13 system is that, well, if you're Critical Access Hospitals,  
14 where's the margin? And the problem is there is a problem  
15 on money and there are places that are getting desperate and  
16 are out there offering incredible dollars. The highest I  
17 have seen so far for first-year fresh graduate going to a  
18 rural location was \$290,000, and it was \$190,000 guaranteed  
19 salary and a \$100,000 sign-on bonus. Quite honestly, we  
20 can't afford to pay that, and so we can't compete against  
21 those kind of numbers. But it's really desperate out there  
22 and locations -- there are some rural locations that are

1 going without a provider. They're using locums, and they're  
2 the ones that if it's \$300,000 or more to get one, they'll  
3 pay it because they're that short. And we're competing  
4 against that and there is just an incredible shortage.

5 Lifestyle, yes, a lot of young people want to be  
6 where the bright lights and the action are, and so that  
7 lifestyle is a problem with some. It's a plus on others,  
8 because rural is typically a very nice place and safe place  
9 to raise a family. I have relatives in Dallas, Texas, and  
10 they just couldn't believe that we let the kids walk home  
11 from school to a house that hasn't been locked all day.  
12 That is just a different lifestyle, and if you're raising  
13 young kids, some people actually recognize that and take  
14 that as a positive. Of course, you know, it's 75 miles to a  
15 McDonald's or Wal-Mart for us, but -- so some of the other  
16 lifestyle things, we work against.

17 Did I answer your question?

18 MR. HACKBARTH: Yes, that's helpful. So what I'm  
19 envisioning is that the problem you describe is pretty  
20 widespread, and so we have large, or potentially larger and  
21 larger areas that have sparser and sparser physician  
22 coverage. So my next and related question, then, is could

1 you just describe a little bit more about how your system  
2 deals with the needs of nearby communities -- nearby in the  
3 North Dakota sense -- that have lost the ability to have a  
4 physician close by? So these people drive to Hettinger to  
5 get to you, or do you have physicians, that as Bruce says,  
6 go out on the circuit? Could you just describe that  
7 relationship?

8 MR. LONG: Oh, okay, and I probably should have  
9 detailed a little bit more about our service area and our  
10 satellite sites, because what we do within that area is  
11 basically they're within 50 miles of us, each of our  
12 satellites. So those are Rural Health Clinics, and we send  
13 physicians out there as well as having mid-level  
14 practitioners there to provide local service. And then we  
15 also work with the Federally Qualified Health Center down in  
16 Isabel, so there's a total of four sites there that we also  
17 go to, as well, to provide supervision of mid-levels.

18 We also do the training for EMS for our entire  
19 area. We have trained paramedics, EMTs, first responders,  
20 not just for Adams County and Hettinger but throughout that  
21 entire area. Our doctors all serve as medical advisors to  
22 other area nursing homes as well as ambulance services.

1           And we formed an education consortium about 20  
2 years ago that we kind of pool with the area nursing homes  
3 and clinics and other medical providers and to do joint  
4 education opportunities, where we figure that rather than  
5 the cost of traveling out, we pay to have speakers come in  
6 and then host within our service area.

7           And then we also subsidize some of the local  
8 transportation. There is a bus that runs between North and  
9 South Dakota, between Hettinger and Lemmon, and we help  
10 subsidize the cost of that transportation service, so  
11 allowing patients to easier get to us as well as trips back  
12 and forth for other purposes. We also provide a subsidy to  
13 the other area elderly services on their bus transportation  
14 also to assist in providing transportation to our residents.

15           MR. HACKBARTH: Scott?

16           MR. ARMSTRONG: First, thank you both. It's  
17 really impressive, the systems that you run and the care  
18 that you provide to your patients. Thanks for being here.

19           Bruce, a question for you. You were describing  
20 the way you've moved what you refer to as your medical home  
21 or a different primary care model into more rural medical  
22 centers. Could you just describe a little bit more how you

1 made that work and how -- I assume those practices are  
2 partly involved with your health plan, but only partially,  
3 and how you begin to support a primary care practice that's  
4 clearly based on different sort of principles and goals.

5 DR. HARMORY: Well, thank you for that question.  
6 Our primary medical home model, of course, is rooted in the  
7 chronic care model based at -- developed at Group Health by  
8 Dr. Wagner and colleagues, and was started between our  
9 health -- as a cooperative effort between our health plan  
10 and our provider group. And so it takes a basic -- a  
11 primary care site which is redesigned so patients can see  
12 their doctor same day or within 24 hours of a request,  
13 redesigns care to more routine care away from the physician,  
14 installs protocols so that diabetics all get the same stuff  
15 done and hypertensives and so forth and so on.

16 And then on top of that is added an in-clinic  
17 nurse case manager. The health plan literally took the  
18 nurses out of its call center and moved them into the  
19 practice site so that it does several things. That nurse  
20 then establishes a personal relationship with the high-risk  
21 patients and their families that he or she is responsible  
22 for managing, so they answer the phone. I mean, one of the

1 problems with the call center, as you know from some of the  
2 Medicare demonstration projects, is very few of us are  
3 willing to answer the phone and start talking about a bunch  
4 of medical care issues with the disembodied voice of  
5 somebody we've never met. And, in fact, early in the PGP  
6 demo, we could never get more than ten percent of the  
7 congestive heart failure patients to answer the phone, let  
8 alone call us every day or every other day and report a  
9 weight.

10           So the health plan moved those people out and they  
11 actually employ them, and the reason for that was so that  
12 the doctors would not start using those people as office  
13 nurses to do blood pressures and all that. Their job is  
14 focused on patients identified through data analysis as high  
15 risk and any Medicare patient admitted to the hospital.

16           Now, that model then was established in our  
17 employed groups. It was moved by the health plan to eight  
18 of their contracted primary care sites with large Medicare  
19 populations, and the health plan, of course, has an MA  
20 program. Geisinger Clinic has been participating with the  
21 PGP demo, and so we're able to support part of this through  
22 the shared savings of the PGP demo because we hit all the

1 quality metrics.

2 The third example is that the governor of  
3 Pennsylvania, Governor Rendell, about five years ago began  
4 to set up some regional projects to improve primary care  
5 home. There is one down in Philly. There's another up in  
6 the northeastern part of our geography which is an all-payer  
7 model and in which the Geisinger model of the embedded case  
8 manager has been employed.

9 And so we have seen repeatedly the same results in  
10 decreased utilization and improved patient satisfaction and  
11 family satisfaction, and early in the process when some of  
12 our sites were up on medical home, others were not, we  
13 actually had instances of patients transferring from one to  
14 the other because the word of mouth said, you're getting  
15 more help over here. So we've seen the same process  
16 repeatedly. We see the same in the analyses of medical home  
17 versus non-medical home, and we will see what happens in the  
18 all-payer model. So that's the difference.

19 MR. ARMSTRONG: So you moved a nurse into the  
20 medical centers. Did you change the payment arrangements  
21 for the providers themselves?

22 DR. HARMORY: Yes, key point. We did. Dr.

1 Gilfillan, who was the head of our health plan at the time  
2 and who is a primary care doctor by background, said he did  
3 not want this to fail for lack of money. So we do provide a  
4 monthly stipend for the doctors. It ranges according to how  
5 many patients they care for. The purpose of that stipend is  
6 to get them to do three things.

7           One is to be available to the patient when they  
8 need to be seen.

9           Secondly is to attend a monthly meeting where the  
10 case manager, all the doctors, the nurses, the front office  
11 staff get together with a lady who brings in all the data  
12 about the people admitted and having problems, and they go  
13 case by case, what could we have done differently. And then  
14 the physicians -- and there's a stipend to the practice site  
15 for the office space, telephone lines, and all that of the  
16 case manager.

17           Last, there is a result share, and like the PGP  
18 demo, it is based on a certain proportion of savings that  
19 are entirely paid on quality parameters, including increased  
20 numbers of visits by the beneficiaries to the practice. We  
21 expect the number of primary care visits to go up, and, in  
22 fact, they do, from an average of around, I think it was

1 eight or eight-and-a-half visits up to a little over ten  
2 visits a year. And, of course, there are multiple phone  
3 calls and so forth in addition.

4 DR. BAICKER: Mr. Long, I thought both  
5 presentations were really very helpful for us, and I'd love  
6 to hear your thoughts on the promise of some of the policy  
7 levers that people talk about to substitute for bodies in  
8 your service area, Mr. Long, versus just getting more bodies  
9 there. How much promise do you think there is from payment  
10 policies that promote the availability of remote consults  
11 that help with telephone management, et cetera, or really is  
12 there just no substituting for getting more physical people  
13 located in your service area?

14 MR. LONG: Looking at the option of telemedicine,  
15 and we have a connection. We have a system that was  
16 established by St. Alexis Medical Center out of Bismarck and  
17 we have connected with that. We have worked with that and  
18 found that patients are willing to work with it. It seems  
19 that physicians on both ends, not so much.

20 And so at our level, we have generally either had  
21 a mid-level provider there or a nurse there to assist at our  
22 end and a lot of frustration because what happens is that

1 the appointment is set for, say, 8:15, and we have our staff  
2 person there. We have the patient there. They sit.  
3 They're all connected, and then at the other end they say,  
4 okay, you're all set? You're all ready? Okay. Well, now  
5 I'll go notify the physician, and he might show up 20  
6 minutes, 30 minutes later, and everybody's just a little bit  
7 dissatisfied with the service.

8           So there are some logistics that still have to be  
9 worked out. I would think personal care is still better  
10 than through a television or a radio system, but it is --  
11 like I say, personal is preferred, but if it is not  
12 available, then I think then people would accept it.

13           DR. STUART: Thank you very much. I think it's  
14 really interesting in terms of how we define rural care. I  
15 actually was a patient of Geisinger when I lived in State  
16 College, Pennsylvania, and there are some people that think  
17 that State College is rural. But if you're right there,  
18 it's not. I mean, it's an urban area. But there are parts  
19 of the Geisinger system that really are rural, maybe not  
20 quite as rural as you have in Southwestern South Dakota, or  
21 North Dakota, but it's still very rural.

22           My question has to do with culture, and I was

1 particularly interested in what Mr. Long said about the  
2 importance of local control and how you are able to manage  
3 this thing locally. Dr. Harmory was talking about moving  
4 into areas, but also making sure that the patient contact  
5 was as local as possible.

6           And my question relates to the locality of the  
7 organization. In other words, how do you deal with the  
8 local doctors in the more rural practices and does this have  
9 any implications for what Jim Long is running?

10           DR. HARMORY: Well, thank you for your comment,  
11 and I'll pay the five bucks for the advertisement later.

12           [Laughter.]

13           DR. HARMORY: I think it's really a design  
14 difference for us, and it depends for us -- we view our  
15 primary care sites as the front door to the organization, as  
16 opposed to the emergency room or something else. We depend  
17 very much on devolving our operational responsibilities down  
18 into the organization. So we do not run to a Moscow-centric  
19 five-year plan in the primary care area, certainly.

20           Each of the counties that we serve -- or not all  
21 of them, but of the 35, we have people in roughly 20  
22 counties -- we'll have a leader that will control or lead --

1 "influence" maybe is a better word than "control" for  
2 doctors. You don't really control doctors, you try to herd  
3 them in the same direction, in a sense. Please don't quote  
4 me on that.

5 [Laughter.]

6 DR. HARMORY: But he will oversee the activities  
7 of about 30 doctors. So it might be one really large site  
8 or it might be an aggregation of six to eight primary care  
9 sites distributed, and he or she then has the responsibility  
10 for building the relationships, along with his physician and  
11 office staffs, with those other primary care doctors. And  
12 the specialty people from Danville will also be engaged in  
13 that.

14 So, for example, the cardiology folks actually  
15 assign one of the cardiologists to the physicians in a  
16 county. So he does out there and does his CME and all that.  
17 They have his phone number and they call him if they've got  
18 a problem. Now, we have a central call center and it's easy  
19 to get people in. But if they're having a patient problem,  
20 they have a name to call.

21 And there is a lot of work with the local  
22 hospitals. We have some full-time people in our

1 administration who go out very regularly and somewhat  
2 frequently to visit the hospital CEOs and others to try to  
3 help them determine what are their needs. And we have an  
4 epidemiology unit which, for example, has recently done, in  
5 conjunction with some of the local hospitals, surveys of  
6 patient health needs in various counties, in addition to  
7 what the State and the Federal Government do. So there's an  
8 active attempt to do that.

9           There has, I would say, we've only recently -- and  
10 that mainly for the group of private practice physicians who  
11 practice at our hospital in Wilkes-Barre -- begun to try to  
12 move IT out to them that they can use in their offices.

13           So I don't know if that really answers your  
14 question, sir.

15           DR. STUART: I think there are two parts to the  
16 question. One was the delivery of service, but then the  
17 other is kind of the culture of the practices in rural  
18 areas.

19           DR. HARMORY: Yes, okay.

20           DR. STUART: What we see here is we've got two  
21 very different --

22           DR. HARMORY: We do --

1 DR. STUART: -- models --

2 DR. HARMORY: Yes, sir. Well, I think the culture  
3 of the primary care -- of the rural practices is very much  
4 as it would be in North Dakota. My granddad actually was  
5 one of those folks years back, and they tend to be a pretty  
6 independent group. Most of the practitioners in  
7 Pennsylvania, in our area, at least, are solo or two-person  
8 practices. For primary care, it's been very unusual to have  
9 more than two in a group. It's a little different for some  
10 of the specialties, cardiology, for example. They are  
11 having a lot of difficulty in recruiting and it is mainly  
12 lifestyle. It is somewhat spouses, either male or female,  
13 reluctant to leave an urban area, or the fact that there are  
14 two wage earners in the family and one person is in  
15 computers and the other person is in medicine and we don't  
16 have a lot of openings for computer people in many of these  
17 towns. It's that sort of thing.

18 I think, you know, as was said, we do find, both  
19 at our place and others, that young people are more willing  
20 to move to a rural or semi-rural area when they begin to  
21 have children. But that is influenced heavily by the  
22 quality of the schools. And so we're fortunate in parts of

1 our geography -- State College is one, and Danville and  
2 Lewisburg and some others are other examples where they have  
3 very good school districts -- and we can and other  
4 physicians can recruit new people to those areas and then  
5 use them to serve nearby or even somewhat distant outlying  
6 areas.

7 MR. HACKBARTH: We've got roughly 45 minutes and  
8 ten or 11 people, so we have to engage in some, pardon the  
9 expression, rationing here. So if we could keep our -- -  
10 right. Right. If we could keep our questions and responses  
11 as crisp as possible, that would be good. Thanks.

12 Peter?

13 MR. BUTLER: Can I ask two quick questions or just  
14 one? Just one?

15 DR. KANE: [Off microphone.]

16 MR. BUTLER: Okay, two -- well, just give me a  
17 short answer. The first one is you mentioned the sweet spot  
18 being when you have a patient in the plan with a Geisinger  
19 Group doctor in a Geisinger hospital. You showed data that  
20 showed the differences between the Geisinger doctor and the  
21 panel doctors and the significant -- what's the incremental  
22 value of being also in a Geisinger hospital, or is that less

1 important?

2 DR. HARMORY: The data I showed are ambulatory  
3 data. We believe that with the redesign of care in the  
4 Geisinger hospital, that helps, in addition. There are  
5 proven care bundles for heart surgery and so forth.

6 I would only add, in keeping my comments brief,  
7 that we have early evidence that even in those primary care  
8 sites where the same care is delivered to every kind of  
9 patient, no matter insurer or no insurer, that there are  
10 differences between the insurance plans in a proportion of  
11 patients that hit those metrics. And interesting, Medicare  
12 and the Geisinger Health Plan people are the two top ones,  
13 followed by a number of the other insurers and Medicaid.

14 MR. BUTLER: Okay. My other question, there's a  
15 challenge to answer it shortly. You have 350 residents.  
16 You didn't talk too much about your commitment to education.  
17 One view might be that most of those are sitting in the  
18 flagship campus subjected to usual ACGME rules and  
19 influenced by Medicare payment. Others may say, no, we've  
20 tailored this as a pipeline to our wide commitment to a  
21 population health and have a fundamentally different model.  
22 So --

1 DR. HARMORY: Very quickly, we have a family  
2 practice residency in the hospital in Wilkes-Barre that does  
3 operate largely in an ambulatory setting. We also have a DO  
4 surgery program up there, which is aimed at producing more  
5 general surgeons. In Danville, we have programs in internal  
6 medicine, med-peds, general surgery, and pediatrics, OB, as  
7 well, and then 32 subspecialty programs. We hire about 20  
8 percent of our doctors from those various training programs.

9 I would tell you, our proportion of interns going  
10 into subspecialties is not significantly different from  
11 those of an academic medical center. We still have a large  
12 number of people go into subspecialties, unfortunately, but  
13 I'm a subspecialist, so --

14 DR. KANE: Yes. This is fascinating, and I guess  
15 I still -- I've been educated by Tom quite a bit, that the  
16 home health situation in rural Dakotas is not so great, and  
17 I guess I'm wondering what happens. So you've got these  
18 hundred square miles, you know, these barren plains with no  
19 trees and one little house with a little smoke coming out,  
20 you know --

21 DR. DEAN: We have trees in South Dakota.

22 [Laughter.]

1 DR. KANE: A lot of snow. You can't even see the  
2 trees. Who's living in those houses? Are they really 95-  
3 year-old single widowed people, or where do they go? So do  
4 they really stay there, or do they start changing their own  
5 living arrangements to be safe and medically -- or how many  
6 sort of single widowed over-75-year-old people are out there  
7 in that area where home health really would be totally --  
8 you know, not having that would be really terrible, or do  
9 the people just accommodate by moving to Florida or moving  
10 in with their children in Dallas? I wonder if you have a  
11 sense of that. I'm just wondering what happens when --

12 MR. LONG: Is that one aimed at me, I take?

13 DR. KANE: Yes.

14 MR. LONG: All right. I don't have the  
15 statistics. All I do know is that there are ones out there,  
16 and we will only go so far. We'll go another 50 miles from  
17 any nurse's site, and we try to have nurses placed  
18 throughout our service area, trying to hire staff that are  
19 nurses -- they're also a farm wife, et cetera -- and extend  
20 our distances. And there are people outside our reach. I  
21 think at some point, they would give it up and sell the farm  
22 and move to town, but right now, they don't have the

1 services available.

2           These are pretty hardy people. One of the --  
3 maybe I shouldn't tell the story, but there was an elderly  
4 couple and he was calving and got pushed down and broke his  
5 hip, and it was just him and his wife and there was a storm  
6 going on, and so she got the loader and got him in the  
7 loader of the tractor, used that to carry him to the house,  
8 dumped him on the doorstep and then drug him in the house  
9 and they had to wait four days before the roads were open  
10 and get an ambulance there to bring him in. So they're  
11 hardy people, but they are out there.

12           DR. MARK MILLER: [Off microphone.] Just on a  
13 related point, you also you had, I think, an assisted living  
14 facility and a nursing facility?

15           MR. LONG: Yes, we do.

16           DR. MARK MILLER: Is that fully occupied? Again,  
17 I'm trying to connect to your point here, in case that's not  
18 obvious. Is that fully occupied?

19           MR. LONG: No, there are beds available. Our  
20 assisted living is full and maintains full, and so it would  
21 be nice to be able to build an additional facility there.  
22 Actually, what we're hoping to -- there are dreams here --

1 one of these days -- is to replace our current skilled and  
2 basic care facility and make it adjacent to our assisted  
3 living and add some more basic care and assisted living beds  
4 at that time.

5 But right now, our skilled beds are not full. Our  
6 basic care and our assisted living beds actually are. And  
7 within our area, yes, we're not -- I don't think the entire  
8 area is full, but pretty well occupied. There is a nursing  
9 home also in Lemmon, one in Bowman, and they also have  
10 assisted living in those locations, as well, too.

11 DR. MARK MILLER: Sorry. I just -- the assisted  
12 living, how would you characterize where the finances come  
13 for that? What's the mix of payer there? How much is out  
14 of pocket and --

15 MR. LONG: For assisted living, the State through  
16 the Medicaid program will pay for the care part  
17 requirements, not the housing part of the requirements, so  
18 on assisted living. If they qualify for basic care, then  
19 that is through Title 19 Medicaid if they don't have the  
20 resources.

21 MR. KUHN: Bruce, Jim, thank you both for being  
22 here. This is a very helpful conversation.

1 I'd like to kind of explore kind of two notions  
2 here a little bit. One is a little bit the incentives  
3 towards integration in rural areas and the other is a little  
4 bit about the ability to transition and begin to manage  
5 population health in rural areas.

6 So, first of all, I'd like you to kind of comment,  
7 either one of you or both of you, if you would, kind of as  
8 you look at the Medicare program, the appropriate attributes  
9 of the Medicare program to move us into kind of the right  
10 integration models that are out there, including any  
11 observations you might have about the proposed ACO  
12 regulation that came out about a week ago.

13 And then the second part of that is a little bit  
14 about the competencies that you all think that we're going  
15 to need in the future in rural health as we move into these  
16 integration models, about the competencies that are going to  
17 be necessary to kind of manage population health as we go  
18 forward. Or, to put it another way, what do we lack in  
19 rural areas right now that we could use in the future to get  
20 us that direction?

21 DR. HARMORY: We're rushing to be first here, as  
22 you can tell.

1 [Laughter.]

2 DR. HARMORY: Well, I think those are complex  
3 questions and will probably take more than two minutes, but  
4 high level. I've spent a good part of the last five days  
5 reading and re-reading the proposed ACO regulations. I  
6 think they are complex. They will be difficult, if not  
7 impossible, for rural organizations other than a Geisinger  
8 or a Group Health that reaches out or some others to meet  
9 for many years, because lack of infrastructure, lack of data  
10 handling, lack of ability to identify high risk, and as you  
11 have heard, extreme difficulty in terms of distance and time  
12 for people to come in and even get preventive care.

13 So I think in terms of the ACO regulations, those  
14 will likely apply, at least initially, much more to suburban  
15 and maybe to inner-city areas, and that's subject to  
16 amendments and the way the thing is phased in and some of  
17 the payment mechanisms. I mean, one of the back-of-envelope  
18 calculations I did was that it probably still pays you more  
19 just to stay with fee-for-service and not do any of that.  
20 But I just offer that as a rapid observation. I need some  
21 more work and our actuaries and all that will look on it.

22 So I think it's a move and it would allow people,

1 if it can be tweaked a little, it would allow people to use  
2 dollars for other things. Some of the examples cited, I  
3 think, are right on. We have a lot of volunteer ambulance  
4 services in Pennsylvania. We spend a lot of time educating  
5 them. The State does, too, but the budget has just been cut  
6 out for all that in Pennsylvania, the State budget. So I  
7 think on that point.

8 I think Medicare support for graduate medical  
9 education is key. I think we're one of only two federally-  
10 designated rural academic health centers, and we appreciate  
11 that support. I do think some changes in the way the  
12 payments are apportioned between primary care and specialty  
13 training would be helpful, and all my subspecialist  
14 colleagues are going to kill me for saying that, but I think  
15 that would be helpful.

16 There are countries -- Norway, I visited -- and I  
17 know that they require all medical school graduates in  
18 Norway to serve two years in a rural area, but the  
19 government is paying the entire bill for the education, and  
20 that's a big difference. So I'll stop there.

21 MR. LONG: Okay, and I guess I'll try to keep mine  
22 short, too. On integration, we work really more

1 cooperatively and we're integrated. We've actually  
2 integrated just to protect and keep it together. For  
3 example, when we brought the clinics in in 1981, they were  
4 integrated because doctors were getting jumpy, scared that  
5 the last man standing could get stuck, and so he says, well,  
6 we've got to keep this together, so we proposed combining  
7 the clinic operations with the hospital.

8           And the same way with the nursing home, is that it  
9 was owned by a for-profit. The main person with that for-  
10 profit nursing home passed away. The place was put up for  
11 sale and we feared that the facility would be sold and the  
12 license for the beds moved out of our service area and  
13 leaving our patients uncovered, because they could be moved  
14 to a more populated area and easily filled up. And so we  
15 purchased the nursing home to integrate it.

16           So our model has really been always trying to work  
17 cooperatively with each other. We integrate when we have  
18 to.

19           As to the ACOs, I think in our situation, like  
20 Bruce mentioned, it would be difficult for us to -- and  
21 expensive to establish it to meet the requirements and then  
22 turn it around and say, we're already, and if you go and

1 look at the data regarding our facility, that we are already  
2 meeting the quality standards. We work very close with our  
3 PRO. We participate in all the studies. We do everything  
4 we can to meet them on items that -- on the services we  
5 provide. And so we think that under the present regulations  
6 is that we wouldn't get paid anything additional for it  
7 because we wouldn't have much level for improvement, no  
8 return on putting that investment into those ACOs.

9 DR. BERENSON: Yeah, thanks, both of you. Bruce,  
10 I want to get into the weeds on one specific topic, eICUs a  
11 little bit. Is that the Visicu product, I'm assuming?

12 DR. HAMORY: Yes, sir.

13 DR. BERENSON: For those who don't know, they're  
14 critical care nurses and doctors in a separate facility,  
15 which can be a long distance away, who have visual contact  
16 with the patient, sound, I mean, they're talking to the  
17 nurse and have real-time physiologic information coming  
18 through.

19 DR. HAMORY: Yes.

20 DR. BERENSON: You said it's a billable service,  
21 and I want to pursue that a little bit. What's billable?  
22 Because I didn't think Medicare covered at least the

1 professional services.

2 DR. HAMORY: It doesn't. It doesn't cover the  
3 professional. I think the technology at the local hospital  
4 end would be part of the cost base.

5 DR. BERENSON: The local hospital base. But it's  
6 still an ongoing issue about whether there should be  
7 compensation.

8 DR. HAMORY: Yes. And, by the way, let me  
9 mention, just at our larger hospital for 20-some years we  
10 have had 24-hour coverage in-house by intensivists. We have  
11 actually seen better results by pulling those people out,  
12 using them to man the ICU in our own intensive care unit,  
13 with falls in mortality rate, for example. So we think the  
14 physiologic monitoring, the ability to catch trends early  
15 and changes in pulse, blood pressure, whatever, physiologic  
16 things, will probably be helpful in that regard.

17 DR. BERENSON: And just to follow up, the last  
18 question on that is you said you have got it in two  
19 facilities or you're connected and you're talking to others.  
20 What are sort of the issues for the rural hospitals about  
21 whether to do this with you?

22 DR. HAMORY: I think a couple. One obviously is

1 the local medical staff coverage. You know, we're the 800-  
2 pound gorilla.

3 The second is that you really have to agree on  
4 protocols. You cannot have, you know, 50 doctors in four  
5 different institutions everybody doing his own thing.

6 The third issue typically is the support in the  
7 local hospital. I mean, as you know, many of the smaller  
8 hospitals, the ICU, in quotes, functions in a sense as post-  
9 op recovery and other things. And so, you know, the  
10 question is, in order to support it, you have to have people  
11 available, a PA or someone, who can put a central line in or  
12 do certain low-level or primary invasive things. If you  
13 don't have that, you don't even start.

14 DR. BERENSON: They would have to do that in any  
15 case.

16 DR. HAMORY: Yes.

17 DR. BERENSON: Or just refer everybody --

18 DR. HAMORY: Well, and that's what some of them  
19 have been doing, is just sending everybody in. And we don't  
20 view that as beneficial for the patient, family, or  
21 appropriate resource use of our really high end stuff.  
22 We're Level 1 trauma, and we never close to trauma, and we

1 try never to close to an admission and succeed in that, you  
2 know, 98 percent of the time.

3 DR. CASTELLANOS: First of all, thank you very  
4 much. It was an excellent presentation. But more  
5 important, thank you for what you're doing in your  
6 communities. We really appreciate that.

7 One of the things we've been struggling with is  
8 the health care delivery system changes and physician  
9 reimbursement. And just briefly, if you could tell me some  
10 of the indications you use, whether it's quality, outcomes,  
11 patient satisfaction, RVUs, briefly how you calculate and  
12 how you do physician reimbursement.

13 DR. HAMORY: Well, we're data rich so actually I  
14 can get a report every week of time to third available  
15 appointment for our doctors and specialists. We expect  
16 primary care to be 24 hours -- I think our chief is saying  
17 48 now -- and the specialist to be under two weeks for a  
18 routine appointment and within 24 hours for urgent or  
19 emergent.

20 We get reports every month certainly on the  
21 proportion of patients seen with diabetes, with CHF, who  
22 came in for a preventive care visit, who have gotten all the

1 elements of that that they require. Our current numbers are  
2 about 65 to 70 percent, which is better than that 54 percent  
3 that Beth McGlynn reported, what, eight years ago now. And  
4 we pay our -- for the salaried physicians, in addition, they  
5 get -- 20 percent of their total comp is incentive. Three-  
6 quarters of that incentive is patient satisfaction, which we  
7 measure at an individual physician level, and quality  
8 metrics. A quarter of it is that their clinic is meeting  
9 their budget. Their budget can be to lose money, but they  
10 have to meet their budget.

11 So that's generally the way we look at it, and we  
12 do -- we are on a model where we do monitor productivity.  
13 We want people seeing patients. You know, we're not  
14 capitated. We're not a staff model HMO. We do not expect  
15 people to make money by not seeing patients.

16 DR. CASTELLANOS: Jim, do you have any [off  
17 microphone]?

18 MR. LONG: Our payment system is really very  
19 simple. We just pay on work RVUs, and we expect them to be  
20 both quality and cover the ER for call, and it's just an  
21 expectation; we don't measure and otherwise compensate.  
22 This is just a work RVU.

1           MR. HACKBARTH: So, Jim, your physicians are  
2 employed by the system, and so the revenue comes to the  
3 system, and then you reallocate it in the way that you base  
4 the --

5           MR. LONG: Kind of.

6           MR. HACKBARTH: Okay.

7           MR. LONG: It's kind of an in-between. We own the  
8 clinics, but the physicians are set up into a professional  
9 service corporation as a group, and then they contract their  
10 professional services, and so that's why I say we have the  
11 expectations. For example, with the on-call coverage, it's  
12 not specific as to physicians, just that the group will  
13 provide the on-call of the ER, and they do that for  
14 everybody. I mean, if a person comes in with an ankle  
15 injury, the podiatrist is expected to come in and take a  
16 look at that ankle.

17           MR. GEORGE MILLER: Again, let me thank both of  
18 you. Jim, I was president plaintiff NRHA in Alaska when we  
19 had that conference. And, in fact, just a side note, one of  
20 our guests that went as rural communities was chosen to be  
21 the graduation speaker on the spot for a graduating class of  
22 four for that trip. So it was very educational to do that.

1           I want to follow up on Nancy's question -- I had  
2 already written a note -- about the access issue, especially  
3 in rural care. Both of you can answer, but particularly  
4 Jim. Have you been able to measure the impact if you didn't  
5 have one of the services like home care, the impact to the  
6 system, what it costs you, and also then the outcomes -- the  
7 impact of the outcomes to the patient who then did not have  
8 that home care, what it manifested, what maybe the problem  
9 by not having home care in the community?

10           MR. LONG: I can't tell you right offhand. In our  
11 own situation is we had looked at the home health, and we  
12 were losing on average \$100,000 a year on it, and so as I  
13 said, critical access hospitals, where do you make it up?  
14 You can't, so we made the decision to terminate it with the  
15 intention of replacing it with a visiting nurse. And so  
16 then we had a period of time without coverage. I didn't  
17 bring statistics along of how many visiting nurse and home  
18 health visits we do make, but it would have made a  
19 difference on quality of life certainly for a good number of  
20 our patients. I'm just trying to remember the numbers that  
21 we have on right now.

22           And for us the visiting nurse was a good

1 substitute. The only thing is it doesn't cover home health  
2 aides, so it's only the nurse. And there are aide services  
3 that would be beneficial, too, and presently they're also  
4 just not available.

5 DR. HAMORY: Very quickly, we have a home health  
6 agency also work closely with the visiting nurses groups.  
7 One of the uses that we found very beneficial in preventing  
8 readmissions is that for those patients discharged from our  
9 hospitals who do not have a Geisinger primary care doctor,  
10 we are increasingly sending the nurses out to visit the home  
11 within a couple days after discharge so they can sit at the  
12 kitchen table, run the medication list, do the med recs, go  
13 through the pharmacy stuff, pitch out all those outdated  
14 drugs, and do a quick survey of the home for fall hazards.  
15 And that's early in its progress, but we know from the  
16 medical home that reconciliation of meds avoids a lot of ED  
17 visits. So too early.

18 MR. GEORGE MILLER: And I guess that's my  
19 question. Those things that you do at Geisinger probably  
20 keeps additional patients coming to the ER, and so, Jim, my  
21 question is: Can you measure that since you've been able to  
22 close? Have you had a spike in falls or any other issue?

1 So there's a correlation to the money you lose on not have  
2 home care, the \$100,000 a year, versus increase in  
3 utilization in the ER or to the hospital that may have been  
4 prevented if you had home care in the community? Would that  
5 have been a net loss?

6 MR. LONG: I don't have anything that I can say is  
7 a measure on that, and I'd say the nursing services have  
8 been retained through our visiting nurse program. And I did  
9 have the statistic, and we do about 2,000 visiting nurse  
10 visits a year. But I can't measure about what has been the  
11 impact.

12 MR. GEORGE MILLER: Thank you.

13 MS. UCCELLO: Thank you both so much for your  
14 presentations. They were really helpful.

15 Jim, you mentioned concerns related to the urban  
16 health systems, and I'm wondering if you can expand upon  
17 that and talk a little bit about concerns about residents  
18 going to the urban systems for care or the urban systems  
19 coming out to the rural areas.

20 MR. LONG: Okay. Presently in our neck of the  
21 Dakotas, there are really four major systems that are out  
22 there that are competing and combining potentially to become

1 two, and each one of them is trying to gobble up more  
2 service area in their battles, and, you know, because being  
3 independent, our physicians choose where their patients go  
4 between them and the patient. It's not dictated by a  
5 system. And so that's why I said, well, it will just be a  
6 loss of an independent.

7 Now, I'm not saying that any of those four systems  
8 are bad, because they're not. But it's just a loss of that  
9 independent choice. What was the second part of your  
10 question?

11 MS. UCCELLO: That's it [off microphone].

12 MR. LONG: That's it. Okay.

13 MS. UCCELLO: And since I don't really think I  
14 used all my four minutes, I'm going to ask quick --

15 MR. HACKBARTH: [off microphone].

16 [Laughter.]

17 MS. UCCELLO: Just quickly, when we had a month or  
18 two back a discussion about Part D and prescription drugs,  
19 one of the findings that I thought was surprising is that  
20 mail order usage really wasn't higher in the rural areas,  
21 and I'm wondering if you want to comment on availability of  
22 prescription drugs in the rural areas.

1           MR. LONG: Mail order, there are two parts to the  
2 equation. There are areas that are dependent on the mail  
3 order, and in some of those cases, it's quite difficult.  
4 Some of them have to drive a fair distance just to receive  
5 the mail order prescriptions. But in our areas you see a  
6 lot of people trying to support their local businesses, and  
7 so I think that's really the bigger factor of why they're  
8 not using mail order as much as they might in some other  
9 locations. But when the price gets to be enough difference,  
10 then they do, even in the really small areas. There's only  
11 so many dollars and how far can you spread it?

12           DR. CHERNEW: That was wonderful. I have a  
13 question for Bruce. So your system serves both Geisinger  
14 and non-Geisinger patients, as you pointed out. My question  
15 is: There's some concern about how systems that become  
16 bigger and in some ways even better price for insurers that  
17 aren't part of their system. So I don't know if you're  
18 willing to say in your case or talk generally, but how does  
19 the pricing work between what you would charge for access to  
20 your system for a non-Geisinger person as opposed to what,  
21 say, Geisinger would internally pay for those same services?  
22 And how much as you get bigger and stronger should we

1 generally worry about the sort of market position of players  
2 like you?

3 DR. HAMORY: It's a fair question. You know, I do  
4 work with several other health systems as well, some of them  
5 trying to do rural health care in parts of Illinois and  
6 Wisconsin. And I think the problem every hospital faces is  
7 just what Jeff said, which is that for our governmental  
8 payers, we're generally a little below cost. Now, we have  
9 made efforts at Geisinger to try to get our cost structure  
10 at or below Medicare payments. For us that's about \$350  
11 million, and we're about 130 into that over a year and a  
12 half. So we still have a ways to go.

13 Medicaid, of course, in Pennsylvania is worse, and  
14 so we cross-subsidize, and we cross-subsidize both from our  
15 own health plan and other commercial payers, and those rates  
16 vary, and they'll vary somewhat by volume of business.

17 Our rates are not extreme. I mean, if you look,  
18 for example, at health care cost containment data in  
19 Pennsylvania, we are actually one of the least expensive in  
20 charges for heart surgery and a bunch of other stuff. I  
21 mean, you know, the guys in Philadelphia are sort of two to  
22 three times what we are. So I don't think there's evidence

1 from that sort of thing that we are, you know, trying to  
2 pillage anybody.

3 In addition, we're pretty efficient in terms of  
4 utilization by most metrics, and so, you know, on a cost --  
5 even on an overall thing, let alone cost per unit, we tend  
6 to be lower than other areas. So, you know, I think our  
7 not-for-profit status and our mission driven has ameliorated  
8 that. I'm aware of some other areas in other states where  
9 the Washington Post has, you know, featured some examples of  
10 overuse of market power.

11 Our health plan does see that, though, in some of  
12 the sole providers in a county where, you know, they can't  
13 do business unless, you know, certain thresholds are met.  
14 So it applies at both ends, I think.

15 MS. HANSEN: Again, thank you very, very much. It  
16 certainly reminds me of my days as a rural health nurse in  
17 Potlatch, Idaho. So one of the questions I'd find it really  
18 helpful if you would amplify is the person-power staffing  
19 that you both have seemingly worked out well with the  
20 relationship of the primary care physicians to your mid-  
21 levels, the nurse practitioners and the PAs and all, and  
22 just how that evolution of the culture change occurred so

1 that you could maximize, you know, people's performance to  
2 their level of skill and license.

3 MR. LONG: Okay. Well, we've been using mid-  
4 levels for really a very long period of time, even before I  
5 got there, and I've been there 28 years. So I can't say a  
6 lot about the evolution because they were already integrated  
7 to the system, and they got their start really from, as I  
8 understand it, after the war there were medics that came  
9 back, and they started the work as mid-level providers.

10 We use them as physician extenders, and they  
11 always have physicians available to ask questions and get  
12 assistance, and what's most important is that they know  
13 their limitations and that they send it on to the physician  
14 if they are unable to properly deal with that particular  
15 patient. Most the mid-levels are actually under the employ  
16 of our system rather than by the physicians because they're  
17 placed in our rural health clinics.

18 Like I say, it has been a relationship that has  
19 been ongoing for a very long period of time.

20 DR. HAMORY: We have, I think, had more recent  
21 experience with the culture changes needed, and some of the  
22 ways our advanced practice people are used are, of course, a

1 result of both the state medical and nursing practice acts,  
2 which in Pennsylvania have loosened up a little bit. But an  
3 issue we face is that the Osteopathy Board and the medical  
4 board have different rules. And so since about 25 percent  
5 of our total physician staff are osteopaths and we have  
6 osteopaths in many of our training programs, it's an  
7 administrative problem with how many people can be  
8 affiliated with or have a practice agreement with or be  
9 supervised by these different areas.

10           The biggest issue, I think, is not from the  
11 competence or skill of the advanced practice people.  
12 They're good folk. My wife's a nurse practitioner so I have  
13 a disclaimer I have to make. But the real issue is  
14 developing the physician confidence and, in fact, I tell our  
15 medical school colleagues -- and I used to be a professor at  
16 one time -- that we're training people the wrong way. We  
17 select doctors as star players on -- you know, a tennis  
18 player. We don't select them for their ability to get along  
19 in groups. We don't teach them how to function in a team.

20           You know, when I was a resident, if a mistake was  
21 made on a patient, it didn't matter what it was. I was the  
22 guy to blame. Right? And we've been doing that. So we've

1 not taught people how to work in these teams, and so when  
2 you bring folks in, they have to be acculturated, and it's  
3 the same, by the way, with an electronic health record.  
4 Docs don't trust electrons. Right?

5           So we've gone through a several-year period of  
6 getting this done. Now when we hire people it's simple  
7 because they're coming into an existing system, and they're  
8 either going to buy in when we hire them or not.

9           DR. DEAN: Well, like the rest of my colleagues, I  
10 certainly appreciate the perspective that both of you have  
11 brought. You've both described impressive, mission-driven  
12 organizations, and I guess obviously our challenge is how  
13 can we replicate what you folks have done, because obviously  
14 you're not the typical model. But, on the other hand, we  
15 wish you were.

16           I guess my question sort of follows up with some  
17 of the things that Cori and Mike mentioned. In our society  
18 we have a deep commitment to the idea that competition  
19 provides accountability and efficiency and all those other  
20 things. And yet we know that especially in trying to  
21 provide complicated professional services in relatively  
22 sparsely populated areas, competition can be your enemy.

1 And I'm just curious about your experiences and any thoughts  
2 you might have about, first of all, your experience working  
3 with other organizations and other providers and so forth to  
4 try to work out these relationships. And I know, Jim, in  
5 your case obviously you're the only show in your area. On  
6 the other hand, I know you've had some tensions with some of  
7 your tertiary care providers and so forth. I'm just  
8 interested what observations you have about, you know, what  
9 could Medicare do, what could the government do in general,  
10 what can payers do to try to support systems that are really  
11 focused on good care rather than just on bettering their own  
12 financial status, which unfortunately we have some of those,  
13 too.

14 MR. LONG: Wow, Dr. Dean. That's an excellent  
15 question, and I'm not sure that I can provide a good answer  
16 to that. What could government do in this competitive  
17 environment as to better things for the patient? That  
18 really has to be the focus, and I'm like you. I think  
19 there's elements of competition that are good. You talk  
20 about the competition with the systems. I'm a little scared  
21 of it. I really quite honestly am. I don't know what's  
22 going to shake down, that we have a lot of different things

1 that we're looking at coming up on this upcoming years that  
2 really keeping an eye out, and that competition, of course,  
3 is one. And the other is regarding the oil development in  
4 the state is that it's already effectiveness, we have  
5 numerous people from our community that have quit their jobs  
6 locally and are driving to work on the oil rigs. And so our  
7 employment base is dropping and getting tougher to compete  
8 for staff, and we have no additional dollars to compete for  
9 staff.

10 So this competition thing is a dual-edged sword,  
11 and what particular guidance I can give, I don't know. And  
12 I think about the larger systems, and I know there's  
13 government policies out there that says, well, you can't  
14 have an incentive to refer, but if they're part of that  
15 system, even if there isn't a direct, there is.

16 So, you know, I wish I had a good answer, a good  
17 response, but I'm sorry, that's all I got.

18 DR. HAMORY: I think that's a key question. I  
19 think it is difficult to answer without a lot of thought. I  
20 think for me the big drivers are a population health-based  
21 focus. And when my administrative partner and I go into an  
22 organization to -- you know, a lot of people come to

1 Geisinger and want to do what we've done. But the first  
2 question we ask is: What is your mission? Is your mission  
3 to grow the organization and make more money? Or are you  
4 here to actually take care of people and figure out a more  
5 efficient way to do it? So I think mission -- and, you  
6 know, I frankly don't know how you do that with money. I  
7 really don't.

8 I do think that alignment of the goals and some  
9 reinforcement by incentives, which I know the thing is  
10 designed to try to do, between the physicians, whether  
11 employed or private practice and other organizations,  
12 whether hospitals or nursing homes, I believe that  
13 facilitates this thing.

14 IT facilitates it because people are not out there  
15 spinning in their own little box not knowing -- you know,  
16 the old thing was pitch somebody over the wall when they  
17 leave the hospital and you hope there's somebody there to  
18 catch them. So I think payment mechanisms that reward  
19 coordination of care, collaboration around care, are  
20 important.

21 As you all know, the real difficulty is that the  
22 high-end stuff -- and that includes minimally invasive

1 surgery -- those things are expensive as the dickens. I  
2 mean, you can't do heart surgery without nurses and  
3 anesthesia and all this stuff. You can't do neurosurgery  
4 without that. You know, and so those things are simply  
5 going to forever be unaffordable in rural and sparsely  
6 populated areas.

7 I think the examples that I gave you, you know, we  
8 believe that there are ways to support necessary, frequently  
9 used, and appropriate services in smaller towns and  
10 communities. That includes home health. We have two PACE  
11 programs; one is rural. But, on the other hand, there's  
12 high-end stuff that should be done in a referral center. A  
13 referral center does not have to be in the middle of  
14 Philadelphia. I mean, we're an example; I think Dartmouth  
15 is an example. There are some others. But you have to be  
16 able in those places to have the capital, the ability to  
17 collect the appropriate specialty teams and support them in  
18 order to deliver that care.

19 MS. BEHROOZI: Thanks to everyone for being so  
20 disciplined. I got the last minute here, and thank you both  
21 for your --

22 MR. HACKBARTH: She's from the rural part of

1 Brooklyn [off microphone].

2 [Laughter.]

3 MS. BEHROOZI: I was going to say as many people  
4 in your entire 25,000-square-mile catchment area as in -- I  
5 can't even say my whole neighborhood, probably about five  
6 blocks of my neighborhood.

7 [Laughter.]

8 MS. BEHROOZI: So this is very interesting and  
9 informative for me, and just my quick question, I think  
10 particularly to you, Jim, is about payer mix. Mark sort of  
11 touched on it with respect to assisted living, but in  
12 general I'm just wondering about your rates of private  
13 payers, particularly employer based -- you were talking  
14 about people working on the oil rigs; maybe they get  
15 insurance that way -- and your rate of uninsured, neither  
16 Medicaid, Medicare, nor any kind of employer.

17 MR. LONG: Okay. And, of course, it depends  
18 whether you're talking which part of the operation, is that  
19 if you're looking at the hospital or you're looking at the  
20 clinics, you're looking at the long-term care, what are the  
21 mixes. But if you look just at the critical access hospital  
22 element, you're going to see a mix of about 70 percent

1 Medicare. And then you're going to see about 15 to --  
2 between 15 and 20 percent of Blue Cross and commercial.  
3 You're going to see about 5 percent Medicaid, and then  
4 you're going to see about, I'd say, 5 percent and better  
5 that is just total self-pay or uninsured. We don't have a  
6 high percentage. And we have a good number of those that  
7 are called insured that are really underinsured, and so out  
8 of our total, we have roughly \$23 million worth of revenue,  
9 and we end up with about a million and a half in bad debts  
10 and charity care.

11 MR. HACKBARTH: Well, this has been terrific,  
12 truly, and we really appreciate your spending your time with  
13 us. I'm sure we could go around and ask at least two or  
14 three more rounds of questions.

15 I do have a question that I want to ask. We don't  
16 have the time to try to answer it now, but maybe we can talk  
17 offline and give you a chance to think about it. And  
18 forgive me if this doesn't come out completely clear because  
19 this is sort of a developing thought that I'm trying to  
20 formulate.

21 One of the clear messages from this discussion,  
22 and other things, is that, you know, rural is really not a

1 very descriptive term. There's huge variety within the  
2 broad category of what Medicare classifies as rural, and  
3 it's well illustrated by the difference in circumstances of  
4 your two organizations. So we're trying to deal not with a  
5 rural problem but actually a complex of widely differing  
6 circumstances.

7           And a second premise of my question is that the  
8 issues aren't just really Medicare issues. They're about  
9 care delivery issues and how you maintain appropriate care  
10 delivery systems, if you will, in very different parts of  
11 the country.

12           Now, traditionally what Medicare has done on the  
13 rural front is have special payment adjustments or special  
14 payment systems for rural providers. As in the case of  
15 critical access hospitals, we'll use cost reimbursement 101  
16 percent of costs. Other payment systems we have rural add-  
17 ons, as is the case for home health. We've got special  
18 rules for rural physicians or in health professional  
19 shortage areas. So we've got all these special payment  
20 adjustments within a basic Medicare payment framework.

21           It seems to me there's a mismatch between that  
22 approach and the diverse conditions in rural areas and the

1 fact that they're often not just Medicare issues. And so  
2 I'm trying to think, are there other ways that we could --  
3 and we here being the Federal Government -- provide support  
4 for the development of needed rural systems outside of the  
5 context of trying to jigger Medicare rates, which I think  
6 are a problematic tool.

7           And so the question that I'm rambling towards is:  
8 Could potentially more good be done with not funneling the  
9 money through Medicare payment systems but through  
10 approaches that gives communities flexibility to deploy  
11 resources in ways that meet their unique characteristics,  
12 their unique set of preferences, so more flexibility,  
13 perhaps, frankly, fewer dollars in the aggregate but the  
14 trade-off is you get to deploy it in ways that you see fit  
15 to build a community-wide system as opposed to just getting  
16 add-ons for Medicare payments?

17           So that's the notion that I'm wrestling with. As  
18 I said, we don't have time to talk about it now, but maybe  
19 we could talk offline and get your reactions to that.

20           Incidentally, you know, this is strictly me  
21 thinking. I don't pretend to be representing anybody else's  
22 thoughts, and for people in the audience, this is not a

1 policy that's being hatched behind the scenes. This is  
2 truly just a question that I'm personally trying to wrestle  
3 with.

4 So thank you again for spending time with us, and  
5 it was really terrific.

6 MR. LONG: Well, thank you for the opportunity.

7 DR. HAMORY: Thank you.

8 [Applause.]

9 MR. HACKBARTH: Now we have a public comment  
10 period after sessions like this, and so I'll invite anybody  
11 in the audience who wants to come up and make a comment to  
12 do so. And then after the public comment period, we will be  
13 adjourned.

14 [No response.]

15 MR. HACKBARTH: Seeing no commenters, we are  
16 adjourned. Thank you very much.

17 [Whereupon, at 10:43 a.m., the meeting was  
18 adjourned.]

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