

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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AGENDA	PAGE
Perspectives on Medicare's financial sustainability	
-- Rachel Schmidt	
-- Joseph R. Antos, American Enterprise Institute	12
-- Marilyn Moon, American Institutes for Research	22
-- Len Nichols, New American Foundation	35
Public comment	100
Reengineering of health care	
-- Anne Mutti	
-- Steve Spear, Massachusetts Institute of Technology	104
-- Gary Kaplan, Virginia Mason Medical Center	119
-- W. Dale Compton, Purdue University	135
SNF quality measures: the effect of small patient populations and low frequency events	
-- Kathryn Linehan	
-- Andy Kramer, University of Colorado	181
Episodes associated with inpatient admissions: initial finds from data analysis	
-- Anne Mutti, Craig Lisk	223
IME and DSH payments for the inpatient PPS	
-- Jack Ashby, Craig Lisk	255
Public comment	311
SGR report: initial analyses	
-- Jennifer Podulka, Kevin Hayes, and Scott Harrison	319
Initial results on rural hospital study	
-- Jeff Stensland, Timothy Greene, and Dan Zabinski	399
The impact of CMS's proposal to change the method used to calculate practice expense payments: preliminary results	
-- Nancy Ray, Ariel Winter, and Kevin Hayes	422

Building quality composites  
-- Sharon Cheng  
Public Comment

1 P R O C E E D I N G S

2 MR. HACKBARTH: Welcome to the first MedPAC public  
3 meeting of our new cycle.

4 We're going to begin this meeting with a  
5 presentation from three outside guests. Rachel, are you  
6 going to do the introductions?

7 DR. SCHMIDT: Yes. In fact I have a few setup  
8 slides before we get started.

9 This morning, once again, we'd like you to  
10 consider the issue of Medicare's long-term financial  
11 picture. We're honored to have with us today three highly  
12 regarded economists and Medicare experts to give us their  
13 perspectives along with suggested policy approaches for  
14 putting Medicare on surer financial footing.

15 To set up, I'm briefly going to go over some  
16 background and review some of the findings of the latest  
17 trustees report.

18 As I'm sure you're aware, an increasing proportion  
19 of our national resources has been devoted to health. Total  
20 health spending, shown in the top blue line, as a percent of  
21 GDP has increased from 6 percent in 1965 to more than 16  
22 percent in 2004 and it's projected to reach about 20 percent

1 of GDP in 2015.

2           Public financing pays for nearly half of total  
3 health care spending in the U.S. In 2004 public spending,  
4 which is the yellow line, made up about 45 percent of total,  
5 and private spending -- has made up about 55 percent. By  
6 2015, the public share is projected to go up a few  
7 percentage points because of Part D.

8           Medicare spending, which is shown in the red line,  
9 as a share of the economy has grown too from less than 1  
10 percent when the program began to about 3 percent today.  
11 It's projected to be nearly 4 percent by 2015.

12           Researchers point to the adoption and diffusion of  
13 medical technology as a driving force behind growth in  
14 health care spending. Many newer technologies benefit  
15 society on average. However, providers do not always know  
16 the relative value of newer technologies compared with  
17 alternative therapies, and they may use newer technologies  
18 more broadly than the relative value of the technology  
19 merits.

20           The diffusion of technology is also fueled in part  
21 by insurance, and beneficiaries and providers may be less  
22 concerned about the comparative value of a new medical

1 technology, a new treatment option, than if they had to pay  
2 for the full costs themselves.

3 Poor incentives in Medicare and in private payment  
4 systems also account for some of the growth in health care  
5 spending. Inaccuracies and prices that overvalue certain  
6 therapies or procedures relative to others as well as siloed  
7 payment systems can sometimes discourage coordination of  
8 care. Our sedentary lifestyle, our country's underlying  
9 health status and treatment norms are also one driver.

10 For example, Ken Thorpe has recently done some  
11 research suggesting that in 2002 about half of Medicare  
12 beneficiaries were treated for five or more conditions.  
13 That's up from about 31 percent of beneficiaries in 1987.  
14 He believes that increased spending for people with that  
15 many comorbidities accounts for a lot of the growth in  
16 spending for all Medicare beneficiaries.

17 The Medicare program faces some particular  
18 factors. The retirement of the baby boomers, of course, is  
19 the obvious one. And although prescription drugs was an  
20 important benefit to add to Medicare's package, it also  
21 means that Part D expanded Medicare's financial obligations.

22 Let's briefly review the findings of the Medicare

1 trustees for 2006. The trustees project that the trust fund  
2 for Part A will be exhausted by 2018. Medicare is no  
3 authority to make payments once the trust fund is exhausted  
4 for Part A services, so Part A will require major new  
5 sources of funding.

6           The SMI trust fund, which covers Parts B and D  
7 services, is financed primarily with general revenues and  
8 beneficiary premiums. It cannot be exhausted. Just to  
9 remind you, general revenues are federal tax dollars that  
10 are not dedicated to a particular use and they're made up of  
11 individual and corporate income taxes. However, the  
12 trustees say that the SMI program will need very large  
13 increases in revenues to cover projected spending. This  
14 means that fewer resources will be available for other  
15 federal priorities and also, on average, beneficiary  
16 premiums and cost-sharing will grow more rapidly than  
17 projected income.

18           Under current law, the trustees are to warn  
19 Congress whenever 45 percent or more of Medicare outlays are  
20 financed with general revenues, and this is known as the 45  
21 percent trigger. The trustees say that the general revenue  
22 funding would reach 45 percent in 2012. If the trustees

1 have the same finding next year that means that the Congress  
2 must consider legislative changes to Medicare in the spring  
3 of 2008. Since the trustees report is released next spring,  
4 2007, the topic of reform could come up at that point.

5           This slide is showing you the trustees  
6 intermediate projections of Medicare spending, and that's  
7 shown by the overall height of the top line, as well as the  
8 projections of Medicare's revenues. That's depicted by the  
9 layers in this chart. Payroll taxes, which are shown in  
10 yellow, are dedicated to the HI program, while SMI spending  
11 for Parts B and D is financed with premiums, which is shown  
12 in pink, and general revenues, shown in green. Payroll  
13 taxes provide most of the revenues today, but as you can see  
14 they will become a smaller share over time.

15           Once the HI trust fund is exhausted Medicare will  
16 need new funding, and that's shown by the HI deficit in red,  
17 to keep making payments for Part A services. Trustees say  
18 that in order to finance deficit through 2080, the  
19 policymakers would either need to raise payroll taxes  
20 immediately from about 2.9 nine percent today to 6.41  
21 percent of earned income, or cut HI spending by 51 percent.  
22 If we are to delay action that would mean even higher tax

1 increases would be needed or even larger spending cuts.

2 Today about 10 percent of personal and corporate  
3 taxes go to pay for SMI services, but trustees project that  
4 that will grow to about 40 percent by 2080. If taxes remain  
5 at their historical share of GDP fewer tax dollars will be  
6 available for other federal priorities.

7 Beneficiaries also face considerable pressure from  
8 higher Medicare spending because average growth in their  
9 Social Security benefits has been slower than growth in Part  
10 B premiums and cost sharing. Between 1970 and 2005, the  
11 average Social Security benefit adjusted for inflation  
12 increased by less than 2 percent annually while the average  
13 SMI premium and cost sharing grew by more than 4 percent per  
14 year.

15 Part D began this year and that falls under the  
16 SMI program. Although enrollees pay a new type of SMI  
17 premium and cost sharing for that, most beneficiaries who  
18 are enrollees probably have lower out-of-pocket spending on  
19 prescription drugs than before Part D. Over time, however,  
20 the trustees project that growth in the SMI premiums and  
21 cost sharing will continue to outpace growth in the average  
22 Social Security income. Between 2006 and 2036, for example,

1 they project that the average Social Security benefit will  
2 grow by just over 1 percent annually after adjustment for  
3 inflation compared with about 2.5 percent average annual  
4 growth for SMI premiums and cost sharing.

5           One issue related to Medicare sustainability is  
6 whether the federal government can raise the resources  
7 required to fund the program's growth. Total federal  
8 revenues have fluctuated a bit over time. That's shown in  
9 the top red line there, but you can see they've averaged  
10 about 18 percent of GDP over the last four decades.  
11 Spending for mandatory programs, which is shown in yellow --  
12 and mandatory programs is made up primarily of the major  
13 entitlement programs, Social Security, Medicare and Medicaid  
14 -- has been requiring an increasing share of GDP, while  
15 discretionary outlays, which are shown in green there --  
16 those are programs which the Congress appropriates money  
17 annually, like defense and many domestic and international  
18 programs -- generally has been receiving a decreasing share.

19           Some questions arise from this. First of all,  
20 whether our society will be going to continue devoting more  
21 of the federal pie to entitlement programs, including  
22 Medicare, over discretionary programs. And also whether the

1 American people will be willing to devote more than 18  
2 percent of GDP to federal spending. I'm sure our panelists  
3 will be sharing some of their opinions about this with you.

4           Just to summarize some of the categories of policy  
5 approaches -- they're depicted on this slide. These  
6 approaches range from strategies for slowing growth in  
7 Medicare spending. You can see, for example, limiting  
8 benefits or raising cost sharing, constraining payments to  
9 providers, and encouraging appropriate care or healthier  
10 lifestyles, to raising the share of Medicare spending paid  
11 for by beneficiaries, to raising taxes. The Commission has  
12 discussed these categories and reviewed some of the  
13 literature about specific proposals in the past March  
14 reports. Policymakers may need to use many of these at the  
15 same time given the projected magnitude of financing needs  
16 of the Medicare program.

17           Our panelists are going to provide for you their  
18 perspectives on approaches they believe the policymakers  
19 should emphasize. They represent a range of perspectives on  
20 how best to balance the goals of the Medicare program.

21           Each of our panelists is a highly-regarded person  
22 for their expertise in Medicare and we're grateful that

1 they're here with us today. Each is widely published and  
2 they have served many senior positions at HHS, HCFA, CBO,  
3 OMB, major think tanks and within academia. Their  
4 credentials are so impressive that it would take a long time  
5 for me to go through each of them so I'll just touch on a  
6 few of the highlights.

7 Joe Antos is a Wilson H. Taylor scholar in health  
8 care and retirement policy at the American Enterprise  
9 Institute, an adjunct professor in the School of Public  
10 Health at the University of North Carolina at Chapel Hill.  
11 He's also a commissioner on the Maryland Health Services  
12 Cost Review Commission.

13 Marilyn Moon is vice president and director of the  
14 Health Program at the American Institutes for Research and  
15 she formerly served as a public trustee for the Social  
16 Security and Medicare trust funds. She was also the  
17 founding director of the Public Policy Institute of the  
18 American Association of Retired Persons.

19 Len Nichols is director of the Health Policy  
20 Program at the New America Foundation. He served on  
21 Medicare's Competitive Pricing Advisory Commission pursuant  
22 to the BBA, and he was a member of the 2001 technical review

1 panel for the Medicare trustees reports.

2 Our panelists will each give their perspective  
3 about Medicare's financial sustainability and then you'll  
4 have the opportunity for questions and discussion. We've  
5 decided to go in alphabetical order so let me load up Joe's  
6 slides.

7 DR. ANTOS: Thank you very much. I appreciate the  
8 opportunity to participate in this panel and I would commend  
9 the Commission for producing a really marvelous March  
10 report, especially the first chapter which I think covers  
11 everything we're going to say anyway.

12 Rachel's presentation emphasizes the financial  
13 side of Medicare's crisis, but in fact if it were just a  
14 financial crisis things would be a lot easier. Social  
15 Security has a financial crisis. Medicare has a health care  
16 crisis. So it's not just about money. It's also about how  
17 we spend that money.

18 The policies that this commission considers, I  
19 think, spans most of the areas that I think need to be  
20 considered. But I don't think this is a financial issue,  
21 per se.

22 So what do we have to consider? We have to

1 consider, of course, how much? And the how much is, how  
2 much are we going to spend and how much are we going to  
3 collect in revenue? Those are no-brainers.

4 But there are issues within them. How much money  
5 do we want to spend in total? How much is going to be the  
6 Medicare subsidy from the government? How much are  
7 beneficiaries going to pay for their health care? What  
8 about the interaction with Medicaid, which I think is often  
9 overlooked, but a very serious problem and will be an even  
10 more serious problem if some proposals to shift some greater  
11 parts of Medicaid back to Medicare actually materialize.

12 On revenue, similar issues. It's not just taxes.  
13 It's what kinds of taxes, the structure of taxes, how  
14 aggressively we want to tax higher income people versus  
15 lower income people. What about premiums, cost sharing?  
16 Cost sharing doesn't represent revenue in the traditional  
17 sense but it does represent a contribution by individuals  
18 for their health care, so I think that counts in my revenue  
19 category.

20 Do we want to subsidize everybody uniformly? What  
21 I label the social insurance model. Or do we want to  
22 graduate the subsidies so that lower income people receive

1 more help than higher income people, which some people have  
2 said is counter to the entire history of social insurance.  
3 It might be, but the Medicare Modernization Act took a big  
4 step in that direction.

5           What are we going to pay for? It is, of course,  
6 the benefit structure. This commission has considered, and  
7 other commissions have considered in the past proposals to  
8 rationalize the benefit structure for traditional Medicare  
9 and to give people actual insurance, true insurance  
10 protection against high costs.

11           But there's also what should be covered? What  
12 services should be covered? And how much cost sharing?

13           Then finally, an issue about how do we compensate  
14 providers for the services they provide? Right now it's not  
15 quite any service and any provider, but it's darn close.  
16 And we're talking a lot about moving to various systems to  
17 pay for effective services for efficient providers, but I  
18 think we're a long way from seeing that be a full reality.

19           And then finally, and I think a very important  
20 issue I wanted to emphasize is, who makes the decisions in  
21 this system? A lot of the discourse seems to want to make a  
22 false dichotomy between consumer decision-making and

1 government decision-making. It's a false dichotomy. First  
2 of all, there are providers in there and they are big  
3 factors in making decisions. Consumers make decisions  
4 whether you want them to or not. Health plans make  
5 decisions. CMS is making decisions separate from Congress.  
6 There are a lot of people making decisions. It's a very  
7 murky situation.

8           But the fact is that we do have a problem. It's a  
9 bigger problem than simple financing. I would characterize  
10 the trustees' projections as projections of promises as  
11 opposed to projections of reality. Those promises can't be  
12 met. The program isn't sustainable. So what we have to  
13 think about is, how do we want to reshape the program to fit  
14 reality rather than, how do we want to somehow come up with  
15 money to pay for promises that can't be met?

16           A few quick comments on why I think this is really  
17 a crisis. As you know, the trustees projections are  
18 understated compared to the entire history of the program.  
19 The program grows much more rapidly than the long-term  
20 spending assumptions that the trustees use you support the  
21 intermediate assumptions. So the numbers are in fact bigger  
22 than we ever really look at if those trends hold.

1           But more importantly, the incentive problems that  
2 drive much of the spending in Medicare also are the same  
3 incentive problems that drive health care spending in  
4 general. In other words, it isn't just Medicare. It's the  
5 entire health system. But on the other hand, we can't wait  
6 to solve the entire health system's problems, we've got to  
7 do something with Medicare.

8           Innovation. There's a lot of it in this country.  
9 We should be glad for innovation. New medical techniques  
10 and new products and services save a lot of people's lives  
11 that weren't saved even 10 years ago.

12           On the other hand, what we really understand about  
13 those product and services and innovations falls short of  
14 the ideal. And beyond that, the whole system is designed to  
15 emphasize the medical part but not the financial part. We  
16 need to connect an understanding of the real trade-offs in  
17 cost and in other opportunities for consumption. And we  
18 need to get that into the medical decision-making in my  
19 view.

20           I have a dim view of the political process. My  
21 real point there is, the horizon is two, four, six or eight  
22 years. The problem is, certainly now, but we have a long

1 history of kicking the can down the road so we've lost a lot  
2 of valuable time. And I don't think the status quo is an  
3 option.

4 I think there are more than I've laid out here.  
5 There are a lot of false hopes about solutions. It would be  
6 nice if there were easy solutions, but this commission knows  
7 there are not any easy solutions. We're not going to simply  
8 grow our way out of this problem. As you can see, in the  
9 past 35 years Medicare has grown substantially faster than  
10 GDP and faster than overall national health expenditures.  
11 Which means that private health spending is growing even  
12 more slowly than that 8.4 percent.

13 We're not going to be able to tax our way out of  
14 the problem either. That isn't going to be the solution.  
15 As you know, when you raise taxes you discourage economic  
16 activity.

17 My colleague at the Heritage Foundation, Tracy  
18 Foertsch and I did a little exercise recently and using the  
19 global insight model we estimated that if Medicare were  
20 fully funded through 2079 using tax financing only -- which  
21 is an unrealistic assumption but you have to start somewhere  
22 -- that would mean that, on average for the first 10 years,

1 the annual impact on taxes, we'd be increasing taxes by  
2 about \$5 billion. But GDP would fall by about \$248 billion  
3 and we'd lose about 2.6 million jobs on average over that  
4 ten-year period.

5 Those are unrealistic numbers. So are the  
6 trustees' projections. But it suggests that we have to be  
7 very careful about thinking that we can simply raise taxes.  
8 There are consequences.

9 And then finally, for this slide but there are  
10 plenty of other things we could talk about, we can't cut our  
11 way out, in that traditional Washington sense of the word,  
12 let's just slash a price. As the Commission knows full  
13 well, controlling prices that way tends to result in  
14 encouraging growth in volume and intensity of services.

15 We have tried managed care. We've tried to  
16 control access to care more directly. That's unpopular. Of  
17 course, it's only unpopular when it's easy to say, let's not  
18 do that. It will become popular again. As we've all felt  
19 for the last few years very keenly and personally, when  
20 there really is a binding price constraint -- I'm thinking  
21 of the sustainable growth rate for physician payment --  
22 there are real threats to access to care. And even more so,

1 it's politically unsustainable. Congress has been so  
2 struggling for a number of years now to get out from under  
3 the policy that they enacted.

4           So what can we do? There are lots of things we  
5 can do. In fact we have to do lots of things. As Rachel  
6 said, this is a matter of emphasis, not a laundry list of  
7 everything we could do. But for me these represent the most  
8 important issues.

9           We really need to restructure incentives in the  
10 program. There are lots of incentives to restructure. It's  
11 not just consumer incentives. We also need to get providers  
12 into the act. There are attempts underway to try to do  
13 that, but we need to work harder at that.

14           I think pay for performance is a good concept, but  
15 I think we are a long ways from having something like that  
16 actually work in the way that we want. The measures are  
17 quite limited. They tend to be measures of process rather  
18 than outcome. And frankly, if I were contemplating some  
19 serious surgery and deciding among hospitals, looking at  
20 Medicare's data today, I would have a hard time picking one.  
21 Although, I'd probably have a pretty good idea about some  
22 level of ambience in the hospital, but that's about it.

1 That's not value, and we need to become value sensitive.  
2 But the we is everybody including providers.

3           Secondly, give consumers realistic options. We  
4 don't have the luxury of saying we're going to continue  
5 everything the way it is now, let's just find some more  
6 money. Or let's just trim in some way that is gentle and  
7 painless.

8           So the realistic options I have in mind are the  
9 painful, realistic options. The choices of health plans  
10 where there are meaningful differences in costs and  
11 meaningful differences in levels of service in some census -  
12 - and that's complicated so let me not expound on that.

13           An important thing it seems to me is to try again,  
14 as we've tried periodically over the years, to think of ways  
15 to put traditional Medicare on the same competitive basis as  
16 Medicare Advantage plans. That means a lot of things. That  
17 means paying equivalent amounts for equivalent services --  
18 something we don't know. But that also means not giving any  
19 one of these plans a pass for past sins.

20           We need to rationalize the benefit structure. We  
21 need to, I think, do more to give people an opportunity to  
22 put their money where their mouth is. Let beneficiaries buy

1 up. If they don't want the most subsidized plan and they  
2 want to move up in some way, they think that there is value  
3 there, that's fine. Let them pay for it.

4 We need to redirect subsidies. I think the  
5 Medicare Modernization Act moved in a very good direction.  
6 I think we need to help people who need the help more, and  
7 we need to help less those who don't need so much help  
8 financially. We need to improve the knowledge base and we  
9 need to use it.

10 I've already said enough about value added and pay  
11 for performance.

12 There's a golden opportunity which we talked about  
13 20 years ago in HCFA and we still think about it from time  
14 to time. Medicare pays an awful lot of claims. It has  
15 essentially the universe of treatments for most diseases of  
16 the elderly, and virtually the universe of treatment for  
17 many things. We could do a better job of exploiting the  
18 information we have. That's not an easy thing to do. It's  
19 not just claims data, although claims data would take us a  
20 long way. But it's hard to do.

21 And then finally, we do have to accept the  
22 absolute reality that the patterns of consumption in this

1 country are going to shift, even further than they have,  
2 towards health care. It's an aging society. We're going to  
3 spend more money. So that means a larger share of taxes to  
4 Medicare and Medicaid. That inevitably means a smaller  
5 share of taxes to other domestic and international  
6 priorities, and that's going to be a tough call.

7 DR. MOON: Thank you. I appreciate being here as  
8 well today and I have to say that I'm surprised that there  
9 is very little that I'm going to disagree with Joe on this  
10 morning.

11 I basically agree that pretty much we have to put  
12 all things on the table, and we have to be willing to talk  
13 very seriously about painful choices. That's one thing that  
14 a commission like yours can do that is not going to come  
15 naturally to members of Congress or an administration. I  
16 think in many ways everyone is going to have to step up and  
17 say, we're ready to do the following things or not and make  
18 it quite clear what the consequences are. We're spending a  
19 lot of time pretending that the problems are not where they  
20 are.

21 But I wanted to focus today more on some issues  
22 about the beneficiary and I'm going to skip over the first

1 slide here, which should be pretty familiar to people, that  
2 shows essentially that the costs are tracking, to some  
3 extent, the population share that's going to be in the  
4 Medicare population over time; people 65 and over and  
5 persons with disabilities, and that's a driving force as  
6 well as the costs of health care.

7           It is not easy to change those numbers and I don't  
8 think that there's much lined up to deal with that in terms  
9 of talking about changing those numbers.

10           For example, once you start to talk about raising  
11 the age of eligibility, we know from studies that have been  
12 done that that will save approximately 1 percent of the cost  
13 of Medicare over time if you raised it from 65 to 68, for  
14 example, because you're taking the cheapest people off.

15           The other problem with that is then you're putting  
16 those cheapest people in terms of Medicare out there in a  
17 private market that just doesn't work well, where they are  
18 the more expensive people and they will screw up that market  
19 even more. So that's one point I wanted to make today.

20           The other is that before we get too incredibly  
21 depressed that I wanted to make the point that the numbers  
22 do jump around and we do make some progress now and then

1 that even turns out to surprise us. In 1997, before the  
2 1997 changes that went into place, the projections for  
3 spending on Medicare A and B, which are shown there in 1997,  
4 for the year 2025 were 6.5 percent of GDP. In 1998,  
5 reflecting mainly the thought of what would happen because  
6 of those 1997 cuts, largely before much had happened, the  
7 projections came down to 5.3 percent of GDP. And then in  
8 the following two years as those changes turned out to be  
9 much greater than people had anticipated, we came all the  
10 way down to projecting GDP as 4 percent by 2025.

11 Now in 2006 that number is higher, but it's higher  
12 largely because of the addition of Part D. Part D does not  
13 bring us all the way back up to where we were in 1997. So  
14 there are things that can be done, and I totally agree with  
15 Joe that you just have to keep working on it. We don't know  
16 today what may work in five years. We don't know a lot of  
17 things about the health care system, and that's a caution as  
18 well as a slightly optimistic view.

19 The other point I want to make today is that out-  
20 of-pocket spending as a share of income among elderly  
21 beneficiaries -- and if it were easy to do the persons with  
22 disabilities would show up looking approximately the same --

1 has been such that we essentially cut in half when we passed  
2 the legislation in 1965 to enact of Medicare, what people  
3 spent out-of-pocket on health care. That makes a lot of  
4 sense because Medicare pays about 51 percent of the costs of  
5 health care spending. It always has, and it will go up a  
6 little bit now that we have Part D, but not nearly as much  
7 as some people think it might.

8           Then the rest of those numbers really show you the  
9 fact that health care spending grows faster than the incomes  
10 of that population, the 65 and over population. The big  
11 difference there that looks like a giant jump up, you should  
12 note, is because there's a period of time in which we didn't  
13 have good data and so that's the big data gap as well as  
14 other things. You'd have to extrapolate from 1987 data to  
15 get something in the mid-1990s. Rather than doing that I  
16 just left it out. So you would see a more gradual increase  
17 if you had it as the years progressed.

18           Now the good news-bad news is that when people  
19 talk about sustainability and affordability I get concerned.  
20 I think Joe talked about it exactly the right way, and that  
21 is, Medicare is not sustainable exactly as it is now. But  
22 that does not mean that, therefore, the solution is

1 automatically to cut the program in some way and just move  
2 on. It's a question of how we want to share our resources.

3           If you don't do anything to change Medicare -- and  
4 I'll admit that the future projections are probably a little  
5 rosy in terms of the costs of Medicare -- nonetheless, when  
6 health care spending overall begins to be 25 or 30 percent  
7 of GDP something is going to happen, whether or not it's  
8 actual policy. But the thing that people forget is that  
9 while the numbers on health care spending are gee whiz, so  
10 are the numbers on GDP growth. The top line there shows you  
11 what per worker GDP, corrected for 2006 dollars -- so it's  
12 taking inflation out -- real spending power, will grow  
13 substantially over time. It will grow close to 55 percent  
14 by 2040 by this kind of calculation.

15           If you take out the per-worker contribution made  
16 towards Medicare, and it involves some calculations I can  
17 talk about further if you'd like, assuming no change in the  
18 Medicare program whatsoever, by 2040 the numbers will be  
19 lower, which is the lower line. But there will still be  
20 substantial growth, 47.6 percent growth in real spending.

21           So it's not a question that we can't absolutely  
22 afford spending on Medicare. The question is, are we going

1 to be willing to make that kind of sacrifice. This is not a  
2 no-tax increase scenario. This certainly would involve  
3 taxes. But it's something important to keep in mind when  
4 people talk about it as if we were going to go bankrupt  
5 tomorrow if we kept Medicare going.

6 MR. HACKBARTH: Could I ask about that graph just  
7 to make sure I understand it? The way I'm interpreting this  
8 is that because GDP grows as well as Medicare expenditures,  
9 that as you move out to 2050, even allowing for growth in  
10 the Medicare burden, the residual wealth left over after  
11 that will be higher than it is today. That's the basis --

12 DR. MOON: That's exactly right. Medicare's  
13 burden grows much faster than GDP but on a smaller base. So  
14 as a consequence it doesn't take away all the growth.

15 MR. HACKBARTH: Now in this, how is the burden  
16 defined? When you say per-worker burden, is that --

17 DR. MOON: What I do is essentially take all of  
18 the spending on Medicare and the taxes that are projected,  
19 sorting out -- you'll see in a minute I have a beneficiary  
20 burden as well because I talk about, for example, the costs  
21 of Medicare -- let me backtrack.

22 It's easier to think about it as a residual in a

1 sense. What I do is talk about Medicare spending, and then  
2 I take away from that the part that individuals pay, in this  
3 case, the Part B premium, although I'm not taking cost  
4 sharing out of here. It's implicitly taken out.

5 So Part B premiums are taken out. The share that  
6 individuals make who are over 65 -- I don't do anything  
7 about disabled -- to income and payroll taxes are also taken  
8 out. That's essentially what it is.

9 MR. HACKBARTH: Thanks.

10 DR. REISCHAUER: But the workers are also paying  
11 for workers' health insurance too.

12 DR. MOON: Absolutely.

13 DR. REISCHAUER: So if we were doing this as  
14 health as opposed to Medicare in isolation --

15 DR. MOON: Then it would be slower, yes,  
16 absolutely, and that's a good point. I haven't done that  
17 but I've also done a calculation of Social Security, and the  
18 Social Security doesn't change the line very much because it  
19 doesn't grow nearly as fast as a share. So the point is  
20 essentially the same. The dollars would be different.

21 But if you think about this also then in terms of  
22 the per-worker burden and the per-beneficiary burden, so in

1 this case the per-beneficiary burden is just on the costs.  
2 It doesn't include cost sharing. It doesn't include what's  
3 not covered by Medicare. This is what beneficiaries  
4 themselves pay towards the costs of the Medicare benefit.  
5 So it's their premiums and the taxes that they pay that go  
6 towards this cost of Medicare over time. Because  
7 individuals like to talk about how -- some people like to  
8 talk about how little beneficiaries actually pay, and that's  
9 not really the case. Beneficiaries pay a substantial amount  
10 of the costs of Medicare.

11 That burden rises over time. But the interesting  
12 thing here I think is you can see the difference between the  
13 number of workers per beneficiary. That change is important  
14 between 2020 and 2040. That's why the per-beneficiary  
15 burden grows a lot more slowly at that point in time than  
16 the per-worker burden.

17 So it's a way of saying, yes, beneficiaries are  
18 paying a substantial amount, will continue to pay a  
19 substantial amount. But the per-worker burden grows more  
20 rapidly relatively over time in terms of 2040. I think this  
21 may be one way of thinking about how one shares burdens over  
22 time. It's just the beginning of thinking about that.

1 MS. BURKE: I'm sorry, I just want to step back  
2 for one second. Did I understand you to say that the per-  
3 beneficiary burden does not include cost sharing but does  
4 include premiums?

5 DR. MOON: That's right. What I'm thinking of  
6 this as, when you see the numbers for Medicare and the costs  
7 into the future, I've essentially just taken those costs and  
8 parsed them out between workers and beneficiaries on a per-  
9 worker or per-beneficiary basis. So I haven't taken out  
10 what people are paying out-of-pocket. This is only the  
11 contributions they make in terms of premiums and/or the  
12 taxes that they pay since seniors pay a substantial share,  
13 for example, of general revenue taxes as well. That's  
14 really a big contribution for them.

15 MS. BURKE: But again, as Bob pointed out a moment  
16 ago, for the worker burden, this does not include what they  
17 pay for health insurance. This is essentially their tax.

18 DR. MOON: That's right. This is really just for  
19 thinking about financing Medicare.

20 So again, I think when we try to think about how  
21 we're going to parse the burdens out over time it's  
22 important to look at it in a variety of different ways, and

1 I think this is just one way of beginning to think about it.

2 I didn't put forward a bunch of solutions because  
3 I thought that Rachel laid out what the options are and  
4 there's nothing new under the sun. Ideally, we'd like to  
5 find ways to reduce the costs of Medicare that don't simply  
6 shift the burdens from one group to another, but that's  
7 going to be the big challenge for all of health care.

8 What Medicare can do, I think, is keep working at  
9 it. I also think that I'm thinking about some increased  
10 taxes over time makes sense, as well as some increase  
11 potentially in burdens per beneficiary. But there are  
12 options among those burdens that are better or less better  
13 over time. If you're going to raise the burden on  
14 beneficiaries, I believe that it's important to think about  
15 it in terms of premiums more than changing the benefit  
16 structure. A Medicare benefit that only covers 51 percent  
17 of health care doesn't turn out to be much of a benefit if  
18 you slash away at that over time. It already has problems  
19 in the sense that it requires people to buy supplemental  
20 coverage.

21 I think one important thing would be ways to  
22 improve the benefit that could ask individuals to pay more

1 but also allow them not to have to buy supplemental  
2 insurance if they choose not to.

3 I think there are some minor tweaks you could do  
4 to the system, especially since the deterioration of health  
5 benefits for everybody else has been so rapid it makes that  
6 probably more palatable than it would have been 10 years  
7 ago.

8 I'm sympathetic to the idea of income related  
9 changes, but we should not forget that Shaquille O'Neal pays  
10 one heck of a lot of Medicare taxes on his salary because of  
11 the fact that there is no upper-bound limit on the taxes  
12 that people pay into the Medicare program. And he's going  
13 to get then just the standard old benefit. So from his  
14 standpoint he'd say, I'm already sharing the burden, thank  
15 you very much.

16 I also believe that you get into two problems that  
17 are very important to think about with an income-related  
18 premium. One is, there aren't enough Shaquille O'Neal's,  
19 when he gets old enough or when he becomes disabled because  
20 he can no longer walk for his knees -- but there are not  
21 enough of them out there to get a lot of money out of an  
22 income-related premium until you really dip down into

1 hurting middle-income individuals, which I suspect would be  
2 extremely unpopular.

3           Secondly, I think the notion is that it's a  
4 difficult tax activity to administer in many cases. It  
5 comes with its own problems. So it's one of those areas  
6 where it makes considerable sense theoretically. The  
7 practical issues, I think, are very important in terms of  
8 it.

9           The final thing that I forgot that I was going to  
10 say that I just finessed over because I couldn't remember my  
11 second, is that we are trying to encourage people to save  
12 and we're encouraging people to try to be responsible about  
13 their retirement. And if we say, by the way, if your income  
14 is over \$50,000 we're going to zap you on Medicare, it  
15 doesn't send a very good message that way either.

16           Thank you.

17           MS. BURKE: Can I just ask one further follow-up  
18 question on this slide?

19           Marilyn, have you also done a slide or an analysis  
20 separating out the Medicare beneficiary person per se, but  
21 the total impact of the payroll tax on individuals in terms  
22 of the increasing size of their disposable income that's

1 consumed, in terms of as the Medicare costs rise? Because  
2 your point that the solution may come in the form of taxes,  
3 but not necessarily income-related premiums but rather a  
4 more widely distributed tax base, the concern being that  
5 that tax, that is the payroll tax, is an increasingly  
6 sizable burden on the working population, consuming a larger  
7 and larger percentage of their income.

8 I just wondered whether there was something that  
9 looked into the future in terms of the impact on the working  
10 individual in terms of its percentage of their taxes.

11 DR. MOON: Since at this point in the payroll  
12 taxes there is nothing that says they're going to go up,  
13 it's not going to become an increasing burden. In fact it's  
14 going to be a declining burden if we continue to see the  
15 inequality of income that we have and the numbers of  
16 individuals paying into Social Security become smaller and  
17 smaller. We're already seeing overall as well that payroll  
18 taxes are dropping as a share of GDP, which is an  
19 interesting phenomenon that needs some further exploration.

20 I think that it's important when anyone talks  
21 about taxes to put all the different kinds of taxes on the  
22 table. I think payroll taxes tend to be popular among a lot

1 of workers for two reasons. One is this seem painless  
2 because they never have to calculate them. And secondly,  
3 they know that they're dedicated to something. You could  
4 deal with that in a more progressive way. You could deal  
5 with other kinds of changes. I think there are ways of  
6 talking about other kinds of taxes that would potentially  
7 achieve some of the income relation that Joe is interested  
8 in, as well as other things.

9           Years ago someone used to refer to the estate tax  
10 as the pay-as-you-go tax. That still stuck with me. That  
11 might be one thing to think about as a dedicated tax for  
12 Social Security and Medicare, for example.

13           MR. NICHOLS: It's a privilege to be here. It's a  
14 challenge to follow the two speakers I have the honor doing.  
15 I would just say, typically, when I'm on a panel with people  
16 this smart, people look to me for comic relief, and I would  
17 like to do that, but I must say I'm feeling not very funny  
18 because this topic is so serious and because, ultimately,  
19 the decisions you make are going to have so much to do with  
20 our opportunities in the future. So I'll cut right to the  
21 chase.

22           The three questions that Rachel posed for us to

1 answer are, is the Medicare program sustainable now? What  
2 drives health care cost growth? And what the heck can we do  
3 about it? I'll be very brief on the first two.

4           The first one always reminds of a line that came,  
5 I think, from John Dunlop at Harvard economics department  
6 when he said a long time ago, if something is unsustainable  
7 it won't be, and for this they give you tenure at Harvard.  
8 But it's also true that, basically, as Joe and Marilyn have  
9 pointed out, what this is going to come down to is our  
10 willingness to tax ourselves, not just in terms of tax  
11 revenue as Joe said, but also in terms of changing the way  
12 we think about health care. I would just say, all of us  
13 agree taxes are more onerous than we would like and so we'd  
14 like to minimize the revenue element of that and, therefore,  
15 we have an obligation to try to get the system more  
16 efficient.

17           Which leads to the second question, what drives  
18 health care cost growth? The short answer there is  
19 technology. Everything else is commentary. I will say that  
20 at the end of the day fundamentally what drives health care  
21 cost growth is the fact that we're far better at fixing hips  
22 and hearts, even broken hearts, than we were 25 years ago.

1 And because of that, it turns out it takes resources to get  
2 better and it turns out we had opportunity costs of those  
3 resources.

4 On average, I'm persuaded by the various learned  
5 studies that suggest it's worth it. That does not mean it's  
6 worth it in every single case. In fact we have a lot of  
7 examples where we know it's not, and that's really what our  
8 business is about. So what is to be done is really what I  
9 want to focus on.

10 I will say the first thing -- and this does echo  
11 something I heard Joe say -- Medicare is not an alien force  
12 dropped in the middle of the U.S. health care system. It is  
13 indeed integral to it. And I mispronounce that word to make  
14 the point it's fundamentally intertwined. So when you think  
15 about reforming Medicare you are talking about reforming the  
16 U.S. health care system, whether you like it or not.

17 When you talk about not reforming the Medicare  
18 system you are also talking about not reforming the U.S.  
19 health care system. So fundamentally, the linkage is real,  
20 it's inexorable and, therefore, you should think about these  
21 things together.

22 Second, I think we can all agree that the proper

1 focus is not reducing health care costs, per se, but it is  
2 on enhancing clinical value per dollar spent. I don't think  
3 there's a person in this room who can tell you what the  
4 share of GDP spent on Medicare or health care should be, or  
5 if they will promise to tell you that, they are lying. So  
6 fundamentally, we need to figure out how to get value for  
7 dollar and agree to go forward and pay for it. But we are a  
8 very, very, very long way from getting value for dollar  
9 amount.

10 Finally I submit, like every simpleminded  
11 economist, what you want to do is define the problems and  
12 attack it. The fundamental problem is the health care  
13 system in any efficiency and excess cost growth. Sometimes  
14 people think about these as two separate problems. You can  
15 make that case. There's some nuances but they're not  
16 identical. But at the same time, I think you have to think  
17 about them the same, or at the same time because they are so  
18 linked and they are so together. As Joe said and I agree  
19 completely, these problems are caused by misaligned  
20 incentives. That's where I want to spend most of my time  
21 today.

22 But I also want to remind us the reason, at least

1 why I'm here, it's because these problems cause quality  
2 health care to become unaffordable for a growing fraction of  
3 our workforce. In 1987, a family insurance policy cost a  
4 little less than 8 percent of median family income. That's  
5 the income at the middle of distribution. Today, a family  
6 insurance policy is 18 percent of the median income and  
7 rising. That's the main reason people are becoming  
8 increasingly uninsured. It's not firms refraining from  
9 offering, because workers are turning down the offers  
10 they're getting.

11 That fundamental dynamic is why politicians, even  
12 though they like to avoid it as long as possible, are  
13 extremely nervous about the 2008 campaign. We can talk  
14 about that later if you'd like. But fundamentally, at the  
15 end of the day this thing is scaring people and we're going  
16 have to get health care costs under control.

17 How do you want to solve it? Let's all take a  
18 deep breath and hold hands, maybe sing Kum-ba-yah and agree  
19 to break eggs. You guys are pretty good at that actually, I  
20 must say. I've read at least 38 of your reports in the last  
21 three days and I'm impressed. You're willing to break the  
22 eggs. I'm just here to encourage you to continue, maybe get

1 a bigger hammer.

2           The three pieces which I'll spend my time on are,  
3 we have to have an information infrastructure to make this  
4 all possible. I want to realign all incentives -- and I use  
5 all to make sure that we're talking about both demand-side  
6 and supply-side because one alone will not be a silver  
7 bullet. If there was a silver bullet you would have it. It  
8 doesn't exist. You know this.

9           The third piece in some ways is the most  
10 controversial but in many ways the most important since  
11 technology drives cost growth, figuring out how to buy  
12 technology smarter is the game.

13           First things first though. Let's remove the  
14 barriers to efficiency that are in place now. All I'm going  
15 to say on this and not belabor the point is, stop being  
16 afraid of using Medicare's buying power. Ever since 1965  
17 there's been this great, oh my God, we can't affect the  
18 practice of medicine. What the hell else is the point?

19           So I would just say, this reminds me, when we look  
20 at those numbers Joe put up, that was quite a tax multiplier  
21 there, Joe. When you put up those numbers it reminds me of  
22 Custer's last stand, and you think about the cavalry

1 standing there. And we don't know a lot about those last  
2 conversations because there were no survivors so it's all  
3 apocryphal, and Sitting Bull wasn't in the mood to take  
4 notes. But, nevertheless, you could imagine I've heard lots  
5 of them and my favorite one is the one of the private who  
6 was assigned the task of holding Custer's horse because they  
7 had dismounted, of course, in final 19th century honorable  
8 death fashion and shot from behind the horses. The 19-year-  
9 old mustered all of the sarcasm a 19-year-old can and said,  
10 well, sir, do you think it might be time to pass out the  
11 ammunition the junior officers asked for when we left the  
12 fort today? I mean, at the end of the day we're getting  
13 clobbered on health care costs, why not try to use buying  
14 power. Trust me, you'll know when you've overstepped the  
15 bounds, and we're a long, long way from that.

16           You want to stop paying for substandard  
17 performance. As an economist I must say, the more I delve  
18 into health care quality the more scared I get. I've  
19 recently learned about Institute for Health Care  
20 Improvement's program on eradicating ventilator-associated  
21 pneumonia. I won't go into details. I'll just say, in 1999  
22 New England Journal articles showed the exact four steps

1 that if you do them on every patient every day you can get  
2 rid of this. You can eradicate it. The death rate from  
3 getting it, by the way, is about 40 percent. The costs are  
4 unbelievable if you get it.

5           The point is, since 1999 exactly 14 hospitals have  
6 done it. Six have made progress. How many hospitals are  
7 there? One could imagine incentives that could entail  
8 paying you more if you do this or paying you less if you  
9 don't and I predict you could accomplish this in about an  
10 hour. But, nevertheless, we have no sense of urgency in our  
11 system.

12           Geographic variation. We'll come back to that.  
13 You know about that well.

14           I will say though you're going to have to spend  
15 money to make money. You're going to have to spend money to  
16 get money back. Way more needs to be spent on data and  
17 technology evaluations and we'll talk about that a little  
18 bit as we go.

19           Let's talk about incentives precisely. This will  
20 not be news. Fee-for-service leads to too much health care,  
21 especially if it comes without any kind of quality  
22 measurement and accountability. At the same time, I think

1 it's fair to say, whether or not it turned out to be true,  
2 people fear that capitation without measurement will be lead  
3 to too little health care. Certainly, the incentives point  
4 that way.

5           So if you think about it, just for about 10  
6 minutes from the point of view of a simple economist, some  
7 combination of capitation and measurement is surely best  
8 because that gets dollars in the right place but it holds  
9 the providers accountable for what actually happens. The  
10 difficulty, as you know, is what unit should be capitated  
11 and what the heck should we measure?

12           I'm trying ask the question, why not think about  
13 trying to align incentives and the information in order to  
14 create not just the Medicare program but the overall health  
15 system you really want? Because you've got to buy Medicare  
16 within that system. If you don't fix it, you don't -- and  
17 the system that we need.

18           What I'm talking about is, how do we move to a  
19 world in which we have efficacious care efficiently  
20 delivered? We all want it. We all can define it. Kind of  
21 like pornography, we'll know it when we see it. But the  
22 point is it's imaginable and indeed it exists in some

1 places. How can we move there?

2 I submit to you what you want to do is somewhat  
3 follow your own logic. PPS worked. It's kind of  
4 interesting to think about why and how, but you see how it  
5 spread through the Medicare program for all kinds of good  
6 reasons, except for physicians, of course.

7 Quality management has begun in Medicare. I  
8 applaud everybody involved, from Tom Scully on down. I will  
9 say, episode groupers are in some ways baby steps toward  
10 capitating physicians. And coordinated care model demos  
11 that are there out now are also, in some ways, baby steps to  
12 it. I'm talking about, take a deep breath; let's take a big  
13 step.

14 What if we did the following? What if we  
15 acknowledged that every human being needs a medical home?  
16 Turns out the Medicare program, roughly 95 percent already  
17 do have a usual source of care. We presume that qualifies  
18 as a medical home. Let the bene pick the medical home and  
19 let's capitate the medical home and hold the home  
20 responsible for quality outcomes and see what happens.

21 Now I know capitation is scary and I've used it  
22 now three times so I'm going to stop using it so I can

1 survive the rest of the morning. But I will say what I'm  
2 talking about here is, pick your home. Let the bene pick  
3 the home. It's very important. I want the consumer to be  
4 at the center of it. The home could be a nurse  
5 practitioner. The home could be a doc, could be a group,  
6 could be a network, could be a group of docs, could be a  
7 hospital, a health plan. Health plans have advantages in  
8 this thing but not tremendous advantages.

9           Because what's the key thing missing in our  
10 transition mechanism? Why don't we have efficacious care  
11 efficiently delivered today? Because of an absence of trust  
12 all up and down the system. It's the most important  
13 problem.

14           Who is the one human in the system the  
15 beneficiaries trust? Their doc, their primary care doc,  
16 their medical home, their source of care. What I'm talking  
17 about is make a new payee category. Call it health system  
18 guide. We'll call it a fee. We won't call it capitation;  
19 we'll call it a fee. We'll pay you for taking care of these  
20 folks, for helping them navigate the system.

21           I was really struck at Tom Bodenheimer's New  
22 England Journal editorial published, I think it was the 31st

1 of August, where he talked about can primary care survive?  
2 And the fundamental dynamic of the reality of practice today  
3 is that they have to see so many patients they can't really  
4 be good at any of them. It reminds of the best line I ever  
5 heard about American economists, but it applies to all  
6 professions I think. The problem with Americans economist  
7 is they're too busy being successful to be good.

8           Think about a doc trying to see 32 patients a day.  
9 It's ridiculous. So let's pay them to pay 20, pay them to  
10 make a living so that they can see fewer patients and then  
11 become the agent, guide, activist for the others. I submit  
12 to you, that will build upon the single most important  
13 element of trust we have now. It will pay them for guidance  
14 services. It will reinvigorate primary care in a way that  
15 we all know we should. And it will, more importantly  
16 perhaps from the point of an economist thinking about  
17 incentives, align beneficiaries, medical home and the  
18 taxpayer. Hey, what a concept. Align them all against the  
19 rest of the system.

20           So what I'm trying to do is get the, if you will,  
21 evidence-based game away from Baltimore versus a doc out  
22 there in Kansas and getting it down to one local doc versus

1 another, is this going to have value or not? Now you can  
2 imagine lots of different ways to structure this and I won't  
3 belabor the point because I'm running out of time. But I  
4 will say, you could imagine full capitation and then let the  
5 medical home buy stop-loss protection back from Medicare by  
6 giving some of the money back.

7           You could imagine paying for different elements of  
8 it and putting whatever you pay them at risk for performance  
9 targets. You could do this lots of different ways, but the  
10 point is to try to align incentives.

11           In the long run, comparative technology  
12 assessment, how are we going to get there? I think we've  
13 made progress in elevating evidence in the decision process  
14 of coverage policy. But as you know quite well, we are  
15 nowhere near where we ought to be. Clearly we need more  
16 funding, public funding. It's got to be public funding --  
17 of an evidence pipeline. We could do way better on that  
18 score. You could have a percentage of national health  
19 spending; whatever you want to do.

20           I would submit to you what I mean by elevating  
21 evidence in the decision process is that when the evidence  
22 suggests against coverage and the political pressures do

1 what they do -- after all, it is a democracy, okay fine.  
2 But you can use payment policy and cost sharing. I submit  
3 linking cost sharing to evidence is probably the single most  
4 important thing you could do in the short run.

5 And then I want, because we have to have it for  
6 the system as a whole, a delivery system culture of value.  
7 What do I mean by that? Three pieces.

8 Information system backbone. I won't belabor  
9 that. What I'm talking about though is more than electronic  
10 record. It really is electronic record with decision  
11 support tools so that every patient-clinician encounter can  
12 have real-time information and they can make a joint  
13 decision about what's best for them.

14 Think about the incentives we have now with drugs.  
15 Now that we pay for drugs in Medicare you have a broader  
16 scope, I would submit, to consider the following. To get a  
17 drug approved now at the FDA basically you have to show you  
18 didn't kill anybody and you beat a placebo. Don't take this  
19 as a flip answer but prayer beats a placebo. So at the end  
20 of the day you might want to think about just a little bit  
21 raising the bar. Show me against which comparative  
22 treatments you beat and for whom.

1           My favorite example here is Vioxx. I saw this in  
2 a presentation about a year ago. You probably know this. I  
3 know Arnie does. When it was discovered or when it was  
4 announced that Vioxx caused an elevated risk of  
5 cardiovascular events among those arthritis patients who  
6 were taking it, in the Kaiser system 3 percent of the  
7 candidates were on Vioxx, which is just about exactly  
8 therapeutically correct, the fraction of folks who are  
9 actually susceptible to the gastro problem that Vioxx was  
10 created for. Within Anthem, a little bit less effective at  
11 managing -- less impressive -- 12 percent. And within  
12 General Electric, generally considered the single best  
13 corporate buyer on the planet, Bob Galvin at this conference  
14 said 55 percent of his arthritis candidates were using  
15 Vioxx. What the hell is that about?

16           It is about the inability to control unfettered  
17 fee-for-service medicine. I rest my case.

18           So you want to raise the bar. We also have to  
19 create evidence-based safe harbors from malpractice. You've  
20 got to give these guys something. I submit, hold  
21 malpractice reform till the very end because they will do  
22 whatever you want to get it. But the point is, you've got

1 to give it to them and you've got to give it to them in a  
2 real way.

3           Then I would say, we could do a heck of a lot more  
4 leveraging other entities. AHRQ, VA, you know about that.  
5 I also would submit the specialty societies, at least most  
6 of them, and academic medicine can actually be your best  
7 ally here. Let's be frank. What the academic medicine  
8 community wants us to be financed. You can get them to  
9 study anything. So why not get them to study what you want?  
10 And that is to say, give yourselves evidence you can then  
11 infuse through the system with the credibility of an  
12 academic center. And I already talked about linking cost-  
13 sharing.

14           Okay, here's the problem and then where I think  
15 the solution is. Here's my little diagram for why health  
16 reform is hard. Nancy-Ann taught me this in her own way but  
17 we didn't have it quite this succinctly articulated. Start  
18 in the lower right-hand corner. People who support health  
19 reform for the right reasons. That would be the wonks and  
20 the eggheads and the well-intentioned saints in the  
21 professions.

22           The problem is, we come up with these great

1 proposals that are all creative and too long, but we attract  
2 support from people who support it for the wrong reasons.  
3 That is to say, they're so pissed off at capitalism they  
4 can't stand the fact that people make money off doing well  
5 in health care. So they grab the pitchforks and whatever it  
6 is and charge the Bastille. That scares the people in the  
7 upper left-hand corner who are opposed for the wrong  
8 reasons. They have stakes in the system. They see these  
9 guys come out they say, oh my God, we can't be for reform.  
10 So they create Harry and Louise ads which scares the people  
11 that really matter.

12           That's where most of the American people live.  
13 That is to say, they are opposed to reform for the right  
14 reasons. Now what do I mean by that? They are mistrustful  
15 of fast-talking Southerners like me who can say, I can  
16 measure quality. I can talk about performance. We can do  
17 all this and you'll be fine. They don't believe me. They  
18 shouldn't believe me.

19           But who will they believe? I submit to you,  
20 they'll believe their medical home. So getting that medical  
21 home on the side of reining in extra resource use,  
22 incentivizing them to do so is, I think, the key.

1 Thank you very much.

2 MR. HACKBARTH: Thank you very much, all of you.  
3 Let's open up questions and comments.

4 DR. REISCHAUER: A combination of comments and  
5 questions. First of all, a little clarification from Joe  
6 who said we can't tax our way out of it and showed some  
7 numbers, which unless I'm wrong, suggested that we could.  
8 And that was that we'd have to raise taxes by \$5.3 billion  
9 but that would reduce GDP by \$248 billion. And you said  
10 annual underneath so my mind is going and I said, the way  
11 out of this is to lower taxes by \$5.3 billion and the  
12 multiplier is about 20 percent and you get so much money  
13 into the system that by lowering taxes to almost nothing we  
14 could finance the world. You can come back after I've gone  
15 through all this and say I'm all wrong.

16 But the question that I had for you, Joe, is sort  
17 of quickly implied that you thought we should have some kind  
18 of basic care which was subsidized and probably available to  
19 more than just the Medicare population and if the people  
20 want to go for something more that's their responsibility.  
21 I have a lot of sympathy for that approach.

22 My question would be, how do you go about defining

1 what that basic care is? Do we do it as a lump of money?  
2 Do we do it as a package of benefits? Do we do it as a  
3 package of benefits combined with a certain kind of delivery  
4 system? Just your thoughts on how you get over all those  
5 complicated issues.

6 Marilyn, and to a lesser extent Len, pointed out  
7 what Medicare was going to cost and had cost as a percent of  
8 income, which I have no argument with and that how it's  
9 rising and has risen. But we've got to remember the product  
10 is a different product than it was in 1974 or will be in  
11 2010. You're getting hips and knees and new hearts and all  
12 sorts of stuff that just wasn't around. So the notion that  
13 this costs more as a fraction of income shouldn't be  
14 surprising.

15 And also when you think about the growing  
16 capabilities of medicine and the reduction in costs of  
17 things like food, clothing, housing and transportation,  
18 you've got to spend your money on something. And if you  
19 don't have to spend it on food and health is providing a  
20 certain kind of benefit, that's where it would go.

21 That was my observation. My question for you,  
22 Marilyn, because you said taxes will have to be part of the

1 solution, and I agree with that, would you how you would  
2 feel about something like a value-added tax dedicated to  
3 health both for the general population and for the Medicare  
4 population and would be a way of getting around a lot of the  
5 problems associated with income-related premiums or benefits  
6 or whatever?

7           Finally, Len, a big part of his solution is the  
8 medical home which sounds very homey or very nice and you're  
9 sort of making it sound like the medical home was almost  
10 your primary physician or something like that. I would  
11 doubt that he would have the capacity to know everything one  
12 would have to know.

13           Don't you run into the problem here that the home  
14 you need, to home you want can change very, very rapidly and  
15 what might appear to be a comfortable home today after my  
16 cardiac arrest tomorrow wouldn't be the house that I would  
17 like to live in. How do we deal with that problem?

18           By the way, thank you. These were tremendous  
19 presentations.

20           DR. ANTOS: Thanks, Bob. A little comment about  
21 that model. I did give the disclaimer that it was  
22 unrealistic of course.

1 DR. REISCHAUER: I was just helping making your  
2 point.

3 DR. ANTOS: Thank you very much. I think you can  
4 blame Global Insights probably for the multiplier. But the  
5 real trick in that particular calculation is to assume that  
6 Congress does what it always does, which is when it gets  
7 money it spends it. So instead of accumulating funds  
8 typically by buying down the deficit, this particular  
9 calculation assumes that any additional tax collections  
10 above the current operations of the government or the  
11 current operations of Medicare are spent for other purposes.  
12 So, obviously, it pushes things.

13 And you're right, it's certainly possible to raise  
14 taxes. I spoke too abruptly, of course. What I was trying  
15 to say was that you can't just tax your way out of the  
16 problem.

17 On how you define the basic health benefit  
18 package, we've talked about this for many years and some  
19 people actually tried to propose ways to do it. But  
20 organized ways don't seem to work in the United States. So  
21 I would argue for it disorganization.

22 I think we need to suffer. We need to have

1 problems. We certainly don't need a commission to sit down  
2 and lay out a list of 500 things that we are or aren't going  
3 to do. Those things have never been very successful.

4 But we need to chip away at the problem and part  
5 of chipping away at the problem is what everybody talked  
6 about to a greater or lesser extent, which is to learn more  
7 about what works under what circumstances in health care.  
8 We will begin, I think, to hone in on some basic truths  
9 about medicine that may even be long-lasting enough so that  
10 you could hang your hat on it in terms of benefits.

11 But it's not just the benefit package. We also  
12 have to chip away at people's expectations. I think that's  
13 more important than chipping away at this technical problem  
14 because I think it's the social and cultural issue that  
15 needs to be dealt with here. Again, it's not just  
16 beneficiaries. When people say that, usually the reaction  
17 is, you're just talking about either beating up on  
18 beneficiaries or consumer empowerment. It's also providers  
19 and employers and everybody else. So that was a fairly  
20 unsatisfactory solution to a really difficult problem.

21 I wanted to make one comment about taxes and  
22 income relating. I think the discussion often

1 compartmentalizes too much. So we have a tendency to  
2 implicitly, not explicitly, accept we have payroll taxes and  
3 we have various methods of collecting revenue. I would  
4 argue that that's the wrong way to go about it.

5 I supported the Congress's approach to income  
6 relating to premium and so on. But that's not the only way  
7 to do it and if we're stuck with those models we'll never  
8 get there. So I think the idea of looking again at all the  
9 financing and all of the mechanisms and asking which are the  
10 most efficient methods, which are the ways that least  
11 discourage work and saving, that ought to be our guide and  
12 we need to work on that.

13 DR. MOON: As a segue to talk about the value-  
14 added tax, it is an efficient tax. It is a tax that does  
15 not have the same kinds of disincentives that a payroll tax  
16 has, and it has the advantage of not piling on to something  
17 like the income tax that already is pretty complicated and  
18 makes it very difficult to talk about an adjustment.

19 If you're going to go that route, and I think  
20 there are some advantages to that, it ought to be dedicated  
21 in a way that is dedicated beyond Medicare. It seems to me  
22 it ought to be a dedicated health care value-added tax and

1 it might be a very good idea from that standpoint. You  
2 don't want to do a value-added tax on a small amount because  
3 that doesn't make any sense. But at a larger amount it  
4 could make substantial sense.

5 It also has the advantage that it, once again, is  
6 not one of those things that people have to fill out all the  
7 forms and do all those kinds of things.

8 You would also want to do some adjustments to the  
9 value-added tax, and there are ways to do that, to keep it  
10 from being a regressive tax. So I think that ought to be on  
11 the panoply of things, but we'll certainly drive people who  
12 don't like taxes crazy to talk about a whole brand-new tax.  
13 But other countries have used that pretty successfully and I  
14 think we should take a look at it.

15 DR. NICHOLS: Good point, Bob. I did think about  
16 that a little bit and I would argue that in fact that's the  
17 whole point of having the beneficiary be the locus of  
18 decision. Let the bene pick the medical home. In a case  
19 where indeed they're using a lot of specialist services,  
20 and/or -- just think about cancer or, in my mother's case, a  
21 few years in her 70s she basically was perfectly healthy  
22 except for increasing urinary incontinence and spent more

1 time in the urologist's office than anyplace else. It's  
2 Arkansas and there's no primary doc anyway so that guy  
3 started doing her blood pressure and giving her a flu shot,  
4 and he was a nice young man so she went back regularly.

5 So the point is, that's a perfectly fine place to  
6 have your medical home if it's appropriate for you. The  
7 point is to have the beneficiary choose it. And then the  
8 point is to create incentives so that human being helps the  
9 beneficiary navigate the system.

10 I would submit, and I tend to agree with your  
11 offhand remark that the doc may not know enough -- then why  
12 the heck do people think the consumer is going to know  
13 enough? Perhaps the doc can learn with the consumer  
14 together so at the end of the day they can at least help  
15 them sort through the literature, which is I'm sure what you  
16 do for your relatives and I do mine.

17 So at the end of the day what I'm talking about is  
18 aligning the interests of the taxpayer with the medical home  
19 and let the bene pick the home. My gut says we would never  
20 be able to force a choice to last longer than a few months,  
21 maybe a year. And that's probably okay, that they should  
22 decide every year who should be the new home.

1           MR. DURENBERGER: Like Bob and others I guess I've  
2 known you all so long but I'm continually surprised by the  
3 things I learn from you. This is so great and I'm really  
4 grateful that Rachel or whoever made the decision to invite  
5 the three of you because it's a wonderful combination. I  
6 think you're known sometimes for your differences but I,  
7 like everybody else here, took more from the areas in which  
8 you agreed than on which you may differ.

9           I guess I'd like to posit my question around the  
10 principal function of the Medicare Payment Advisory  
11 Commission, which goes to probably the issue of misaligned  
12 incentives since most incentives will be financial. I think  
13 there are plenty of others, particularly when we think about  
14 health professionals. They have very serious reasons for  
15 being in that business. We probably don't do as good a job  
16 as we should sometimes of recognizing why they do it. It  
17 isn't only money. But money today has become such a  
18 critical part of it, and your characterization of the  
19 economist and so forth is probably too true.

20           But if in fact, either as a commission or as a  
21 country we're going to refocus on the incentives it strikes  
22 me we need a couple of things. One, we need some advice on

1 exactly what are the financial tools we're going to use,  
2 which are the easiest ones to start to change. And then we  
3 need the issue of leadership. When I look at Joe's who  
4 decides, consumer, provider, health plans, CMS, Congress,  
5 it's sort of like everything now. The Congress just decided  
6 that the consumer is going to do it everybody said, no  
7 that's not going to get us there.

8           But one decision that MMA did take was -- and I  
9 don't want to exaggerate this only because I believe it --  
10 and that is that we're going to move the Medicare program  
11 out of Washington D.C. and out to Minnetonka, Minnesota, or  
12 wherever the case may be. But it isn't only Minnetonka,  
13 it's Louisville and other places like that.

14           So I'd love to get on the trust factor  
15 principally, because we're really talking about major  
16 changes. What are your judgments about the specific roles  
17 of health plans in the transition of the financial  
18 incentives in this country versus some alternative such as  
19 you've suggested, the medical home, which leans more heavily  
20 on physician leadership, and then building into that, I'm  
21 sure, roles for Congress and so forth?

22           But we clearly are on a policy track in this

1 country, at least the majority in the Congress, that we are  
2 going to move this system, whatever you called it, Medicare  
3 is integral, is going to move to Minnetonka or to Louisville  
4 or someplace like that.

5 I'd just love to get your individual judgments if  
6 -- not that I'm saying it's the wrong course but I'm trying  
7 to figure out what is the most appropriate role for us to  
8 think about because part of our work here is to recommend  
9 how much money should be paid to Medicare Advantage plans in  
10 order to fulfill some objective. But nobody, to my  
11 knowledge, has ever defined what that the objective is  
12 except Medicare Advantage is better than single-payer. But  
13 nobody has ever said we're going to pay for realigning  
14 incentives, we're going to pay for improved quality, we're  
15 to pay for efficiency, and then judge them on their  
16 performance.

17 I'll shut up because I think I've made my point  
18 and I wonder if you could react to it.

19 DR. NICHOLS: A great question. I would say in  
20 many ways, Dave, the reality is health plans have a number  
21 of natural advantages in my little scheme because at the  
22 moment, except for a few multi-specialty group practices and

1 a few integrated health systems, they are the only creature  
2 that can do the coordination in an efficient way.

3           The disadvantage, I would opine, health plans have  
4 is some people don't trust them to look out for the best  
5 interest of the beneficiary in terms of quality care. They  
6 fear that in fact they're more interested in other things.

7           I would submit, most people I know who run health  
8 plans have about as high integrity is you're going to find.  
9 Certainly most of the clinicians one encounters in the  
10 system are doing the best they can in a deeply flawed  
11 system. So I don't think there's any -- but the reality is  
12 people are worried about that.

13           So what I was trying to do somewhat provocatively  
14 was to say, let's find the creature they're most connected  
15 to and empower that. Now that physician, if you will, or  
16 nurse practitioner or whatever, multi-specialty group, is  
17 typically part of the network and they typically have  
18 arrangements with plans. Certainly it's true the average  
19 primary care doc couldn't take on the functions I laid out  
20 in totality at the moment. But they could band together  
21 with others. And then each of them would have the patients  
22 that they have the relationship with and they would then

1 theoretically be able to either go out and collectively buy  
2 stop-loss or indeed take on the risk themselves.

3           So I would submit your job as a commission is to  
4 not get in the way of flowing efficiencies in the sense that  
5 you should, in my simple view, you should not take sides  
6 between sight of care or type of provider but keep the  
7 incentives focused on health outcomes for beneficiaries.  
8 The payment policy has to be reflective of both the aligned  
9 incentives we've talked about and the income dimension that  
10 Marilyn is so eloquent on, so I'll turn to her.

11           DR. MOON: I also think this was a really good  
12 question because I think it gets right to the heart of the  
13 issue. And that is, I think that there are sincere people  
14 who believe that these private plans can be exactly the  
15 right way to align incentives correctly. And I totally  
16 agree with that, if I could choose the plans I want to  
17 choose and look at them and do that. What I don't see is it  
18 happening enough in practice to have total confidence in  
19 that.

20           I also don't see the distribution of resources  
21 around the country in alignment enough to make that work  
22 well in the traditional way that we think about.

1           So the legislation has created a system in which  
2 is encouraging private plans not only by paying them extra  
3 money, which I'm deeply opposed to, but also by encouraging  
4 private fee-for-service and other kinds of activities that I  
5 see have none of those kind of advantages. They are just  
6 another dimension, another way to move those incentives out  
7 to the public so that the public can get access to  
8 incentives in Iowa that they might not otherwise have.

9           So the first thing I think needs to be done is to  
10 align incentives between the fee-for-service traditional  
11 Medicare and these private plans.

12           The second I think is to eventually come out with  
13 a set of goals that such plans have to meet or have to be  
14 seeking to achieve before they get certified to participate.  
15 If an incredibly deeply for-profit organization does a very  
16 good job, I'm all for it and all for them making a lot of  
17 money. But an awful lot of plans started out with that was  
18 their goal and nothing else. I think that that's a  
19 difficulty.

20           I'm also very sympathetic to Len's approach. In  
21 fact in a new book I just did on Medicare I talk a little  
22 bit about exactly that, so I can't claim that I'm stealing

1 it -- because I think we're going to have a mixed system for  
2 a very long time. One of the things that I think we really  
3 need in terms of improvements is coordination of care. And  
4 that needs to happen sooner rather than later.

5           And waiting until everyone is in the ideal  
6 integrated system isn't going to happen. So I think that we  
7 need to find ways to allow individuals to choose a Medicare  
8 home. I'm not sure that we want to require it initially but  
9 I think we want to find ways to have incentives both the  
10 beneficiary to do that and the provider to do that and then  
11 hold them to certain standards. They can only be a  
12 certified Medicare home if they do the following kinds of  
13 things.

14           That I think would allow you to change some of the  
15 payment incentives that are so wacky now where primary care  
16 physicians are chumps if they do that for their Medicare  
17 patients as well as for other patients in the system. What  
18 we're counting on right now is that there are some very  
19 well-intentioned chumps out there who are willing to do for  
20 their patience. I think that's a very foolish way to  
21 operate a health care system.

22           So I agree about alignment of incentives. I agree

1 about encouraging private plans up to a point. But I think  
2 we've gone too far thinking that's a magic bullet and can  
3 just get Washington out of the issue.

4 DR. ANTOS: I think Len just said that people  
5 don't trust their health plans and I think that's certainly  
6 right. I am sure virtually everybody I can think of -- one  
7 person who may trust his health plan, but everybody else has  
8 undoubtedly talked to an honest person on the phone and  
9 wondered why the heck they didn't understand my problem. So  
10 the idea of talking to an actual human being is probably a  
11 good idea, Len. We ought to try that in health care.

12 So it's true, people don't trust their health  
13 plans, especially with regard to quality of care.

14 But in traditional health care we just don't know.  
15 So people have not have a basis for understanding what  
16 quality of care means in any operational sense. Traditional  
17 Medicare has largely been the same mystery that health care  
18 is to everybody. So we just don't have a face to put it on  
19 -- don't trust. We don't know. But the level of trust  
20 ought to be the same because the system is the same.

21 Now this idea about a Medicare home I find  
22 interesting because it sounds very positive. But there must

1 be an edge to it. Why would you do it unless it did  
2 something? And what is it that it's going to do? Sure,  
3 we'll get some guidance. My primary care doc has his  
4 opinions and he tells me and sometimes I believe him,  
5 sometimes I don't. But if Medicare is going to create a new  
6 provider type we'd better make sure we're getting something  
7 for it.

8           So I think it requires a lot of thought about what  
9 that is and even more thought about whether you can sell it  
10 to the average patient. This is the kind of idea that  
11 floats around in public policy circles but until you  
12 actually see it with your own eyes as a normal patient  
13 you're not sure whether this is such a wonderful idea.

14           In other words, yes, it's a good idea for you but  
15 let me make my own decisions. It's a common American  
16 failing.

17           MR. HACKBARTH: I wanted to follow up with  
18 Marilyn. I largely agree with your comments about how  
19 Medicare deals with private plans. I really believe in the  
20 concept but I've had some issues with the execution and I  
21 think that's evident to everybody in the room.

22           But the other side of this coin that I worry about

1 is the federal government's capacity for improvement. Len  
2 mentioned the 38 MedPAC reports that he read yesterday and  
3 they are chock full of very specific recommendations for how  
4 to improve the Medicare system. Yet what we find is that  
5 the system's capacity to make those changes is a lot less  
6 than we might like it to be. It's less in terms of the  
7 resources within CMS to make the changes. It's less in  
8 terms of the political will sometimes in Congress to deal  
9 with the difficult choices that must be made to refine  
10 payment systems, make them more accurate, or to introduce  
11 cost-effectiveness into our coverage policies.

12           So, yes, there are reasons to have reservations  
13 about private health plans as decision-makers. Many people  
14 distrust them. There are some real problems I believe in  
15 the execution of Medicare Advantage.

16           On the other hand, are we really going to get to  
17 where we need to go relying on this very creaky mechanism of  
18 public policy to improve traditional Medicare let alone the  
19 whole health care system?

20           Any thoughts, reactions, all of you, on that?

21           DR. MOON: I guess my first reaction is that  
22 absolutely right but I'm not sure that I see the private

1 plans stepping up in all cases. There are some things that  
2 I think are truly public goods. That is they don't make any  
3 sense to be provided by one single group. One of those is  
4 evidence-based work. It may need to be taken out of the  
5 hands of government. To some extent AHRQ certainly got into  
6 big time trouble trying to do some of this a few years ago.

7           But it doesn't make any sense for Aetna to take on  
8 the job of proving whether or not Vioxx is better than  
9 Celebrex, et cetera. That's obviously a bad case because  
10 that one we've figured out. But the point I'm trying to  
11 make is that there some things that I think the government  
12 should be doing. I agree that we're in a world in which at  
13 the moment we're kind of having some people who are rooting  
14 for the government to fail to demonstrate that the private  
15 sector will do better. And that's really a race to the  
16 bottom, which bothers me a lot.

17           I think we have to hold the government to some  
18 standards. That's why I think a mixed system for some  
19 considerable period of time, where we work really hard to  
20 keep the incentives level, makes the most sense. Let Kaiser  
21 become dominant and take over the world by proving that  
22 they've got a better animal. That's fine. Or Humana or

1 whomever.

2           But I think that we are in a world in which there  
3 are no perfect incentives in health care. There are no  
4 perfect models out there for how everyone operates that  
5 satisfies all consumers, which we know in the United States  
6 people do have a lot of different views on this.

7           But where I would push really hard is to push on  
8 the evidence base. I think that's an area where you can get  
9 some consensus, and you can have some mechanism in which you  
10 push very hard and fund that research. Then I would have  
11 Medicare be a leader and say, one way to hold down costs is  
12 we're going to have really high cost sharing for things that  
13 don't prove to be effective.

14           Other plans want to do something different, fine.  
15 But I think you've got to strive to have Medicare be a model  
16 as opposed to a creaky old system that you're letting die on  
17 the vine by subsidizing private plans.

18           I just hate to see us give up because government  
19 has problems. It does have problems but so do private plans  
20 that can make arbitrary and capricious decisions. Medicare  
21 has to be creaky, which is a disadvantage in some ways. But  
22 it also protects consumers and providers to a certain extent

1 more than some of the plans have over time.

2 DR. NICHOLS: I always find it ironic to come in  
3 this building and think about the President who called the  
4 government the problem now has a building named after him  
5 that's the largest government building in the United States.  
6 But I will say his favorite saying, which I quote often, is  
7 "trust, but verify."

8 What I'm talking about in moving to a transition,  
9 and the reason I want to start with this medical home as the  
10 cornerstone of that movement, because what we really want is  
11 for patience to learn that the data can be meaningful. We  
12 all know it. A lot of people don't share our view. Who  
13 better to learn it from than physician or the medical home  
14 that you actually trust now?

15 So what I'm talking about is, essentially, back to  
16 Bob's point. Yes, the docs now don't know, but they can  
17 learn faster than we can and they can help us. They can,  
18 indeed, if we properly pay them, I would submit, they will  
19 perform that function quite willingly, even vigorously.

20 And the edge Joe talked about is what I really  
21 want is basically to have the debate be between clinicians  
22 about what this patient needs, rather than what a coverage

1 policy panel might do in Baltimore versus Minnetonka.

2 That's just too great a distance right now.

3           Once the people come to take the data as a given,  
4 that's different. We're not there yet. We can't wait  
5 because it costs to damn much.

6           DR. ANTOS: That feeds into something that I was  
7 thinking about which really has to do with, again, how clear  
8 are the data for any conclusion about health care? It turns  
9 out, not so clear. We have that darned patient in the way  
10 and patients usually don't come equipped with only one  
11 disease, and they don't necessarily follow the doctor's  
12 orders, and the doctor doesn't necessarily follow the  
13 protocol. So it's a really complicated situation.

14           It seems to me that what Len said just now is just  
15 exactly right. You want that debate. You want that medical  
16 debate about, how am I going to treat this patient right  
17 here?

18           But at the same time, there is a financing issue  
19 here. In the end, there is a larger organization, whether  
20 it's traditional Medicare or a health plan. You have to run  
21 a business. So you have to have some rules about what  
22 you're going to cover and under what circumstances.

1           We've got to find a way to blend these two models  
2 if we're going to be at all successful. But in the end the  
3 idea that there's going to be a learned panel that is going  
4 to say, okay, this is good, this is bad, I think is a  
5 totally an impractical idea because in most of health care  
6 it's not so clear what is good and what is bad.

7           And furthermore, going back to maybe I as a  
8 consumer would be willing to take a chance and I'd be  
9 willing to put my money on that. I ought to have that  
10 option. I think we need to be able to blend it.

11           DR. NICHOLS: I want to, if I could, I need to  
12 make it clear that I agree with Joe that we want to let him  
13 spend his own money on stuff that we don't think is going to  
14 work.

15           But I also want to say -- and it is an important  
16 American principle. I also want to say that I'm not talking  
17 about using coverage policy. In fact I'm trying to get away  
18 from using coverage policy. My associate back there will  
19 tell you, because he lost a lot of sleep this week trying to  
20 prove that coverage policy was a solution. I don't think it  
21 is.

22           Let's go back to Vioxx. It's going to be very

1 difficult to say, this particular good and new idea has no  
2 value for any human on the planet. It's going to have value  
3 for somebody. The trick is to getting that treatment with  
4 value to the right people and not paying for it for the half  
5 of the population that won't benefit at all.

6 That's why I want the decision at the clinician  
7 versus clinician level, preferably in the long run in  
8 collaboration, and I think we can incentivize the system by  
9 moving some pots around and making that indeed feasible.

10 DR. CROSSON: I'd like to thank all three of you  
11 as others have because I think it's going to take me awhile  
12 to consider and reflect on all that you've said but each of  
13 you have given us another perspective on the problems.

14 But I do have a couple of comments and I'd like to  
15 address them to Len because I usually like to address my  
16 comments to whichever individual mimics my own prejudices  
17 most closely.

18 [Laughter.].

19 DR. CROSSON: So I think I agree with several  
20 things. The technology assessment combined with mal-aligned  
21 incentives comes as close to defining the problem as  
22 anything could.

1           I also think, just in my two years here, that  
2 every time we approach the issue of technology assessment,  
3 or comparative effectiveness analysis, or research or  
4 whatever we want to call it we hear drumbeats. And as Glenn  
5 said, from just a purely political perspective, dealing with  
6 that central issue is going to be one of the most difficult  
7 ones.

8           I wanted to talk a little bit though about the  
9 model you have. I'm not going to use the word decapitation.  
10 I don't use it anymore. I've never used it actually. We,  
11 in our organization, have tended to use the prepayment. In  
12 fact prepayment to the delivery system is probably the best  
13 explanation for what we have contributed as a model over the  
14 last four or five decades. Because I think prepayment to  
15 the delivery system at the scale that we do it is really  
16 what we do well, and then drives some of those results that  
17 you mentioned. It's not, as the issue was described in the  
18 '90s, as incentives for less care, at least in my thought.  
19 After 30 years, it's creating or neutralizing incentives to  
20 allow practitioners to make the appropriate decisions based  
21 on the science, which gets you to the 3 percent of non-  
22 steroidal anti-inflammatory agents, being Vioxx in that

1 situation.

2           But as I look at the medical home model I am a  
3 little bit concerned about how you get -- because I think  
4 you described the capitation or the prepayment to the  
5 delivery system, which is what I would call it, as full  
6 prepayment or full capitation as it would have been called,  
7 not just simply capitation for individual services. So that  
8 at least as I think we used to think about it raises some  
9 significant problems just in terms of -- because I think  
10 actually for me it begins to raise -- if you're talking  
11 about full prepayment to an individual practitioner for all  
12 the services, hospitalization, referral services and other  
13 things that that individual might need, that actually for me  
14 does create the potential I think for concerns about ethical  
15 and professionalism issues and the like. Because even with  
16 stop-loss the movement of dollars would be pretty  
17 significant for one person.

18           But beyond that, the ability of that person, nurse  
19 practitioner, physician, or even a small group of  
20 physicians, to have the capacity to manage those downstream  
21 costs in the way that you described, that large group  
22 practices or independent practice associations can -- some

1 of them anyway -- or health plans can do is pretty limited.

2           So while I agree with your formulation completely,  
3 it tends me to bring me back to the middle of your line here  
4 which is what I would describe as integrated delivery  
5 systems of such scale and capability that they could in fact  
6 provide that trusted intermediary but also have the capacity  
7 to make it work economically.

8           DR. NICHOLS: It's clear we share both prejudice  
9 and logic because I agree completely. I would say that what  
10 I'm talking about, what I was trying to do is catalytically  
11 move us to a conversation about where the money ought to  
12 start and where the trust is from which we can move to this  
13 vision of a more efficient system.

14           Certainly it's true that an individual physician  
15 practicing alone could not do what I'm talking about today  
16 all by themselves. But part of the reason for beginning the  
17 conversation is to try to think about, why not, and what do  
18 we need to make it happen?

19           I would submit to you, physicians are in networks  
20 and what I'm talking about is a world in which you are going  
21 to have, at least before too long we should have and we  
22 should try to make it happen quicker rather than later, an

1 information system that allows seamless coordination of care  
2 across offices, across organizations, across networks.

3           So we could imagine a world in which physicians  
4 banded together too accept the fee. You could also imagine  
5 -- I did talk about total in the heuristic. But you could  
6 also imagine putting less than total in a fee to manage,  
7 let's just say ambulatory care, and then have the rest stay  
8 outside. Again, you could also envision it as simply buying  
9 different sizes of stop-loss for different things. You  
10 could imagine, in essence, putting them at risk for  
11 different levels of services.

12           Bo back to Bob's model of a seriously ill patient  
13 who knows they need a lot of specialist attention because of  
14 what happened yesterday or last year or their own history.  
15 They may put their medical home decision in a specialist  
16 office and that person may decide, I'm not going to mess  
17 with this primary care stuff. You could imagine all kinds  
18 of arrangements.

19           I tried to say, integrated health systems as well  
20 as health plans have natural profound economies of scale  
21 advantages from the get-go. So I wouldn't recommend we  
22 start this in January of 2007. But I would say it's the

1 right thing to be thinking about and that's what they told  
2 me to do two weeks ago.

3 So give me a little more time, I'll flesh out some  
4 detail.

5 DR. MILSTEIN: One of the common themes that you  
6 shared with which I very strongly agree is the idea of  
7 making Medicare's provider payments more value sensitive.

8 As one of my fellow commissioners keeps pointing  
9 out to me that a challenge that the use of such a policy is  
10 the pricing power that enables aggregated providers in some  
11 health service markets to offset performance sensitive  
12 Medicare payment losses by raising their prices to private  
13 sector purchasers.

14 None of your lists of policy prescriptions  
15 included more competitive antitrust laws as they pertain to  
16 health care providers. Would this be a useful adjunct,  
17 either across the board or at least in relation to urgent  
18 and emergency services?

19 DR. NICHOLS: Yes. No question. No question  
20 about it.

21 DR. BORMAN: A question that strikes me going  
22 across the common themes that you have, and each of you make

1 me think about something in a different perspective and I  
2 welcome that. All of you I think I agree that the Medicare  
3 program is an essential component of our current health  
4 delivery system in the United States. So there's more than  
5 Medicare that is impacted by the things that you advise and  
6 the work of the Commission.

7 On the other hand, there's a fair amount of  
8 emphasis, appropriately so, on value for the Medicare  
9 dollar.

10 You also mentioned that the expense of the  
11 individual has gone up for those who are purchasing outside  
12 of Medicare's as well as for the beneficiary out-of-pocket  
13 costs. And yet there was an implication that people only go  
14 uninsured for health care because they can't afford it. I  
15 would submit to you that perhaps some of those people go  
16 uninsured because they count on a safety net. And the  
17 safety net comes in part from perhaps this discretionary  
18 pool that we all seem to believe is in the Medicare program.  
19 And what are we going to do about that safety net piece if,  
20 when we go to the primary focus is the value to the Medicare  
21 beneficiary because of the spillover effect of the program,  
22 what is the parallel plan to provide that safety net?

1           We haven't talked about that piece of it and it's  
2 one of those difficult societal questions that nobody seems  
3 to have the will to step up to the plate to say something  
4 about. But I think it has to be out there on the table.

5           I would just offer one comment that all of you, I  
6 think, have agreed that evidence, when brought to the level  
7 of the individual patient, may in fact be less than black-  
8 and-white clarity over crispness. And I would submit to you  
9 that part of the protection to the individuals making those  
10 recommendations, whether they be a nurse practitioner, a  
11 physical therapist, a physician or a health plan, is better  
12 professional liability protection. So I would have to  
13 disagree with you that -- I hope you were somewhat  
14 facetiously saying that that needed to be the last step in  
15 the package of reform. Because I think if we agree that  
16 evidence will not always yield a single individual answer  
17 that we're going to have to provide some protection for  
18 that.

19           DR. MOON: I have to admit that I've always been  
20 somewhat uncomfortable with the idea that we provide,  
21 through Medicare, safety net funding. As we get more and  
22 more concerned about what we're going to pay for Medicare,

1 just as private insurance companies, employers and so forth  
2 have said, we don't want to pay for that. We want to just  
3 pay for what we're getting and value-based and so forth. We  
4 are squeezing, I think, on the safety net and I think we  
5 just have to recognize that and either decide to deal with  
6 it directly or build it into these mechanisms.

7 I think we kid ourselves to think that we have a  
8 system in which people without insurance are getting decent  
9 care in the United States. I think there's a lot of  
10 evidence that it's not the case, that it costs us more in  
11 the long run and so forth. But it seems to be something  
12 that Americans at the moment are willing to live with.

13 That is something that concerns me, but it also  
14 concerns me to think about it as part of the whole Medicare  
15 mechanism. Medicare is complicated enough and difficult  
16 enough to align the incentives correctly. When we add in  
17 yet another social burden to that I have some real problems  
18 with that.

19 On the evidence-based side I would say that I  
20 think that it's absolutely right, we don't have good  
21 evidence on a number of things. But there are some things  
22 that are coming out to be pretty black-and-white and pretty

1 clear. There is some evidence, and you read it all the time  
2 although you don't read it nearly in the same way that the  
3 first time something comes out that's based on seven  
4 randomly assigned people from a teaching hospital show some  
5 promise. But when you see it in practice and they determine  
6 later on that it doesn't work as well or doesn't make sense  
7 to do this, I do believe that there are a number of areas in  
8 which you could step in pretty early on and say, this just  
9 doesn't seem to work well. There can be exceptions. People  
10 can apply for exceptions, but this is one of those very  
11 questionable areas. I don't think we should start it across  
12 the board. You've got to take the ones that are quite clear  
13 and for which actually there is pretty good consensus in the  
14 community that that's the case, a move in that direction.

15 We're going to have to take some baby steps before  
16 we get there. But I think there clearly are some areas in  
17 which that's pretty certain. I would hope, for example,  
18 that nobody is taking Celebrex or Vioxx that doesn't really  
19 have to anymore. That's a really good example of something  
20 that came up after the fact, and in this case got enough  
21 attention. I don't think it's controversial any longer.

22 DR. ANTOS: One of the problems with the way we

1 finance hospitals in Medicare is that we're not getting a  
2 clear connection between some of the payments and the actual  
3 output. So that kind of safety net really doesn't work very  
4 well, but that's because we've chosen to do it that way. We  
5 want implicit subsidies. We don't want explicit subsidies.  
6 For some reason we want to subsidize institutions rather  
7 than individuals.

8           It's the individuals who need the health care, and  
9 if we did a better job of connecting the money to them, if  
10 we did a better job of having a structure which could  
11 involve the medical home idea, but I think a lot of other  
12 things as well, a structure to funnel people to the right  
13 kind of provider -- it won't work perfectly, but get them  
14 out of the emergency rooms as much as possible -- we'd be  
15 that much further ahead.

16           Let's not forget that we also pump a lot of money  
17 other ways, not just through Medicare, for what are called  
18 safety net providers. So this is a big problem. This is  
19 not a small problem. It cuts across a number of programs.

20           On evidence-based medicine, think I'm agreeing  
21 with Marilyn that in essence you have to get it out there in  
22 the field. I think this is one of the very smart things

1 that Medicare has done, the idea of coverage with evidence  
2 development. It's hard to imagine how you do this on a  
3 massive scale, quite honestly. But the principle seems  
4 pretty sound. After a drug is approved, after a device is  
5 approved, after somebody invents a procedure and it begins  
6 to become popular, that's when we're actually performing the  
7 real trial about whether it works. And so we really need to  
8 do more to collect, again, the information from the program  
9 that we could collect to better understand what's going on.

10 One last comment about Vioxx and Celebrex. The  
11 problem with that example is that now it's very difficult  
12 for people who actually need it to get it. So the pendulum  
13 has swung a little bit too far over to the no side. It's a  
14 real problem.

15 DR. NICHOLS: I will just echo the safety net  
16 comments that have been made. I think the reason we do it  
17 back, implicit, is because we're willing to tax ourselves  
18 appropriately for what we actually want. I'll leave that  
19 question for the philosophers.

20 On the evidence base I would say, that's precisely  
21 what I want to do, is to move the gray area to a  
22 conversation among clinicians, one of whom is incented to do

1 it, one of whom is incented not and let that debate be fair.  
2 Kind of like lawyers going at it; let's have a fair fight.  
3 Make it a fair fight.

4 Third, on malpractice, you're right. I didn't  
5 mean to say should do it last, but it should be the last  
6 piece of the agreement in the bill so that you get  
7 everything else that you want. Otherwise you won't get  
8 there. But it's definitely got to be part and parcel,  
9 absolutely central. Nothing else works if we don't solve  
10 that problem.

11 MS. HANSEN: First of all I do want to thank you  
12 all for your really very stimulating conversation on this.  
13 I bring a couple of areas with the focus really back to the  
14 beneficiary, is going to be my last comment. But I also  
15 come from a focus of 25 years in, whether we call it a  
16 managed care model, a capitated model, or in some ways a  
17 prepaid model with working and ONLOC for about 25 years  
18 which was the PACE program. So some of the offerings, Len,  
19 that you bring up are things like I think, well, of course.

20 But one of the big issues I certainly see, one of  
21 the issues is scalability. Good idea, good principles, but  
22 the ability to change this has so much to do about

1 incentives as well as culture change, which is an area on  
2 the table when you talk about bringing two physicians to  
3 talk about it and argue it out. It's about deep-rooted  
4 cultural patterns and how do we address that. And it  
5 becomes a domain issue. It becomes an economic issue.

6 We didn't call it evidence-based practice at that  
7 point but we had some standards that physicians in our model  
8 had to keep. And if they performed they actually got paid  
9 bonuses beforehand.

10 But let me switch back then to the beneficiary  
11 side and thinking about it. What role do any of you feel  
12 that the consumer, the beneficiary can play? Because the  
13 power is in the policymakers, the providers, the health  
14 plans and so forth because that's where the decisions and  
15 the money play. We talk about the consumer more.

16 Where is that tipping point in the vernacular  
17 going to happen that we raise this so that there's more of a  
18 people's demand for this in a way? Do have some thoughts on  
19 how that can be elevated, to elevate the debate so to speak,  
20 and the visibility?

21 DR. MOON: I think one of the key issues is that  
22 so far most of the discussion about consumer empowerment has

1 really been on what I facetiously say, consumer  
2 impoverishment, of talking about very high deductible plans,  
3 for example, which I think make no sense. You're just  
4 tossing people out there who don't know what's going on and  
5 asking them to be good consumers.

6 I know there are some of my colleagues who like to  
7 talk about how they'll call around when they need an MRI and  
8 get the best price and so forth, but I question whether the  
9 average consumer that's not inculcated with the economics  
10 would do that. Most people, when somebody says to you, we  
11 think you may have cancer and you need to have an MRI, and  
12 then they hear cancer, cancer, cancer, from then on and they  
13 don't hear anything else. So they're certainly not going to  
14 call around and do anything to delay getting what they think  
15 is the best answer.

16 I do think having some incentives such as  
17 differential copays on the basis of evidence base is a way  
18 to get people to be responsible and buy into the system.  
19 It's also important for people to have sources of  
20 information that they feel are credible.

21 We're getting better at it on the Internet and  
22 faster than I ever thought we were. There's an awful lot of

1 garbage out there, but there are four or five sites that  
2 anybody who knows much can go to and get pretty good  
3 information. But it's never going to be the case that the  
4 average consumer is going to be taking over all of this.

5           So I think what you have to find -- and I agree  
6 with Len -- is that you have to find a way for people to  
7 have trust. And if that trust is a website that has great  
8 information and steers them in certain cases, if that trust  
9 is the information they're getting from a health plan that's  
10 on the cutting edge -- and there are some out there who now  
11 send out information to people and say, here are your last  
12 six visits. This is what was done to you. You probably  
13 need to ask your doctor whether you should be taking this or  
14 that, or getting this test done. I think there are lots of  
15 different ways that can happen and will happen over time,  
16 but it is important to get the incentives right and not to  
17 expect that the incentives are going to be so broad on  
18 consumers that they are really faced with throwing up their  
19 hands and not knowing what to do.

20           The other thing that I think we need to do is  
21 begin educating people very early on. It's a big cultural  
22 difference as well. One of the reasons I'm convinced that

1 we are different in our spending than people in other  
2 countries is we have very different attitudes and  
3 philosophies about health care. We bow down to the God of  
4 technology -- and don't tell me that it is just because  
5 there is rationing in France. They don't like MRIs and  
6 they're just not going to have them done as often as we do.

7 I think that there are cultural differences that  
8 we need to think about whether or not those are the right  
9 attitudes in health care; that a pill will solve everything,  
10 just give me a solution when I leave the doctor's office.  
11 And if that means taking 25 tests instead of waiting a week  
12 to see if these symptoms just go away on their own, I think  
13 there a lot of things that we need to do that are really  
14 very basic in terms of people understanding.

15 That goes back to the whole issue of the most  
16 effective preventive services are usually those things that  
17 are lifestyle, that people can do for themselves.

18 DR. ANTOS: Easily spoken, hard to do.

19 DR. MOON: Yes.

20 DR. ANTOS: Marilyn is making excellent points.  
21 If you're sick, shopping around probably doesn't make a lot  
22 of sense at that moment. However, there was a time when you

1 could shop around and I think that's why there's been such  
2 an emphasis on choice of health plans. That's a sensible  
3 point at which most people can actually make a decision.  
4 But the problem is that then, getting locked into a health  
5 plan that might not actually be the plan you want.

6           So there's a lot to be said, I think, for trying  
7 to put more flexibility into Medicare and into the health  
8 insurance system in general. I think maybe this is more a  
9 comment about people who are trapped in plans by their  
10 employers than Medicare beneficiaries but I think it's a  
11 relevant point. If people got used to the idea of making  
12 real choices, as opposed to having a choice of two but  
13 they're the same plan, which is the norm, by the time they  
14 got to Medicare they might actually be in a position to be  
15 familiar with those kinds of choices that are in their power  
16 to make with some help, but nonetheless they can do it.  
17 They can buy televisions. They can buy into health plans.

18           As far as choosing your doctor, I think that's a  
19 tougher call. Choosing your medical home, that's a real to  
20 call because that could really matter to you.

21           So I don't think it's just a matter of what  
22 treatment you choose or a shopping around for the price of

1 your MRI. I think it's even more fundamental than that.  
2 It's just not easy. At the health plan level at least  
3 you're buying into a structure you can sort of understand.  
4 And if you've been there for a year then you know whether  
5 it's for you or not and you can move on. If you pick a  
6 doctor that's wrong or a medical home that's wrong you might  
7 not actually know it because you don't know enough.

8 DR. MOON: I'd like to just say one quick thing  
9 though in response to that. I think one of the worst policy  
10 decisions that was made last year in the prescription drug  
11 plan was to encourage people to use the plan finder to  
12 figure out how to save the most, which plan saves them the  
13 most at that point in time. Because that encouraged people  
14 on the basis of what they were taking in November for drugs  
15 when next July they might be taking a whole different  
16 panoply of drugs. And it encouraged people to choose plans  
17 that might look really good but turn out to be too  
18 restrictive when they find they need more.

19 I think we need to be very careful about how we  
20 provide these kinds of incentives to choose something as  
21 broad as a health plan. I think that the drugs are a really  
22 good case in point where well-meaning people were trying to

1 help folks make good choices but many, many people are going  
2 to find out after the fact made bad choices, even if they  
3 spent lots of time trying to make the right choice.

4 DR. NICHOLS: If I could just very briefly get  
5 back to the question of how to bring consumers into this in  
6 an appropriate way, I would submit a lot of what's been said  
7 I would agree with. I would also say, decision support  
8 tools are probably the single most important way to engage  
9 appropriately. I would submit the evidence that comes from  
10 some of the Wennberg team's work on how people with  
11 complicated choices, and the evidence is not so clear --  
12 that is to say, one versus this -- those people shown those  
13 options worked through by a first-rate clinician and then in  
14 conjunction with their local physician, their medical home,  
15 if you will, they made choices that were less invasive, less  
16 aggressive. Most people don't want that stuff unless  
17 they're more confident that it's going to work than we can  
18 often be. So I think that's the key to life.

19 Just 30 seconds on rebuttal to Joe because he was  
20 so good at jabbing me there at end. I would say, yes,  
21 picking your doc is hard. People manage to do it. Ninety-  
22 six percent of the Medicare population answers the question,

1 yes, I have a usual source of care. And 98 percent of them  
2 mean their medical physician home. So I submit, yes, you  
3 could get it wrong. But the point of this is to learn  
4 together. The point of this is to start where you trust and  
5 learn together.

6 I would submit, a great line came from a dean of a  
7 medical school who was in his sixties when he told me this a  
8 few years ago. He said, you know when I started my practice  
9 in internal medicine 35 years ago I really had to understand  
10 eight drugs, because that's basically how many we use in a  
11 garden-variety. There were 246 new ones last year. No  
12 human can know all that. You've got to learn this stuff  
13 together. Let's learn it where we trust.

14 MR. HACKBARTH: We are just about out of time but,  
15 Ron, you're going to have the last word.

16 DR. CASTELLANOS: Just a few seconds. First of  
17 all, I really appreciate you being here and I thought it was  
18 a great discussion and I really thank you for doing that.

19 I'm a practicing physician and my comments  
20 basically are the word trust. It's sort of like lawyers,  
21 nobody likes lawyers but everybody likes their lawyer.  
22 Nobody likes or trusts their health plan but for the most

1 part they trust their physician.

2           On the converse side of that, it's a lot easier as  
3 a physician when there is a trust and an understanding and a  
4 communication between the patient and the family. It's  
5 easier to help that person navigate the medical system.  
6 Sometimes it's hard to get into the system, but if you can  
7 get into the system with a trusting physician or health care  
8 it's easy to navigate. I may not know a lot about  
9 neurosurgery, but I surely know who to send that patient to  
10 and to be able to navigate that system.

11           I guess one of the real problems or questions I  
12 have as we race to the bottom, as we heard, do you think we  
13 as a society or do you think Congress individually as  
14 policymakers, do we really have the guts to come together  
15 and try to solve this problem? We've been talking about  
16 this for a long time. I know we're having this race to the  
17 bottom but I'm very, very concerned that we're just going to  
18 be talking about this for awhile.

19           DR. NICHOLS: I am in the think tank business and  
20 that means it's the time of season when presidential  
21 candidates come shopping for ideas. I'm at a centrist think  
22 tank. I manage to piss off both parties pretty much every

1 day, so I'm a bipartisan kind of guy. And I learned enough  
2 to know we've got to do it on a bipartisan basis. So  
3 anyway, I have both Republicans and Democrats -- four have  
4 come to me in the last few months -- and the two Republicans  
5 both asked the same questions and it's quite interesting.

6 The first one was, my aide has heard you talk  
7 about the moral case for universal coverage. What is that?  
8 And they listen and they pay attention because they're  
9 devout.

10 But the second question in some ways is more  
11 interesting, and that is, how can I make universal coverage  
12 consistent with Republican principles?

13 Now I'm not telling you to suggest I'm the smart  
14 guy that's going to give them the four-line sentence that  
15 will get us to universal coverage on a bipartisan basis.  
16 I'm telling you this because they're polling and their focus  
17 groups and their money guys are telling them, if you want to  
18 run in '08, by God, you've got to have a plan. Romney, God  
19 love him -- none of these guys are Romney -- put it on the  
20 map. And I submit to you that's because when they go to  
21 Iowa and New Hampshire what they hear on the ground, yes,  
22 we're worried about the war on terror, yes, we're worried

1 about gasoline prices and we sure would like more ethanol  
2 subsidies. But at the end of the day, how the hell am I  
3 going to pay for health care is what they're hearing, and  
4 that's why they're coming back with this.

5           So I submit to you, sir, because health care costs  
6 are growing so much faster than incomes it's becoming  
7 unaffordable at a level of the middle class that was not  
8 true in '91 or '92. So I don't know that we're going to do  
9 it next year. I don't know that we're not going to have  
10 some international disaster and we'll postpone it for four  
11 more. But you might have heard it, the boomers are coming;  
12 they're going to retire. It's going to happen in 2010,  
13 2011. So I submit to you, we're going to have to talk about  
14 it as an adult, an adult conversation, because the cost  
15 problem is so pervasive.

16           DR. KANE: What did the Democrats ask?

17           DR. NICHOLS: They wanted to know how to cover 18  
18 people and cost no money.

19           [Laughter.]

20           DR. ANTOS: I think there's another point to be  
21 made, which is that everybody has a financial interest one  
22 way or another in the health care system and there's a lot

1 of rent seeking in market economies. We're all rent seekers  
2 and what we've got to do, all the organizations and all the  
3 individuals have to realize that they're going to have to  
4 give up something. That's the hard part.

5 DR. MOON: I think the hard part is that we have a  
6 conspiracy at the moment that the consumers, the general  
7 taxpayers of the United States want to hear that we can get  
8 something for nothing, and politicians want to tell them  
9 that they can get them something for nothing. Until one  
10 side gives and doesn't get penalized for it, that's not  
11 going to happen.

12 I'm afraid I don't see it coming from the  
13 politicians. I see it has to come from individuals who say,  
14 for the right things, with the right controls, we're willing  
15 to pay. And until that happens I'm not very optimistic.

16 I wish I were because I think that that's a  
17 crucial thing and we're going to hurt ourselves by denying  
18 this for as long as we're going to deny it. But I think  
19 that's where we are at the moment.

20 MR. HACKBARTH: Thank you very much for your  
21 knowledge, your expertise, your humor. It's been very  
22 helpful. Thanks.

1           We are about 20, 25 minutes behind schedule. We  
2 will have a very brief public comment period before lunch.

3           I want to remind the commissioners though that  
4 after lunch we have another guest panel and because of that  
5 I'd really like to stay on schedule. So please come back  
6 right at 1:15; 1:15 is the scheduled start for the afternoon  
7 session.

8           We'll go to the public comment period, but let me  
9 just say a word about the ground rules. As always, we ask  
10 people to keep their comments very brief. If someone makes  
11 essentially the same comment before you, please don't feel  
12 the need to repeat it at length. Just say that you agreed  
13 with the preceding commenter.

14           Because of our time constraints today I'm going to  
15 limit comments to two minutes, so please don't take personal  
16 offense if after two minutes I cut you off.

17           MR. SCHONGALLA: My name is Tom Schongalla. I  
18 attended the first Commission meeting here some 20-plus  
19 years ago and I would like to bring something to your  
20 attention that you might want to examine. I was at a  
21 meeting, an international meeting where a hospital manager  
22 from Munich spoke about his budget, and he said his total

1 budget was \$220 million a year. A hospital manager from the  
2 U.S. at the same type hospital said his budget was \$1  
3 billion a year.

4 At some point you all need to go and look at  
5 similar settings in OECD countries and see why do 600-bed  
6 hospitals in these places cost so much less than the ours?  
7 Ten we need to put that out in the public arena.

8 We also need to explore why professors in these  
9 international settings earn so much less? Further, we need  
10 to see why the staffing is so different. Now that covers my  
11 two minutes but if you'd like to go more in those areas I've  
12 got more points.

13 I don't think you need to enumerate all the 600-  
14 bed hospitals in OECD countries. But you might want to list  
15 them and pick a sample of 25.

16 If I noticed anything in this commission is, I  
17 respect you but you are members of the industry, but you are  
18 the referee members. But there's been an absolute  
19 resistance in saying that providers are taking too much.  
20 We lay down in front of the providers all the time. But  
21 nobody wants to say that because you get skewered.

22 I work independently and I won't say who I work

1 for because it will cause flak. You need to examine that,  
2 and you need to lay out some numbers. If you want more  
3 points, let me know.

4 MR. HACKBARTH: We will reconvene at 1:15. Thank  
5 you very much.

6 [Whereupon, at 12:25 p.m., the meeting was  
7 recessed, to reconvene at 1:15 p.m., this same day.]

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1           So with that, let me briefly introduce our  
2 panelists. We're very fortunate to have all of them today.

3           I'll start with Steve Spear, who is a senior  
4 lecturer at MIT. I wrongly got that at Harvard Business  
5 School in your materials. He has changed places. And he is  
6 also a senior fellow at the Institute for Health Care  
7 Improvement. He has spent a fair amount of time of his  
8 focusing on different initiatives in reengineering and  
9 identifying the characteristics of them.

10           We also have with us Dr. Gary Kaplan from the  
11 Virginia Mason Medical Center in Seattle, Washington. He'll  
12 speak to their experience, why they sought to introduce  
13 reengineering in their system and its effects, so far  
14 anyway.

15           Lastly, we have Dale Compton here with us from  
16 Purdue University. He is a professor of industrial  
17 engineering there. Most recently he was a co-chair of an  
18 IOM panel on reengineering health care and he can speak to  
19 their findings and thoughts on the topic.

20           So with that, me turn it over to Steve.

21           DR. SPEAR: Good afternoon, everybody. Let me  
22 just start by saying it's an honored to meet so many

1 luminaries on the panel. And I'm really quite flattered  
2 that you're interested in the research and work I've done  
3 the last number of years.

4           For the sake of brevity, let me start with a very  
5 simple proposition and back it up. The proposition is that  
6 it's possible to deliver much, much better care to many more  
7 people at much less cost with much less effort. This  
8 doesn't require any re-regulation. It doesn't require any  
9 change in payment systems or anything like that. But the  
10 possibility and the potential to do so lies within the  
11 organizations that already deliver health care to Americans.

12           The proposition I'm making is not hypothetical.  
13 There's been ample proof of concept already. What I'll do  
14 is just very briefly summarize some of the results of proof  
15 of concept.

16           You have the opportunity to hear from Gary Kaplan,  
17 whose system has been one of the leading proofs of concept  
18 of this. So I'll defer to him the details. Let me give you  
19 a quick summary.

20           At Massachusetts General Hospital in Boston, in  
21 primary care, a team increased the efficiency of their flu  
22 shot vaccinations from six shots per staff hour to 30 over

1 the course of three two-hour sessions. In other primary  
2 care practice, they reduced by 80 percent the number of  
3 times patients had to call a second time to get a medication  
4 refilled.

5 In oncology, another team at Massachusetts General  
6 Hospital increased by almost 100 percent the number of  
7 patients who could go through on a daily basis the proton  
8 beam therapy. If I could just add a little bit to that,  
9 that my understanding is that for many patients who suffer  
10 cancer, proton beam therapy is a treatment of last resort.  
11 Everything else has failed before you get to this.

12 The device itself and the building in which it's  
13 housed is tens of millions of dollars. And essentially this  
14 team created another one for free.

15 At a hospital in Pittsburgh, a pre-surgical  
16 nursing unit decreased from seven out of 42 patients a day  
17 to zero out of 42 patients who were ready for their  
18 operations but didn't have blood work ready to continue.  
19 Other work was done to improve the dietary practice.

20 A hospital in Pittsburgh, UMPC Presbyterian, in  
21 the pathology lab, improved the efficacy of its diagnostics  
22 and cut by over 50 percent errors related to screening for

1 cervical cancer.

2           In intensive care, teams at the STRICU, that's  
3 Shock Trauma Respiratory Intensive Care, at LDS Hospital  
4 achieved superlative results by emphasizing processes around  
5 treating very, very sick people.

6           I'll talk in more detailed at the end of my  
7 comments about some work done in Pittsburgh, where the  
8 community as a whole reduced -- let me just back this up. I  
9 think it's something like a quarter million patients a year  
10 receive central lines for the quick delivery of medication.  
11 Of those, some very large percentage end up with what's  
12 called a central line associated bloodstream infection.

13           Hospitals in Pittsburgh reduced the rate of  
14 infection by well over 60, almost 70, percent, for the  
15 community as a whole, with some hospitals reducing the rate  
16 of infection by 90 percent. The cost in patient suffering  
17 was dramatically, dramatically less, and I'll talk to that.  
18 But there have been estimates about the cost of, the  
19 financial cost, of these nosocomial infections of anywhere  
20 between \$10,000 and \$70,000 per infection. So if you take  
21 the results that were averaged in Pittsburgh and multiply it  
22 out over the national rates, we're talking about billions of

1 dollars in savings. And if you take the results done at  
2 some of the superlative institutions and take that out, it's  
3 tens of billions dollars and even greater magnitude.

4 Let me talk a little bit more about how this  
5 happens, how you get these proofs of concept, and start with  
6 the basic problem that I perceive in health care, as someone  
7 who comes from to health care from an industrial  
8 perspective.

9 The problem is neither poor people nor poor  
10 science. There's no doubt that the science that is employed  
11 in health care is nearly miraculous, particularly from the  
12 perspective of a layman. The ability to cure diseases is  
13 just staggering. I don't think I'm all that old, but I know  
14 there are diseases and illnesses and conditions which, even  
15 when I was a young adult, let alone a child, were considered  
16 fatal. And now they've been reduced to chronic conditions  
17 or something that is easily treated.

18 So the problem is not the science, nor is it the  
19 people. It's that the systems in which these people employ  
20 great science are crummy. So what you end up having is that  
21 people work very, very hard to add value. And then, when  
22 the work they do is handed off to someone else, that value

1 is destroyed rather than added to. So the next person,  
2 rather than contributing more, has to do rework.

3 More specifically, the characteristics of lousy  
4 systems, systems in which people work very hard and then are  
5 forced to re-create value, then constantly creating more  
6 value, is that often there's deep expertise within  
7 functional areas. And certainly health care -- and again,  
8 it's the curse of success. As the science advances, it's  
9 necessary to have ever more deep knowledge within ever  
10 narrower disciplines. But the problem is in order to  
11 deliver care to patients, you have to integrate more and  
12 more of these narrow slices, these disciplinary slices into  
13 a harmonious whole. And lacking a process view, a process  
14 perspective and process expertise within the organizations  
15 that deliver care, what you end up having is having people  
16 within disciplines create great value and that value  
17 destroyed as its passed from one to the other.

18 So let me just talk a little bit more about how  
19 systems display these characters of deep expertise within  
20 functions and poor integration across functions.

21 There's one problem, which is in the design of the  
22 systems, which is that the disciplines or the elements, if

1 we think in terms of technical systems, the elements are  
2 developed and executed in isolation and not in terms of the  
3 relationships they have with the work that's done before and  
4 after. So that's the design of the systems.

5           Then there's an issue of the management and the  
6 improvement of the systems. And the characteristics of  
7 faulty systems are that when problems do occur because of  
8 this design of elements in isolation of the system as a  
9 whole there's a tremendous tolerance and almost an  
10 encouragement and dependency for people to work around the  
11 problems they experience.

12           It's not uncommon to see doctors and nurses and  
13 technicians and administrators starting to do work, knowing  
14 what they would need to do that work perfectly as it were,  
15 but encountering situations in where what they need is not  
16 there in the right form, the right quantity, the right time,  
17 the right place and having to somehow make do.

18           I think we're probably all familiar with people  
19 and organizations in which this ability to work around the  
20 deficiencies of a system not only are necessary but they're  
21 heralded. And that people get promoted and rewarded and get  
22 badges and pins and all sorts of notations for their ability

1 to work around the poor performance of the system of which  
2 they're a part.

3 I just want to emphasize the irony of this  
4 situation. It's not that you have good people compensating  
5 for the poor performance of bad people. You have good  
6 people compensating for the poorly preserved performance of  
7 other good people.

8 So what's the alternative to this? For this, I  
9 talk about a process perspective taken from industry, but  
10 especially as Dr. Kaplan will talk, applied with great  
11 success in health care.

12 The idea is not that you give up developing this  
13 tremendous, tremendous knowledge within disciplines. But  
14 then when the work is designed to bring that disciplinary  
15 knowledge to bear is designed, it's designed within the  
16 context of what proceeds and what follows.

17 And to make it more literal, imagine designing  
18 care not from the perspective of the oncologist, the  
19 psychiatrist, the internal medicine specialist, the GI  
20 specialist and so forth. But imagine designing -- and this  
21 is not imagine, this is actually what has occurred --  
22 designing work from the perspective of the point of delivery

1 of care to the patient, and asking the question what has to  
2 be in place, in what quantity, what form, what location,  
3 what time, for whom so that when someone goes to deliver  
4 care to a patient they can do it perfectly? And then you  
5 just do the decomposition backwards, which is if the person  
6 who is about to touch the patient and there are certain  
7 characteristics of the situation for the work to be done  
8 perfectly, and that's step N, what are the characteristics  
9 of step N minus one and N minus 2 and N minus 3, and all the  
10 way back as far as you might dare trace?

11           When approach is taken toward the design of work,  
12 designing the pieces in relation to the pieces, particularly  
13 pieces that follow and the pieces that proceed, you get  
14 much, much better performance out of people.

15           And then this other element. I mentioned before  
16 that characteristics of flawed systems are both in the  
17 design of work, designing pieces in isolation of what  
18 proceeds and follows. And then there's the deficiency in  
19 terms of improvement, asking people to work around problems  
20 when they experience them, rather than contain them and  
21 address them, investigate them and prevent their recurrence.

22           Characteristics of great, highly performing

1 systems then are not only that work is designed not in  
2 absolute isolated terms but in relative terms of what  
3 proceeds and follows, is that high-performing systems are  
4 very, very sensitive to when something is imperfect. So  
5 even the micro disturbance, the tiny little contrary  
6 indication of something different than expectations,  
7 triggers people to contain a problem so that it doesn't  
8 spread and infect other parts of the system. It triggers  
9 them to investigate the root causes, conduct a diagnosis of  
10 why the microproblem occurred, and then do some type of  
11 treatment to prevent the problem from recurring.

12           As you can see in my terminology, and we can  
13 discuss this later on, there are very, very strong analogies  
14 between what is the good design and operation and treatment  
15 of process systems and what's the good diagnosis and  
16 treatment of patients who are ill.

17           Let me just conclude with two things. One is a  
18 specific example around central line infections, and then a  
19 very brief recommendation.

20           The example is out of the experience of Allegheny  
21 General Hospital in Pittsburgh. This experience is reported  
22 in September's issue of the Joint Commission Journal on

1 Quality and Patient Safety.

2 In 2003 the cardiac critical care and medical  
3 intensive care units at AGH, Allegheny General Hospital, had  
4 approximately 1,700 patients. 37 of those patients suffered  
5 central line infections and 19 of those patients died.  
6 That's one in 100.

7 That realization, that the rate of both nosocomial  
8 infection and the serious consequences of those nosocomial  
9 infections was, I can say, devastating to the staff in the  
10 hospital. The reason I mentioned this being devastating is  
11 that many of these patients were released from the hospital  
12 and so the complications and the presentation of those  
13 complications happened outside of the hospital.

14 So it was only when they did this chart by chart  
15 review of every patient who is in their care in 2003 that  
16 they realized how unreliable the processes were around  
17 central line placement and maintenance.

18 In 2004, again on a patient population of slightly  
19 more than 1,700 patients, six patients suffered a central  
20 line infection as opposed to 37 in 2003. One of those  
21 patients died, as opposed to 19 in 2003. For 2005, the  
22 numbers are even better. It was more patients, more acuity,

1 more line days and lower rates of infection and mortality.

2 To take

3           So the question is how did the folks at Allegheny  
4 General Hospital get from the 2003 results to the 2004  
5 results? The first thing I want to emphasize is this was  
6 done entirely internally to the ICU and the cardiac critical  
7 care units. This didn't require help from Harrisburg or  
8 Washington.

9           The second thing I want to emphasize is that these  
10 staggeringly positive good results were gained over the  
11 course of two months of work. This was not a multi-year  
12 effort.

13           The effort itself was to keep -- and there's a  
14 certain irony here again and appropriateness here again --  
15 is that the folks who were very, very closely monitoring  
16 very sick patients, this is cardiac critical care and  
17 intensive care units, realized that they had to treat their  
18 work processes as very, very critically sick. And just as  
19 their patients were laced with all sorts of monitors to  
20 detect any deviation, any sign of abnormality, they realized  
21 they had to do the same for their processes.

22           And so over the course of several weeks they

1 watched every single time a line was placed and every single  
2 time a line was maintained to see what made the work  
3 difficult for the physicians and nurses responsible for the  
4 care for patients.

5           Along the way, they literally found dozens of  
6 factors that made it difficult to place lines correctly and  
7 maintain lines correctly in such a way that patients would  
8 get the benefit of the line placement, the benefit of the  
9 well-trained people employing miraculous science but in such  
10 a way that they wouldn't suffer the consequences of broken  
11 systems.

12           By watching every placement and every maintenance  
13 over the course of several weeks and responding to all the  
14 deviations, and especially the micro deviations, the folks  
15 at Allegheny General Hospital had to redefine some roles and  
16 responsibilities, certainly redefine and reengineer how  
17 certain hand-offs were made from one process step to the  
18 next, and then redefine and reengineer some of the methods  
19 used by the individuals. But as a result, they had these  
20 phenomenal results.

21           So let me just conclude with one recommendation.  
22 First the observation, that the current condition in health

1 care is that you have phenomenally well-trained, talented,  
2 bright, extraordinarily well motivated people bringing to  
3 bear incredible science. The problem is they're doing so in  
4 a system that doesn't do justice to their training, their  
5 efforts and their potential.

6           The reason for that is that there has been, and  
7 for very good reason -- I don't want to say anything  
8 disparaging -- for a very, very good reason, a long-term  
9 emphasis on deepening the knowledge people have within  
10 disciplines. But the problem is, of course, they don't have  
11 nearly the same level of process knowledge that we see in  
12 superlative leaders within industry and increasingly in some  
13 hospitals within health care.

14           So that's the problem is that the science drives  
15 depth of disciplinary knowledge but that the processes, in a  
16 sense vertical versus horizontal, the horizontal integration  
17 of the disciplines into a whole is done in somewhat an ad  
18 hoc kludge fashion.

19           So the countermeasure I'm suggesting is that the  
20 folks who have responsibility for processes, those who are  
21 about to become charge nurses, nurse managers, residents,  
22 chief residents, fellows, attendings and such complement --

1 not replace but complement -- the training they have  
2 vertically deep within their disciplines with some  
3 perspective and some knowledge of the science by which  
4 processes are designed and continuously improved.

5           The one point I want to address is that some might  
6 say this will add to what are already perceived to be long  
7 periods of training within the medical professions. The one  
8 thing I want to offer is the observation, and I and some  
9 colleagues have done studies and there's certainly many more  
10 studies, that for nurses, for example, of the time they  
11 spend on shift typically a third to at most half that time  
12 is spent actually caring for patients. One-half to two-  
13 thirds of that time is, as one nurse put it, spent caring  
14 for the system of which she's part, chasing down all the  
15 things she needs to deliver care to her patients.

16           Better processes, and many of these examples laced  
17 within that, better processes return extraordinary,  
18 literally extraordinary amounts of time to people. I would  
19 suggest -- and this is the one part of my statement which is  
20 somewhat hypothetical and not based on proof of concept --  
21 is that if you taught these skills to people, you would  
22 return so much time to them that you could probably reduce

1 the amount of time spent on training doctors and nurses  
2 currently.

3 I'll end there and welcome your questions later.

4 Thank you again.

5 DR. KAPLAN: Good afternoon. It's a pleasure to  
6 be here and tell you a little bit about our story at  
7 Virginia Mason.

8 We are very much embarked on a change journey. In  
9 fact, this journey has been ongoing now for over five years.  
10 What I'm going to tell you about is a very, very small  
11 subset of that journey. I have slides and I think you have  
12 a handout.

13 Our ability to continue to progress on the  
14 trajectory we are on actually depends on the ability to  
15 align our health care delivery systems with our payment.  
16 And so it's a real privilege and, I think, potentially  
17 turning point for our journey to have the opportunity to  
18 share our thinking with you.

19 We really have a dream at Virginia Mason, and this  
20 is a quote from our sensei, Mr. Nakao, in Japan. And our  
21 dream is that we can transform a single organization and in  
22 so doing potentially demonstrate how to transform an

1 industry. That's what's driving us.

2 We're not a huge multi-hospital system but we're  
3 not small either. We're an integrated delivery system  
4 tucked up in the Pacific Northwest which traditionally, as  
5 you know, has been a low-cost part of the country.

6 We're a not-for-profit entity. Our roots are in  
7 the group practice of medicine. We were founded in 1920 by  
8 physicians who came from the Mayo Clinic and the University  
9 of Virginia. They believe that physicians working as a  
10 teammate made more sense than physicians in their silos. So  
11 it's very much part of our culture. They soon built their  
12 own hospital, as opposed to the trend in recent years of  
13 hospitals going out and acquiring physicians.

14 We cover the Pacific Northwest. We're 5,000  
15 employees. And we have very much an academic mission.  
16 We're somewhat of an academic halfway house in that we're  
17 not a university by many of our faculty have come from  
18 academia. They want to teach. They want to do research.  
19 But they, most importantly, want to take care patients.

20 Our journey really, in many ways, stems from our  
21 board, my boss, a community public board who led our  
22 strategic planning process in 2001. This is our strategic

1 plan. I used to worry about putting it out in print, and  
2 then I realized you could get it on our website. This is  
3 it. It's all right here. I just want to highlight a couple  
4 of elements to provide context for this work.

5           It starts with the patient. Everybody in health  
6 care says they're all about the patient. We said that in  
7 2001, and our board said wait a minute, dig deeper, take a  
8 look at your processes. And as we did that, we found out  
9 that our processes are really all designed around us.  
10 They're designed around the doctors, the nurses, the  
11 managers, the caregivers. Just think about what are waiting  
12 rooms but they're wait states so you can hurry up, be on  
13 time and then wait for us.

14           Or if you realized what's happening with our  
15 precious resources on the weekends in our institutions.  
16 They lie fallow, things that would not be tolerated in other  
17 industries.

18           So we've redesigned our processes and our driving  
19 force is designing it around our customer. Our customer is  
20 not be admitting physician. Our customer is the patient.

21           What's our vision? What do we aspire to be? We  
22 aspire to be the quality leader. I'm going to tell you a

1 little bit more about that, because really this whole  
2 journey around reengineering is about quality. What we're  
3 finding, and this is a jump to the punch line maybe, but it  
4 used to be said you get what you pay for, you've got to pay  
5 more to get better quality. It's actually inversely  
6 correlated. If you take out cost by taking out waste, we  
7 are finding time and time and time again that we are  
8 delivering a higher quality, defect-free product.

9           And then finally, what I'm going to tell you much  
10 more about is a management method. As we looked around  
11 health care, when I took over as CEO in 2000, we looked at  
12 every management model we could find in health care and we  
13 didn't find anyone that we wanted to emulate. We found when  
14 I tend to call an ad hococracy of management, a little bit of  
15 this and a little bit of that.

16           Almost serendipitously, we discovered the Toyota  
17 Production System, which we now call the Virginia Mason  
18 Production System, and I'm going to tell you more about  
19 that.

20           In order to have massive change in health care,  
21 and I know in many ways you all are students of the need for  
22 change, you've really got to tackle some key issues. I

1 don't have about 20 talks in 10-plus minutes.

2 But you've got to tackle issues related to  
3 professionalism, professional autonomy. What is it that are  
4 the clear expectations? How do you create a culture of  
5 transparency? How do you create a culture of feedback?

6 Save for organizations like Permanent, that Jay is  
7 involved in, and some others around the country, most  
8 physicians never get any feedback. We're never trained to  
9 give it and we're certainly not trained to receive it.

10 At Virginia Mason every one of our physicians gets  
11 a 360 feedback evaluation every year. I only point this out  
12 because it's part of the foundational elements that have to  
13 be in place in order to have this level of change.

14 I was asked to comment on the applicability of  
15 what we're doing to other kinds of systems. And it's not as  
16 easy perhaps, although I feel like it's a huge stretch for  
17 us, it's not as easy perhaps in other types of systems. But  
18 I would say that the methods and the tools are directly  
19 applicable no matter where you are in the industry, or in  
20 any other industry for that matter, as Steve points out.

21 So we adopted the Toyota Production System because  
22 we were serious about achieving our strategic plan. We were

1 serious about our vision of becoming the quality leader.

2           Why the Toyota Production System? It turns out,  
3 to our thinking, it's the most highly evolved management  
4 method that currently exists in the world today. If you  
5 look at the Toyota Motor Company, which started as a weaving  
6 company at the turn-of-the-century, it is obsessed with the  
7 customer. That's what we want to be about. It's associated  
8 with unprecedented levels of quality and safety, has very  
9 high-levels of staff satisfaction, because it's the people  
10 closest to the work who understand the processes of the work  
11 that are redesigning the work.

12           And then, almost as a byproduct, it's associated  
13 with a very economic successful economic enterprise.

14           When we talk about quality, one of the things  
15 we've done is we've changed our definitions. This is what  
16 we call that Virginia Mason quality equation.

17           So quality: appropriateness, outcomes, safety,  
18 service divided by waste. That is used to say cost. The  
19 way we used to manage costs in health care was well,  
20 everybody whack 3 percent out of your budgets this year.  
21 Well, that was the roots of poor quality, worker  
22 dissatisfaction, and not focusing on the customer. But what

1 we're finding is that you take out costs by limiting waste,  
2 quality goes up.

3           You can do the best surgical procedure with superb  
4 outcomes, have very satisfied customers, no waste. But if  
5 the patient didn't need it to begin with, there's no quality  
6 there. And that's my appropriateness is a critical  
7 component of our quality equation.

8           What we found as we've studied the Toyota  
9 Production System is that in every industry where it's been  
10 applied, these are the magnitude of improvements that are  
11 achievable. What we're finding now, five years into this in  
12 health care, is we're able to achieve the same magnitudes of  
13 improvement: 50 percent reduction in labor costs or  
14 productivity improvement; greater than 50 percent  
15 improvements in throughput, defect reduction, inventory  
16 reduction.

17           What we see as the most important metric we're  
18 following now, lead time reduction. From the start of the  
19 process to the end of the process. If you shorten that time  
20 by taking out waste, you're taking out defect prone  
21 situations and processes that do not need to occur. We  
22 define waste as non-value added for the customer, non-value

1 added variation.

2           So in 2002, we said to our senior executive team,  
3 if you want to be a senior executive at Virginia Mason you  
4 have to come with us on this trip to Japan. And so I led a  
5 team of 32 senior executives to Japan in June of 2002.  
6 We've now taken seven trips of physicians, nurses, managers,  
7 front-line staff, working in the factories at the Hitachi  
8 Air Conditioning Corporation and the Toyota Motor  
9 Corporation

10           By the way, you don't want to buy an air  
11 conditioner built in June of 2002, 2003, 2004, or 2005  
12 because a bunch of doctors from Seattle built them.

13           But actually, we redesigned the processes. And  
14 what we found out is you didn't need to know anything about  
15 air conditioner manufacturing to redesign the work in a  
16 better way. At the end of the day they thanked us and they  
17 put in place our process improvements. And when we went  
18 back the next year they were still in place. A  
19 transformational experience.

20           So how are we applying this to health care? These  
21 are the basic themes: that waste and needless variation is  
22 a huge contributor to health care costs, that I believe more

1 than 50 percent of what we spend money on in health care  
2 today adds no value for the customer. The Toyota method is  
3 one method, and there are others, that speaks to us, can  
4 improve value and control costs. That when you bring  
5 together teams of stakeholders thinking, as Steve says,  
6 horizontally as opposed to vertically, you can reduce waste  
7 and make major steps in aligning reimbursement with value.  
8 And these improvements then become self-funding because  
9 you're taking waste and cost out of the system.

10           There's no shortage of health care dollars. We  
11 know the cost of poor quality. It is a huge driver of the  
12 cost problem in health care. Mary McClinton, some of you  
13 may have heard of. She was a woman who came to us two years  
14 into this work and we failed her. We failed her because of  
15 a defect in our processes. And she died from a preventable  
16 medical error at Virginia Mason. And we were two years into  
17 this work.

18           The cost of poor quality. The cost of delays. We  
19 wouldn't need so many parking spaces if we didn't keep  
20 people waiting so long to access their services. And on and  
21 on and on.

22           The next two slides are very important slides, and

1 they really speak to the requirement for standardization.  
2 That is a dirty word too many in the health care industry,  
3 the cookbook medicine.

4 Well actually, what we talk about is we talk about  
5 standardizing processes, taking the non-value added  
6 variation and standardizing it, which then gives us more  
7 time with our patients, more time to focus on the things  
8 that really add value. In fact, not 20 percent can be  
9 standardized but close to 80 percent or more of what's going  
10 on in health care today can be easily standardized.

11 When you do that, you can build in quality and you  
12 can build in speed. The result is better, faster, more  
13 affordable care.

14 This is our quality strategic plan, and this is  
15 not an insignificant slide. We all know, and I know you are  
16 students of evidence-based medicine. In fact, even this  
17 term guidelines is a problem for me. If you've got  
18 evidence, you know the best practice, why do we call it a  
19 guideline and imply that it's optional? But here it is,  
20 evidence-based practice. A third of what we do there's  
21 evidence. Two-thirds of what we do we've got good guesses,  
22 aggregation of anecdote, emerging evidence.

1           But even that, if you take that, that we have no  
2 double-blind controlled evidence, as well as what we do have  
3 evidence for, take the waste of the processes and still  
4 create standard work, you've got a better product. You've  
5 got a better, faster, more affordable care.

6           A very important concept because right now the  
7 lack of evidence has been taken as a license to do whatever  
8 you want. But if you actually standardize, you can then  
9 study it, measure it, improve it and develop evidence.

10           So what we've done at Virginia Mason now is we've  
11 educated all 5,000 employees in these methods. We're  
12 applying standard systems and doing rapid cycle improvement  
13 workshops, which we've done now over 400.

14           We're designing facilities using these methods, or  
15 I should say not designing facilities using these methods,  
16 because there are many facilities we thought we needed that  
17 we don't need. And the building boom in health care today -  
18 - I mean, we do need to do a few things on our campus -- but  
19 the building boom in health care today is like the arms race  
20 and it's out of control and is really questionable on terms  
21 of value.

22           We have what's called our patient safety alert

1 system, which comes from the stop the line process that we  
2 saw at Toyota on the very first trip. The results now of  
3 these methods are reduced production and labor costs,  
4 construction costs, and even in high variation providers,  
5 which are not appropriately in our organization any longer.

6 Here's an example. This is a schematic of a value  
7 stream from the start of a process to the end of a process.  
8 I happened to pick flu shots. Patients need flu shots.  
9 Look at the wait and delay. Wait on the phone, make the  
10 appointment, come in, drive, park, register, et cetera.

11 We analyzed the value stream to get a simple flu  
12 shot and what did we come up with? We drive in and have a  
13 drive-through flu shot window, basically. You stick your  
14 left arm, or if you're a passenger you're right arm, out the  
15 window and you get your flu shot. Look at all the waste  
16 that was in that simple little process.

17 We're applying this to the marketplace now and  
18 working in very innovative ways with employers in our  
19 communities, Starbucks, Costco, Alaska Airlines, who want  
20 the same things we want, better, faster, more affordable  
21 care. We're focusing on their diagnoses that are of the  
22 highest cost to them. We're using evidence-based medicine.

1 We're using our Toyota Production System methods and then  
2 cost accounting to align value.

3 Here's another example. This is uncomplicated  
4 back pain. This is the way it's usually -- this is the  
5 number one cause for patients to be out of work at  
6 Starbucks. Many people in this room, I'm sure, have  
7 uncomplicated low back pain.

8 Did you know that 60 percent of people with low  
9 back pain for two weeks or longer get an MRI? In fact, this  
10 is the way it's usually accessed? You wait to get care,  
11 then you go and maybe see your primary care doctor. You  
12 might get referred to a neurologist, if the neurosurgeon is  
13 thinking of doing something you'll end up getting an MRI and  
14 medications. And then maybe you'll get to the physical  
15 therapist. A perverse value stream full of waste and  
16 unnecessary cost.

17 What we did was we redesigned the value stream,  
18 working in concert with Starbucks. A patient comes in for  
19 back pain, they're triaged immediately in the spine clinic.  
20 Those who need MRIs, 6 percent, because of signs and  
21 symptoms, get them. Those who don't get immediately to  
22 physical therapy, and 90-plus percent of those people are

1 back to work with no time off of work. All these cost items  
2 are basically way down the value stream for those who need  
3 it.

4 We put this in place within three months  
5 conjointly with the employer. Waiting time was reduced  
6 from 30 days to one day. MRI utilization went from 42  
7 percent to 6 percent. Patient satisfaction soared. No work  
8 loss in 94 percent of patients. 73 percent didn't even need  
9 any drugs. The cost savings of 65 percent to the purchaser  
10 translates to millions of dollars to Starbucks every single  
11 year, et cetera.

12 The problem is the insurance company does better,  
13 Starbucks does better. Turns out the only place we made any  
14 money out of low back pain and had any kind of margin -- we  
15 do need margin as a not-for-profit -- is the MRI, which  
16 we're not doing anymore because it adds no value. PT has a  
17 margin of \$32. The MRI had a margin of \$450. This is fee-  
18 for-service medicine run amok.

19 Correction of the perverse incentives needs to  
20 occur. What Starbucks has done now is we're going to apply  
21 a portion of the savings from the MRI to pay you more for  
22 physical therapy to at least not disincentivize you from

1 doing the right thing or not doing the wrong thing. The  
2 total cost becomes self-funding.

3           We're doing this in migraine. We're doing this in  
4 heartburn. We're doing this in heart rhythm abnormalities  
5 and conjointly with employers in our community. We have 20  
6 value streams that we're doing this on right now that we  
7 would like to take live. The problem is that we might  
8 improve ourselves, take waste out of our systems into  
9 bankruptcy because the places where we have margin are going  
10 to go away unless we find a new way to get payment for  
11 value.

12           So what we've learned in one year, applying the  
13 Toyota Production -- this is in one year of work with  
14 employers and in five years of our work with the Toyota  
15 Production System. It's associated with improvement in  
16 quality, reduced costs, very high levels of customer  
17 satisfaction. 50 percent of health care costs are  
18 avoidable.

19           And once we take those out, I would suspect that  
20 we're going to continue to whack away at cost. Because  
21 Toyota is seeking perfection and they've been at it 60 years  
22 and they are continuing to do this every single day.

1           We need to change the payment system that  
2 separates the buyer and the seller and is misaligned and  
3 incentivizing the wrong things. And alignment of this  
4 reimbursement is going to be key.

5           We may want to think about bundling payments for  
6 episodes of care. We may want to think about bundling  
7 payments for chronic disease management. Frankly, we gave  
8 up on capitation because it was underfunded in the late  
9 '90s. I'd take it in a minute. I would guarantee to  
10 Starbucks, which we have, you give us all your patients at  
11 today's rates, you won't see a rate increase for the next  
12 five years.

13           But we got a guaranteed volume. We get those  
14 patients. We get the money to work with. And we will take  
15 waste and cost out of the system.

16           And frankly, it's about changing our mindset in  
17 health care. And I don't yet, Dave and others, tell our  
18 congressmen you're paying us too much because we can't solve  
19 the problem ourselves. But frankly, there's more than  
20 enough money in health care today. Our mindset needs to  
21 move from scarcity to abundance. It's just what we do with  
22 our money.

1           That's what we're learning at Virginia Mason,  
2 applying these methods to the market place.

3           It's a pleasure to share that with you.

4           DR. COMPTON: Ladies and gentlemen, thank you for  
5 the invitation to share with you some comments relative to  
6 the Joint Study by the Institute of Medicine and the  
7 National Academy of Engineering centered around what is the  
8 opportunity of bringing engineering methods to support the  
9 improvement in health care.

10           You've just heard some fine examples of how to do  
11 that. The Toyota system is certainly to be commended. It's  
12 one that I worked with while at Ford Motor Company for 15  
13 years and so it has enormous opportunities.

14           This report had a central question: can  
15 engineering assist in making the health care delivery system  
16 safer, more effective, patient centered, timely, efficient  
17 and equitable? You will recognize those as the six aims of  
18 the Institute of Medicine Report study in 2001.

19           If the answer to that question is yes, then how  
20 and why?

21           We had a committee of experts, the names of whom I  
22 will share with you in a moment. We had three workshops.

1 More than 40 health care providers and engineers presented  
2 their views and conclusions. One amongst those 40 was Dr.  
3 Milstein, who was very helpful for us.

4 The overwhelming conclusion was that ways should  
5 be found to attract more of the engineering profession into  
6 the study of health care delivery. In addition to the fine  
7 work that's been done already in engineering through  
8 bioengineering and biomedical engineering, we're really  
9 talking about engineers from a more broad categorization  
10 than just those two disciplines.

11 Why? Because engineering has a long history of  
12 dealing with large, complex and distributed systems. It has  
13 tools that can be used effectively to analyze and to  
14 optimize the performance of those systems.

15 Central focus for this study became the emphasis  
16 on systems. I might say a word about the definition.  
17 System can be many things. It can mean a laboratory within  
18 a hospital. It can mean an ambulatory clinic. It can mean  
19 a full hospital. It can mean a distributed system over a  
20 region. And as you draw the box larger and larger around  
21 that, the more complex it becomes.

22 And so we're talking about tools not to replace

1 the ones that you just heard about, which are terribly  
2 important for optimizing performance of individual  
3 activities. We're talking about tools that can address the  
4 more complex large systems groupings of individual items  
5 that make up the health care system.

6           System engineering tools have been used  
7 successfully in a variety of industries: transportation,  
8 manufacturing, finance and telecommunications to mention  
9 just a few. The focus is to improve overall performance  
10 including safety, cost and efficiency.

11           There's a special challenge in all of this. The  
12 health care delivery "system" -- and I put the word system  
13 in quotes -- was not designed as a system and it does not  
14 operate as a system. With a few exceptions, it is a  
15 collection of discrete entities that tend to operate large  
16 independent of each other. Oftentimes we refer to those as  
17 the silos that are essentially isolated from each other.

18           Key to understanding large systems. Recognizing  
19 the interaction of the many elements that compose that  
20 system and recognizing that changes in the one of the  
21 subsystems influences the performance of others.

22           It can be shown quite conclusively that optimizing

1 the sub-elements seldom, if ever, lead to optimization of  
2 the entire system. The condition that is needed to allow  
3 one to really optimize only the sub-elements is that all of  
4 the elements have to be completely mathematically  
5 independent. And that simply does not happen in real life.  
6 So optimizing the silos will not optimize the performance of  
7 the system.

8           In complicated highly distributed systems like  
9 health care, this requires the use of mathematical models  
10 that quantify the relationships among the many variables and  
11 the constraints that exist between those. For the health  
12 care delivery system, many of the tools used to create these  
13 models are derived from industrial engineering, including  
14 operation research/human factors and always augmented by  
15 information and communication technology.

16           The models allow the asking of what if questions.  
17 If we change the following what is the impact? If we  
18 redesign this activity, how does it impact the entire? What  
19 if, doing the tests mathematically prior to doing them in  
20 real life. And then measuring the productivity evidence,  
21 efficiencies and cost. The key issues here is that those  
22 mathematical models require reliable data, much of which

1 does not exist and has to be collected if one is to proceed.

2           These are some examples of application of system  
3 engineering tools to health care delivery systems. I'd like  
4 to just mention in detail a couple. We're working with an  
5 ambulatory clinic in Central Indianapolis. 40 percent of  
6 the patients at that clinic neither keep nor cancel their  
7 appointments. The scheduling problem is enormous. And one  
8 has to have these kind of models which couple into the  
9 demographics, into the reason people don't keep their  
10 appointments, before one can really design proper staffing  
11 and proper equipment.

12           Flow of patients through a facility. Use of a  
13 very simple mathematical procedure called queuing theory  
14 allows one to identify the following variables: how long  
15 does the average patient spend in the facility? how many  
16 patients are in the facility? What is the increase in  
17 efficiency if you add an extra person at an individual  
18 station in the facility? What are the bottlenecks? What  
19 does it take to break those bottlenecks?

20           With the collection of the data to allow this and  
21 its entry into a computer those answers can be obtained into  
22 seconds with an average sized computer these days using

1 queuing theory.

2 I've listed another group. I won't spend time on  
3 those in the current situation.

4 The importance of information technology for  
5 gathering data and distributing it. I list two different  
6 examples here that go well beyond that: communication of  
7 information between the chronically ill patient and their  
8 health care providers remotely. Remotely so that office  
9 visits are reduced. And the sensing and communication of  
10 critical variables from the homebound patient to the  
11 provider.

12 The question that is facing us now is what's the  
13 role of the Internet going to be, in terms of health care?  
14 How can we really use it effectively, other than as an  
15 information exchange medium?

16 One of the many recommendations in this report I  
17 would like to share with you, private insurers, large  
18 employers and public payers, including the Federal Center  
19 for Medicare and Medicaid Services and state Medicare  
20 programs, should provide more incentives for health care  
21 providers to use system tools to improve the quantity of  
22 care and efficiency of care delivery. Reimbursement

1 systems, both public and private, should expand the scope of  
2 reimbursement for care episodes or use other bundling  
3 devices to encourage the use of system engineering tools.

4           House Bill 4157, the Health Information Technology  
5 Promotion Act of 2006, is designed to spur health  
6 information technology by health care providers. It's not  
7 yet been passed except at the House. The Senate is still  
8 considering it. But the need to stimulate system  
9 engineering applications in the health care field is very  
10 similar to that of information technology. One would hope  
11 that a similar effort could be mounted to encourage health  
12 care providers and engineers to improve the application of  
13 system thinking.

14           Let me close with one caveat. We're not  
15 advocating converting the system engineer into a clinician  
16 or the clinicians into system engineers. But clinicians  
17 need to understand what questions they can ask of the  
18 engineers and then what to do with the answers when they get  
19 them back. And similarly, engineers need to know how to  
20 find the appropriate ways to use their system tools in the  
21 health care arena. They need to be able to talk to each  
22 other and understand each other's languages and the

1 constraints that each work within.

2           Communication is key to achieving this. We need  
3 to create an environment where engineers and health care  
4 providers can work collectively, interact closely and  
5 jointly discover how to improve the system. Joint  
6 involvement in demonstration projects and educational  
7 efforts and in the search for ways to diffuse results across  
8 many elements are needed.

9           Our study committee was jointly chaired by Jerry  
10 Grossman of Harvard and myself, Proctor Reid, Director of  
11 the Program Office for the National Academy of Engineering.  
12 These were our members of our study committee, many of whom  
13 would be known to you. And these are the organizations that  
14 provided support for that study.

15           Thank you.

16           MR. HACKBARTH: Thank you very much. Those were  
17 excellent presentations.

18           Arnie, do you want to go first?

19           DR. MILSTEIN: Thanks to all of you for an  
20 excellent presentation and for giving us all a sense of the  
21 order of magnitude opportunity that is before us if we and  
22 others who set Medicare payment policy can begin to elicit

1 this kind of mainstreaming of modern management science into  
2 health care delivery.

3           As I reflect on Dr. Kaplan's estimate of a 50  
4 percent rate of waste in current health care spending and a  
5 similar estimate from the IOM/National Academy of  
6 Engineering report, which is 30 to 40 percent wasted  
7 spending, and irrespective of whether or not the true amount  
8 of waste as a percentage of current health care spending in  
9 the United States turns out to be 30 or 50 percent, looked  
10 at on a one-time or static basis, it's a finite amount.

11           Just before lunch, all of us heard a description  
12 of what is the fiscal problem faced by Medicare in terms of  
13 saleability. As articulated to us, it's not just a static  
14 problem. I mean certainly if we took 30 to 50 percent, if  
15 we achieved a 30 to 50 percent reduction in how much we  
16 spend on the Medicare program while improving quality, it  
17 would postpone very far into the future the point at which  
18 we face the kind of crises that we now face relatively  
19 imminently.

20           But a time would come when what is basically a 2  
21 to 4 percent waste at which technology driven health care  
22 spending is outgrowing GDP would eventually catch up to us.

1           So my question for any of you is imagine a point  
2 in the future where somewhere between 30 to 50 percent of  
3 current wasted spending has been taken out of American  
4 health care due to the enlightened policies that MedPAC  
5 recommends to Congress. But now the waste that we see today  
6 is eliminated.

7           My question to you as is this tool powerful  
8 enough, once that initial static waste is eliminated, to  
9 generate two to four points of annual efficiency capture,  
10 which is what we, or any other stewards for Medicare will  
11 need to continuously align health care spending with our GDP  
12 growth?

13           DR. KAPLAN: Yes.

14           I'll just make a comment.

15           I think that what needs to happen is we need to  
16 change our minds about how we do our work. And so I don't  
17 know specifically, Arnie, if -- I'd like to get to the 30  
18 percent or the 50 percent. And then we can --

19           MR. HACKBARTH: Then we can worry about the other.

20

21           DR. KAPLAN: Yes.

22           But even to get to there requires the kind of

1 change of mindset that I believe would it lead us until new  
2 technology comes along. We can automate bad processes and  
3 then we can move -- excuse the phrase -- crap at the speed  
4 of light. But unless we automate redesigned waste-free  
5 processes, we won't be able to reach our full potential.

6           So we see this as a continuous journey. It's  
7 something that never ends and that we will always -- there's  
8 low hanging fruit. I think 20 or 30 percent is low hanging  
9 fruit. And then it's going to get a little harder, then  
10 it's going to get a little harder. But I think it's a way  
11 of thinking that will allow us to continue to identify  
12 opportunities and they will go beyond the big aggregate  
13 opportunity that we're talking about today.

14           DR. COMPTON: Arnie, one thing that I think we've  
15 seen over and over again in industry is that the changes  
16 that are being proposed, which are very real and very  
17 doable. But the success is fragile. And it's very easy to  
18 lose those benefits and to have to start over. Even Toyota  
19 has delayed recently production of their new models by eight  
20 to 12 months because their quality has slipped.

21           It's a very tough problem and you have to keep  
22 working at it constantly. But I think I agree entirely.

1 The answer is yes, you can have those kind of continual  
2 improvements if you have the right organization, the right  
3 mentality.

4 DR. SPEAR: If I could just add a brief comment in  
5 this regard, I'm reluctant to speculate as to what the  
6 impact on health care would be, but I have a frame of  
7 reference in industry. And so what Dr. Milstein was  
8 describing is one can think of two curves. What is the  
9 growth of the economy as a whole, and the other is the  
10 growth of health care. The problem is that health care, one  
11 is an issue of shifting the health care curve down. The  
12 second is changing the slope of that curve so it's not  
13 constantly creeping up on the economy as a whole.

14 The evidence out of industry is that the key  
15 differentiator between leaders in one industrial sector and  
16 everyone else is not a different process technology,  
17 different markets, or different products. It's that the  
18 organizations both have an inherent structure or  
19 architecture and then an ongoing dynamic of constant  
20 internal innovation and improvement. And that both the  
21 structure and the dynamics of innovation and improvement  
22 first lead to the extraction of waste out of processes, but

1 it's decidedly nonstatic because what's happening is this  
2 constant self-reflection, self-reinforcing introspective  
3 management of work so that waste is discovered. And with  
4 the discovery of waste comes the investigation as to why it  
5 exists in the first place. And with that investigation  
6 comes deeper knowledge, both of the disciplinary components  
7 but also the processes themselves. And with that knowledge  
8 comes greater functionality, efficiency and performance.

9           One only has to look across multiple industrial  
10 sectors to see whether it's semi-conductors following  
11 Moore's Law where every few years you have twice the  
12 performance at some fraction of the cost. In the auto  
13 industry, where one would expect those curves to have been  
14 diminished, industry leaders continue to provide greater  
15 functionality providing what is now standard -- what used to  
16 be options -- with greater reliability at far less cost.

17           So the underlying thing, and it is a very, very  
18 fragile organizational dynamic, as the professor has  
19 suggested, is managing work and work processes as if they're  
20 critically ill. And just as you take critically ill patient  
21 and monitor them and every time there's a deviation from  
22 normal you diagnose the cause for that deviation, treat it,

1 and prevent it from manifesting itself as symptoms. You do  
2 the same thing for work processes.

3 When that's done what ends up happening is a much  
4 deeper knowledge of how to conduct work. So you get both  
5 the shift in the curve and the change in its slope.

6 MR. HACKBARTH: Anne, could you put up page 11  
7 from Dr. Compton's package? It's the page that has the  
8 recommendations from the IOM National Academy report?

9 There's a list of, for example, changes in payment  
10 policy that would be compatible with and support this sort  
11 of work. And it resembles MedPAC's list of things to do.  
12 We're very much in sympathy with these directions in payment  
13 policy.

14 A problem, of course, is that there's another  
15 kludgy process, namely the political process, that makes it  
16 more difficult to do some of these things than to conceive  
17 of them.

18 My question is this: within the existing  
19 admittedly flawed payment mechanisms, it seems to me that  
20 there are still opportunities for providers of various types  
21 not only to do these things but to be rewarded for doing  
22 them. In some cases, as Gary says, clearly the payment

1 system is an obstacle. We take away the profitable business  
2 and you end up doing more of the unprofitable.

3 But for an example, under the inpatient hospital  
4 payment system for Medicare patients, there is a substantial  
5 bundle and an opportunity for the hospital to benefit from  
6 improved processes. Yet we see relatively little of this  
7 work, too little of this very important work. For me, that  
8 raises the question, in addition to payment barriers, what  
9 are the other barriers and what recommendations or  
10 suggestions would you have in particular for Medicare to do?

11 That's for anybody and everybody.

12 DR. KAPLAN: I think you're exactly right. We do  
13 have better alignment on the inpatient side and the  
14 improvements have been slow in coming.

15 I think the focus, even on the inpatient payment  
16 premium, the pay for performance programs, has been on small  
17 incremental enhanced payments for doing the right thing,  
18 aspirin for acute MI and all of the metrics that we have in  
19 place now and the CMS pilot project and others, pay-for-  
20 performance initiatives.

21 I predict that those are small incremental  
22 improvements. They're not insignificant from a hospital

1 executive standpoint. But from the individual clinical  
2 decision-making standpoint, they're pretty low on the radar  
3 screen from those who order the tests and the connectivity  
4 between that payment.

5 I would suggest that we also take a look at  
6 rethinking about pay-for-performance, not just to pay for  
7 doing the right thing where eventually, within the next few  
8 years we will aggregate so it will be almost indiscernible  
9 whether you're at a 98 or 99 percent compliance rate with  
10 doing the right thing, to incentivizing payments to not do  
11 the wrong thing. And to calling out what are the commonly  
12 done wrong things that add no value.

13 They're omnipresent and they're high yield areas  
14 that are actually not just part of the cost problem but part  
15 of the quality and defect problem.

16 So by studying and identifying those things and  
17 then incentivizing those much is you're doing with pay-for-  
18 performance today, you can make a big difference.

19 The other things, though, I think it has to do  
20 with changing the minds of leadership. It's not all about  
21 us. But one of the things we have is we have a model, a  
22 structure, a committed leadership team, and very engaged

1 physician leaders. I think that's what it's going to take  
2 because in the final analysis the clinical teams need to  
3 think horizontally, they need to think about waste, and you  
4 need to engage them. That's not an easy thing to do.

5           That's why when I say our work is very much a work  
6 in progress, we're five years into it and I get tested every  
7 single day. Are you serious about this? Do you really mean  
8 it?

9           So I think those are the kinds of issues, and I'm  
10 not saying that's within the purview of this body. But  
11 those are the kinds of challenges we face, the issues around  
12 professional autonomy and what does that mean? And is being  
13 a professional the same thing as being autonomous? It  
14 actually is not, to my thinking, but it is to the minds of  
15 many professionals.

16           Those are just some random thoughts.

17           DR. COMPTON: May I give a slightly separate  
18 answer because I'm not involved in the hospital  
19 administration end, so therefore I can't really speak to it  
20 that way. I think you have to recognize that there's two  
21 levels at which we're talking about participation of people  
22 in terms of improving the system.

1           What you've heard about are some outstanding ways  
2 and successes in doing it in terms of the management of the  
3 system, in terms of the physicians and the nurses. But  
4 there's another level. And that level is does the medical  
5 profession respect the engineering profession to have  
6 anything to bring into it? At the moment, the answer is,  
7 except in a few locations, the answer is no.

8           And so one needs an extra incentive to try and  
9 begin to build that relationship, to demonstrate its value,  
10 and to then begin to diffuse it out into the system. So we  
11 really have to recognize that there are several levels of  
12 barriers here.

13           DR. KANE: Actually, my questions are pretty close  
14 to Glenn's but I wanted to get back to Steve, who made a  
15 point, I think, of pointing out that the central line study  
16 at Allegheny was done by internal forces that had nothing to  
17 do with Harrisburg or Washington.

18           I'm just curious to know A, why you said that?  
19 And whether you think, therefore, that Harrisburg or  
20 Washington have no role in motivating these types of  
21 changes? What is the best way to change leadership? Are  
22 you suggesting that this has to come from within or from

1 employers? Poor Arnie is going to be a busy fellow if he's  
2 the source of all of this.

3 I hear that the need to change medical education  
4 may be part of it. So where does Albany or Harrisburg or  
5 Washington, where does the government fit into this, other  
6 than as a payer?

7 DR. SPEAR: You put me on the spot as to making  
8 recommendations to people who have jobs which are more  
9 complex than my own.

10 What I meant by my statement about the folks at  
11 Allegheny General Hospital is that there is extraordinary  
12 potential within the walls of the hospitals themselves to  
13 make change. And I think this point that those within the  
14 medical profession -- and again it's very understandable.  
15 Sometimes the things I say may come across as disparaging  
16 and I don't mean it that way.

17 I have a very close friend and colleague --  
18 colleague first and friend because we've worked together so  
19 long, who's a cardiologist. At one point he was challenged  
20 by his eight-year-old daughter who said Daddy, I start the  
21 third grade today. What grade did you go to?

22 And he started running through primary education,

1 secondary, pre-med, med school, residency, fellowship, a  
2 masters degree in physics because his specialty is not just  
3 cardiology or angioplasty but laser angioplasty. It added  
4 up to about 27 or 28. And he said well, I guess I went to  
5 the 28th grade.

6 Of course, his eight-year-old daughter wasn't  
7 impressed, and said well, I start the third grade.

8 But the point of the example is that he had to go  
9 to 28 grades and he has to continue to study within his ever  
10 more narrower or ever deeper discipline to remain on the  
11 cutting-edge of science, which advances at a rampaging rate.

12 The problem, for my friend is that when he went  
13 through the 28th grade, and I don't what the graduation  
14 looks like, if you get another diploma. But when he was put  
15 in charge they said Dr. Schmidthoffer, congratulations,  
16 you're in charge of the care for these patients for this  
17 month. And he said what do you mean? They said you have to  
18 make sure they get good quality care.

19 Now he knew, as someone who had treated patients  
20 and consulted to others, that the care of patients depended  
21 on doctors and nurses, so that's a professional distinction  
22 right there. There's an expertise distinction between the

1 students, the residents, the fellows and the attendings.  
2 There are other distinctions between the cardiologist and  
3 the cardiologist with particular knowledge and the  
4 psychiatrist who might be called in for a consult, the  
5 oncologist, whoever might be called in for a consultation.

6 And he said well, I have knowledge within my  
7 discipline but I don't have knowledge about integrating  
8 across these disciplines. The answer was well, you'll you  
9 figured it out. Now that's a rather inadequate answer.

10 It gets to this point about people who have  
11 developed very, very deep expertise, realizing that there's  
12 an expertise in integrating parts into a coherent whole.  
13 And that is a change which can occur within units within  
14 hospitals and within systems and doesn't necessarily depend  
15 on the intervention of Albany, Harrisburg or Washington.

16 That's not to say that intervention by those  
17 parties and those authorities couldn't help and might move  
18 things faster but they're not necessary to some of the  
19 successes we've been reporting on today.

20 DR. KAPLAN: I think government has got a  
21 significant role to play. What is government? It's the  
22 voice of the public. It's the voice of the patient, whose

1 the customer.

2           And so while I agree that a lot of this bubbles,  
3 the means to this lies within the walls of the hospitals and  
4 within the walls of the profession. But the willingness to  
5 pursue it, and it is so formidable, there needs to be a  
6 catalyst. There needs to be incentive to change.

7           And I think that the bar needs to be raised  
8 higher. The American public, the people paying the bills,  
9 whether it's CMS representing the American public or the  
10 employers in today's marketplace, need to raise the bar and  
11 then not disincentivize the leaders, who will then create  
12 potentially a new marketplace.

13           I want what we're doing, frankly, to be  
14 competitive advantage and then I want to keep moving. Like  
15 Toyota says, we'll Nissan, we'll teach Honda, we'll teach  
16 Ford Motor Company and then they can chase our taillights.

17           So I think that the role of government is not  
18 sufficient. It's necessary but not sufficient. But I think  
19 it's got an important role to play.

20           DR. SCANLON: You just made the point I was going  
21 to make. I think what Steve is talking about, in some  
22 respects, is the how. Government's role is not getting into

1 the organization and dealing with the how this is going to  
2 be accomplished. But the issue of government is the why.

3 I was going to point out that in Pennsylvania it's  
4 one of the few states where there is quality reporting by  
5 hospitals and nosocomial infections was one of the areas  
6 that they have been interested in over the last few years.

7 So it's create a why. Why is a hospital  
8 interested in doing this? It's because there's going to be  
9 some accountability at a public level for this.

10 DR. CROSSON: I'm going to wander along the path  
11 that Glenn was wandering on also, so Gary get ready.

12 First of all, as somebody who's spent a lot of  
13 time in a funny pre-paid delivery system trying to support  
14 engineering change, engineering practice change, I have to  
15 say I'm amazed actually by what you've presented because  
16 you've had to do that in a system where, as you say, the  
17 payment incentives -- your own success in the end of your  
18 group practice and your hospital aren't necessarily aligned  
19 with that.

20 So I guess the thought for me is if you could  
21 imagine a way, and you've been trying to get as you said  
22 some of the larger employers in the Seattle area to see the

1 light and to help you by reengineering the payment system  
2 and the payment incentives at least.

3           If you could imagine, because I think you started  
4 out with the comment that you first have to dream about it  
5 before you can do it. If you could imagine a way that over  
6 time the Medicare payment system, and I mean both to your  
7 hospital and to your physicians, could be changed to fully  
8 support the reengineering capabilities that you have, what  
9 might that look like?

10           DR. KAPLAN: I think about it, but I obviously  
11 don't have that magic bullet answer. But I'll tell you, I  
12 wish I was in your payment model. I wish I had capitation.  
13 We, at Virginia Mason, had our own health plan in 1997, 1985  
14 to 1997. And we sold it because we're not in the insurance  
15 business. And it was underfunded, frankly, based on our  
16 AAPCCs for the Pacific Northwest and we found ourselves  
17 losing money and it was before we discovered how to do this  
18 work anyway.

19           But today, I would rather have pre-payment that  
20 was consistent and care for populations of patients and be  
21 able to then take the waste out of the system and reap the  
22 benefits.

1           I think that we have a huge window of opportunity  
2 and I think that it's going to take some demonstration  
3 projects along these lines that will then help prove that  
4 there's a better way and then get other people to get on  
5 board with this.

6           Frankly, you said that you were surprised we were  
7 able to do this. There are a lot of things we can work on  
8 with these methods. We can work on our internal costs. In  
9 fact, that's what our CFO wants to work on. He wants me to  
10 say we're going to work on our internal costs. We're not  
11 going to deal with the sharp edge. We're not going to  
12 eliminate more MRIs.

13           Because an internal costs, no matter how we get  
14 paid, whatever you or Medicare or the employer community or  
15 the single-payer system or whatever comes, we're going to do  
16 better if we've got our internal costs as low as they can  
17 be.

18           But the cat's out of the bag for us. Our  
19 clinicians have seen that there's better, faster, more  
20 affordable care. Nobody wants to spin their wheels and  
21 waste their time.

22           We just have to figure out and make our choices as

1 to what we're going to work on. I think that's the dilemma  
2 we face right now.

3 MR. HACKBARTH: Gary, are you folks in the group  
4 practice demo?

5 DR. KAPLAN: We have not been a participant to  
6 this point.

7 MR. HACKBARTH: I was just wondering. That's  
8 hardly full prepayment, but it gets a little bit closer in  
9 the sense that there's an aggregate total cost target, some  
10 opportunity for sharing in savings. I wonder how much of an  
11 advance that is.

12 DR. KAPLAN: It's partial prepayment. I think  
13 more relevant would be the DRG payment system on the  
14 inpatient side and how we just really need to focus on where  
15 our DRG opportunities, and they're huge, too.

16 MR. BERTKO: I'm going to ask a question that  
17 would hopefully help us think about where we, as MedPAC,  
18 should put our focus.

19 I live in the West and I'm very appreciative of  
20 all the large group practices there. But I work for an  
21 insurance company that covers the Midwest, southwest,  
22 Southeast, where the vast bulk of the practices are small

1 single practice, single specialty or just small groups. And  
2 Gary, both you and Steve cited what I think I interpreted as  
3 fairly large hospital systems where these are most  
4 effective.

5           So my question is do you have any thoughts about  
6 A, can we extend this to small groups of physicians  
7 practicing? Or B, because of this 30 to 50 percent number,  
8 should we as MedPAC be focusing on hospital systems, and  
9 particularly large hospital systems, as the first place to  
10 start? And then maybe somewhere down the road, five years  
11 from now when we have EMRs and all of that, focusing on  
12 docs?

13           Any thoughts you have would be helpful.

14           DR. KAPLAN: I'd ask Jay Crosson. Jay's working  
15 on a project that we're participating in to some extent  
16 called the Council of Accountable Physician Practices. And  
17 basically his premise is that the group practice of medicine  
18 is a better model for patients.

19           MR. BERTKO: First, I agree with that. But we  
20 ain't going to be there until the next century.

21           DR. KAPLAN: So the question is either how do you  
22 get there or what do you do in the meantime? And I don't

1 have an easy answer.

2 I do know that what are the aggregators? The  
3 aggregators are hospitals, they're group practices, or even  
4 insurance companies. And so potentially, I mean you ask  
5 what's the value add of the insurance industry? They're  
6 claims processors. They're supposed to organize the  
7 marketplace for us, if there was such a thing as a  
8 marketplace. But they're aggregators.

9 So I think that may be a place to focus. On our  
10 fourth trip to Japan the CEO and COO of Primera BlueCross of  
11 Washington and Alaska came with us. We invited them to join  
12 us because we believe that we can't do this by ourselves.

13 So they're actually working on projects now of  
14 taking out waste in claim submission processes and those  
15 things.

16 So I think thinking of whatever the logical  
17 aggregator is in a given community, it may be the hospital.  
18 It could be the senior citizen center. I don't know.

19 But trying to find a price were you can get people  
20 to come together for a common purpose and then begin to talk  
21 about these horizontal linkages, because that's, I think,  
22 where the rubber meets the road, as Steve said.

1 DR. SPEAR: I'd like to share an observation  
2 listening to the conversation here. Dr. Kaplan, in his  
3 organization and some of the other organizations which I  
4 cited, have been working very, very hard to be Toyota-like  
5 in terms of their internal operations, managing their work,  
6 the integration of the pieces into a whole so that they're  
7 reliable in the short-term and highly innovative and self-  
8 improving over the longer haul.

9 One of the things that strikes me, and this gets  
10 to a difference between Dr. Kaplan's situation and that of  
11 my friends at Toyota, is that the folks at Toyota are in a  
12 situation where anyone can walk in, look at a Camry, compare  
13 it to a Taurus, both in terms of quality and price, and then  
14 have a decision and on a choice to make about the  
15 transaction in which they engage. And there's a certain  
16 irony the Dr. Kaplan was describing efforts over the last  
17 several years within Virginia Mason to get the operations to  
18 look more like Toyota.

19 And what strikes me by his comments is now he's  
20 trying to create internal private markets for the very good  
21 work that's being done in the absence of very good markets  
22 external to his organization.

1           MR. HACKBARTH: We're getting short on time so  
2 three more.

3           MR. DURENBERGER: Thank you all, the three of you,  
4 for your individual comments, for what you do for a living.  
5 It always reminds me that the Mayo Clinic had a famous doc  
6 by the name of Plummer out there who was an engineer. And  
7 they were one of the most efficient operations in the  
8 country until he died. They named a building after him,  
9 then they forgot what he taught them for a long, long period  
10 of time. So I was glad to see Denis Cortese was back on  
11 your study.

12           My big aha here today was thinking about -- and  
13 I'm going to use this -- optimizing the silos will not  
14 optimize the system, and thinking about within, whether it's  
15 Virginia Mason or it's Alina or one of our local systems in  
16 Minnesota, there are all these silos within the hospital  
17 system.

18           And so along comes a bunch of silos, the specialty  
19 surgical hospitals, the heart hospital, the independent  
20 radiological center. Here come all these silos. And the  
21 reaction of the hospital industry do that is to say well,  
22 this is unfair competition and all of the rest of that sort

1 of thing, not realizing that their so-called full service  
2 community hospitals are a bunch of silos which you have  
3 learned -- all three of you -- have learned or taught people  
4 to break down.

5           It seems to me the response to the competition, if  
6 you will, from specialty facilities is to eliminate the  
7 competition within your own organization or the isolation  
8 within your own organization, which will make you just as  
9 efficient or more efficient, if the data that we get from  
10 our staff is right, than all of these doctor-owned,  
11 orthopedic doctor-owned, cardio doctor-owned. So that was  
12 my aha.

13           My question is in response to what the chairman  
14 and, I think John, also referred to, and that is the  
15 difference in the country and how we learn from each other  
16 and things like that.

17           The greatest opportunity right now is to  
18 demonstrate what it takes to get the job done for you is not  
19 in a physician payment demonstration or in some of these  
20 other -- you know, if you change diabetes by so or whatever  
21 it is you get one percentage point. It really lies in the  
22 646 demonstration, which is something we should all be

1 paying more attention to. We have an application in to have  
2 the whole upper Midwest go into some kind of a prepaid  
3 system. It's so beyond any bureaucrat at CMS we'll probably  
4 have a hard time -- now that Mark's gone, to convince  
5 anybody that it's a great idea.

6 But if you take Kings County, not just Virginia  
7 Mason. If you took Kings County and included your  
8 competitors and so forth, and you thought about that in the  
9 context of what would some form of a demonstration which  
10 would allow basically the savings that accrue over a period  
11 of time to each of the contributors to whatever your goals  
12 are for the county, to stay with those institutions in some  
13 way. Would that not provide the kind of incentives that  
14 everybody in your community needs?

15 I know you want to have them chasing your  
16 taillights, but they still will because you'll be the  
17 leader.

18 DR. KAPLAN: Actually some of you may know about  
19 the Puget Sound Health Alliance, which was started by Ron  
20 Simms, our Kings County executive. So there's another what  
21 I would call natural aggregating force, would be local  
22 government or regional government. But we've got employers,

1 the government, the public sector, all of the hospitals, all  
2 of the insurers now have signed on to this.

3 Now it's only a year old but it's starting with  
4 defining the metrics in the data and creating transparency  
5 around that.

6 But that's fine with us because we think what will  
7 come of that will be incentives to do the right thing and to  
8 not do the wrong thing. And the score will be all about  
9 execution. And so those within the demonstration that are  
10 able to execute will win and those who have trouble with  
11 that won't.

12 So I think the competitive thing is one thing, but  
13 I think you're right that we have an opportunity within an  
14 entire community right now. Unfortunately we've seen, and  
15 Arnie knows about this, we've seen other experiments like  
16 PBGH in California doing some good work but also coming  
17 face-to-face with a lot of barriers.

18 So I'm hopeful, and we're very engaged in that  
19 Puget Sound Health Alliance Project and that's another  
20 aggregator that we should look to.

21 MS. BEHROOZI: I also want to thank the panel for  
22 really stimulating and thought-provoking presentations that

1 have really helped me think about some concepts I'd like to  
2 introduce into the organization that I run, which is not a  
3 health care system. But what we do is provide health care  
4 coverage for health care workers in New York City  
5 represented by a union that works with many of the  
6 managements of the hospitals where we represent the workers.  
7 Those workers range from dietary workers and housekeepers  
8 through supply clerks, lab techs, pharmacists, RNs -- not  
9 physicians.

10 We work with many of those hospital managements on  
11 initiatives to improve quality, reduce waste. One of them  
12 that comes to mind is an initiative where with the supply  
13 clerks and the OR clerks and the purchasers and everybody  
14 sitting down together, they figured out how to reduce the  
15 procurement and supply time period from something like 26  
16 days to two days or something like that.

17 Dr. Kaplan, I wondered if you could comment. Your  
18 presentation focused very much on the physicians who are the  
19 drivers of so many of the choices, of course, that are made  
20 in a health care delivery system. But in terms of the  
21 ultimate quality and efficiency and waste, I think actually  
22 Steve Spear's examples that he uses kind of intimate that

1 there a lot of other layers of activity that goes on that  
2 influence those outcomes.

3           So I wonder if you could comment on whether you  
4 have processes in place to receive that input and change  
5 those behaviors at those other levels?

6           DR. KAPLAN: Absolutely. As I mentioned, my  
7 comments are really a very, very small subset of -- we could  
8 talk for days about what we were doing. One of the things I  
9 wanted to highlight was we've trained all 5,000 employees in  
10 these methods. So supply chain management, for example, or  
11 set up production, finance and billing, information systems  
12 processes.

13           One of the things we've said is we're not going to  
14 do this on a project basis where we're going to work on  
15 diabetes and after we fix that we're going to apply the same  
16 principles to asthma, and then we'll apply the same  
17 principle to heart disease. We said this is the way we're  
18 going to run the whole organization.

19           Which then tore down instantly the silos that  
20 we've been talking about and forced us to think and  
21 decentralize as they've done at Toyota so that you can have  
22 finance people working in the Cancer Institute and not in

1 just a centralized finance department.

2           So we've had almost 500 workshops that have  
3 engaged in everything from soup to nuts. And I only wanted  
4 to emphasize the physician piece because without changing  
5 the minds of the physicians, you will constantly run up  
6 against that. And you may have the best management in  
7 materials management, supply chain, human resources and  
8 everywhere else in your infrastructure, but it won't go  
9 where it needs to go without the physician component of it.

10           I think much of the opportunity, just inventory,  
11 inventory turns, one of the metrics. People think we don't  
12 have a lot of inventory in health care. Well, we've got a  
13 ton of inventory in health care.

14           And if we had just what we need when we need it  
15 where we need it, instead of all this inventory, we wouldn't  
16 have to build storerooms and then we wouldn't have to build  
17 warehouses and then we wouldn't have to hire people to  
18 manage the inventory. That's all waste if you're working  
19 with your suppliers, which we're now doing, to get us just  
20 what we knew when we need it. They want the same thing we  
21 want.

22           So it's fascinating. I think your point is well

1 taken, it's way beyond the physicians.

2 MS. DePARLE: I'll be brief.

3 I found this presentation to be fascinating and  
4 really stunningly this inspiring. I guess, Dr. Kaplan too,  
5 I want to thank you for coming here and talking about Mary  
6 McClinton. I don't know that I've ever heard someone come  
7 and talk about a patient who did not have a good result at  
8 his or her institution. It takes a lot of integrity and a  
9 lot of guts to do that and I think we all appreciate that  
10 you did that.

11 John and I were exchanging this enthusiasm and I,  
12 on the one hand, are excited by what I hear you say. On the  
13 other hand, I have been around Washington a while. And I  
14 guess I wonder, even if Washington isn't the answer, you've  
15 been involved in the Medical Group Management Association I  
16 noticed, which Jay -- aren't you involved in, as well? And  
17 Nick.

18 But you're not as involved, it looks like, in the  
19 major hospital organizations. So I'm kind of curious about  
20 that and what you think.

21 There's what, 5,000 community hospitals, 6,000?  
22 What percentage, if you were just guessing, of them could do

1 what you've have done? It is doable, as Steve sort of  
2 suggested, you can do these things? I'd love to know what  
3 you think about that.

4 DR. KAPLAN: Oh, I think it's doable. I'm an  
5 unmitigated optimist. But they're very interested. So our  
6 roots are in the group practice of medicine. Then we built  
7 the hospital, as I said.

8 In the past couple of years I've had the  
9 opportunity to speak at the leadership conferences of the  
10 American Hospital Association, the leadership of Governance  
11 Institutes. There's an amazing amount of interest.

12 I think hospital administrators, I guess I am one  
13 sort of, are a little bit different breed than group  
14 practice people. In many ways, the customer is the  
15 admitting physician. Or how do we keep the physicians under  
16 control kind of thinking. I think that's actually a dynamic  
17 that's ongoing.

18 But I think they're beginning to realize, whether  
19 it's the competition from the specialty hospitals, whether  
20 it's the doctors who are trying to pull all of the margin  
21 generating activities out of the hospital, that they've got  
22 to operate from a different paradigm. They just don't know

1 what that should be.

2 So we are, and others, trying to help them.

3 NIHI, which Steve is a senior fellow in and we've  
4 been involved in. We'll be presenting our five-year results  
5 there are in December at the annual forum, it's heavily  
6 hospital. And up to this point it's been heavily hospital  
7 quality people, quality improvement people, nurse managers,  
8 people who are passionate. But they're at the middle of the  
9 organization. They've said we just can't get the attention  
10 of our CEOs.

11 So they've got something called the CEO Forum,  
12 which we've presented at and are participating in, that has  
13 occurred now for several years. You can just feel the  
14 momentum building in that group.

15 So I think it's happening. It's slower but it's  
16 not without hope.

17 MS. DePARLE: Do you find that patients do want a  
18 Toyota? Are patients coming because of what you're doing?

19 DR. KAPLAN: They're very interested. I still  
20 practice, albeit not as much as I used to. My patients say  
21 something's different. I barely got to sit down and open  
22 Good Housekeeping. And so I think they are seeing a

1 difference and they're seeing that it doesn't -- we've got  
2 the metrics. It doesn't take Toyota to do this or process  
3 improvement. But they answer the phone, I get a human  
4 voice, I get my lab results within 24 hours, that kind of  
5 thing. So they're taking notice.

6 DR. REISCHAUER: This has been a fantastic panel  
7 and I think we've all learned a lot that should help us.

8 I want to make a Maoist comment here. And that is  
9 I'm listening to the description of the kinds of changes  
10 that can occur and what their implications are for resource  
11 use. And there is one category which is, let's say  
12 inpatient care which, because of the reengineering, we have  
13 nurses waste less time, there's less inventory, et cetera,  
14 et cetera. In other words, your costs go way down.

15 From Medicare's standpoint, no matter what your  
16 costs are we're going to pay you the same amount and it's  
17 determined somewhere else. So you should be a real happy  
18 camper on that group.

19 Then there's a second group, let's take the  
20 outpatient example you gave of the flu shot. The amount of  
21 resources you have to put in to sticking the flu shot into  
22 the person's arm as he drives by has gone way down, you can

1 do 1,000 a day rather than 100 a day. Maybe Starbucks will  
2 say I'll only pay you 90 percent as much, but still you  
3 should be okay. In fact, quite happy there, too.

4           And then third, there are the groups of things  
5 where because of the efficiencies, because you're doing  
6 something right, the person doesn't show for the cardiac  
7 surgery where the profit margin was 40 percent. And if  
8 there aren't enough people who really do need that kind of  
9 service then maybe you've taken a hit.

10           But it strikes me in this whole area there's  
11 really a tremendous opportunity for you to internalize  
12 savings and keep them. Maybe you share them with Starbucks  
13 or the insurer that's sending you there. Maybe you're  
14 sharing it with your staff or something like that. But  
15 there are, and have been all along, huge incentives to do  
16 this. And yet it hasn't taken place.

17           What's going on here? My Maoist comment is is  
18 everybody really too fat and happy? What if we just went  
19 out and cut payments by 30 percent and said some of these  
20 places have shown that they can do it. You better learn how  
21 to do it, too. Or is it because the institutional social  
22 structure is so complex within the average hospital that, as

1 Steve was saying to me, there is the CEO and he has a  
2 secretary but nobody else really reports to him. There's  
3 the physicians and they're sort of part of the hospital but  
4 not really part of the hospital, floating out here. And  
5 it's just a very, very hard thing to manage change on.

6 Why is it that there aren't more of you?

7 DR. SPEAR: Let me offer a bit of speculation on  
8 this. I think we've all encountered the term when something  
9 goes wrong well, that's health care. I don't know what it  
10 happens to be, but that always seems to be the fallback  
11 position.

12 There are a whole lot of issues around incentives  
13 certainly and regulation certainly and payment which would  
14 probably make the situation better. But I want to come back  
15 to the example of my colleague, Dr. Schmidthoffer with the  
16 27 grades of education and the bratty third-grader of a  
17 daughter.

18 He didn't realize that there's a science, to which  
19 Dr. Compton was talking about, that there's a science of  
20 designing and improving processes. He knew there was a  
21 very, very deep science around cardiology, angioplasty and  
22 laser major angioplasty specifically. But he didn't even

1 know there was a science out there. And so for him, the  
2 design and improvement of the processes by which care was  
3 delivered was ad hoc, it was improvisational, it was kludge.

4

5           It was a huge enormous revelation for him to  
6 discover that there is a science of process, a science of  
7 delivery. And if that science is learned and mastered that  
8 one affect great change, much higher quality at much less  
9 cost. The comment he made which sticks with me is that  
10 through much of his education he thought that he was  
11 battling disease and that the patient was the battlefield.  
12 When he realized that there was this science of process  
13 design and science of process improvement, he realized he  
14 was actually engaged in treating people.

15           DR. KAPLAN: I don't know if why there aren't more  
16 people doing this work, other than they didn't realize it,  
17 they don't feel the need to change. I think there is no  
18 burning platform in many places for change. I don't want  
19 you to cut payments 30 percent. Because I think what will  
20 end up happening is places like ours will potentially being  
21 drastically hurt. But I think we've got to find a way to  
22 create the compelling case. I think it's talking about how

1 bad care is. I mean relatively. I'm very proud of American  
2 medicine. I'm a product of it. But how much better it  
3 could be and how we can't sustain this cost escalation.  
4 Frankly, it's happening already. The cost shifting that's  
5 going on to the employees in most employer-based health care  
6 systems.

7 I think the public's going to have to demand it.  
8 It's going to have to be, in some ways, a political solution  
9 that's going to force people to get off the dime. I don't  
10 know.

11 MR. HACKBARTH: 10 seconds or less, Arnie. We're  
12 25 minutes behind.

13 DR. MILSTEIN: In a number of ways, you have each  
14 said incentives aren't enough. Actually, over the last few  
15 minutes you've said what's missing is knowledge and  
16 education. Medicare is a major funder of health  
17 professional education in this country, but has thus far  
18 steered far clear of linking any conditions on how those  
19 medical education dollars get spent.

20 I'm going to give you another chance to maybe just  
21 respond as to whether or not this might be a way in which  
22 the government could play a useful role.

1 DR. KAPLAN: I have to respond because we just had  
2 this conversation yesterday. Do you know that in teaching  
3 hospitals -- and we're a teaching hospital -- it's the least  
4 trained people between the hours of 6:00 p.m. and 8:00 a.m.  
5 that are taking care of patients and making critical life-  
6 threatening decisions? It's a big deep dark secret of how  
7 medical education happens in this country.

8 And we're saying that really it needs to be co-  
9 managed. That being on your own as an intern is not a right  
10 of passage. But that's how it's become.

11 And so we need to rethink how we educate. What  
12 we're saying is that one of the criteria for our 150  
13 residents to complete their training at Virginia Mason is  
14 they have to participate in rapid process improvement  
15 workshops and learn the methods of tools of LEAN.

16 Now that may keep some residents from coming to us  
17 but I think at the end of the day they will feel like they  
18 got better training and it could be an asset for our  
19 training program. And I think you've got to move upstream.  
20 And Medicare has the power to do that.

21 MR. HACKBARTH: Thank you very much, very helpful,  
22 very interesting.

1 Dr. Compton, thank you.

2 I'd like the record to show that although the vice  
3 chairman is a Maoist, the chairman is not.

4 DR. REISCHAUER: I sit at the feet of the  
5 chairman.

6 MR. HACKBARTH: Our next agenda item for today is  
7 SNF quality measures. Kathryn, you'll handle the  
8 introduction?

9 MS. LINEHAN: We're going to talk about measuring  
10 SNF quality.

11 I'm happy to introduce Dr. Andrew Kramer, who's  
12 the Head of the Division of Health Care Policy and Research  
13 at the University of Colorado at Denver Health Sciences  
14 Center. He's also the Peter Shaughnessy Endowed Chair in  
15 Health Care Policy and Research in the Department of  
16 Medicine. He has authored more than 90 publications and  
17 major policy reports. And his research primarily focuses on  
18 quality and outcomes of care for critically ill older  
19 persons.

20 He's here today to discuss a paper that he and his  
21 colleagues wrote for MedPAC that examined the effect of  
22 small patient populations and low-frequency events on the

1 stability of SNF quality measures, avoidable  
2 rehospitalization and discharge to the community.

3 This paper was intended to investigate whether  
4 SNFs had enough short stay patients to yield a stable  
5 measure of quality at the facility level.

6 I'll turn it over to Dr. Kramer.

7 DR. KRAMER: Good afternoon.

8 I guess I'd like to begin by just highlighting  
9 that this presentation is really about performance  
10 measurement in skilled nursing facilities. I hope, over the  
11 course of this, it will become increasingly clear how if you  
12 examine certain critical performance measures in skilled  
13 nursing facilities you can understand better the role they  
14 play that can truly affect hospitalization and whether  
15 individuals get home and have far reaching implications in  
16 the health care system. But in the past, those things have  
17 not been examined as performance measures in a very  
18 widespread manner.

19 First of all, by way of background, there are  
20 15,000 skilled nursing facilities currently. The numbers  
21 have been declining slightly, but these are Medicare  
22 certified skilled nursing facilities. They treat 2.5

1 million Medicare beneficiaries per year.

2           The only publicly reported quality measures and  
3 the way quality is monitored in these skilled nursing  
4 facilities come from the 2002 nursing home initiative, for  
5 which there are 15 quality measures. If you were to look  
6 at, for example, the nursing home survey you'd find very  
7 little emphasis on post-acute care. They don't even sample  
8 post-acute care patients in the existing nursing home  
9 survey. So this publicly reported quality measures are sort  
10 of intended to get at this.

11           Of them there's only three that deal with post-  
12 acute care. They are delirium, pain and pressure ulcers.  
13 Well, delirium and pain are measures of 14 day prevalence of  
14 delirium and pain. Pressure ulcers is a five/14 day change  
15 measure.

16           There are ongoing criticisms about validity,  
17 coding and risk adjustment issues with the MDS. But what  
18 I'm particularly concerned about with these measures is they  
19 require this 14 day MDS. The 14 day MDS is actually only  
20 present on about half of Medicare SNF patients. And there  
21 is attrition that varies from one facility to the next. And  
22 this biased attrition actually has serious implications for

1 how a facility looks on these publicly reported quality  
2 measures. And we'll talk more about that later.

3 That is one of the big issues. So one needs to be  
4 considering other measures that are more widespread, more  
5 influential, more critical for skilled nursing facility  
6 patients.

7 The two alternative measures we're going to  
8 discuss are based on both claims and baseline MDS. They  
9 don't depend on the 14 day MDS. One of them is  
10 rehospitalizations for potentially avoidable causes, which  
11 is a key role that skilled nursing facilities play.

12 The other one is discharge to community.  
13 Recognize that 78 percent of skilled nursing facility  
14 admissions receive rehabilitation services. And one of the  
15 major goals is discharge to the community.

16 So again, if SNFs are failing in these two major  
17 areas, and people are either going back to the hospital or  
18 they're not getting home, they're failing in their major  
19 roles.

20 So our purpose was, first of all, to optimize risk  
21 adjustment for these two measures. Then we wanted to go and  
22 address these issue of minimal sample size, which is always

1 a concern. Then we wanted to go on to discuss definitional  
2 issues. And finally, I think you're going to see some  
3 fascinating trends in these measures once you take into  
4 account all these methodologic issues.

5 The sample we used was not really a sample. It  
6 was the universe. We used all SNF stays from calendar year  
7 1999 through 2004. So we have this five-year period,  
8 actually. We had over 11 million valid stays and we linked  
9 them.

10 If you look at facility characteristics, they are  
11 kind of as you would expect, the skilled nursing facility  
12 characteristics, where you have disproportionate numbers in  
13 urban and hospital-based and large providers. What's  
14 particularly interesting is that this 8 percent of  
15 facilities that have 25 percent -- 25 stays of fewer,  
16 actually have less than 1 percent of the total stays. And  
17 then there's these big ones, a quarter of the facilities  
18 with 200 stays. They account for 55 percent of the stays.  
19 So there's this distribution of patients.

20 Our two measures were defined in the following  
21 manner: community discharge were individuals who were  
22 discharged to their home or assisted living, multiple

1 sources. But basically they didn't go on to a long-stay  
2 nursing home or a hospital and they did not die.

3 Rehospitalization within one day of skilled  
4 nursing facility: we really looked at five major conditions,  
5 much like the way you approach the ambulatory care sensitive  
6 conditions for quality measurement in the ambulatory care.

7 The literature really suggests that these are the  
8 major causes of hospitalization and over half are  
9 potentially avoidable. And so we looked at electrolyte  
10 imbalance, heart failure, respiratory infection, urinary  
11 tract infection and sepsis, bacteremia, from one of these  
12 infectious sources. And a composite measure of any of these  
13 five. And deaths in the interval of the measurement were  
14 excluded.

15 These are just raw rates when you pool all  
16 patients of these measures at 30 days and 100 days. And  
17 what you can see from here is that between 30 days and 100  
18 days the rate of community discharge does go up. By 100  
19 days you see about 38 percent going home. And for the re-  
20 hospitalizations for potentially avoidable causes, you can  
21 see they have varying frequencies. Any of the five  
22 conditions actually accounts for up to 17 percent of re-

1 hospitalizations. And that's actually three-quarters of the  
2 hospitalizations for any reason. So these potentially  
3 avoidable causes, for which there is a potential -- you can  
4 have an impact -- actually account for a large proportion of  
5 the hospitalization.

6           So how did we go about risk adjustment? Well, we  
7 used a combination of MDS and claims data. We used  
8 variables related to demographics and advance directives and  
9 function and cognition, services, comorbidity, and really  
10 spent quite a bit of time on the comorbidity issue and used  
11 both an index and diagnoses.

12           We also used hospital-based freestanding as a risk  
13 adjuster. The reason we did is because there's this sort of  
14 unexplained variation in patient characteristics that you  
15 can't get at with all these other issues.

16           And we ended up with models with C-statistics,  
17 definitely in the 0.7 to 0.8 range. Those are you that are  
18 familiar with the coronary artery bypass graft comparison  
19 surgery, when they used risk adjustment models similar to  
20 this for public reporting, that's the range of their C-  
21 statistics from there ROC curve. So these models have a  
22 very strong fit for the data.

1           We use the same procedures that are used widely  
2 for risk adjustment. The sample size estimation, I'm afraid  
3 this is an area that is really not done very thoroughly in  
4 quality measures. It was not done in quality measures very  
5 effectively for the nursing home ones. And in many reported  
6 measures, people don't really do it.

7           We actually used three different methods, and I'm  
8 not going to go through all three methods with you in  
9 detail. The bootstrapping, the second method, is probably  
10 the most traditional method, but we also looked at two other  
11 methods. Of course, one of the risks of using three methods  
12 is that if they don't agree you have to choose which one  
13 you're going to go. So most people try to avoid that. In  
14 our case they actually converged very nice, and so we felt  
15 very strongly, very comfortable with the conclusions of  
16 them.

17           But what these methods yield in this case is we  
18 looked at the mean standard deviation of multiple samples in  
19 this bootstrapping technique, for example. And you can see  
20 from this slide that if you start way down at samples of 10  
21 stays, the mean standard deviation is extremely high. So  
22 there's a lot of variability if you have samples of just 10.

1           If you go on to 12, that drops pretty rapidly. If  
2 you go on to 14 it drops, 20 it drops. You're on a pretty  
3 fast decline there in the early phases. You get to around  
4 25 and the drop is pretty modest. You don't gain a lot  
5 after 25. And this is for 30 day measures, 100 day  
6 measures. I have graphs that look just like this, actually,  
7 for the other two methods. So we were pretty confident that  
8 25 stays was a pretty good denominator size.

9           Well, with 25 stays, you only use 10 percent of  
10 facilities and less than 1 percent of stays. So really,  
11 these measures are really very robust and you don't lose a  
12 lot of facilities with them.

13           We also engaged in a number of measure  
14 definitional issues. We looked at 100 day versus 30 day  
15 measures. We like the 100 measures better in the end,  
16 although you're going to see there's some interesting  
17 information you get from 30 day measures, because they had  
18 greater stability over time. They were more normally  
19 distributed. There were fewer facilities with no occurrence  
20 of an event. And facilities with no occurrence of an event  
21 are hard to deal with.

22           We found that the rehospitalization measures

1 actually worked well as a composite. And this was very  
2 pleasing. There was very good correlation among the  
3 condition specific measures, principal components found a  
4 single factor, similar covariates, greater stability. So  
5 once again that was very good.

6 We also found advantages of the one-year reporting  
7 window. The reporting window is the period of time over  
8 which you pool the data. So we found that if you went to  
9 six months you lost 25 percent of facilities. But if you  
10 stayed at a year you actually only lost that 10 percent and  
11 you didn't really gain much by going beyond a year.

12 So here we get to sort of the punch line of all  
13 this. Once you've create these new measures you can start  
14 to look at risk adjusted trends at the facility level over  
15 time.

16 First of all, the first row deals with the 30 day  
17 community discharge rates. You can see between 2000 and  
18 2004 those declined from 27.6 percent down to 23.9 percent,  
19 a 13 percent relative decline.

20 Now it's interesting when you go to the 100 day  
21 measure you don't have that kind of decline. So what that  
22 says to you is that of the people being discharged to the

1 community, they have longer lengths of stay over time than  
2 they did in the earlier days. It's taking more days to get  
3 them out. They're not getting out in 30 days as frequently.  
4 But they are getting out by 100 days.

5 We'll talk a little later about some of the  
6 potential implications of that.

7 One of the most striking and extremely concerning  
8 results is the rehospitalization composite. You can see  
9 that in 30 days between 2000 and 2004 we go from 9.5 to 13.4  
10 percent rehospitalization in 30 days, a 51 percent increase.  
11 And in 100 days it goes from 11.8 to 17.1. So we have this  
12 alarming increased rate of rehospitalization.

13 Very few performance measures change anywhere near  
14 that rate, and particularly ones with as many implications.  
15 I mean rehospitalization rates then put people back in the  
16 hospital, result in significant hospital costs, lack of  
17 community -- slower rates of community discharge are  
18 critical.

19 So these findings, once you have these key  
20 performance measures, raise issues about why aren't we  
21 monitoring these things in skilled nursing facilities? I  
22 mean, if these are the major functions of what skilled

1 nursing facilities are trying to do for people who are  
2 unstable and are discharged from the hospital, what are the  
3 incentives in our current system question for  
4 rehospitalization and community discharge? What are the  
5 implications? What can we do to remedy the situation?

6           So the conclusions here, and then I'd like to  
7 discuss a little bit some of the inferences, these risk-  
8 adjusted measures for community discharge and  
9 rehospitalization for skilled nursing facilities, I would  
10 argue are more robust, less gameable and more appropriate  
11 than the present post-acute quality measures. And yet, the  
12 others have been reported since 2002. And we'll discuss one  
13 of the ways they actually create perverse incentives for  
14 rehospitalization.

15           These measures are stable in facilities with 25  
16 admissions, excluding only 10 percent of facilities and less  
17 than 1 percent of stays. They actually include 90 percent  
18 of patients. Mostly you exclude those that die. And so  
19 once again you have a very widely applicable measure.

20           Between 2000 and 2004 length of stay increased for  
21 patients discharged to the community. And between 2000 and  
22 2004, rehospitalization increased by 45 percent.

1           Let's talk implications for a minute, and then I'd  
2 like to open it up for question and answer and discussion.  
3 Some of the conjectures we have on the rehospitalization  
4 side, which actually a second study is being funded by  
5 MedPAC to look at this issue further because of the  
6 implications.

7           One of the first issues is whether acute hospital  
8 length of stay may be contributing to this in some way. You  
9 know, there's been declining acute rehospitalizations, acute  
10 hospital lengths of stay. The problem is in the recent  
11 years it's going down about 1 percent a year. So maybe we  
12 get a 5 to 6 percent decline over the last five years. I'm  
13 not sure you can make too much of that case.

14           Another one is over this period there's the  
15 skilled nursing facility prospective payment system that's  
16 really been in place where the incentives in that system are  
17 not to take care of sick patients in the skilled nursing  
18 facility. You know that the most poorly reimbursed groups,  
19 according to providers, are where you have a lot of non-  
20 therapy ancillary services where you require a lot of  
21 medications and you require respiratory therapy. So the  
22 incentives for treating bad infections with third-line

1 antibiotics are not going to be terribly great for a nursing  
2 facility.

3           And at the same time you've got the physician  
4 issues, physician reimbursement for how much they're going  
5 to go to the nursing facilities.

6           But in particular that SNF PPS, if there's not an  
7 incentive for the nursing facility to keep them, it's pretty  
8 easy to send a message to the doc when you call them at  
9 night that this person is too sick and we can't take care of  
10 them. So that's a big one.

11           Another one is the quality measures themselves.  
12 Think about a quality measure. I'm running a facility and  
13 I'm coming up to 14 -- I admit people, and I start to get  
14 patients who have delirium, bad pain, progressing pressure  
15 ulcers. Do I want to keep them in the facility so my  
16 quality measure looks worse? Or do I want to get them to  
17 the hospital as soon as I can? And then my quality measure  
18 is actually going to look better because the people that  
19 stay in my facility are actually the people that are the  
20 better ones.

21           We don't know yet how much facilities are  
22 responding to the publicly reported to QMs. We don't know

1 how much consumers are responding to them. We don't know  
2 how much facilities are responding to them. But the current  
3 quality measures with that selection bias encourages you to  
4 discharge as fast as you can people who don't look good and  
5 hold onto people who do look good, which is the flip side of  
6 it.

7           If these people are well reimbursed, if they're in  
8 the rehab groups which get the highest payments and they  
9 will look good on your quality measures, there's no reason  
10 to rapidly let those patients go. And so maybe that's why  
11 lengths of stay are not as low as they once were. So those  
12 quality measures are actually working in potentially  
13 perverse ways, as is payment.

14           A couple of other issues that are worth thinking  
15 about, and it's hard to know. The hospital-based  
16 freestanding one is always a fascinating one. You know  
17 there's both sides to it. There's the sort of selection  
18 bias in hospital-based facilities. There's also the  
19 argument that gee, maybe they do certain things better and  
20 people keep somebody in a hospital-based facility rather  
21 than rehospitalize them because have a transitional care.  
22 It's a transitional care unit, doctors can get there, nurses

1 can get there.

2 But as you do know, the number of hospital-based  
3 units is dropping and it's dropping pretty steadily. And so  
4 one of the questions that we'll be exploring is are  
5 rehospitalization rates changing when you stratify for  
6 hospital-based versus freestanding providers?

7 Another issue is staffing and the extent to which  
8 nursing home staffing is getting worse over this period.  
9 Some of our other work shows a very strong relationship  
10 between rehospitalization rate and staffing levels of all  
11 types of staff and staffing skill levels, not just how many  
12 CNAs do you have and total levels but RNs and experienced  
13 RNs that aren't turning over frequently. And so if that  
14 situation is getting worse, again you're going to drive up  
15 re-hospitalizations.

16 So it's a multifaceted problem but it's a serious  
17 problem. And certainly one way to address it is the way  
18 they're trying to address it in pay-for-performance, where  
19 they have this array of quality measures that are going to  
20 be used for paying facilities. And the one that's going to  
21 be weighted most heavily, actually, is hospitalization  
22 because that's where the pool of money is going to come from

1 to pay the incentives. So it's going to be a critical  
2 measure for pay for performance.

3 That's certainly one way to do it, put an  
4 incentive in place and see what providers do. But public  
5 reporting is another way.

6 So at this point I guess I'd be curious on  
7 people's thoughts and take questions on the issues.

8 DR. MILLER: Let me just do one thing before we go  
9 to the questions, and this is for the public and for any of  
10 the new commissioners.

11 There's obviously the sort of what's going on here  
12 aspect to all of this. But the other way that this work  
13 fits into what we've been doing is a year and half ago we  
14 made a set of recommendations on pay for performance for  
15 various areas, hospitals, physicians, and other areas. One  
16 of the areas that we didn't feel prepared to move forward on  
17 was skilled nursing facilities because the measures were so  
18 general to nursing homes we weren't sure that we were really  
19 capturing the experience of the skilled nursing facility  
20 patient.

21 That surfaced the issue of well, if they're not  
22 serving tremendous amounts of patients can you, in fact, put

1 together measures and stable enough measures to use it in a  
2 pay for performance system? And that's what brings us to  
3 this presentation.

4 So the other ball to keep your eye on here is  
5 moving forward are we going to be looking at these measures  
6 and feeling that they're robust enough and stable enough to  
7 then move forward and start making recommendations on pay  
8 for performance in skilled nursing facilities?

9 MS. BEHROOZI: I guess I want to start with where  
10 Andy ended. When I was reading your paper, I put little  
11 stars next to the places where you identify the issue that  
12 you just mentioned, which is that increased hospitalization  
13 rate, rehospitalization rates, may be associated with  
14 growing staffing shortages and increases in staff turnover.  
15 You say that same thing at least three different times in  
16 here.

17 And while it's not quantified, it seems like --  
18 referring back to the more, I guess, developed pay for  
19 performance and quality measure scheme that's been developed  
20 on the hospital side, there are both process and outcomes  
21 based measurements. And so the staffing ratio and the  
22 training of staff seems like the perfect kind of process

1 measure that you could put in next to these outcome  
2 measures. You'd capture that additional 10 percent of  
3 facilities that you couldn't otherwise capture. You would  
4 control for some of that distortion that you were talking  
5 about in a purely outcomes based system where the incentives  
6 would be to hide the fact that they are dumping the patients  
7 that aren't going to make them look good and things like  
8 that if they also have to meet this other standard.

9           And I wonder if seeing it quantified, seeing  
10 increases in staffing produces this much of a reduction in  
11 the rehospitalizations factor, if that would be helpful to  
12 seeing whether this would be a useful process measure.

13           DR. KRAMER: I'm glad you opened that door because  
14 there are several issues related to that. The first is that  
15 in the report we did we actually looked at incremental  
16 benefits of staffing and the reductions in potentially  
17 avoidable hospitalizations. There are these striking  
18 incremental benefits as you go up the staffing levels that  
19 are associated with reductions in rehospitalization rate.  
20 In this study we'll actually explore it further by doing  
21 some other comparison of high staffed and low staffed  
22 facilities.

1           Your point is extremely well taken about using  
2 that in pay for performance, along with other measures. CMS  
3 has recognized in part because the technical expert panels  
4 have been pushing it, and we've been pushing it for years  
5 because frankly I also think for public reporting, if you  
6 could give people a really robust and well risk-adjusted  
7 staffing measure it, but simplify it into a way that they  
8 could understand it, it would mean more to a potential  
9 nursing home resident than anything else you can give them.

10           I mean a delirium rate or a prevalence of UTIs is  
11 pretty hard to interpret. But how many people are there  
12 working for me, working in the facility relative to what the  
13 needs are? How fast do these people turn over? Do I get to  
14 see the same people every day? Those are the things that  
15 people want to know. Those are the things I want to know.

16           The problems we've encountered, one is a data  
17 issue. The current staffing information is reported through  
18 this self-report, facility self-report system, OSCAR, online  
19 survey and cert. And that's what goes up on the nursing  
20 home compare website. It has really been shown to be not  
21 very accurate, particularly at low end staffing, which is  
22 where you're concerned. So that's one of the big problems.

1           We've actually done some studies recently where  
2 we've been studying how to use payroll data directly  
3 downloaded from facilities and standardized reporting. You  
4 can get many more measures from payroll data because you get  
5 shift measures, you can get staff mix measures, you can get  
6 turnover measures, you can get longevity measures. You can  
7 really get nice measures from payroll data.

8           And so that's really what we've been pushing. And  
9 that's going to require some standardized specification  
10 requirement for what payroll companies will have to submit,  
11 and some incentives to make sure they do submit that. But  
12 ultimately, that's the way to go. You don't have to audit  
13 it because they use it for payroll purposes.

14           And then you also need to handle the risk  
15 adjustment thing because, as you know, there's such a  
16 variability in nursing homes that staffing levels in one  
17 facility really aren't accurate for staffing levels in  
18 another.

19           But I think you're right. I think we need to go  
20 there and I think we need to go there really aggressively.  
21 And I think we need to make very strong recommendations. If  
22 it forces the payroll industry to comply, and nursing homes

1 to comply because of various incentives, you do that rather  
2 than have everybody filling out these forms.

3 DR. MILLER: I think there's also just a couple of  
4 other things to think about here, and we had something of  
5 this conversation when we were going through the prep for  
6 this.

7 I think there are some parts of your work that  
8 suggest it's not just staff counts. You did touch on this  
9 but I want to make sure that this gets drawn out. It's how  
10 much turnover, how much experience, what level of training.  
11 So you'd want to be real careful in moving to these kinds of  
12 measures. If you say I can meet the body count, that  
13 doesn't necessarily mean that you're actually getting the  
14 "staffing ratios" -- to put quotes around it -- that you're  
15 really looking for.

16 The other little problem here, or maybe it's a  
17 bigger problem, is once again the Medicare skilled nursing  
18 facility beneficiary sits inside the nursing home. And so  
19 the question becomes if the staffing is for that patient --  
20 will the staffing actually be meeting the needs of that  
21 patient? Or is this more of a general measure for the  
22 nursing home?

1           Now I would argue there's probably some  
2 relationship there. But again, we're also trying to drive  
3 on getting measures that are fairly specific to this  
4 population. Which is not to rule out the staffing, but I  
5 think there's a couple of issues here beyond the data that  
6 also need to be thought through.

7           DR. SCANLON: I have comments in two areas. First  
8 of all, I thought this was an incredibly piece of work. I  
9 really enjoyed it. Particularly I think in terms of -- and  
10 this is the first area -- setting out, in some ways,  
11 elements of a framework for thinking about coming up with  
12 measures for either pay for performance or quality  
13 measurement. And I guess you touched on it, Andy, this  
14 issue of something where we don't have to worry as much  
15 about the reported data. These are two measures that are  
16 very hard to game because the people actually left the  
17 institution, as opposed to sending in something off of the  
18 record that no one has looked at to see whether or not it's  
19 accurate.

20           We may not have many circumstances like this where  
21 we have these kinds of measures available, but when we do we  
22 should think about can we exploit them.

1           The second thing, which you didn't talk about in  
2 your presentation but which is in the paper, is the issue of  
3 multiple measures and what do we get for multiple measures?  
4 This is in terms of the rehospitalizations by condition and  
5 the fact that you did statistical analysis and you looked to  
6 see is there independent variation or can we go to with a  
7 composite?

8           I think that's something that we need to pursue  
9 more, is the idea of statistical analysis to decide how much  
10 independent variation there is among all of these different  
11 variables and can we create composites?

12           You did a relatively simple composite. There is  
13 the issue that statistics sometimes can create very arcane  
14 composites, which are powerful from a statistical  
15 perspective but not necessarily from the understandable  
16 perspective.

17           Tomorrow there's going to be a discussion of  
18 composites and the idea of some of what goes on in the  
19 consumer world. If you think about it, the number of smiley  
20 faces or the number of stars, those, in some respects, are  
21 not very understandable either. It's not the number of  
22 stars for some very specific thing. It's somebody's

1 judgment about a whole array of factors. And this becomes  
2 the rating.

3           There is that issue of whether that actually is  
4 more valuable to a consumer, to have some kind of bottom-  
5 line judgment, even though it's much harder to get to the  
6 "details", aspirin after heart attacks.... that kind of  
7 thing.

8           We need to know whether we can mature, in terms of  
9 our confidence in data, our confidence in statistics and the  
10 ability to summarize things to get to that level because it  
11 may actually be more powerful in distinguishing the  
12 differences in terms of provider performance.

13           The last thing, I think, was the issue of the risk  
14 adjustment and the careful effort in that regard and how  
15 critical that is.

16           Having said that, and this is the second area,  
17 which is is this ready for prime time in terms of pay-for-  
18 performance? And even there I guess my concern is that as  
19 careful as you are, this is an area where risk adjustment is  
20 fraught with difficulty. I would raise the issue that the  
21 geographic variations in the patterns of post-acute care and  
22 in the availability of nursing home care and the

1 availability of assisted living complicates this story.

2           One of the things, if we're talking about pay for  
3 performance on a national level, is we need to be thinking  
4 about what kind of equity issues we're raising, given these  
5 underlying variations.

6           MR. BERTKO: I just wanted to again add something  
7 only on the technical topic of risk adjustment and  
8 comorbidities. In the larger Medicare world comorbidities,  
9 other studies have shown, have gone up dramatically in the  
10 last four or five years. And in the Medicare risk  
11 adjustment for payment purposes: the comorbidity studies,  
12 when updated, have had bigger effects and larger interaction  
13 terms.

14           So I was just nothing here, on one of your sites  
15 you talk about it. But comorbidities could depend on the  
16 baseline. When you set the coefficients, particularly in  
17 the time of rapid movement. Any comment that you had about  
18 how comfortable you are with the comorbidity adjustment  
19 might be useful, too.

20           DR. KRAMER: We were extremely concerned about  
21 this same issue of the comorbidities, in part because  
22 although the functional measures and other things drive

1 community discharge and some of these other things, clearly  
2 the major predictors in a lot of these hospitalization areas  
3 were the comorbidities.

4 We actually examined three different comorbidity  
5 indices quite extensively for this, the DAO, the Elixhauser  
6 I, and then the Dartmouth/Manitoba I. We actually worked  
7 with all three of them.

8 Whenever we do comorbidity analysis like those  
9 scales, we actually go back retrospectively six months for  
10 picking up ICD-9 codes and comorbid diagnosis. Because, as  
11 you know, the prior hospitalization may only have the ones  
12 people have thought of. They don't necessarily have the one  
13 from the hospitalization six months ago. And yet the person  
14 had diabetes six months ago. It's just nobody thought about  
15 writing it down this time around because it wasn't on the  
16 radar screen on this hospitalization, which lasted a day and  
17 a half. It's understandable. So we use that to go back.

18 We actually had rather -- I know Kathryn was  
19 concerned whether we were ever going to come up with our  
20 models and agree on what they were because we kept changing  
21 and relooking at our comorbidity scale. So we would lay  
22 them out in different ways, see how they interacted.

1           That's why, in addition to having comorbidity  
2 indices, we actually use selected diagnoses for each of the  
3 models, as well, because even though the comorbidity index  
4 would read one way, there were clearly selected conditions  
5 that would be associated with some of the individual  
6 conditions. And then we pooled them for the combined model.

7           That being said, I think that's an example of how  
8 much respect we have for the issues that you two have raised  
9 about risk adjustment and comorbidities. Whether that makes  
10 me ready to say we've sort of overcome any problem with it,  
11 I'm not sure I am ready to say that. But on the other hand,  
12 I look at the risk adjustment modeling that's being used and  
13 I think we're well ahead of a lot of what those models look  
14 like.

15           This pay-for-performance thing, it's discomfoting  
16 when you figure you're going to tie these payments, these  
17 incentive payments, to these risk-adjusted rates. Because  
18 you really don't want to put facilities that are taking  
19 sicker patients at risk.

20           But I actually think, again, these measures are  
21 more robust and it's easier to risk adjust them than I think  
22 they've had with almost any of these other measures.

1           MS. HANSEN:  Actually, a couple of the areas have  
2  been covered but I just wanted to underscore the element of  
3  the personnel factor, of the continuity of the personnel is  
4  such a major factor in terms of the care and the handoff,  
5  per se.

6           The other one has to do with I'm really pleased to  
7  see this whole aspect of the time frame because it relates  
8  to our whole sense of episode, of what happens to the  
9  individual rather than the discreteness of the three quality  
10 variables, per se.  I would like to see how that potentially  
11 relates to some earlier work that we also have on the  
12 hospital side because the point of dumping back-and-forth  
13 that occurs.

14           Let's just take the decubitus issue that was  
15 raised before in acute episodes, because quality is measured  
16 there as well, too.

17           Is there a way to follow the person, other than  
18 the physical facility, say the skilled facility in the  
19 nursing home?  Because it's oftentimes the one and the same  
20 patient.  But if a system like this supports dumping it back  
21 and forth, the quality of care issue as well as the system  
22 issue really isn't addressed relative -- whether it's the

1 risk adjuster payment or whether it's the whole sense of  
2 appropriateness of just location for that care.

3           So that's one of the areas that I just wonder  
4 about, having it more person-focused and follow the claims  
5 on the individual, and then sorting out the facility issue  
6 because it's the same individual.

7           DR. KRAMER: I think that's very important. Let  
8 me comment briefly on both the points. The first one, on  
9 the retention or turnover. One of the biggest problems with  
10 the publicly reported quality measures from OSCAR, the  
11 staffing measures from OSCAR, is they don't have any  
12 information on turn over retention. One of the reasons they  
13 don't is, again, people estimate that in all different ways.  
14 The payroll data has allowed us to come up with various  
15 standardized and accurate measures of that.

16           I think you're right, the limited work we've been  
17 able to do in that field suggests that it's key.

18           The second issue, about linking the episodes, I  
19 think is absolutely key. A lot of these patients are your  
20 classic frequent fliers. They are in and out and they are  
21 in and out and to call the episode ending when they go to  
22 the hospital misses the full picture. We are doing some

1 other work where we're putting together patient histories  
2 and linking multiple episodes and not basing it purely on a  
3 single say.

4 Of course, you run into all of these issues about  
5 which provider now are you talking about and so on and so  
6 forth. But nevertheless, I think that needs to be done.

7 MS. HANSEN: I just want to emphasize the staffing  
8 part of it is hospitals are already feeling the shorting of  
9 getting qualified nurses. And nursing home facilities are  
10 kind of a lesser desired place to go. So you have even a  
11 volume and quality component of that.

12 Just as a point of information for many people who  
13 don't deal with nursing homes, the turnover rates for  
14 supportive staff are oftentimes 100 percent over the course  
15 of a year. So it really is an issue that has an impact on  
16 quality.

17 DR. KRAMER: And incidentally, the most recent  
18 work we've done on turnover suggests that it's not just CNAs  
19 that everybody publicizes where there's supposed to be high  
20 turnover. We found RN turnover rates equally as high as CNA  
21 turnover rates. This is highly skilled staff that are  
22 turning over nowadays. It's not just the CNAs that had 75

1 hours of training or something.

2 DR. MILSTEIN: First of all, relative to the last  
3 batch of measures we looked at, these do score a lot better  
4 on conventional measures of are measures good enough,  
5 clinically important, scientific validity and  
6 feasibility/usability. They score well across all of those.

7

8 But for measures to be good for pay-for-  
9 performance, it's relatively important that there be some  
10 significant differences, facility to facility, on these  
11 measures.

12 As I look at our 2004 numbers and look at the 100  
13 day rates, if I interpret these correctly, I know I want the  
14 community discharge rate to be high and I want the  
15 rehospitalization rate to be low. So I'm looking at the 100  
16 rate and I'm saying it looks like normative currently in the  
17 United States is about a two-to-one ratio, if I divide  
18 community discharge divided by rehospitalization rate  
19 because I want the high numerator, low denominator.

20 If that's my composite index, if the two-to-one  
21 ratio is average, order of magnitude, you've had a chance to  
22 look at these numbers, what do you think top decile or top

1 quintile performance would be? Would it would be 2.2 to  
2 one, four to one? In other words, how much better than  
3 average are the best of the facilities on these two  
4 measures?

5 DR. KRAMER: The community discharge, and we  
6 actually have another paper looking at some of that, it is  
7 actually extremely variable. I was actually pretty stunned.  
8 It's easily two-to-one on the upward side. You can go down  
9 very, very low. What's interesting is not only do you get -  
10 - there's a couple of other things about that that are  
11 interesting.

12 One thing is that there's an MDS item that says,  
13 that is about -- where you rate the patient on whether  
14 they're going to go home at the end of the stay. One of the  
15 things you find is in the facilities that have a very low  
16 community discharge rate, many of the people that they rated  
17 as likely to go home don't go home. And in the places that  
18 have a very high rate, many of the people they rated as  
19 maybe not being likely to go home actually go home. All of  
20 that stuff follows it.

21 The other thing you find is facilities that have a  
22 very high volume of rehab services have higher rates of

1 return to the community. Places that have very low volumes  
2 of rehab patients can actually have low rates.

3 We also did a validation study of community  
4 discharge with processes and there were certain key process  
5 variables related to therapy and discharge planning and care  
6 planning that were associated with likelihood to go home.

7 So I think there's a lot of things here. The  
8 rehospitalization one, again you can go up pretty high. One  
9 of the issues, we haven't look so much, is the composite.  
10 On the individual ones you get down into zeros pretty fast  
11 on some of them. Like the sepsis one, probably the 50th  
12 percentile is zero.

13 But again, we found they're pretty discriminating.  
14 You get pretty good variability on them.

15 DR. MILSTEIN: Am I interpreting these measures  
16 correctly, that we would aspire to facilities that were  
17 outstanding on both measures?

18 DR. KRAMER: Yes.

19 DR. MILSTEIN: So that the ratio would be, our  
20 ultimate -- if we needed to base a smiley face on a small  
21 number of things, you'd want the ratio and maybe some of the  
22 other structural measures that Mitra raised.

1           Also, can you remind me where we stand on patient  
2 experience measures? It seems to me on all levels of care  
3 on which we might think patient experience might be a very  
4 important variable, I would think nursing home would be one  
5 I would put right near the top. It's a prolonged stay and  
6 the humanity with which people feel treated is something  
7 that intuitively, it seems to me, would be very important  
8 because of that.

9           DR. KRAMER: I think that's a very important  
10 phrase. Let may point out a couple of things. There is  
11 this sort of nursing home CAHPS that's being discussed. I'm  
12 not that engaged in it.

13           There has been a long-standing tendency to avoid  
14 talking to residents and family in nursing homes when you're  
15 assessing quality. There's a large proportion of them that  
16 are cognitively impaired. So you have to take that with a  
17 grain of salt. But nevertheless. that hasn't been the focus  
18 of it.

19           We actually have been -- in a CMS initiative,  
20 we've been developing an alternative survey process. One of  
21 the things that goes on in that survey process is an  
22 extensive resident and family interviews. It's called the

1 quality indicator surveys and they're very structured  
2 interviews.

3 In fact, there's a cognitive assessment that you  
4 conduct first to test people's insight and try to capture  
5 those kinds of things and determine whether people are  
6 interviewable or not interviewable. And CMS, that was part  
7 of the nursing home initiative, as well. The General  
8 Accounting Office has been pushing that. It's a  
9 demonstration now in five states. It's a major undertaking  
10 to change the survey process.

11 I'm very hopeful, anyway, that that will see the  
12 light of day because it does require you to talk to  
13 residents and family.

14 DR. REISCHAUER: The discharge rates are adjusted;  
15 right?

16 DR. KRAMER: These are risk-adjusted rates; right.  
17 The unadjusted ones show up on that sixth slide, 28.8 for 30  
18 days and 38.2 for 100 days. But those aren't facility  
19 means. Those are just if you took all SNF residents, what  
20 proportion of them go home in 100 days? The ones in this  
21 final slide --

22 DR. REISCHAUER: But I mean, for Arnie's measure,

1 you would want risk adjustment enumerator --

2 DR. KRAMER: Those are in the final slide where we  
3 actually have risk-adjusted facility mean rates, because  
4 that's really what you're looking at.

5 DR. SCANLON: Since it was the discharge to the  
6 community which was the one with the greater variance, that  
7 was actually where my concern was more because it includes  
8 discharge to assisted living which I think of as potentially  
9 the nursing home of the 21st century or the ICF of the 21st  
10 century.

11 So if it's possible, it would be nice to look at  
12 discharge to home instead of to the community, because I  
13 think that potentially is a more valid measure of the kind  
14 of rehabilitation that might go on.

15 DR. REISCHAUER: With or without home health.

16 DR. SCANLON: That's an issue. But I guess I'm  
17 concerned about this geographic equity. I think that the  
18 prevalence of assisted living as a substitute is different  
19 in different areas. You've got places like Minnesota, where  
20 they've had a moratorium on construction of nursing homes  
21 for 20-some years. So they've probably got a relatively  
22 healthy assisted living industry instead.

1           So people are going to be going there, as opposed  
2 to staying in a nursing home that would've been built over  
3 the last 20-year period.

4           DR. KRAMER: Since that distinction is not in the  
5 data, as to where they're discharged to, would you be  
6 comfortable -- or at least reassured to some degree -- if  
7 you adjusted for assisted-living beds, nursing home beds  
8 using a hierarchical model for some of those kinds of  
9 things?

10          DR. SCANLON: Right, or exploring some of the  
11 geographical differences, I think would be helpful in terms  
12 of reassuring.

13          MR. HACKBARTH: Andy, in talking about the  
14 increase in rehospitalization in the 2000 to 2004 period I  
15 think it was, you said one hypothesis was declining length  
16 of stay for inpatient hospital means tougher patients. But  
17 you said you didn't find that all that persuasive, given  
18 that during that time period the declines in acute patient  
19 stays were not that great.

20          You said another hypothesis was that this was when  
21 the SNF prospective payment system was really taking hold  
22 and, given its features shall we say, it may be creating a

1 strong incentive to send back to the hospital patients that  
2 require a lot of care, at least certain types of care. I  
3 want to just pursue that for a second.

4 I've had concerns about the very idea of laying  
5 side-by-side prospective payment systems for inpatient  
6 hospital and post-acute care because of the potential scene  
7 it creates and the incentives each way to sort of throw  
8 things over the wall to people on the other side. We often  
9 talk about silos. This seems to be a particularly egregious  
10 risky case for having payment silos.

11 I often wonder whether we're just barking up the  
12 wrong tree entirely in trying to have a SNF prospective  
13 payment system and really the only sensible way to think  
14 about this is bundling the acute with the post-acute SNF  
15 care.

16 Any thoughts on that?

17 DR. KRAMER: You know, I agree with your first  
18 point. I don't know how you win this battle you now have.  
19 Even that 1 percent decline in hospital stay, given that  
20 hospital stays are so short now, that 1 percent overall, I  
21 don't know what it means in terms of an individual hospital  
22 SNF relationship and whether somebody is really getting

1 there that much more unstable and with that much less  
2 information and so on.

3           So I am very curious about -- and that's one of  
4 the things we're going to look at here is places where there  
5 are longer lengths of stay relative to shorter legs of stay.  
6 Do those places have different rehospitalization rates?  
7 Some of that issue. So that side makes me very nervous.

8           You're very right, the PPS for SNFs, I think it's  
9 a set up for patient dumping back and forth.

10           You know, probably better than I, the sort of  
11 struggles over bundling. But I do think that ultimately  
12 some kind of a bundled system is going to be necessary to  
13 deal with this.

14           Part of the reason I say that is not just because  
15 of this work but some of the other work we're doing, for  
16 example, stroke rehabilitation. You know very well the SNF  
17 PPS was implemented when the rehab hospital PPS was  
18 implemented and the home health PPS was implemented.

19           One of the things we saw in our SNF study, which  
20 is post-PPS, it's an ASPE funded study -- is that the rate  
21 of multiple provider episodes has just gone off the charts.  
22 I mean, 90 percent of people that go to inpatient rehab

1 facilities have at least one or more providers, and many of  
2 them have two. They go to SNFs and then they go to home  
3 care and then they go to outpatient care. It's like this  
4 across the board. Of the SNF patients, two-thirds of them  
5 are going somewhere else subsequent.

6           The home health, the direct admits to home health,  
7 they're least likely go somewhere else. But they're the  
8 healthier bunch of patients.

9           So you're right, we have a system now where people  
10 are stepping down. Lengths of stays, we showed between 2003  
11 and 2004, a two day drop in length of stay in inpatient  
12 rehabilitation hospitals in one year after implementation of  
13 the PPS for stroke patients.

14           I mean, we're cutting the stays smaller and  
15 smaller, taking full payments. I know you'll adjust those  
16 payments at some point because you'll say well it's less  
17 cost. But you're right, we're going to wrong direction on  
18 the post-acute care side. We really are fragmenting these.

19           Our offices, we have a couple of people doing a  
20 lot of work on care transitions. You not only introduce  
21 these extra costs, but you really introduce quality problems  
22 because medication lists get fouled up as you move people

1 very rapidly across these settings.

2 MR. HACKBARTH: Obviously people have talked about  
3 this at a conceptual level for a long time, and that is  
4 bundling these things together. One of the problems is  
5 political, is that you've got institutions with vested  
6 interests and their concerns about the one losing autonomy  
7 and power and money to others, who are given the money to  
8 manage, so to speak. All of that is very real and very  
9 difficult to deal with and I understand and sympathize.

10 On the other hand, when we talk about our big  
11 health care issues, we talk about how care is fragmented and  
12 we've got this atomistic approach to health care delivery in  
13 the U.S. and if we allow to drive payment policy as  
14 traditional institutional arrangements, we'll never get out  
15 of that. And so at some point payment policy needs to start  
16 driving institutional realignment and organizational change,  
17 as opposed to that becoming a barrier to sound payment  
18 policy.

19 The key, obviously, is to make the payment policy  
20 aligned with what is good care for patients. That needs to  
21 be the guiding principle, and not historical institutional  
22 frameworks. I think there are many examples of that in

1 Medicare. I don't think there's maybe a better one than  
2 post-acute care.

3 So that's my speech for today.

4 DR. MILLER: Can I say something right here? That  
5 was a really great set up for the fact that the next  
6 conversation that we're going to have, and I don't mean to  
7 move this along, but the next conversation is going to start  
8 with the hospitalization as the focal point for the episode  
9 and begin to examine resource use across multiple providers,  
10 including post-acute care. Quality obviously has to become  
11 part of it, too, but at least we're beginning to try and  
12 look at it from an analytical point of view. The policy  
13 problem that you've identified still exists.

14 DR. KRAMER: If I might add these, performance  
15 measures that we're talking about here, one of the nice  
16 things about them is even though the data systems have to  
17 evolve and so on and so forth in some of these other areas,  
18 these kind of performance measures can cut across post-acute  
19 settings. They're not depending on an MDS or an OASIS.  
20 These are the big things that you have to do after you  
21 discharge somebody. If they're acutely ill or post-acutely  
22 ill, you've got to keep them from going back into the

1 hospital. If you're trying to get them better, they're  
2 going to have to recovering and get home. It doesn't matter  
3 how many different settings you go through to do it.

4 And that's why they're compelling and that's why  
5 they're useful in those kinds of frameworks.

6 MR. HACKBARTH: This is an excellent terrific  
7 piece of work, Andy. Thank you very much.

8 Now we must move ahead to the next topic which, as  
9 Mark said, is episodes associated with inpatient admissions.

10 MS. MUTTI: This presentation describes our  
11 approach to and initial findings when creating relatively  
12 short episodes that are triggered by an inpatient hospital  
13 stay.

14 We have explored this possibility in the context  
15 of our work on measuring the relative efficiency of  
16 providers. And again the thought here is that if we can  
17 validly measure the relative efficiency of providers, we can  
18 design policies that will encourage that efficiency, align  
19 incentives. Examples of such policies might be public  
20 disclosure of performance, P4P, bonus payments, bundling of  
21 services. Many of these things have been touched on today.

22 We have sought to measure resource use in

1 particular here around episodes of care so that we can  
2 measure the longitudinal efficiency and identify the widely  
3 documented variation in service use by providers.

4           This work is intended to complement our other work  
5 that has looked at ETGs and MEGs, the two commercial episode  
6 groupers. Those groupers identify both short episodes and  
7 longer episodes. They capture chronic care episodes as well  
8 as acute care episodes. And they don't necessarily require  
9 an inpatient stay to trigger the episode. So those are all  
10 differences to the approach that we're going to talk about  
11 today.

12           Our hope here, though, is that by exploring  
13 multiple ways of defining episodes, each which has its  
14 advantages and disadvantages, that we'll help policymakers  
15 move closer toward thinking about measuring resource use,  
16 pairing it with quality measures and eventually enabling us  
17 to purchase much more efficiently and value-based.

18           As I mentioned, in this analysis the episodes are  
19 triggered by acute inpatient stays and they are limited in  
20 duration. These types of shorter episodes -- and in this  
21 analysis we've experimented with 15, 30, 60 day long  
22 episodes -- have certain advantages. They recognize that

1 many fee-for-service providers have little experience  
2 managing care over multiple sites and over time.

3 Combined with the fact that beneficiaries are free  
4 to go to any other providers in fee-for-service Medicare  
5 that they'd like, some providers may be uncomfortable being  
6 held accountable or being measured for their care over a  
7 long duration.

8 Another reason to focus on shorter episodes  
9 triggered by inpatient stays is that they capture the most  
10 costly Medicare covered services and many of the most costly  
11 Medicare beneficiaries. So if you're looking for an initial  
12 step, this one may be particularly cost-effective.

13 Additionally, because the hospital is central to  
14 these episodes, there is the potential for the hospital to  
15 pay the role of convener. Some researchers have identified  
16 this convener role as really integral to getting the  
17 behavior change that you're looking for.

18 As a convener, hospitals can help inform  
19 physicians about their variations in practice styles, enable  
20 discussions about evidence-based medicine and best practices  
21 across sites, and where they have a role in changes in the  
22 process of care, like some of the ones that we heard about

1 earlier today, investing in staff, and investing in IT, or  
2 other examples.

3           One of the key disadvantages of measuring care  
4 over these shorter episodes is that providers are only  
5 measured on their management of acute and post-acute care.  
6 Except in the case of readmissions, they are not measured or  
7 potentially rewarded for their ability to provide the good  
8 chronic care and preventive care that would have prevented  
9 the inpatient stay in the first place.

10           The longer the time frame, the more providers have  
11 the time and incentive to invest in the preventive care and  
12 realize the gains associated with the avoided admissions.

13           A related concern is that multiple episodes per  
14 beneficiary may dilute per episode spending, making certain  
15 providers look more resource conserving than they truly are.  
16 So to prevent this possibility, that is of rewarding  
17 physicians with the lot of episodes, we may need to pair  
18 measures of resource use during these shorter episodes with  
19 a measure of the number of episodes. This is consistent  
20 with those dimensions that we had talked about in the past  
21 where a third dimension is to look at the volume of episodes  
22 in addition to the spending per episode.

1           To begin to assess some of the implications of  
2 this approach, we created episodes using three years of  
3 data, 2001 to 2003 from a random sample of 5 percent of  
4 beneficiaries. We calculated standardized Medicare payments  
5 for each service. That is, we used national payment rates  
6 that neither reflect geographic adjustment for input prices  
7 or wages and they also don't include teaching or outlier  
8 payments. We included all services except hospice and  
9 durable medical equipment. This is the same data that we  
10 used for the physician resource use exercise.

11           We experimented with four types of episodes that  
12 vary in duration. The first type is the inpatient stay  
13 only. This includes Medicare spending for the inpatient  
14 stay, the DRG payment, as well as all physician services  
15 delivered during that stay. This also includes the  
16 multitude of short episodes as well as the less frequent  
17 very long episodes, the 50 or 60 day long stays.

18           The second type that we looked at was inpatient  
19 stay plus 15 days. Again, the duration of the episode  
20 varies depending on the length of the stay and then 15 days  
21 are added to it.

22           The third type was 30 days from the date of

1 admission. This window eliminates the variation in time and  
2 the episode length, which may be useful in examining how  
3 services may be substituted for one another and their  
4 implication on total episode costs.

5 Our last type that we looked at was 60 days after  
6 the date of admission. Here we hoped to capture more  
7 readmissions and post-acute care.

8 We looked at the data to understand the magnitude  
9 of spending measured by these episodes and the dynamics of  
10 varying their duration. For this stage of our examination  
11 we have not risk adjusted the data.

12 As expected, average spending increases as the  
13 episode grows longer. For our first type of episode, the  
14 inpatient stay only, the mean episode duration is 5.4 days.  
15 That mean spending for that episode is \$6,776. The median  
16 spending is \$4,807. We see the number of episodes for the  
17 year 2002 for that episode type is 515,209.

18 As you can see, looking down that column, the  
19 number of episodes shrinks as we get to the longer episodes  
20 types. And this makes sense because the longer the episode  
21 duration, the more care -- and particularly admissions and  
22 time -- are captured in a given episode, which in turn

1 permits fewer episodes.

2 Not surprisingly, the distribution of per episode  
3 spending is skewed. A minority of extremely high-cost  
4 episodes raises the mean of per episode spending above the  
5 median for each episode type.

6 DR. MILSTEIN: [Inaudible.]

7 MS. MUTTI: Right. Because the episode length is  
8 longer, it just permits fewer episodes in a defined period  
9 of time. Did that help?

10 DR. MILSTEIN: At the end of whatever arbitrary  
11 period there's still some episodes that are unfolding.

12 MS. MUTTI: Right, and we will also see that we  
13 will not count those if they have not completed. So in 2003  
14 we'll have more episodes that we did not include because  
15 they were not complete.

16 DR. KANE: The inpatient stay is completed  
17 discharge plus 15 days -- [inaudible.]

18 MS. MUTTI: Right but that's only a factor for  
19 2003 here. I think that that's kind of a sideline  
20 consideration. I don't know if you want a give it a try.

21 DR. MILLER: Go ahead.

22 MS. MUTTI: If you had the whole thing and you

1 were going to allow yourself to divide it into very small  
2 pieces, you could have the potential for many more small  
3 pieces, many more small episodes.

4           If we say an episode is 60 days long and it will  
5 only be triggered by an inpatient stay, there's just the  
6 opportunity for fewer episodes. Maybe this will help.  
7 Because more of those admissions will be considered  
8 readmissions.

9           DR. MILLER: Let me say it just a little bit  
10 differently. Your point about starting and ending episodes  
11 at the end of the year is well taken, but just to deal with  
12 that, I think, relatively quickly. These guys have put  
13 together three years of data. As we've tried out work  
14 through this, I think your results mostly focus on 2002. So  
15 we're sort of picking a year in the middle where we have the  
16 least problem with sort of end of the year problems or  
17 episodes being cut off or truncated.

18           Le's put that aside for one second.

19           I think this is the way to think about it. We had  
20 to talk about this a while internally too, but think about  
21 it this way: let's say you said I'm going to have an episode  
22 that is 15 days long, and then you get admitted on the 17th

1 day. That starts a second episode so you'll have two  
2 episodes.

3 Now somebody says let's make the episode 20 days  
4 long. That second episode disappears from the data because  
5 it's now counted in your -- exactly. That's really the key  
6 thing to keep in mind here. And that's why the number  
7 drives down as you expand the number of days.

8 DR. REISCHAUER: Why don't we want to add the  
9 second readmission to the first episode?

10 DR. MILLER: That is precisely what you're doing  
11 as you move up to 30 and 60 days.

12 DR. KANE: [Inaudible.]

13 DR. MILLER: You could do arithmetic like that.  
14 But if there's a readmissions that occurs, then that is  
15 counted in the episode.

16 MR. LISK: Just to clarify, the readmissions do  
17 not start a new episode, do not start an episode themselves.  
18 They are only counted as part of an episode that may have  
19 occurred if it happened in the window.

20 MR. BERTKO: But here's a problem when you  
21 contrast that with the way the commercial ones to it. You  
22 are blending together here readmissions for the same

1 diagnosis as opposed to a new admission because there was a  
2 hip fracture following an illness.

3 DR. MILLER: That is precisely right in and Anne  
4 was trying to lay out at the beginning. Now you have the  
5 episode groupers that we've been talking about prior to all  
6 of this that are conditioned based and they have certain  
7 characteristics and all the rest of it.

8 I think the underlying logic here -- and I'm using  
9 that word to say we're exploring here -- is the episode is a  
10 significant event. To the extent that you capture the  
11 services very close to that, a little further out, a lot  
12 further out, you're starting to get things that are probably  
13 related to the admission when they're close.

14 And then the \$64,000 question is at 60 days, am I  
15 still catching stuff related to that admission? Or are we  
16 talking about something else?

17 So this is more of a data-driven episode where we  
18 have the clinical driven episodes kind of working in that  
19 separate project that you've seen those results, as well.  
20 So we're trying to run both of these tracks is what we're  
21 doing.

22 MS. MUTTI: I meant to mention that earlier.

1 DR. MILLER: You did.

2 MS. MUTTI: Another important consideration is the  
3 magnitude of Medicare spending that has captured by  
4 measuring these types of episodes. We found that it was  
5 fairly a large percentage. Our shortest episode type  
6 captured 39 percent of Medicare spending, and our longest  
7 episode type, the 60 day long episode, captured or measured  
8 53 percent of Medicare spending.

9 We also looked at how episodes in which a  
10 beneficiary died compared to episodes in which the  
11 beneficiary survived. And while far less common than  
12 survivor episodes, the decedent episodes are quite a bit  
13 more costly.

14 As you can see for the inpatient stay only  
15 episode, average spending for decedent episodes was \$10,793,  
16 which is about 64 percent higher than the \$6,572 for  
17 survivor episodes. Accordingly, they account for 4.8  
18 percent of episodes but a higher percentage of episode  
19 spending, 7.7 percent.

20 A key question for policymakers is what portion of  
21 providers are involved in a sufficient number of episodes to  
22 allow valid measurement? We have only preliminary data on

1 this question at the moment, but our one indicator is our  
2 examination of the percent of hospitals with at least 25, 50  
3 or 75 episodes in our sample. Looking at all acute care  
4 hospitals -- and this includes the smallest of the small, as  
5 well as the very largest -- we found that the majority had  
6 more than 75 episodes across a three-year period. And  
7 perhaps another helpful statistic is one example is 86  
8 percent of hospitals have more than 25 inpatient stay plus  
9 15 day episodes and 66 percent have more than 75.

10           Obviously a larger sample will increase these  
11 percentages, and we'll be coming back to you in the future  
12 with a more refined analysis so you'll have a better sense  
13 of what to conclude on this.

14           Commissioners have expressed interest in focusing  
15 on the most common or the most costly conditions as a place  
16 to start in measuring resource use. So we have illustrated  
17 the implications of selecting the 20 most frequent DRGs. We  
18 found that just these DRGs accounted for a substantial  
19 portion of Medicare spending, ranging from 15 percent for  
20 our shortest episode length to 22.3 percent for the 60 day  
21 episodes.

22           So by limiting the focus to these, we account for

1 just less than half the spending that we captured when  
2 looking at all DRGs. So just to make sure we're all clear  
3 on this, under the 60 day window we capture here 22.3  
4 percent of spending, looking at the top 20 DRGs. In  
5 contrast, if we looked at all DRGs, we would've captured 53  
6 percent of spending.

7 We also found that a majority of acute care  
8 hospitals had at least 25 episodes over our three-year  
9 window in each of our episode types. On the last slide I  
10 highlighted the implications for our inpatient stay plus 15  
11 day episode in my example. There I said in looking at all  
12 DRGs, 86 percent of hospitals had 25 stays. Here it is  
13 somewhat lower at 76 percent.

14 This slide gives you a sense of what services are  
15 captured in the episodes and the amount of their spending  
16 compared to the rest of the episode. As you would expect,  
17 the initial stay is the largest part of episode spending.  
18 For episodes defined by the inpatient stay only, the portion  
19 of spending for the initial stay is 88.5 percent. The  
20 remainder is comprised of physician spending. That's in the  
21 yellow there.

22 As the episode length extends, a greater

1 proportion of spending in the episode is for readmissions  
2 and for other types of services, including post-acute care.  
3 Readmissions grow from 7.1 percent of episode spending in  
4 episodes that include the stay plus 15 days, to 14.3 percent  
5 for the 60 day episodes.

6           And lastly, we have taken a look at what  
7 percentage of Medicare spending for each service is captured  
8 in these episodes. So on this slide we show you the 30 day  
9 episode, as an example.

10           By definition, the vast majority of Medicare  
11 inpatient spending is measured. We defined this as episodes  
12 triggered by an inpatient stay. A large portion of spending  
13 for SNF inpatient rehabilitation facilities and long-term  
14 care hospitals is also captured in these episodes. A  
15 substantial portion for physician and home health spending  
16 is also picked up. It's just less than a fifth for each.  
17 Outpatient hospital services, which include ASCs, are the  
18 least likely service to be captured in this approach.

19           Of course, these percentages increase when we look  
20 at the 60 day stay and they decrease when we look at the  
21 shorter episode lengths.

22           The dotted vertical line there shows that across

1 all services this type of episode accounts for 47 percent of  
2 all Medicare spending and that it is consistent with an  
3 earlier slide.

4 Our immediate next steps in this analysis are to  
5 risk adjust the episodes and calculate per hospital average  
6 spending for each of these episode types, examine the degree  
7 of variation in spending for hospital and MSA, and examine  
8 spending patterns by episode type, medical versus surgical  
9 care, and by hospital characteristics.

10 But for the moment we are looking for your input  
11 on this research design and we're certainly not asking you  
12 to pick one of the options we've outlined here. In fact, we  
13 would like you to comment on whether these are the ones that  
14 most interest you.

15 I should also note that the collectively we that  
16 I've used through this presentation also includes Craig,  
17 Jack Ashby, and Sharon Cheng also.

18 MR. BERTKO: I want to be helpfully critical,  
19 perhaps, because I know the amount of work that goes into  
20 this.

21 My first question is one which would be what's the  
22 unit of observation? On the surface of it, it would seem to

1 be that you're looking at hospitals that had an admission.  
2 I can think of another one almost immediately, which would  
3 be hospital and its affiliated, even if inferred, physician  
4 systems, so a PHO, physician hospital system.

5 In that case, then I worry a lot about risk  
6 adjustment, which I just see you're getting to, because in  
7 some ways I could see some of the most efficient physicians  
8 might be successfully treating people and keeping them out  
9 of hospital, but when they get a hospital stay it's a very  
10 sick person. So the resource use for that very sick person  
11 would be quite high.

12 By missing the front end of that, which if I'm  
13 interpreting you right, the beginning of every episode is a  
14 hospital admission. So you may be missing a bunch of stuff  
15 out here and thus piling folks up differently.

16 So I guess I would look to you to maybe think  
17 about that unit of observation in terms of trying to rate  
18 it, and the whole thing again about implying physicians to a  
19 hospital, particularly in a lot of multi--- let's see, MSAs  
20 or cities with multiple hospital systems with multiple  
21 admitting privileges, could be actually quite difficult.

22 I'll throw that out as a conundrum and then maybe

1 Arnie, if you have any comments, if you've thought about  
2 that.

3 I caught him off guard for once. Arnie's  
4 speechless.

5 DR. MILLER: Yes, but you didn't catch me off  
6 guard. I'll cover for you, Arnie. Get your thoughts  
7 together.

8 You raise a very good point. And another place  
9 that you should keep in mind that this issue will be brought  
10 on point is as part of the mandated SGR report. Cristina is  
11 kind of riding shotgun on this. We're going to be bringing  
12 work in front of you that looks at the hospital and the  
13 related physicians as the unit and begins to start thinking  
14 about that. So there'll be a process there to discuss that.

15 But we can also think about how to tool this  
16 project in that direction and address those questions.

17 DR. BORMAN: Just related to what was just brought  
18 out, how difficult would it be if this is the trigger to  
19 then go back 30 days forward from the inpatient trigger?  
20 And then there's a lot better statisticians and analysts  
21 here than me, including you. But in looking at your chart  
22 about the percent capture spending with the different

1 models, there's something of an implication that the  
2 inpatient plus 15 and the 30 day total come pretty close to  
3 measuring the same numbers. And whether or not there's  
4 utility to continuing to pursue both those models, as  
5 opposed to taking your time and effort and you maybe adding  
6 the 30 days in advance, or whatever.

7           Because my guess is the reason for that is that  
8 the inpatient plus 15, that if the inpatient stay is 15 or  
9 less it's going to come pretty close to meeting your 30 days  
10 post-admission. Those two groups seem to be measuring a lot  
11 of the same thing. And whether or not those are worthwhile  
12 keeping as separate models, I don't know.

13           Maybe that's just a naive question based on how  
14 the numbers present.

15           Another question would be as you're looking at  
16 other data, is there the opportunity, for example, to take  
17 some of these same -- you've look at this in a Medicare 5  
18 percent sample. Could you look at this in the VA system for  
19 similar conditions?

20           And the reason I ask that is number one they have  
21 more likelihood to have an integrated system. That is, that  
22 they're inpatient, outpatient, SNF, whatever care, is more

1 likely to be captured within a single system.

2           Number two, it's a highly geriatric base  
3 population, perhaps not quite the same. And it's one in  
4 which, at least in theory, there are fewer incentives to  
5 initiate separate episodes or to increase resource use,  
6 other than potentially say that my hospital works harder and  
7 gets a bigger share from the VISN. But on an individual  
8 level there's less incentive.

9           There might be value in being able to look at some  
10 of those things from a database that presumably should be  
11 one that could be gotten to.

12           DR. SCANLON: I would say it would be valuable if  
13 we could identify that the person got all of their care from  
14 the VA because these people very often are going to be  
15 Medicare eligible, as well. So there's that pattern of  
16 people using some Medicare services of some VA services.

17           DR. BORMAN: They would most likely stay in one  
18 system as opposed to --

19           DR. SCANLON: VA has a constraint, a supply  
20 constraint. So there's the issue of waiting and closeness  
21 to home, et cetera. And so, depending upon those  
22 circumstances in the particular VISN that they're in, there

1 could be very different patterns.

2 MS. MUTTI: We can think about adding the 15 days  
3 beforehand or a time period before hand. That is something  
4 we can give some thought to. It should be possible.

5 I just want to clarify, and maybe I'm  
6 misunderstanding your point a little bit on the difference  
7 between the two types of episodes. The first one is just  
8 the inpatient stay only. So this chart is showing for that  
9 episode, what's the portion of services that are comprising  
10 it? It makes sense that the inpatient stay, and then it  
11 would only be the physician services that were delivered in  
12 that stay. The 15 day one then allows us to look -- all  
13 right, that episode includes the post-acute care also  
14 delivered, and physician visits outside the hospital. What  
15 is that distribution?

16 DR. BORMAN: I'm not asking between those two.  
17 I'm asking between the inpatient plus 15 versus the 30  
18 total.

19 MS. MUTTI: I'm sorry.

20 DR. BORMAN: Those two seem to be relatively  
21 measuring a lot of the same things. They're not 100 percent  
22 overlap, but they measure a lot of the same things. And

1 maybe you don't need one of the two of those, freeing you up  
2 time to look in other ones.

3 DR. MILSTEIN: I don't have a good answer to  
4 John's question. And it really is more of an intuitive  
5 suggestion, and I can't really pull it together in a way  
6 that is as coherent as I wish it were.

7 But it seems to me that one of the considerations  
8 in selecting the ideal length of episode around which to  
9 create measures and incentives is -- it would be helpful to  
10 consider, for our beneficiaries, what is the average patient  
11 recovery trajectory? So that we could begin to, as one of  
12 the things that we might consider, identify the average  
13 length of time post-hospital admission where the average  
14 functional recovery curve begins to flatten.

15 I'm trying to think of what are the different  
16 variables we might want to take into consideration in  
17 deciding. And that, it seems to me, would be one of them.  
18 If we knew that the vast majority of beneficiaries, by day  
19 50 under average care, are really at the flat of the curve  
20 in terms of level of functional recovery, that to me would  
21 be a factor I might want to -- one of the factors, not the  
22 only factor -- I would want to consider in selecting an

1 optimal post-admission duration.

2 DR. REISCHAUER: But it would differ for each DRG  
3 and for each severity category too, probably.

4 DR. MILSTEIN: Yes.

5 DR. CROSSON: Just a small comment, but then  
6 there's a question related to it. As Mark said, we're now  
7 going to be looking at two different kinds of episodes and  
8 they're conceptually different. It struck me as I was  
9 reading this before that using the term triggered in this  
10 sense has different meanings to people. In the sense it's  
11 used here, as I understand it, means triggered analytically;  
12 right?

13 DR. REISCHAUER: Not associated with the 8.4  
14 percent that died.

15 DR. CROSSON: But in health care we often use  
16 triggered to mean causality. So just for clarity, as we  
17 starting putting together documents, it might be better to  
18 use a different term, like defined by an initial  
19 hospitalization, or something like that.

20 But that then was also related to the question,  
21 and you alluded to it, but are we going to have a sense  
22 after time across at least the three or if we go to two on

1 the right there, what actually is the percentage of the care  
2 that is in some way rationally related to one medical  
3 condition versus a collection of very different things?  
4 Because that will then sort of play very differently, I  
5 think, in the end with issues around attribution and things  
6 like that.

7 MS. MUTTI: I'm trying to follow you.

8 DR. CROSSON: If you take the 60 days one after  
9 admission, I assume we're going to get, at some point, some  
10 information to suggest that on average this way of  
11 categorizing episodes, 75 percent of the time is  
12 characterizing an episode that in some sense of clinical  
13 logic would be consistently related to one medical condition  
14 or associated medical conditions, as opposed to only a third  
15 of the time because it actually collects a whole lot of  
16 different things, automobile accidents and heart attacks and  
17 things like that.

18 I would imagine that the number would be maybe 85  
19 percent or something, but it would be interesting to know  
20 what that was.

21 MS. MUTTI: If you did basically apply a clinical  
22 logic to this, so that we could be sure that all the care in

1 that window related to that underlying condition.

2 DR. CROSSON: It won't be but just to know what  
3 the level of confidence or validity is.

4 MS. MUTTI: Right. We can look into that, too.

5 DR. MILLER: I would suspect that our ability to  
6 do it, particularly in this dataset which is different than  
7 the other work that we're doing, is somewhat more patchy.  
8 So for example if, in the 30 day episode there's two  
9 hospital admissions, you can probably go in and check the  
10 diagnosis codes for the two hospitalizations and start to  
11 see whether they are at least in the same neighborhood.

12 But for the other types of care you can, in some  
13 instances, go and look at the kinds of codes that are put on  
14 the claims that come with it. But it may get much more  
15 variable in terms of being able to say -- to draw up rules  
16 and say I think this is related, this is not related.  
17 Because you really won't have a medical record type of  
18 detail that you would want.

19 So it will be, I think, somewhat approximate.  
20 That's a nice word.

21 DR. KANE: I'm still trying to understand what  
22 we're going to do with it. And I think it's not just

1 condition but it's also somehow linking together providers  
2 who may be totally unrelated to each other. People get  
3 moved around from one facility to the next by discharge  
4 planners who make that transfer and have nothing more to do  
5 with the patient. So you may have two or three different  
6 managements in charge or physicians in charge.

7 I guess I'm just having trouble getting a sense of  
8 how you create a locus of responsibility when you start  
9 moving outside of the institution.

10 And then I guess I promised myself I would always  
11 bring up the fact that you need the pharmaceutical  
12 information in here, as well. I just didn't want to forget  
13 that. But I think where's the responsibility here for these  
14 kind of artificially created episodes?

15 MS. MUTTI: I'll start and I see that John has  
16 something to say, too. We have focused here on this idea of  
17 how to define the episode, because that's because we felt  
18 this is a really critical underlying question.

19 But assuming that we can define this right, the  
20 idea here was -- and we've talked about this a little bit  
21 before -- that if you can actually make people more  
22 cognizant of their partners and the continuum of care that

1 beneficiaries have and it is their responsibility, that they  
2 have a substantial role in caring for that patient. If we  
3 can encourage them to take greater responsibility for the  
4 continuum of care, then we can get some of the results that  
5 we're striving for.

6 I'm not sure what kind of policies you might  
7 design around this, but you could either hold the hospital  
8 accountable for that episode of care, and that would  
9 encourage the hospital to think about who it partners with  
10 and how it trains its discharge planners, please consider  
11 home health if that is appropriate, think about your lower  
12 cost alternatives. It may make them look toward working a  
13 little bit more with their SNFs and encouraging their  
14 physicians to try and limit the readmissions that you might  
15 see to the hospitals.

16 The hospital scores will look better and they may  
17 have a role in that.

18 Alternatively, you could hold more than just the  
19 hospitals responsible for this episode. You could have  
20 multiple players held accountable for this episode, and I  
21 think we've touched on this in the past. It could be the  
22 hospitals as well as the medical staff. It could be the

1 SNF, also, so that they collectively have the incentives to  
2 work together to make the overall performance across the  
3 whole episode more efficient.

4           They would have to think about their partners.  
5 They would probably need more information about who their  
6 partners were and how effective and what kind of quality  
7 they were delivering and what kind of resources they were  
8 using so that they could make some better decisions. I  
9 think this is kind of consistent with some of the change  
10 that we've been talking about today.

11           MR. BERTKO: Just to continue what Anne was  
12 saying, in a commercial universe where Arnie and I are going  
13 with some of ours is to say what should we pay hospitals  
14 that are more efficient? I should be willing to pay a  
15 higher unit cost per day or per admission to those hospitals  
16 that do a better job widely spoken.

17           In our context here, we've got DRGs which are  
18 focusing strictly on inpatient stuff with a little bit of  
19 outpatient. Here's where I could see the P4P, along the  
20 lines of the presentation from the guy from Virginia Mason,  
21 and saying if we're going to spend some extra money here,  
22 where should we do it? And in fact, it's for that topic I

1 brought up.

2           Again, with all respect to what Jay's and group  
3 practices are trying to do, I'd like to get something done  
4 in Texas and Wisconsin and a variety of other places where  
5 the docs work by the twos.

6           DR. CROSSON: Not Wisconsin.

7           MR. BERTKO: There's only a couple parts of  
8 Wisconsin.

9           DR. CROSSON: Every single county in Wisconsin has  
10 a large group practice presence in it.

11           MR. BERTKO: And then there's a bunch of docs who  
12 don't belong to it.

13           DR. REISCHAUER: I'm actually with Nancy on this.  
14 I think we've transferred the use of the term episode  
15 inappropriately. Because episode in the groupers had a  
16 relationship to a condition. And episode now means a length  
17 of time, no matter what's going on during that time.  
18 Efficiency relates to how well the accountable parties deal  
19 with something.

20           And what Nancy was pointing out is there could be  
21 several somethings going on. I have a heart attack, go into  
22 the hospital and my episode starts. But I had a broken

1 ankle before, or something like that, and I'm still going to  
2 somebody for that. So those costs are suddenly lumped in  
3 with this episode and we're mistakenly saying this isn't a  
4 very efficient provider.

5           We're making an assumption that these expenditures  
6 relate to this condition. Most of the time it will, but  
7 some of the times won't. And that might be what  
8 distinguishes two hospitals.

9           MS. MUTTI: Absolutely. I guess I failed to  
10 mention one of the caveats here is that we knew we took some  
11 shortcuts in this analysis. We didn't have the clinical  
12 logic underneath. But it is something that we thought that  
13 would be necessary to add on before you would ever implement  
14 such a thing.

15           But for us to do this in-house, to look to the  
16 data and start exploring the idea of -- it's a baby step in  
17 the episode world. We thought that it was -- for  
18 expediency, we decided okay we're going to fudge this a  
19 little bit. We're not sure that every readmission is  
20 related, every service is related to the initial condition.  
21 But we wanted to start at least bringing to you this idea  
22 that it would be possible. I think that there are vendors

1 out there that have products that could be overlaid, that  
2 the logic could be overlaid on this.

3 But we wanted to start getting a sense of okay, if  
4 you took a baby step like this in episode creation, what  
5 kind of impact could you hope to have in terms of capturing  
6 Medicare spending? If people were more comfortable starting  
7 with a shorter episode, a very defined episode, it's a  
8 little bit similar to the Centers of Excellence kind of  
9 approach. If people wanted to start somewhere along those  
10 lines, let us give you a little sense of the scope of what  
11 it could cover.

12 But by all means, we knew that we didn't have the  
13 clinical logic and that it wouldn't be appropriate to do it  
14 without it probably.

15 DR. REISCHAUER: By definition you're capturing  
16 all of the Medicare spending for those individuals who go  
17 into the hospital. And what you've told me here is most  
18 medical expenditures are by those people who go into the  
19 hospital. You know, I knew that already, from long study.

20 DR. MILLER: I don't think I would back off as far  
21 as you just did, Anne. I think a couple of things here.

22 We just had this conversation. Glenn just made a

1 whole set of comments about post-acute care and related to  
2 the hospital and we have this fragmented system. A  
3 different way to take your comment is you're right, 60 day  
4 episodes we're probably getting out there. But 15 days  
5 around the episode? Or maybe you come back off of that.

6 In your example, Nancy, you said the discharge  
7 planner just hands this person off and they don't think  
8 about them anymore. That's the point. I think we're trying  
9 to begin to bring the data together. We know that when that  
10 discharge planner hands off the patient to the hospital, at  
11 least that's related to the hospitalization. And I guess  
12 some of the conversation we could have here is about well  
13 maybe we need to keep these episodes relatively short.

14 Because I think the closer you are to the episode  
15 the stronger the argument is that the care is related to  
16 that episode.

17 I agree that when you get further out you really  
18 start to implicate this issue. And I think that's part of  
19 the way I would respond to this.

20 DR. REISCHAUER: Can you marry this or compare  
21 this with the commercial groupers? For these DRGs -- I  
22 mean, this is a very fast and easy way to do something. If

1 you found out that there was a correlation of 0.98 between  
2 the two, then you could drive them all out of business.

3 DR. KANE: Can you just take the physician project  
4 and say let's take a subset of them, anybody who had an  
5 inpatient admission. That makes sense.

6 MR. BERTKO: You could resort those. It's  
7 technically possible. I don't know how difficult it would  
8 be based on what you're doing, to do just that and then  
9 maybe do that correlation.

10 MS. MUTTI: We thought about doing this. It was  
11 just a resource constraint. We were still coming up to  
12 speed on using the groupers, and to ask it to do two  
13 projects at one time seemed like a lot so we thought we'd  
14 get started with this.

15 But we could look at that, certainly.

16 MS. CHENG: [off microphone.] There's one more  
17 issue with the groupers that the team did spend a little bit  
18 of time thinking about. For some of these services,  
19 especially for the SNF and the long-term care hospitals,  
20 Medicare is the primary user of the settings. The groupers  
21 that we have that we're been working with extensively are  
22 generally for a commercial population.

1           So we do have a little bit of an advantage here in  
2 that at least when we do it this way we're going to capture  
3 what Medicare actually uses. We might see some [inaudible]  
4 in our population that the grouper wouldn't see as well  
5 because it's not set up particularly well to capture the  
6 kind of services that we're very interested in doing. So  
7 there's always going to be a little bit of tension.

8           MR. HACKBARTH: If possible, I'd like to steal a  
9 few minutes here and move ahead to our next topic since  
10 we're well behind schedule. Good job, Anne and Craig

11           Next up is IME and DSH payments.

12           Jack and Craig, before you start, let me just set  
13 the stage on this. And if I'm stepping on your lines and  
14 taking things from your presentation, I apologize. I just  
15 wanted to talk about the history here because this is an  
16 issue that we've taken up in the past with some controversy.

17           We last discussed Medicare payment for indirect  
18 medical education two or three years ago. At that point we  
19 considered a draft recommendation offered by me to cut  
20 payments for indirect medical education, specifically to cut  
21 the amount above the so-called empirical amount, that is the  
22 amount that is analytically tied to the actual expenses

1 associated with medical education.

2 That draft recommendation was defeated, rejected,  
3 on a nine to eight vote.

4 We spent a lot of time on the issue, and what the  
5 time did uncover was a consensus among commissioners, the  
6 commissioners at that time, that although people weren't  
7 prepared to cut the payment, not all was well in the world  
8 of payment for medical education.

9 And although we didn't take a vote on it, per se,  
10 I know from both the public discussion and individual  
11 discussions with each of the commissioners, that there was a  
12 very broad consensus that there was a problem in how we were  
13 paying for medical education, a problem specifically with  
14 the IME adjustment.

15 The problem was, and we articulated this in our  
16 report, we were paying a lot of money without any assurance  
17 that we were achieving specific Medicare policy goals with  
18 that investment. And that, especially in these times of  
19 growing fiscal challenges in general and for Medicare in  
20 particular, that was something that we ought to look at  
21 correcting.

22 So we talked conceptually about a number of ways

1 that might be done. And one, as an illustration, hardly  
2 something that we were prepared to embrace, but as an  
3 illustration, one might say well, we ought to take this  
4 increment above the empirically justified amount and tie it  
5 to a specific policy goal like uncompensated care. And we  
6 talked about that in the abstract and identified both some  
7 positive potential there, but also some potential problems  
8 with doing that, and said that well, we would come back to  
9 this issue once we had information on uncompensated care so  
10 that we could talk not in the abstract about that potential  
11 policy but actually have some data.

12 Consistent with that, the Congress mandated the  
13 collection of data on uncompensated care from hospitals.

14 Now fast forward to the present. An effort was  
15 made to collect those data, but the data really are rife  
16 with problems and pretty much unusable from a policy  
17 perspective.

18 So here we are several years later, and we've not  
19 got the data that we would like to have to advance the issue  
20 the way we discussed it several years ago.

21 So the question becomes well, if we don't have the  
22 data, why talk about it? And that's the thing I wanted to

1 address at the front end. Believe me, given how difficult  
2 this was last time, this isn't something I really was  
3 running up excited and eager to do. But there are two  
4 reasons I think it is important to take it up.

5 One is interest from our principal customer, the  
6 Congress. I wouldn't characterize it as a clamoring, but  
7 we've had specific inquiries about this issue and requests  
8 for us to look at it again from both the House and the  
9 Senate.

10 The second reason for my thinking that it's time  
11 to take a look at it again will be evident as we go through  
12 the presentation. I won't go into detail, but it seems to  
13 me that there is a reason to be concerned that there's a  
14 growing equity problem here, namely a growing disparity in  
15 financial performance under Medicare between teaching  
16 hospitals and non-teaching hospitals. And that disparity is  
17 getting bigger over time.

18 So for those two reasons we are back again, two or  
19 three years later, talking about indirect medical education.

20 DSH has a little bit separate history but many of  
21 the same issues arise there.

22 So with that preface, Jack, do you want to take it

1 from there?

2 MR. ASHBY: Glenn has covered some of our  
3 presentation and we'll shorten up in spots, as a result.

4 This session does launch a project to consider  
5 whether changes are needed in the IME and DSH adjustments.  
6 These adjustments, both of which are structured as  
7 percentage add-ons to base rates, have played a major role  
8 in distributing payments in the acute PPS over the last two  
9 decades, as we're going to show in a moment.

10 Unlike any of Medicare's other PPS also, the acute  
11 inpatient PPS has separate base rates for operating and  
12 capital costs. We're going to address capital costs in this  
13 project, as well, because the DSH and IME adjustments are  
14 both applied to capital, and also because capital has yet a  
15 third adjustment and that is a payment add-on for hospitals  
16 in large urban areas.

17 And then finally, we're going to address outlier  
18 payments. The central question here is a little different.  
19 It's whether changes in outlier payment policy would be  
20 needed under MedPAC's proposals to refine Medicare's DRGs  
21 and DRG relative weights.

22 So we'll begin by providing some descriptive

1 information on the IME, DSH and capital payments, how each  
2 has evolved and how they work today and so forth, starting  
3 with IME.

4 MR. LISK: To make clear from the start, Medicare  
5 does provide two payments to teaching hospitals. We want to  
6 make sure that's understood. There's the indirect medical  
7 education adjustment, which Glenn went over, which covers  
8 higher patient care costs associated with teaching  
9 activities in the hospital but not the cost of the residents  
10 themselves. That's reimbursed under the direct graduate  
11 medical education payment system. That's not going to be  
12 our focus. Direct GME is not going to be the focus of our  
13 discussion here. That's separate and that's a separate  
14 payment provided by Medicare.

15 To give you a little history, first of all, IME  
16 payments totaled about \$5.5 billion in 2004. The IME  
17 adjustment was established in 1983 at the beginning of the  
18 inpatient prospective payment system. The IME adjustment  
19 was put in place because analysis showed teaching hospitals  
20 to have higher costs than other hospitals, higher patient  
21 costs than other hospitals. That's after removing direct  
22 GME expenses.

1           However, when the financial impacts of the  
2 original system were being studied and what was the  
3 "empirical level" at that point in time, they found that  
4 teaching hospitals weren't going to perform very well under  
5 the new payment system. So Congress doubled the adjustment.  
6 And that doubling was a quick and easy way for Congress to  
7 deal with this problem in terms of the system. So that's  
8 what was happening.

9           It's also important note though that, in doubling  
10 the adjustment, the doubling was done through reducing the  
11 base rates. It was funded from the rest of the payment  
12 system. So it wasn't added money to the system, it was  
13 money taken out of other hospitals.

14           Another important point about the current IME  
15 adjustment is when the BBA went into place, the resident  
16 numbers and the resident-to-bed ratio that's used was  
17 capped, although there are some exceptions to that. But at  
18 the same time, the IME payments started to be made for  
19 Medicare Advantage patients.

20           This next showing slide shows the history of the  
21 IME adjustment over time. When the system first went into  
22 place the adjustment was very high, at 11.6 percent. It

1 then dropped down to 8.1 percent when the DSH adjustment was  
2 put into place. When some further expansions of DSH were  
3 put into place again in 1989, I think, the adjustment  
4 dropped again down to 7.7 percent, where it stayed for a  
5 long time. And then with BBA some reductions took place.

6 Today, in 2006, the adjustment is about 5.5  
7 percent for every 10 percent increment in resident-to-bed  
8 ratio.

9 If you're interested in what the exact formulas  
10 are for IME for inpatient operating, in the very back of  
11 your paper the formulas are actually there. They're  
12 different for operating and capital payments.

13 In 1988 Medicare paid about \$1.8 billion in IME  
14 payments to hospitals and, as we already said, in 2004 they  
15 totaled \$5.5 billion. This is more than \$60,000 per  
16 resident that Medicare supports.

17 The Commission has also conducted empirical  
18 analysis of the IME adjustment. Our most recent estimate,  
19 based on 1999 data, which was part of our 2003 March report,  
20 showed that teaching hospitals costs increased about 2.7  
21 percent for 0.1 increase in the resident-to-bed ratio.  
22 Thus, the current adjustment is about double what the

1 empirical level is, based on this earlier analysis.

2 Our estimates of the empirical analysis as we've  
3 done at ProPAC and at MedPAC before, our estimates of the  
4 empirical level have come down over time. And we will be  
5 coming back to you at the next meeting with some new  
6 estimates based on 2004 data on the empirical level.

7 This next graph just shows you for information  
8 purposes how the adjustment changes with increases in the  
9 resident-to-bed ratio. The top line is a current adjustment  
10 and the bottom-line is what the adjustment would be if set  
11 at the empirical level using 1999 data.

12 For example, just to give you an example, a  
13 hospital with an IRB of 0.1 gets an add-on of a little more  
14 than 5 percent. A hospital with an IRB of 0.5 would get an  
15 add-on of a little more than 24 percent.

16 This next slide goes over the conclusions that the  
17 Commission made in 2003. I'm not going to review them  
18 because Glenn did a very good job of going over that. And  
19 so we'll going to go on to DSH and then we'll come back to  
20 with some other data after that.

21 MR. ASHBY: Turning to the DSH adjustment, the  
22 adjustment was implemented in 1986, two years after PPS

1 began, and payments now total \$7.7 million as of 2004. The  
2 add-ons are determined by formula, and each hospital's low-  
3 income patient share. That low-income patient share is the  
4 sum of two ratios: Medicaid patient days as a percentage of  
5 total patient days and patient days for low-income Medicare  
6 patients, those eligible for the SSI program, as a percent  
7 of Medicare days.

8           You'll notice that these two ratios have different  
9 denominators. One of the implications of that is that a  
10 hospital can actually have a low-income share that exceeds  
11 100 percent.

12           The original justification for the DSH adjustment  
13 was to compensate for the cost increasing effect of treating  
14 low income patients. The initial regression, done when it  
15 was first implemented, showed that that effect on cost was  
16 small and it was concentrated among large hospitals located  
17 in urban areas.

18           So the original adjustment was predicated on those  
19 results and in aggregate provided only a 1.9 percent add-on  
20 to base payments, as we see in this next slide.

21           But over the last decade many observers have  
22 argued that the adjustment subsidizes indigent care provided

1 to the uninsured and underinsured. And largely on that kind  
2 of rationale, Congress has expanded eligibility for the  
3 program and the adjustment rates several times.

4 In addition, the courts have expanded the count of  
5 Medicaid days that go into calculating low income shares.  
6 Just one example is that days paid for under 1115 waivers  
7 are now counted. They once were not.

8 As a result of these two phenomenon, DSH payments  
9 as a percentage of base payments have grown fivefold, from  
10 1.9 percent in 1987 to 9.9 percent in 2004. There have been  
11 two legislative increases just since 2000 and both of these  
12 were geared towards improving DSH payments for rural  
13 hospitals.

14 This next chart shows the distribution formula for  
15 the operating DSH adjustment, which is actually three  
16 formulas. We have one for urban hospitals with more than  
17 100 beds, that's represented by the solid line; one for  
18 smaller urban and most rural hospitals, that's represented  
19 by the dotted line. The key feature here is a cap of 12  
20 percent on the maximum add-on that can be obtained. And  
21 then we have a special adjustment of 35 percent, which only  
22 goes to a handful of hospitals, shown by the green dots

1 here. That adjustment is targeted to public hospitals that  
2 receive substantial subsidies from a state or local  
3 government, which is viewed as a proxy for providing  
4 substantial amounts of uncompensated care.

5 One other thing to note about the distribution  
6 approach here, and that is that there is a 15 percent  
7 threshold. In both of the primary formulas, only hospitals  
8 with low-income shares above 15 percent receive any  
9 adjustment at all.

10 Again, if you're interested in more detail, the  
11 complete formulas are in the back of your handout.

12 The formulas for the capital DSH adjustment are  
13 quite different. Just to summarize quite briefly, the add-  
14 ons are a lot smaller. They are restricted only to urban  
15 hospitals with more than 100 beds. Rural hospitals don't  
16 get anything on the capital side. The 15 percent threshold  
17 does not apply, which is kind of a curious aspect of it, in  
18 some sense, because that leaves several hundred hospitals  
19 getting only a DSH adjustment on the capital payments, which  
20 is really tiny, in the neighborhood of 0.1 or 0.2 percent of  
21 their inpatient payments.

22 Now we're going to turn to capital payments. A

1 little background on this. Capital was initially paid as a  
2 pass through up until the capital PPS was implemented in  
3 1992, with a 10 year transition. But payments were almost  
4 immediately thought to be too high, in part because of a  
5 curious practice at the time of basing the update to capital  
6 payments on the growth in capital costs rather than the  
7 growth in a market basket, representing prices. So Congress  
8 made two cuts, the second one in the BBA, totaling 22  
9 percent.

10 One other unique thing about capital payments is  
11 that CMS, rather than Congress, sets the update each year.  
12 CMS now does have a special capital market basket to guide  
13 those decisions.

14 Once capital payments became fully perspective in  
15 2002 there was no longer any need for separate operating and  
16 capital base rates. The only reason we still have the two  
17 separate base rates is because the distribution formulas for  
18 IME and DSH are different on the capital side, and then also  
19 because there is this third adjustment. And that is that on  
20 the capital side hospitals in large urban areas get a 3  
21 percent add-on to their payments. That policy was suggested  
22 by a regression back in 1991 that showed a cost difference

1 associated with large urban locations.

2           One other thing to note about capital payments,  
3 for sort of perspective, and that is that because it's a  
4 fully prospective system now hospitals' capital payments are  
5 not affected in any way by how much they spend on  
6 construction and equipment. And conversely, hospitals are  
7 not required to use their capital payments to purchase  
8 capital items.

9           MR. LISK: So how much do we spend on IME, DSH and  
10 GME, as we show these in this overhead here for operating  
11 capital and Medicare Advantage program. But we see  
12 combined, IME and DSH combine to totaled about \$13 billion  
13 in fiscal year 2004 or about 14 percent of Medicare PPS  
14 payments were distributed through these two adjustments, a  
15 substantial portion of those payments.

16           Teaching hospitals also received an additional  
17 \$2.6 billion in Medicare direct GME payments.

18           And also just to note on this aspect, nursing  
19 allied health programs is an additional \$2 billion  
20 distributed hospitals for this.

21           This next slide shows the proportion of hospitals  
22 receiving IME and DSH payments. As you can see, many more

1 hospitals receive DSH payments than IME payments, 75 percent  
2 receive some DSH payments whereas 30 percent receive some  
3 IME payments. Almost a quarter of hospitals receive both.

4 Now both urban and rural hospitals, a substantial  
5 proportion of both urban and rural hospitals receive DSH  
6 payments. But IME is, of course, concentrated where  
7 residency training takes place and that's an urban  
8 hospitals. So only 7 percent of the payments are to rural  
9 hospitals for IME.

10 What you also can see here though is that over 90  
11 percent of major teaching hospitals also received DSH  
12 payments. Major teaching hospitals are those with 25 or  
13 more beds. I think -- 7 percent of rural hospitals receive  
14 IME payments. I said -- never mind.

15 In this next chart we show the destination of IME  
16 and DSH payments and add-ons as a share of base payments.  
17 What we see is that hospitals can have some fairly large  
18 payment add-ons for these adjustments. 10 percent of  
19 hospitals receiving just IME payments haven't an add-on of  
20 13 percent or more. That's the 90th percentile there. 10  
21 percent of hospitals receiving just DSH adjustment receive a  
22 payment add-on of 18 percent or more.

1           But add-ons go to that quarter of hospitals that  
2 receive both IME and DSH payments. Over half of this group  
3 receiving adjustments add-on of 19 percent or more and 10  
4 percent receive an adjustment of 52 percent or more added to  
5 their base rates. That's about 2.5 percent of all PPS  
6 hospitals. This can result in substantial difference in  
7 payments between hospitals in the same market, one that has  
8 no DSH and IME payments. For instance for a stroke patient,  
9 if they are in a wage index area of one, would receive about  
10 6,400 for that patient whereas a hospital at that 90th  
11 percentile in that group receiving both of those payments  
12 would receive about \$3,300 more for the same case.

13           Another point we'd like to make is that these  
14 payments are highly concentrated. 200 teaching hospitals  
15 out of 3,500 hospitals total account for 68 percent of the  
16 IME payments. They receive 68 percent of the IME payments.  
17 Similarly, the top 200 DSH hospitals out of 3,500 hospitals  
18 receive 38 percent of DSH payments. Finally, of the \$13  
19 billion in total DSH and IME payments made in 2004, 45  
20 percent of these payments go to just 200 hospitals, an  
21 average of almost \$30 million per hospital.

22           MR. ASHBY: Turning to our inpatient margin data,

1 we can readily see the substantial role that IME and DSH  
2 payments play in determining hospitals financial performance  
3 under Medicare. Major teaching hospitals have by far the  
4 best performance. But you'll notice that the high margins,  
5 over 12 percent, are limited to those that are getting both  
6 IME and DSH. Those getting IME only have a margin about 2.3  
7 percent. Many of those are getting quite small adjustments.

8           The other teaching hospital group is below average  
9 as a group. But again, those getting both IME and DSH are  
10 faring considerably better than those that get IME only.

11           Among non-teaching hospitals we see that just  
12 under one-fifth of all hospitals that get neither IME or DSH  
13 have margins that are averaging below minus 14 percent. So  
14 there's quite a range that can be linked to these payment  
15 adjustments.

16           The next chart shows the distribution of inpatient  
17 margins. You'll notice here that the group receiving both  
18 IME and DSH has substantially higher margins than the group  
19 receiving neither at every point along the distribution.  
20 And then, at the top of the distribution, we have some  
21 strikingly high margins here, 30 percent and above in the  
22 group receiving both adjustments as well as the group

1 receiving DSH only.

2           Next we turn to the policy questions for the  
3 Commission to consider as this project progresses this fall.  
4 For IME and DSH, in light of the large and growing gap in  
5 financial performance between those that do and do not  
6 receive the adjustments, the question is are the current  
7 levels of the IME and DSH adjustments justified? If not, we  
8 might think in terms of returning any savings from reducing  
9 the adjustments to the base rates so that the overall effect  
10 of the change will be an improvement in the equity of  
11 payments among all hospitals.

12           Our first step in addressing this question, as  
13 Craig mentioned, will be to establish the relationship  
14 between Medicare costs and both the teaching activity and  
15 treating low-income patients.

16           Then I was next going to cover that uncompensated  
17 care issue. Again, I think Glenn covered that pretty well.  
18 The data collection is underway but there has been pretty  
19 much substantial agreement by a number of people that have  
20 looked at the data that there are substantial problems with  
21 them and the data, at the moment, are essentially unusable.

22           Staff have worked with CMS on revising the data

1 collection forms and instructions but we are at least two  
2 years away from having usable data there.

3           The second major question is whether changes are  
4 needed in the formulas that govern the distribution of  
5 payments, somewhat apart from the overall level of the  
6 payments?

7           For capital the first question is whether the DSH  
8 and IME adjustments really need a separate distribution  
9 formula for capital payments? The second question is  
10 whether the 3 percent capital add-on for location in a large  
11 urban area is justified? And in an analogous way, we will  
12 begin looking at that question by establishing the  
13 relationship between costs per case and large urban location  
14 at our next meeting.

15           Then, depending on how the deliberation of these  
16 first two questions comes out, the Commission can consider  
17 whether the program even needs to have separate operating  
18 and capital payments? They were once essential because of  
19 the transition. We might revisit that today.

20           MR. LISK: Finally, we wanted to turn briefly to  
21 discuss outlier payments. Outlier payments are for  
22 extraordinarily costly cases. Outlier cases are identified

1 by comparing their costs to a DRG-specific threshold. It  
2 acts as an insurance policy for extremely costly cases.

3 Outliers are funded through an offset to the base  
4 rates, 5.1 percent for operating and 4.8 percent for  
5 capital. This is like a premium that the providers pay to  
6 fund this insurance.

7 Outlier payments are made once the cost of the  
8 case exceeds its payments plus a fixed loss threshold, which  
9 in 2006 is set at \$23,600. We can also think of this amount  
10 as the deductible for each to receiving outlier case.

11 This fixed loss threshold is adjusted for input  
12 prices so that hospitals in low wage markets have slightly  
13 lower fixed loss thresholds and those in high wage markets  
14 have slightly higher fixed loss threshold. CMS attempts to  
15 set the fixed loss threshold so that it will pay out the  
16 full 5.1 payment onset, though CMS often misses the mark.

17 Once the fixed loss threshold is reached, CMS pays  
18 80 percent of costs for the case over the amount. You can  
19 think of this as the coinsurance amount. And costs are  
20 determined by multiplying a hospital-wide cost-to-charge  
21 ratio by the total allowable Medicare charges for the case.

22 So with severity adjustment potentially on the

1 horizon, is it time to rethink our current outlier payment  
2 policy? One of the issues is whether the current 5.1  
3 percent payment offset remains appropriate. CMS, by law, is  
4 required to set it between 5.1 and 6.1 percent. Severity  
5 adjustment may reduce the risk associated with high-cost  
6 patients that the outlier policy is set to cover. Thus, a  
7 lower offset might be appropriate given refinements to the  
8 system. A reduction in the offset would result in higher  
9 base rates and a smaller share of PBS payments going to  
10 cover outlier cases.

11 Another issue to consider is whether the 80  
12 percent marginal cost factor is appropriate. The 80 percent  
13 marginal cost factor likely pays more to hospitals than the  
14 direct costs they incur after the fixed loss threshold is  
15 reached. Although it may allow hospitals to recoup some of  
16 the losses they incur in reaching this amount, it may also  
17 reduce the incentive hospitals have to discharge these  
18 patients or to treat these patients efficiently once they  
19 start receiving outlier payments.

20 Any change in the marginal cost factor would  
21 result in a redistribution of outlier payments. It would  
22 not affect total program spending.

1           We are going to be looking at IME, DSH, capital  
2 and outliers over the next three meetings, and actually  
3 there is some relationship with outlier payments and IME in  
4 terms of the empirical level. If we pay out less in outlier  
5 payments it may affect our empirical level for the IME, and  
6 that's one of the reasons we're bringing this issue up for  
7 you today.

8           We would be interested in any issues you have or  
9 concerns you have with IME, DSH, capital, and outlier  
10 policies as we discussed today, and where you might like us  
11 to focus our analysis.

12           MR. HACKBARTH: Thank you.

13           Let me just start this. At the beginning I talked  
14 about the recommendation we considered several years ago to  
15 cut the payment. The way that recommendation was  
16 formulated, any reduction in the payment would have resulted  
17 in savings to the Medicare program, which would have gone to  
18 the Treasury.

19           That is not the way I think we ought to even  
20 approach the issue, regardless of whether we choose to move  
21 forward or not. I think the context is quite different now.

22           Several years ago, when we looked at this,

1 hospital Medicare margins were substantially higher than  
2 they are now. As you'll recall from our discussion last  
3 year around the update, the average overall Medicare margin  
4 is negative -- I think it was what, minus 2 percent or  
5 thereabouts?

6 MR. ASHBY: Minus 2.2 for '06.

7 MR. HACKBARTH: Given that overall picture, my  
8 thinking about this discussion is that we're talking about  
9 not taking the money out of the system if we change IME but  
10 rather putting it back in the base and redistributing it.  
11 So I just wanted to make that clarification at the front  
12 end.

13 There are two commissioners who are not here who  
14 have a lot of knowledge and experience about this that they  
15 wanted to make sure got into the discussion. One is Ralph  
16 Muller and the other is Sheila Burke. I'm Ralph, and this  
17 is Sheila. I'm going to do Ralph's part.

18 [Laughter.]

19 MR. HACKBARTH: Incidentally, Ralph has had a  
20 perfect attendance record at MedPAC. This is the first  
21 meeting he's missed and this is his sixth year on the  
22 Commission. But he just had a conflict with a board

1 commitment that he simply could not miss. And it only came  
2 up very recently or we would have rescheduled the whole  
3 discussion to have it when Ralph was here.

4 But because of that I told him that we would make  
5 sure that his observations were on the table and he'll have  
6 plenty of opportunity later on to talk about this  
7 personally.

8 The first thing he wanted us to raise on his  
9 behalf is that we had said we would come back to this when  
10 we had uncompensated care data. We don't. That's not the  
11 fault of hospitals, from his perspective. And so he really  
12 would prefer that we not take it up at this time, consistent  
13 with our earlier discussion.

14 The second point that Ralph wanted to make is that  
15 right from the outset Congress knew that they were setting  
16 the payment at higher than the empirical level. Indeed, it  
17 was a quite conscious decision to double it, and Dave  
18 Durenberger can speak quite directly to that.

19 From Ralph's perspective, that was a conscious  
20 congressional decision to shift resources to teaching  
21 hospitals because of the important mission that they serve  
22 beyond simply caring for Medicare patients. And he thought

1 that that piece of history, at least his vantage point on  
2 the history, ought to be on the table.

3 He would also note that there are other examples  
4 within the Medicare system of Congress making somewhat  
5 similar judgments that we have to use Medicare dollars to  
6 support broader public policy missions. For example, some  
7 of the rural hospital adjustments, critical access  
8 hospitals, a conscious decision is made to pay more under  
9 Medicare to assure access, not just for Medicare patients  
10 but for all patients in rural areas meeting certain  
11 standards.

12 Finally, Ralph wanted to note that the data that  
13 Jack and Craig just went through on margins is inpatient  
14 margin information, whereas we usually look at overall  
15 Medicare margin information. And for the uninitiated, the  
16 difference is that the overall Medicare margin combines  
17 Medicare payments for both the inpatient care and hospital-  
18 based, SNF care, hospital outpatient departments, and  
19 combines all of those revenues and all of those costs.

20 The overall margins for teaching hospitals is  
21 substantially lower than the figure that Jack presented.  
22 For major teaching hospitals the overall Medicare margin is

1 6 percent, as opposed to 12.5 percent for inpatient alone.  
2 For other teaching hospitals, just to continue the series so  
3 we've got comparable figures, other teaching hospitals have  
4 an overall Medicare margin of -- is that a minus 2 or a 3?  
5 Minus 3.5 percent. The Medicare inpatient margin for other  
6 teaching is minus 1.5 percent.

7 For the non-teaching hospitals, the Medicare  
8 inpatient margin is minus 6.5 percent. That's the number  
9 that Jack showed. Whereas the overall Medicare margin for  
10 non-teaching hospitals is minus 7.5 percent.

11 So those were points that Ralph wanted to make  
12 right at the beginning of the discussion. Sheila?

13 DR. MILLER: And Sheila wanted to make the  
14 following points. First of all, she said that she thinks  
15 that it's healthy that we revisit this issue but, much like  
16 Ralph, she said that hospitals have missions that go beyond  
17 just serving Medicare patients, they have community  
18 missions. This concept that Medicare payments may be for  
19 more -- you can make Medicare payments all about efficiency  
20 and accuracy, but also Medicare payments can also reflect  
21 social policy.

22

1           So she said that it's important that when we  
2 consider this we consider it in the broader context that  
3 there are other parts of Medicare where payments have social  
4 policy. And she, too, cited the critical access hospitals,  
5 swing beds that type of thing.

6           She then went on and said that, and I think this  
7 gets to the -- the next two points are sort of the nut of  
8 some of her concerns -- is that on the one hand one could  
9 argue, and it's not an unreasonable argument, that Medicare  
10 maybe shouldn't be involved in this. This is a social  
11 benefit for society in general. And that maybe it should be  
12 something that's more of a general revenue, an appropriated  
13 type of function. Here I'm talking about IME specifically.  
14 That was the example I think she had most in her mind.

15           She said one could make those arguments. But she  
16 has at least a couple of concerns. One is will Congress, in  
17 fact, step forward and fund this if Medicare does not? And  
18 two, she also was making the point more eloquently than I am  
19 right at the moment that there's also some assumption that  
20 maybe the private sector should pay its part. She also is  
21 skeptical that the private sector would step up to that  
22 responsibility.

1           Then she said one other concern that I think I  
2 should make is we have -- and Glenn did this just a second  
3 ago -- we have cast this as if we pursue this, the notion of  
4 taking the adjustment down and redistributing the dollars to  
5 other hospitals --and she pointed out that of course  
6 Congress does not have to do that, they could choose to take  
7 the money out of the system.

8           And so she had that concern, as well.

9           MS. DePARLE: I'm glad we're having this  
10 discussion again, too. And I want to replay the tape a  
11 little bit. We've talked already some about the history of  
12 this issue. And it's reminding me how unsettled I was at  
13 the end of our last discussion of it and the vote that we  
14 too -- I can't remember, Glenn, whether it was two or three  
15 years ago, I think two. I'm worried that we're about to get  
16 drawn into the same kind of discussion in this way.

17           What was unsettling to me was that at the end of  
18 it, and Bob and I and at that point Jack Rowe, a fellow  
19 commissioner, had spent 18 months on an IOM panel examining  
20 some of these issues, the future of academic health centers.  
21 And in both processes I felt at the end that we concluded we  
22 don't really know whether we are getting what we're paying

1 for here. What is it that we want to get out of these  
2 payments? And are we getting them?

3 I worry, it's a natural thing to get drawn into  
4 these numbers. But I want to make sure that in re-examining  
5 this, which I support, that we look at, for each one of  
6 these items, what was the policy objective? Is that still  
7 appropriate? And then get into is it the right amount for  
8 it?

9 Because I do think there needs to be more  
10 discussion of that. I actually think we could probably  
11 reach consensus in this group on that. We haven't really  
12 had the time to do that. It will take time.

13 But I would just urge that we try to do that.

14 I actually think both Sheila and Ralph's comments  
15 kind of go to that issue, as well. Let's figure out what  
16 this is for.

17 I don't think it's in here but just looking at the  
18 numbers, we're talking almost \$20 billion a year now that  
19 we're spending on all the items together; right, if you add  
20 it all up?

21 MR. ASHBY: \$13 billion for IME and DSH.

22 MR. LISK: \$13 billion for IME and DSH. If you

1 add indirect GME, it's another \$3 billion.

2 MS. DePARLE: But you've got capital and outliers  
3 up here, as well. Are we talking about all of them?

4 MR. ASHBY: Capital, remember, is part of the base  
5 rate so we're not considering that.

6 MS. DePARLE: You're not looking at that  
7 separately.

8 MR. ASHBY: We're looking at capital because the  
9 IME and DSH adjustments are made to capital as well using  
10 totally different formulas.

11 MS. DePARLE: What about outliers? Is it in there  
12 again just as a context?

13 MR. LISK: Outliers is one way we distribute  
14 payments for exceptionally high costly cases and it's  
15 really, under DRG refinement, rethinking whether 5.1 percent  
16 as the right amount and whether how we distribute it out in  
17 terms of paying 80 percent of marginal costs after they  
18 reach that point.

19 DR. MILLER: To her point, if you threw that in  
20 the pot, that's another \$5 billion?

21 MR. LISK: Yes.

22 DR. MILLER: So she's about right.

1           MS. DePARLE: There is some commonality among --  
2 there's some overlap in the policy objectives here. So it  
3 starts to be a rather large amount of money. So what are we  
4 getting for it? After all this time I'm still not sure.

5           DR. SCANLON: I definitely agree that this is an  
6 important area for us to be looking at. It's in the broad  
7 context of what's the basis for Medicare payment. I think  
8 one of the things that, in some respects, started with  
9 ProPAC when we first introduced the PPS and it has  
10 continued, is the idea that we're going to measure as well  
11 as we can the cost of delivering a service and then try to  
12 make payment as close as possible to the cost of that  
13 service.

14           I think we have to recognize that in the case of  
15 hospitals -- and since I'm agreeing with some of what Ralph  
16 and Sheila have said in the respect -- is that hospitals  
17 potentially provide social benefits that go beyond the  
18 service. We need to think about how is it as a society  
19 we're going to fund those social benefits.

20           And while, in an ideal world I would like to know  
21 what all those social benefits are and hold all hospitals  
22 accountable for how much they got for them and did they

1 deliver them, I also recognize the difficulty of measuring  
2 all of the social benefits.

3           The idea of having data on uncompensated care  
4 would have meant a movement in the direction of measuring a  
5 social benefit. But it would have been one social benefit  
6 out of many. And one that has concerned me a lot, starting  
7 with some work that I did or was done while I was at GAO, is  
8 the whole issue of emergency capacity. We had to look at  
9 the capacity of hospitals to respond to outbreaks of  
10 infectious disease. We found that hospitals didn't have  
11 much in the way of that kind of capacity. The response of  
12 executives was that they had taken the signals that all of  
13 the payment changes had given them, in terms of rightsizing,  
14 and they had right-sized out all of the slack that you might  
15 want to have in the case of an emergency.

16           How do you define how much slack you want to have?  
17 How do you define whether it's there? It's a really big  
18 challenge.

19           And then I think if we sat down and thought hard  
20 enough we could come up with a set of even more intangible  
21 social benefits that we might want to have and we might  
22 threaten, depending upon how good we get at getting payments

1 down to the level of the costs of an individual service.

2           So I think this is a big issue. It extends well  
3 beyond teaching hospitals. It really extends to the  
4 hospital sector because hospitals, in some respects, are  
5 unique among the provider community. They are the provider  
6 of last resort. Not just by practice. We've made them  
7 provider of last resort by law. We've said that if you're  
8 going to participate in Medicare, you better treat people  
9 that show up at your door. And that's unique among all the  
10 providers that we've got.

11           So I think we're right in doing this. We've got a  
12 lot of challenges in terms of how we end up trying to  
13 resolve it.

14           MR. DURENBERGER: One question first about  
15 outliers. I just spent part of my vacation with Jack  
16 Wennberg and his wife in the Tetons. You can't get 10  
17 minutes into any conversation without him telling you about  
18 the outliers and the excessive volume and running you  
19 through every hospital, every community in America and the  
20 disparities.

21           So just watching that at work and looking at the  
22 data, it impressed me that thought might not otherwise get

1 mentioned here, to compliment you both on the inclusion of  
2 that in this analysis and the work that we'll all benefit  
3 from that Dartmouth and others have done on that subject.  
4 It goes way beyond the fraud and abuse stuff. It goes to  
5 the heart of how is it best with limited dollars to  
6 compensate people.

7           The second thing that I would love to see in  
8 looking at this, and I agree with everyone that this is the  
9 right thing to do. It's going to take a long time to do it.  
10 I don't think we should set deadlines for ourselves. Maybe  
11 our discussion will stimulate others who should be  
12 interested in the topic to get more interested in it.

13           But one thing that's sort of like a distributional  
14 question that I have, which is in what states will we find  
15 what amounts of GME, IME, DSH money? I think I know the  
16 answers to the first two, at least in bulk, but I think it  
17 would be important because it is important to talk a little  
18 bit not about distribution but to talk about the quality of  
19 education and the quality of the educational system in  
20 health professions and the role that Medicare should pay in  
21 that. And I'm going to bring that up in a second.

22           Since I was around when we did all of this, I'd

1 like to first mention the basic policy goal. The basic  
2 policy goal was to restrain costs in the health care system.  
3 That's what we were up to. That's what drove the whole  
4 prospective payment system approach.

5           Having made that distinction, having adopted in  
6 the early '80s to the DRG as a way to do that with regard to  
7 hospitals, we went on a very fast learning curve. And  
8 again, by we, we're not a bunch of researchers. We're not  
9 the talent around this table. We're a bunch of politicians,  
10 basically.

11           But the nice thing about it was it was never  
12 partisan. It was always people deeply concerned about how  
13 do you broaden access by reducing cost, if that's even  
14 possible?

15           So the learning curve involved a variety of  
16 things. One, if you start literally averaging everybody in  
17 the country and giving them one of whatever it is DRG  
18 categories and so forth, you're going to bring a lot of  
19 things to a halt that are currently being subsidized inside  
20 America's hospital systems. And a lot of that was  
21 uncompensated care. We knew about that. We didn't know how  
22 to deal with that at the time. Eventually the DSH comes out

1 of it.

2 But the one we did know about was teaching and was  
3 education. The feeling at the time was -- and I hope I do  
4 this passionately enough for Sheila, too. But the feeling  
5 at the time was what good is talking about high quality  
6 medicine, access to high quality medicine, if you're going  
7 to use the cost reduction system to kill off the education  
8 system?

9 So it was a conscious decision for us to adopt GME  
10 and IME and a lot of these support systems.

11 There was a conscious decision taken early on to  
12 put more money into that reimbursement than we necessarily  
13 felt might be necessary. But it was important, as we did in  
14 some other areas, to protect the beneficiaries and to  
15 protect the people who were involved in the infrastructure  
16 for education.

17 So as I recall, particularly that six or seven or  
18 eight year period of time, there were a lot of learning  
19 curves. We began to learn about some of the claims that  
20 were made by academic medicine that all of their cases that  
21 they treated were much more severe than other hospitals was  
22 not necessarily true. And also the claim that was made that

1 all academic medicine and all teaching hospitals had more of  
2 a burden of uncompensated care than other people. That  
3 wasn't true. Not that they're being dishonest, but simply  
4 that's what the research was showing, as we still see here  
5 today.

6           So a lot of the evolution of the policies since  
7 then was not in the direction of not necessarily having any  
8 role at all in what we've come to call social benefits or  
9 social policy like the uninsured, but say are we doing it  
10 realistically?

11           With regard to medical education and the teaching  
12 adjustment, the notion in the beginning was that everyone  
13 ought to contribute towards the cost of caring or for  
14 providing health professions education. We hoped that by  
15 the example that Medicare was going to play with regard to  
16 GME and IME that we would provide a precedent for private  
17 insurance to take on the burden for the non-Medicare  
18 population. It really hasn't worked out that way. But the  
19 idea never really went away.

20           As I recall in the early 1990s on the Finance  
21 Committee we voted on a very specific 3 percent tax. We  
22 said there should be a 3 percent tax on all health insurance

1 in this country to provide for medical education.

2 I remember voting against that, not because I  
3 thought that was anything wrong with education or funding  
4 education but because I had a deep concern about what we  
5 were going to get for our money if we just levy a 3 percent  
6 tax and create a whole new fund. There was no distribution  
7 formula. There was no qualitative or evaluation or anything  
8 like that.

9 And I also had my own personal feelings, which is  
10 if you're going to fund education, you ought to fund the  
11 students, you ought not to fund the institutions. But I  
12 don't bring that up here today.

13 The challenges that we're spoken to by both Ralph  
14 and Sheila, who's had even more experience or longer  
15 experience than I have, you talk about the politics of this.  
16 The politics of this over the last umpteen years have been  
17 driven by the distribution formula, which you will see when  
18 you see where all the money is going. You can look on the  
19 Senate Finance Committee or the Ways and Means Committee.  
20 And if you think you're talking policy, you're not really  
21 necessarily talking good national policy. You're talking  
22 good national politics being practiced by a few people who

1 are well positioned.

2           And since I'm talking about people I admire more  
3 than anybody else, Daniel Patrick Moynihan and others, I  
4 don't diminish their contribution to national policy in any  
5 way. Simply that we can't just say it's always been  
6 congressional policy that we ought to do what we've been  
7 doing for 20-some years. You can reconsider it.

8           I would say the same thing about critical access  
9 hospitals. It's pretty easy to point to the chair and the  
10 ranking member of the Senate Finance Committee and say but  
11 for the fact that they were there, would we be spending that  
12 much money?

13           So mainly I'd like to get on the table the issue  
14 that what may have been the right thing to do in those days,  
15 as Len Nichols said this morning, many of us were too busy  
16 being successful to be very good at what we do. But what  
17 may have been the right thing to do in the '80s may not be,  
18 with a whole new policy goal which is pay for performance,  
19 pay for value, it may not be the best policy today. But we  
20 can't leave either the poor or the uninsured or the  
21 education issue behind. It may not be -- I don't happen to  
22 think it's the right thing to use beneficiary money to pay

1 for the uncompensated in this country. I think we all have  
2 a responsibility for that.

3 But I do think that we have some responsibility to  
4 think about what is the specific role that we would expect  
5 from health professions education, as far as beneficiaries  
6 are concerned.

7 If I were voting today I would vote to end a lot  
8 of these programs as being paid out of the trust fund and  
9 have them hopefully be appropriated, recommended them be  
10 appropriated, authorized and appropriated, from other  
11 sources.

12 But having said that, I think it's probably an  
13 important contribution we could make as a commission if we  
14 did talk at least about the important connection between  
15 high quality high performing health professions education  
16 and the quality of care that we expect for all the  
17 beneficiaries in this country, regardless of what we may say  
18 about how that should be financed.

19 DR. KANE: I'm trying to remain passionate at 5:30  
20 and it may be a little hard, so I'll try to be short.

21 But I think one lesson that I learned, and not  
22 just in the teaching hospital IME adjustment, but that being

1 vague about the social benefit you expect and yet allowing  
2 large sums of money to go out on their behalf does not  
3 result in the social benefit being provided. But it often  
4 gives amazing competitive advantage to those who can latch  
5 on to the gravy train.

6           So what we have, even though the overall Medicare  
7 margin is only 6 percent for teaching hospitals, if they're  
8 competing against hospitals with a minus 3.5 percent overall  
9 Medicare margin, they have competitive advantage. As I've  
10 said before, we have seen some of the implications of that  
11 in markets where there is a concentration of academic health  
12 centers. Certainly Massachusetts is one of them, where I'm  
13 from.

14           So I would argue that I certainly don't want to  
15 not pay for indirect medical education, but doubling the  
16 adjustment seems totally unfair to those who have to compete  
17 against those hospitals.

18           Now perhaps critical access has that same problem,  
19 or all the other adjustments, and we do really need to think  
20 about what are we getting from them? Are we getting it?  
21 And is the right way to do that?

22           I guess I always thought that the doubling was

1 there to get the political situation such that the teaching  
2 hospitals bought in on the DRG system, and that once you're  
3 bought in you sort of stop those things. So maybe I just  
4 have a misunderstanding of why the Congress doubled the --

5 MR. DURENBERGER: I think that sustained it.

6 DR. KANE: I guess if we want to rationalize the  
7 IME, the only other thing that seems nonsensical to me or of  
8 concern, is that right now the IME is distributed on the  
9 basis of an inpatient adjustment. Well, there's a lot of  
10 teaching that's not inpatient. There's a lot of outpatient  
11 out there. Is the inpatient only adjustment giving  
12 incentives to maintain an inpatient treatment when it should  
13 be outpatient? Is it keeping more of our care inpatient  
14 that should perhaps go outpatient? I mean, why is it just  
15 inpatient care? Is that just so we can attach it to the  
16 trust fund instead of Part B? Why is IME only based on an  
17 inpatient formula?

18 DR. REISCHAUER: They can use the money for  
19 anything.

20 DR. KANE: I understand, but there's an incentive  
21 -- I know how they can use it. They can finance competitive  
22 strategy with it. But if you really -- you have a formula

1 right now that you can -- that gives you an incentive to  
2 increase your interns and residents per bed and then make  
3 sure you have -- it's only coming through your inpatient  
4 payment, not through your outpatient payment; is that  
5 correct? So you're only going to get it through the DRG  
6 system. You're not going to get it through the APC system.

7           So I'm just wondering, have we thought about why  
8 it's all loaded into the inpatient side? That's just the  
9 piece that might be legitimately for IME right now gives  
10 incentives to treat people on the inpatient side rather than  
11 outpatient that maybe no one's thought about. But somehow I  
12 think the teaching hospitals have figured it out.

13           MR. LISK: When the outpatient prospective payment  
14 system was developed CMS did an analysis and didn't find an  
15 indirect effect. We do, though, see lower outpatient  
16 margins for major teaching hospitals compared to other  
17 teaching hospitals. So you're right, on a theoretical  
18 standpoint you do have that incentive type of thing  
19 potentially there. It's something that we could consider.  
20 We were going to be focusing on, and our analysis has been  
21 on the inpatient side. It hasn't been on the outpatient  
22 side. We're going to focus on the inpatient. But it's a

1 good point.

2 MR. HACKBARTH: Because it is linked as a  
3 percentage add-on to the inpatient payments, it also means  
4 that the amount that an institution gets is proportionate to  
5 its Medicare volume and case mix. It really isn't linked to  
6 how much teaching it's doing. It's linked to its Medicare  
7 volume. Those two may not track perfectly with one another.

8 DR. MILLER: The only thing I was going to do is  
9 take Nancy's point and make it sort of even broader than  
10 your incentive inpatient/outpatient. It's even broader than  
11 that. If someone woke you up in the middle of the night and  
12 said let's pay for the teaching function in a country, you  
13 would pick one payer and tie it to their inpatient formula.

14 It's a good question, is what I'm getting at.

15 MS. BEHROOZI: I think in light of Sheila's  
16 caution, and I think some people have echoed it and it's  
17 implicit in a lot of what Dave says, the inability to  
18 control the response of those who have control over the  
19 payment system to MedPAC's identification of a problem and  
20 suggestions that we might make about how to cure the  
21 problem, it becomes that much more important how we define  
22 the problem, define and measure the problem. I think that's

1 also underlies what Ralph pointed out about the measurement  
2 that was initially presented was based on the inpatient  
3 margin rather than the overall margin. The problem doesn't  
4 look quite as big. You're right, there's still a gap but  
5 it's not quite as big.

6           So I think that we should bear in mind that there  
7 are judgments embedded in the comparisons that we make, the  
8 denominators that we use, saying that the current system  
9 pays double the empirically justified amount. Right now  
10 you're raising questions about whether that empirically  
11 justified amount is too high, is too low. Does it really  
12 reflect the actual inefficiencies in indirect costs?

13           So as we proceed, I think we should proceed very  
14 carefully and not just go on the face of what looks right  
15 now like a really out of whack system. Maybe it's slightly  
16 less out of whack. Or maybe it's in whack with other  
17 things. Maybe there are other societal goods to be  
18 measuring it to, some of the things that Bill has brought up  
19 about the necessity of maintaining hospital capacity. Or  
20 simply the fact that Medicare beneficiaries  
21 disproportionately utilize doctor services, physician  
22 services, and that's not strictly measured when you're just

1 talking about the inpatient payment system. But the  
2 necessity to maintain a core of physicians ready to treat  
3 those patients outside of this context is another one of  
4 those goods to measure this against, I think.

5 DR. BORMAN: I have a couple of numeric questions  
6 first, and then just a couple of philosophic points. The  
7 first thing is is the resident-to-bed ratio the right thing  
8 in today's world? I can tell you in what I do fully 50  
9 percent of the patients are either AM admits or true  
10 ambulatory surgery. And I think that the resident-to-bed  
11 ratio may be a number whose time has passed.

12 Exactly what the best substitute of the number is,  
13 I'm not sure we know but I think there certainly is a  
14 question about that.

15 I would ask, you've showed us the increases over  
16 16 and 17 year periods in the IME and the DSH. Are those  
17 adjusted for inflation? And if not, what has medical  
18 inflation been over that time? Because there are huge  
19 increases, billions of dollars, serious money. But they are  
20 over a fairly long prolonged period.

21 MR. ASHBY: On the disproportionate share chart,  
22 we were showing the payments as a percentage of base

1 payments. So that's implicitly controlling for medical  
2 inflation. And with that controlling, we still had a  
3 quintupling of the payments.

4 DR. BORMAN: How about on IME though?

5 MR. ASHBY: IME, we didn't put it quite in that  
6 form. The payments were 7.9 percent of base as of 1997,  
7 which is actually the last data we have, and are down to 6.2  
8 percent as of 2004.

9 But we have to remember that even some of that is  
10 offset by the fact that there was new IME money coming in  
11 during that period for MA patients. So it's part of the  
12 overall IME picture.

13 DR. BORMAN: Do we know what percentage of MA  
14 patient, though, seek care in teaching hospitals? I frankly  
15 don't know the answer to that, but I'm not sure if they are  
16 outside of that because frankly, a lot of capitated plans or  
17 predefined payment, or whatever we want to call them, are  
18 less often associated with those hospitals.

19 MR. ASHBY: I can't answer the number of patients,  
20 perhaps Craig can. But let me just qualify what I just said  
21 a moment ago.

22 The reduction in IME payments as a percentage of

1 base was from 7.9 to 6.2. They said if you input the MA  
2 patients into that, it's reduced from 7.9 to 7.0. So it's  
3 not a huge reduction. really.

4 MR. LISK: In many ways the MA payments offset  
5 some of the reductions that were made in the IME adjustment  
6 because before BBA we were not paying for MA patients in  
7 terms of this additional amount. Currently, we now pay the  
8 teaching hospitals an IME adjustment specifically for those  
9 patients. That's \$600 million dollars in 2004. And in  
10 addition, the MA plans also have additional money from the  
11 IME adjustment that they're getting when they did -- was  
12 that the BBA? I'm sorry, the MMA plan they put that money  
13 back into the plan.

14 DR. BORMAN: So as best we can tell, we believe  
15 that we're comparing apples to apples over time?

16 Another question would be what is in table 4 in  
17 the handouts a couple of slides back where you do the 25th,  
18 50th, 75th, 90th, whatever percentile. Just on an  
19 eyeballing basis, this looks like a hugely skewed to the top  
20 end curve, and that does suggest that some of this is driven  
21 by outliers.

22 And again, in your information about concentrated

1 among certain hospitals, I think that's a pretty important  
2 point here because we're getting pretty wrapped up in that  
3 there are some things -- as Nancy points out -- some groups  
4 that are being enabled to do some things that we think would  
5 not be good by this. But I think we have to be a little bit  
6 careful about what might be an outlier phenomenon versus the  
7 validity of an entire principle or process or system or  
8 whatever we want to call it, a deployment of money or  
9 whatever. It just looks to me when you look at this, that  
10 when you go from the 50th percentile on IME is at 3.3  
11 percent. Yet when you go, it's like it almost exponentially  
12 goes up. It doubles at the next level and comes close to  
13 doubling again.

14           There's a high-end askew here. And I think that's  
15 pretty important and it's not intrinsically obvious just  
16 looking at the numbers.

17           And then a couple of things. There was a mention  
18 of the \$60,000 per resident, and I know that that sounds  
19 like a pretty substantial chunk of change, and I don't mean  
20 to say that it's not. But I would point out to you that, as  
21 we've learned recently in substituting for residents with  
22 mid-level providers relative to the work hours, which was

1 not incentivized by this at all, it costs way more than  
2 \$60,000 a year to make up for one of those individuals.

3 MR. LISK: I do need to clarify, from a Medicare  
4 standpoint that was just for IME. It's actually more than  
5 \$60,000. When you talk about direct GME, you're talking  
6 another \$30,000 and total Medicare's paying about \$90,000 on  
7 average per resident, Medicare itself.

8 DR. BORMAN: I understand. I just want to try and  
9 put it in a perspective when you try and equate, is that a  
10 good number? What does that buy you outside of the resident  
11 market? I would tell you that we budget probably that  
12 \$90,000 easily for someone that takes the place of one of  
13 those individuals. Again, it was necessitated by a totally  
14 different context than trying to constrain costs. So just  
15 in terms of what are you buying, that's just a comparison  
16 number.

17 I think philosophically just a couple of things.  
18 Number one, remember that teaching hospitals are not only  
19 teaching physicians, they are probably the place that's more  
20 often associated with nursing students, lab tech students,  
21 EKG students, whatever they may be. And so that when you  
22 adjust this, you may in fact be affecting the spectrum of

1 care, of people that participate in care, not just  
2 physicians. So you want to be just a little bit careful  
3 about what is the impact here on allied health? And is that  
4 something that you want to think about as well?

5           The idea of it being nice and clean in an  
6 appropriations setting absolutely has clarity of thought  
7 appeal. That you unwind this from Medicare and you say  
8 we're consciously funding this. It introduces, however, a  
9 level of volatility that, considering the pipeline of  
10 medical education, a minimum of four years in medical  
11 school, a minimum of three years of residency, that that  
12 makes it pretty hard to sustain an educational program if  
13 the volatility in your funding from year to year might be  
14 like we see for certain other specific appropriation items.  
15 Or that we can mandate it but not fund it. That does create  
16 some special issues on a long educational pipeline.

17           The issues of what social good are you getting  
18 have already been well addressed.

19           I would point out that as a very gross measure of  
20 are we getting benefit from this, that we still have a huge  
21 number of people from other countries who seek medical  
22 education, and in fact even retraining, here for some

1 reason. So there must be something positive about our  
2 medical education system. And it may not be as crisp as we  
3 would like to see it elucidated. But there's some  
4 background, gestalt, smiley faces, whatever, that would  
5 suggest we are sought by others who go to a lot of lengths  
6 to get to it. Presumably there is value to what we're  
7 producing.

8 I support the notion that we should have some  
9 criteria to know what are we buying. And I despise the fact  
10 that there are not better data. I will push in every form I  
11 can that we get better data to be available because this  
12 does need to be a data-driven decision.

13 One last comment would be a background issue here  
14 that is a little bit certainly beyond the purview of the  
15 Medicare program entirely, but is the issue of physician  
16 workforce. As every medical school almost in this country  
17 is increasing its enrollment, there will clearly come the  
18 question of funding the training of those individuals and  
19 anticipating is this the work force that is going to be  
20 needed to care for an aging population?

21 So that is a background issue here. And while we  
22 can't solve the issue of workforce, I think maybe some

1 projections about where that's going will figure into this  
2 discussion. And it's obviously a fairly lengthy complex  
3 project.

4 Than's for listening.

5 DR. CROSSON: I'll be brief.

6 I'm speaking to IME again. And I support us  
7 taking a thoughtful look at that, for a number of reasons  
8 but I'll just talk about one of them.

9 Without getting into the question of whether  
10 Medicare should be providing subsidies for a social benefit  
11 which is different from what it's actually paying for, it  
12 would seem to me that if it is and if we're going to talk  
13 about this, we ought to talk about what that social benefit  
14 is or what we think it is.

15 So I tried to write one sentence thinking about  
16 what I think it is. And it might sound something like well,  
17 it's to produce a well-trained physician workforce with  
18 skills to match the nation's need for health care services.  
19 That would be something like it.

20 The second question then would be how effective is  
21 that? How effective is the subsidy at meeting that goal  
22 today, as opposed to where it was when it was originally

1 designed? As Dave said, things have changed.

2 And I think at least in one area, and we've talked  
3 about it before, it appears to be failing in that regard.

4 And that has to do with the issue we've brought up before  
5 about the growing maldistribution in the production of  
6 primary care physicians versus specialists.

7 That's not to say at all that that's the fault of  
8 the teaching hospitals. I think it's not, actually. It has  
9 more to do with payment policy.

10 But I think it would be a legitimate question to  
11 talk about whether or not the teaching hospitals might have  
12 a role in helping craft the solution to that problem.  
13 Because if the, again, the social benefit is to, in fact,  
14 produce a well-trained physician work force with skills to  
15 match the nation's need for health care services, and that's  
16 failing, then we would expect, I hope, that the teaching  
17 hospitals would have a role in helping craft the solution.

18 DR. CASTELLANOS: I'd like to address both of the  
19 issues. Under DSH, you're right, EMTALA requires the  
20 hospital to provide this care. In my community, we have 20  
21 percent of the people that are uninsured and 20 percent on  
22 top of that that are underinsured.

1           I just want to make a comment that the DSH money  
2 just goes to the hospital. The physician who's taking care  
3 of those patients don't enjoy any benefit from DSH.

4           Under IME, first of all, I find it's deplorable  
5 that there's no good accountability and I think this needs  
6 to be corrected and directed for the IME money.

7           Karen, I don't really agree with you on the  
8 workforce problem. I think we have a significant problem  
9 today with the work force. I think you can look at the data  
10 and it's not just with primary care but it's with  
11 specialties. I think this may impact on the access to care  
12 to the Medicare beneficiary.

13           So before, I would like some information on where  
14 do we stand today with the workforce problem, and the  
15 potential problem we may have by cutting back on IME funding  
16 for medical education.

17           We have two potential new medical schools in  
18 Florida today, that's where I love. Both of these are  
19 having startup problems. One is funding. Another one is  
20 they can't find a hospital where they can work at and have  
21 that post-graduate medical education paid for.

22           Thank you.

1           DR. MILSTEIN: I just wanted to endorse Nancy-  
2 Ann's three-part approach. I think that's a nice way of  
3 organizing the task. It would be helpful to me the next  
4 time we discuss this to actually have in front of us what  
5 are available in terms of measures for ascertaining a  
6 hospital's either level of or performance in delivering  
7 uncompensated care services to lower SES patients, teaching  
8 content specifically in the areas -- it would be helpful to  
9 Medicare. And I would think Jenny's point about geriatrics.  
10 And I think the point made in the prior panel about training  
11 in cross-silo process engineering. That would be near the  
12 top of my list.

13           And last but not least, measures of -- ways of  
14 ascertaining hospital levels of and performance in, taking  
15 care of outlier patients but in categories generally  
16 considered to be not preventable.

17           There's where I think, if I had to be critical of  
18 outlier policy in terms of our overall policy objectives,  
19 it's an outlier policy that treats categories of outliers  
20 that are generally considered either totally preventable or  
21 highly preventable, the same as being struck by lightning,  
22 if you'll excuse the inappropriate metaphor.

1           MR. HACKBARTH: Okay, more on this later. We are  
2 at six o'clock and well behind schedule.

3           I do want to have a very brief public comment  
4 period, and I mean very brief. The usual ground rules. For  
5 those you didn't hear me this morning, no more than two  
6 minutes. And if someone before you has said what you were  
7 going to say, say ditto and we'll move ahead.

8           And could you identify yourself and your  
9 affiliation before you go?

10          MS. HELLER: I'm Karen Heller from the Greater New  
11 York Hospital Association. And I just want to make a couple  
12 of recommendations for the ongoing analysis.

13          First of all, I think it's vitally important to  
14 look at total hospital margins as well as the Medicare  
15 inpatient and the overall Medicare. The Commission has  
16 pointed out over and over and over again, year after year,  
17 that the major teaching hospitals have the worst overall  
18 margins in the country.

19          Just as Dr. Compton this morning was talking about  
20 silos affecting the whole system, Medicare does affect the  
21 whole system. So we have to do that.

22          Number two, with respect to uncompensated care,

1 even though the data collected from the cost reports weren't  
2 very good, one idea -- I don't know if CMS could do this --  
3 would be to collect the DSH CAHPS of all the hospitals.  
4 Because for the Medicaid DSH program, every hospital has to  
5 compute uncompensated care that meets the federal definition  
6 for that.

7           So I don't know if the states actually give that  
8 to CMS or not, but it's something that could be explored  
9 potentially.

10           Thank you.

11           MR. SCHONGALLA: Tom Schongalla. I'm an  
12 independent economist. Three minor points.

13           Any discussion of DSH has to include the \$15  
14 billion each year put out in the state Medicaid programs.  
15 Completely different program but covered by statute. It's  
16 18 USC something. I don't know how we can segment one  
17 without the other.

18           Second, I'd like to direct this comment to Dr.  
19 Reischauer. I've looked at both the actuarial type of  
20 projection for the payments by people before they draw  
21 Social Security and Medicare. I think somebody ought to get  
22 a CRS or CBO report that gives us some numbers that we can

1 hang our hats on. Right now nobody knows what those numbers  
2 really are.

3 I did some numbers yesterday for a talk I'm giving  
4 in the not too distant future that said that a person  
5 retiring this year is going to have a lump sum of something  
6 in the neighborhood of \$450,000 that he's accrued, including  
7 imputed interest.

8 I would like to see what a reasonable calculation  
9 is because you're ultimately going to have to ask people how  
10 much have you put in? How much are you drawing down from  
11 what you've put in? And how much is left? Perhaps the  
12 Social Security actuaries have done that.

13 DR. REISCHAUER: The second part of that is really  
14 easy. It's a negative number.

15 MR. SCHONGALLA: Yes, but not for the guy retiring  
16 this year.

17 The last one that I would use, which is the same  
18 type of question, is what's the total malpractice outlay  
19 each year? If you take \$30,000 per physician or \$40,000 per  
20 physician and you multiply it by times 532,000 practicing  
21 physicians, you come up with something between \$17 billion  
22 and \$20 billion a year. That's less than 1 percent of the

1 health outlay.

2           But we keep -- you know, you guys have been around  
3 longer than I've been. Three times in the last 25 years  
4 we've trooped out this medical malpractice crisis. And  
5 somebody needs to come up with some numbers again that you  
6 can hang your hats on so we can decide how serious it really  
7 is.

8           MR. MAY: Don May with the American Hospital  
9 Association, and I really appreciate the conversation we've  
10 had today. A lot of good things have come out.

11           All of the questions and issues that you've raised  
12 I think we really need to dig into those and move very  
13 cautiously as we talk about IME and disproportionate share  
14 payments to hospitals.

15           Unlike a lot of the topics that you all talk about  
16 every month, this goes way beyond just the Medicare program.  
17 And the system as a whole really needs to be thought about  
18 as we start to think about tinkering with this one piece of  
19 the inpatient payment system.

20           So I just would urge you to move slowly and  
21 cautiously and think about all the different issues that  
22 you're raising and really try to get behind some of the

1 analysis on that.

2 Thank you.

3 MS. LUKENS: Hi, I'm Ellen Lukens with the  
4 National Association of Public Hospitals and Health Systems.  
5 We represent over 100 safety net providers and I just want  
6 to make two quick points.

7 One is that in the March 2000 report I think,  
8 which was reiterated here, we would agree that there is a  
9 social benefit to supporting safety net hospitals and  
10 ensuring access for Medicare beneficiaries at those  
11 hospitals.

12 The second point I'd like to make is that we also  
13 really support MedPAC's efforts to better target DSH funds  
14 and to include all low-income patient care costs in that  
15 formula, including uncompensated care costs.

16 And I believe that -- we are happy to work with  
17 MedPAC. We've put a lot of thought into this. And I think  
18 there are ways that we can get around some of the data  
19 limitations. And we are happy to work with you further on  
20 this.

21 Thank you.

22 MR. HACKBARTH: Okay, thank you very much. We

1 reconvene at 8:30 tomorrow.

2 [Whereupon, at 6:03 p.m., the meeting was  
3 recessed, to reconvene at 8:30 a.m. on Friday, September 8,  
4 2006.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, September 8, 2006  
8:23 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair  
ROBERT D. REISCHAUER, Ph.D., Vice Chair  
MITRA BEHROOZI  
JOHN M. BERTKO  
KAREN R. BORMAN, M.D.  
RONALD D. CASTELLANOS, M.D.  
FRANCIS J. CROSSON, M.D.  
NANCY-ANN DePARLE  
DAVID F. DURENBERGER  
JENNIE CHIN HANSEN  
DOUGLAS HOLTZ-EAKIN, Ph.D.  
NANCY KANE, D.B.A.  
ARNOLD MILSTEIN, M.D.  
WILLIAM J. SCANLON, Ph.D.

## 1 P R O C E E D I N G S

2 MR. HACKBARTH: Good morning everybody.

3 First up on this morning's agenda is our report on  
4 SGR. Kevin?

5 MS. PODULKA: Actually, I'll be starting off.  
6 Kevin and Scott will be joining me.

7 Good morning. We're here to talk about our  
8 mandated report on alternatives to the SGR. As you know,  
9 after a period of low growth, the past several years have  
10 seen spending on physician and other SGR-related services  
11 growing quickly. From 2000 to 2005 expenditures grew by  
12 more than 60 percent and about three-quarters of this growth  
13 is due to increases in the volume and intensity of services  
14 provided. These increases contribute to the SGR calling for  
15 multiple years of physician fee cuts, which most call  
16 unsustainable.

17 As a result the Deficit Reduction Act of 2005  
18 requires that we report on mechanisms that could be used in  
19 place of the current SGR system for updating physician fees.  
20 That report must do several things: identify and examine  
21 alternative methods for assessing volume growth and the

1 extent to which these alternative methods should be  
2 specified in law; review options to control the volume of  
3 physician services while maintaining beneficiary access; and  
4 examine the administrative feasibility of implementing these  
5 options, including the availability of data and time lags;  
6 examine the existing application of volume controls under  
7 the physician fee schedule, as well as a potential for  
8 volume controls using five alternative types of target  
9 tools: group practice, hospital medical staff, type of  
10 service, geographic area and physician outliers; and  
11 finally, identify the appropriate level of discussion for  
12 the Secretary of HHS to change payment rates or take other  
13 steps to affect physician behavior.

14           The report is due March 1 of 2007. We will be  
15 presenting information about each of the five specified  
16 alternatives from September through January at the  
17 commission meetings. This month we'll be beginning with  
18 preliminary data about the geographic area and type of  
19 service alternatives.

20           All of these alternatives raise many questions  
21 about design and implementation. None is likely to solve

1 all of the flaws of the current system. MedPAC is not  
2 required to recommend any of the five alternatives but we  
3 will explore the advantages and disadvantages of each to  
4 provide information for the Congress.

5           While the report must explore these modifications,  
6 we realize that the commission feels that other reforms  
7 should also be contemplated. Therefore, the report will  
8 also examine a number of other mechanisms. You see the  
9 examples on the slide. These potential reforms range from  
10 large systemic mechanisms that recognize that Medicare  
11 exists within a broader health care delivery system which  
12 contain signals that affect the program. And these signals  
13 may need to change in order to affect real reform.

14           The reforms also range from broad Medicare changes  
15 that are designed to improve the value of the program to  
16 narrower more technical Medicare changes also designed to  
17 improve value. We will be presenting more information about  
18 these other reforms in subsequent commission meetings.

19           Coming back to the mandated five alternatives, as  
20 we've begun to examine each of them we've identified a  
21 number of crosscutting issues that we ask you to keep in

1 mind as we present our preliminary data today. We would  
2 appreciate your feedback on how you would like to see these  
3 crosscutting issues addressed.

4 First, in a target system how should targets be  
5 set? For example, under the SGR targets are cumulative but  
6 that leads to problems when large amounts of past excess  
7 spending needs to be recouped.

8 On the issues of levels versus growth, should the  
9 target address initial levels of volume, rates of growth  
10 over time or a combination of the two?

11 On the next bullet for trade-offs among  
12 administrative feasibility versus volatility and  
13 accountability, for all of the alternatives, a number of  
14 pools and the criteria we use will affect the volatility of  
15 updates and the degree to which an individual physicians are  
16 held accountable.

17 For example, if we were to use a very small  
18 geographic area such as a county or ZIP code, we would come  
19 much closer to the individual physician but actual spending  
20 would tend to be more volatile due to year-to-year changes  
21 outside of physicians' control.

1           In addition, moving to these smaller unit pools  
2 would increase the administrative complexity of a system  
3 that is already faced with data availability time lags.

4           Starting on the next column, any of the  
5 alternatives carry the risk of unintended consequences. For  
6 example, given the way beneficiary cost sharing is currently  
7 structured, paying physicians differentially could  
8 perversely affect co-pays. If high quality efficient  
9 physicians were rewarded with better payment updates, then  
10 beneficiaries would have to pay more to see these  
11 physicians.

12           In the coming months, as we continue to work  
13 through these alternatives, we will also be discussing  
14 crosscutting issues associated with attributing spending and  
15 volume to physicians, risk-adjusting and data availability  
16 questions.

17           Now Kevin and Scott will present preliminary data  
18 analysis about the type of service alternative.

19           DR. HAYES: Just as an alternative to the existing  
20 policy, the single national target, a system of multiple  
21 expenditure targets could have separate adjustments for fees

1 based on targets for various types of services, visits,  
2 imaging, procedures and so on.

3           There is precedent for this. Under the volume  
4 performance standard policy that preceded the SGR, targets  
5 were set for three types of services: surgery, primary care  
6 and other nonsurgical services.

7           A rationale for doing this would be mainly that it  
8 would focus payment adjustments on services experiencing  
9 rapid volume growth. This option would also be a way to  
10 make adjustments to payments for health services priorities  
11 such as higher payments for primary care or other services.

12           Third, there is the issue of mispricing. It's  
13 possible, under a mechanism like this, to use targets to  
14 serve as a set of signals that payments are no longer  
15 accurate.

16           As you know the commission, in recent reports, has  
17 addressed problems with the five-year review of RVUs in the  
18 physician fee schedule as well as other issues.

19           The first design issue to address with an  
20 alternative like this would be setting the targets? As  
21 Jennifer said, setting targets requires consideration of

1 whether the targets apply to the level of spending or growth  
2 in that spending. In addition, targets could be based on an  
3 objective standard. GDP growth is one such standard.  
4 Others, of course, could be considered.

5           Historical trends for each type of service are  
6 another possible basis for the targets.

7           And finally, spending could be allowed to fall  
8 within a corridor around the target before updates affect  
9 it, or not.

10           In your mailing materials, we addressed all of  
11 these issues in the context of a type of service SGR.

12           For the next few slides, though, I want to focus  
13 on the middle bullet shown here and that is the objective  
14 standard versus basing the target on trends.

15           In the examples that I will show, we have chosen  
16 to compare various options for type of service targets with  
17 growth in the volume of services and not growth in spending.  
18 In doing so, we assume that the factors other than volume  
19 which determine spending, prices and enrollment, would be  
20 addressed in the type of service SGR just as they are in the  
21 current SGR. Taking these other factors out of the

1 comparison allows us to compare volume growth with various  
2 targets such as GDP growth and see clearly how fee updates  
3 would change depending upon the type of service target  
4 considered.

5           So let's look first at a GDP growth as a type of  
6 objective standard that could be used in a type of service  
7 SGR. This would be relevant if the choice was to simply  
8 modify the current SGR and establish a target for each type  
9 of service with objective standard being GDP growth.

10           The measure of GDP, by the way, is a measure of  
11 goods and services produced in the United States and is used  
12 as an allowance for how much growth in volume society can  
13 afford.

14           In a type of service SGR what are the likely  
15 impacts of using such a standard equal to GDP growth?  
16 Considering broad categories of services, evaluation and  
17 management, imaging, major procedures, other procedures and  
18 tests, we see on this slide that recent trends in volume  
19 growth for each of these types of services would have all  
20 exceeded a standard of GDP growth. E&M and major procedures  
21 would have been closest to the standard. Imaging, other

1 procedures and tests would have exceeded the standard by  
2 wider margins.

3           Comparing volume growth and a target, the  
4 differences in percentage point terms would determine the  
5 payment adjustments under a type of service SGR. In this  
6 example, E&M and major procedures would be subject to  
7 payment cuts of just over 1 percentage point. Imagings  
8 growth differs from the target the most. That type of  
9 service would experience a cut of 8.8 percent in this  
10 example.

11           Of course, objective standards could be higher  
12 than just GDP. If we were to just raise the target here and  
13 move to something like GDP plus one, for example, CMS's  
14 Office of the Actuary uses GDP plus one in its projections  
15 for the report of the Trustees and Medicare trust funds. If  
16 we were to consider this standard and compared it to trends  
17 and recent experience with volume growth, we see that E&M  
18 and major procedures nearly met the standards.

19           Rapid growth in volume of imaging, other  
20 procedures and tests, by contrast, in recent years have  
21 exceeded the standard. So those services would still be

1 subject to negative payment adjustments.

2           Moving now to other bases for the targets, we  
3 could consider trends. The rationale for basing the target  
4 on trends is that volume growth -- those trends represent  
5 technological advances, changes in beneficiary needs for  
6 care and other factors that could be considered in setting  
7 targets.

8           As shown on the slide, we did something very  
9 simple to illustrate how this approach to setting targets  
10 might work. We took the trend in volume growth for the  
11 years 1999 to 2004, split off the last year of growth, which  
12 is growth from 2003 to 2004, and compared that last year to  
13 the trend of 1999 to 2003. We then had a year of volume  
14 growth to compare to a trend. Very simple illustration is  
15 all we're after here.

16           Looking more closely at this example, we can take  
17 E&M services and see how payment adjustments would be  
18 calculated. For E&M we see that volume growth fro 2003 to  
19 2004 was 3.3 percent. By contrast, the trend in previous  
20 years was slightly higher, 3.6 percent. Basing the payment  
21 adjustment on volume growth in that most recent year, we

1 could calculate a payment adjustment for E&M as the  
2 difference between the most recent growth and in the trend,  
3 or 0.3 percentage points.

4 In this kind of an illustration, similar  
5 calculations would show an increase for major procedures but  
6 cuts for imaging, other procedures, and tests.

7 In addition to these specific examples that we've  
8 shown here, objective standards versus trends, we could also  
9 consider some combination of the two approaches to setting  
10 targets. In the interest of time we are not showing the  
11 example, but there is one in your mailing materials.

12 The rationale for this approach would be a desire  
13 to recognize trends in volume growth for selected services  
14 but at the same time to apply an objective standard that  
15 would, say, bear on volume growth overall. Thus, payment  
16 cuts would be calculated and targeted -- payment cuts would  
17 be targeted at selected services.

18 Let's now consider another issue related to the  
19 type of service alternative, and that has to do with how  
20 services are defined and grouped. Within all of the type of  
21 service options that we have discussed policymakers could

1 choose among alternative ways of doing this. Services could  
2 be grouped into five categories we considered in the  
3 examples: E&M, imaging, major procedures, other procedures  
4 and tests. Alternatively, a more detailed breakdown is  
5 possible, such as the one shown on this slide.

6           And then within these different types of  
7 categories you can consider more finer detail still. Within  
8 the other procedures category, for example, we could get  
9 down to the level of detail that would include things like  
10 minor procedures, ambulatory, skin procedures, cataract  
11 removal and so on.

12           Just to summarize here on this type of service  
13 alternative, we can think about some advantages and  
14 disadvantages that go with this. The advantages are the  
15 ones that I mentioned earlier about payment adjustments  
16 focusing on rapidly growing services. It's a way to address  
17 health services priorities. And it's a way to address  
18 concerns about mispricing.

19           Disadvantages are listed here, also. We can see  
20 that one problem with the targets and adjusting payments by  
21 type of service is that the volume of specific kinds of

1 services depends only in part on the physicians who provide  
2 them. For example, the volume of imaging services depends  
3 in large part on referral patterns of physicians ordering  
4 diagnostic services for their patients and not just the  
5 physicians who furnish the services directly.

6 Another problem concerns the one that was  
7 encountered with the previous VPS policy. If such targets  
8 were readopted, over time they could undermine the purpose  
9 of the fee schedule. We would have payment adjustment that  
10 would override other parts of the payment system that  
11 account for differences among services and resource  
12 requirements.

13 A third issue with this option concerns perverse  
14 incentives whereby physicians might substitute among  
15 services to avoid payment cuts.

16 And lastly, while using targets by type of service  
17 would account for technological advances and other factors  
18 unique to those services, the price for doing so is that the  
19 trends could include some high volume growth that you might  
20 not want to reward.

21 We're now ready to move on to another variant on

1 this, and Scott will talk about that.

2 DR. HARRISON: I'm going to present a type of  
3 service option that is motivated by rationalizing volume  
4 growth with the growth in physician work time and increases  
5 in physician productivity, as well as the desire to address  
6 the mispricing Kevin has mentioned.

7 Let's briefly explore the relationship between  
8 volume growth, work time and productivity. How can  
9 physicians increase Medicare volume? Well, they could  
10 increase the time they devote to treating Medicare patients  
11 by either working longer hours, increasing the number of  
12 physicians who treat Medicare beneficiaries, or by shifting  
13 some of their time away from other types of patients and  
14 devoting a larger share of their time to Medicare.

15 Alternatively, physicians could increase their  
16 productivity by either performing services more quickly or  
17 by substituting capital or non-physician labor for physician  
18 labor.

19 The physician time available stays the same, and  
20 this is something we would want to research, but if it were  
21 true, then physicians must be performing services more

1 quickly, meaning they would be increasing their  
2 productivity.

3           How do we account for increased physician  
4 productivity? Under the current SGR, all volume growth is  
5 treated the same regardless of where the growth comes from.  
6 This option we will discuss here attempts to account for the  
7 increased productivity and focuses on the volume of work  
8 RVUs performed. Work RVUs were intended to reflect the  
9 physician time and intensity required to perform a service.  
10 The more time required, the higher the work RVU value  
11 assigned to the service.

12           Kevin has already discussed that we have doubts  
13 about the accuracy of the RVUs and we are especially  
14 concerned that productivity gains are not reflected in  
15 updated RVU values.

16           We will now go through an example of a type of  
17 service option that uses a productivity model. The payment  
18 effects of the option could be accomplished either by  
19 adjusting the actual work RVU values or by allocating the  
20 updates to reflect volume for increased productivity for  
21 different types of service.

1           You have a table in your meeting materials that  
2 gives a hypothetical example of three specialties producing  
3 a mix of three types of service in two time periods. The  
4 point of all of the math in that example is to measure the  
5 contribution of each type of service to the overall  
6 productivity gain. Once we do that we can allocate total  
7 payment changes to different types of service based on the  
8 type of productivity gains physicians have made in  
9 delivering those services.

10           Let's look at the example in your materials in a  
11 simplified way. In this hypothetical example, we have three  
12 services X, Y and Z. As shown in the first column, Service  
13 X volume was the same in the two periods. Service Y's  
14 volume grew by 6.7 percent and Service Z's by 15 percent.  
15 Overall volume growth here is 6.3 percent.

16           In this example we assume that the total work  
17 performed for Medicare patients stayed the same over the two  
18 periods, and thus the physicians were able to perform these  
19 services more quickly. We calculated an adjustment factor  
20 for the work RVU portion of the fee schedule through the  
21 model to account for productivity gains for individual types

1 of service. Those adjustment are found in the second column  
2 of this table.

3 Those values are dependent on assumptions of  
4 specialty and service mix that we are not showing here but  
5 are in the materials. Again, those assumptions are purely  
6 hypothetical. The calculations behind this adjustment  
7 process are complex and conceptually they're similar to the  
8 method used to calculate the practice expense values for the  
9 physician fee schedule.

10 Note here that even though volume did not change  
11 for Service X, it would receive a downward adjustment in  
12 order to help account for overall volume growth. It does  
13 receive a smaller negative adjustment than average under  
14 this option, however, whereas under some of the others  
15 everybody would get an average reduction.

16 Presumably we would still have a target update  
17 under this assumption. For this example we chose a target  
18 of 3.2 percent for all services, and that's displayed in  
19 column three.

20 The conversion factor update, shown in column  
21 four, for a type of service combines the work RVU adjustment

1 factor and the target update. So Service X would have a  
2 very small conversion factor update in this example, while  
3 those services with volume increases would have negative  
4 updates in this example.

5 DR. MILLER: If I could just say something here to  
6 draw your attention to it. The example is assuming some  
7 kind of standard like GDP, if you look at the first column,  
8 volume growth has exceeded that standard by three-some-odd  
9 points. So what this process does is says based on the  
10 volume growth of this particular service you're allocating  
11 the impact differently. And that's what the last column is  
12 trying to get at.

13 So if people are wondering why is there a  
14 reduction here, it starts with the assumption that if your  
15 target is 3.2 in the third column at the bottom, and volume  
16 growth was 6.3 at the bottom of the first column, you're  
17 saying you exceeded the target. And then the rest of the  
18 example is how it ends up getting worked through the type of  
19 services.

20 DR. HARRISON: This approach would have the  
21 ability to address mispricing but it is not clear how the

1 pricing decisions would interact with the RUC process that  
2 also has been set up to address mispricing.

3           The example we just went through would result in  
4 different conversion factors by type of service. It could  
5 be done instead by keeping a single conversion factor and  
6 changing the RVU values by the RVU adjustment factors that  
7 you saw in the second column of the table. Neither method,  
8 however, would account for the substitution of practice  
9 expense costs for physician labor. For example, if  
10 physicians were more productive because they hired more  
11 nurses or bought labor saving machines, the model would  
12 recognize productivity savings but not the additional  
13 practice expense.

14           The practice expenses are just one of a number of  
15 new data needs this approach would require. Ideally, we  
16 would also like to see the timely collection of work force  
17 data, physician work hour data, and data on the share of  
18 total time devoted to Medicare patients. Administration of  
19 such a system is likely to be complex.

20           Now I would like to turn it over to Jennifer who  
21 will discuss geographic options.

1 MS. PODULKA: The geographic area alternative  
2 mechanism for controlling expenditures is motivated by  
3 regional variation in physician practice patterns. The  
4 target formula would still be used to determine how much  
5 total spending growth society could afford but the overall  
6 target would be allocated to each geographic area. Each  
7 year each geographic area's target could be based on how the  
8 rate of increase for Medicare physician services in one area  
9 compared with the national average. The target could be  
10 based on the level of volume, volume growth, or some  
11 combination of the two.

12 Because reducing volume growth would be more  
13 difficult to achieve in areas where the volume of services  
14 was already low, the formula may have to take into account  
15 initial volume levels. Regional per capita spending would  
16 be adjusted for risk and updates would be higher in areas  
17 with lower volume growth and/or lower volume levels.

18 To illustrate the potential impact of using this  
19 geographic area alternative pool we chose to use the 50  
20 largest metropolitan statistical areas. These are largest  
21 in terms of the number of fee-for-service Medicare

1 beneficiaries.

2           For this first example, we're looking at volume  
3 levels. Our analysis of physician claims for 2004 revealed  
4 that volume level measured by RVUs per beneficiary adjusted  
5 for risk varied nearly twofold across the 50 largest MSAs,  
6 from 44 to 81 RVUs per beneficiary with an average volume of  
7 58.

8           If we look at the other option, so this example is  
9 volume growth over time, the rate of growth of volume of  
10 services per beneficiary from 2000 to 2004 also varied  
11 widely, from 9 percent at the low end to 37 percent, with an  
12 average growth of 25 percent. Of course, this indicates  
13 that rapid volume growth is widespread. Only one area, the  
14 lowest there, fell within the SGR's allowance for growth of  
15 less than 10 percent during this time.

16           These two sets of findings suggest the following  
17 question: do areas with high levels of volume also  
18 experience high growth and vice versa? We found the  
19 following: areas initial volume level in 2000 had a weak  
20 inverse correlation with volume growth from 2000 to 2004.  
21 That correlation coefficient there of negative 2.7, to put

1 it in perspective, zero would mean absolutely no  
2 correlation. Negative one would be a perfect flip-flop  
3 inverse match. In other words, areas that started at a  
4 high-volume level in 2000 were somewhat likely to have low  
5 volume growth from 2000 to 2004.

6           Despite this, we found that areas ranked by volume  
7 level in 2000 had a very strong tendency to remain in the  
8 similar volume level rank in 2004. You see that that  
9 correlation coefficient is nearly one. This means that  
10 high-level areas had a very strong tendency to remain high  
11 and low level areas tended to remain low.

12           So if one were to pursue a geographic area target  
13 alternative, ideally areas that have both low volume growth,  
14 low level would be rewarded with better physician fee  
15 updates. Conversely, areas with both high volume growth and  
16 high volume level would be penalized with lower or even  
17 negative fee updates.

18           However, a key remaining implementation question  
19 is what to do about the other two combinations: high  
20 growth/low level and low growth/high level. How should  
21 these areas be treated?

1           To summarize the advantages and disadvantages for  
2 this option, under advantages you can see that payment  
3 updates are a function of variation in practice patterns and  
4 volume and this may help to address variation over time.

5           Under disadvantages, selecting the appropriate  
6 geographic unit size involves some trade-offs, which I  
7 mentioned earlier, among accountability, volatility and  
8 administrative feasibility. We've selected the 50 largest  
9 MSAs as an example here. This, of course, does not  
10 incorporate the entire area of the country.

11           Also, updates based on levels lock in existing  
12 variation while updates based on growth, given the  
13 incredibly high rates of growth in some areas, could result  
14 in deep cuts which could harm beneficiary access to  
15 physician services.

16           And finally, attributing spending and volume of  
17 services to physicians requires assumptions about those  
18 physicians responsibility for those services. And of  
19 course, we face the key problem in fee-for-service Medicare  
20 that beneficiaries are free to see multiple physicians.

21           This concludes our presentation and we look

1 forward to your comments.

2 DR. CROSSON: Thank you.

3 DR. REISCHAUER: Can I just ask a point of  
4 clarification?

5 When we're talking about high growth or levels,  
6 we're talking about just physician fee schedule payments or  
7 total payments for Medicare?

8 MS. PODULKA: That's just the SGR-related.

9 DR. REISCHAUER: Do we have correlations between  
10 the two? Between that total and --

11 DR. MILLER: To the extent that research has been  
12 done on this in the past, these tend to be correlated. So  
13 in other words --

14 DR. REISCHAUER: Positive.

15 DR. MILLER: Positive, yes. So your point is if I  
16 do more physician, do I do less hospital?

17 In the past that has not been the case, that if  
18 you do more physician you see more hospital, you see more  
19 test. It's pretty much correlated across the board. I  
20 think you see that in the Wennberg work and some other work  
21 done a few years back, maybe a lot of years back, as I'm

1 vaguely remembering.

2 DR. CROSSON: Thanks a lot. I continue to think  
3 that this is a fruitful area for analysis. Every time we  
4 look at it we see not only the complexity and the  
5 disadvantages but we open up a new set of ideas.

6 I have the sense, not to gainsay our discussions  
7 later in the fall, that we may find something in the end  
8 that is a combination of these five approaches and in so  
9 doing minimize some of the disadvantages that are obvious in  
10 any one individual approach.

11 I had two questions for clarification in the type  
12 of service growth option. I guess one comment and one  
13 question. The first one is I think that you present two  
14 options for setting the target. One is the objective  
15 target, the growth in GDP, which is currently used. And  
16 then trend target.

17 But I wonder, and it plays out in the geographic  
18 option, if in fact there's not another choice. And that  
19 would be to use the growing body of evidence about regional  
20 variation, or perhaps other types of variation by, for  
21 example, delivery system type, to essentially set a running

1 benchmark. For example, the 25th percentile of regional  
2 variation or the 10th percentile or something that would be  
3 consonant with our philosophical approach which says  
4 something about the efficient provider.

5           So I think that would be something to explore.

6           With respect to the productivity approach, I may  
7 be wrong here but I was trying of understand if, in fact,  
8 what was being said was that if more services are provided  
9 per unit of time, that represents an increase in  
10 productivity. And not being an economist, I would think  
11 that generally it does, provided that the output is  
12 standardized.

13           So yesterday we heard, for example, from Dr.  
14 Kaplan that in the management of low back pain there was a  
15 prior pattern which involved, as I remember, 50-some percent  
16 of people receiving an MRI and x-rays of the back and  
17 multiple consultations. And then the end product was  
18 management by physical therapy.

19           And then after reengineering, they changed the  
20 process. There, in fact, were less services developed but  
21 the output arguably was the same.

1           So if you measured productivity by the number of  
2 Medicare services provided over a unit of time and, in fact,  
3 decided that that was better productivity but the output was  
4 the same, is that actually better productivity? Or is it  
5 not?

6           MR. HACKBARTH: Any comment on that?

7           If you think in terms of bundles, like caring for  
8 low back pain and you're not talking about a discreet  
9 service, you can imagine how the mix of services might  
10 change to get the same or better outcome with fewer inputs.  
11 And therefore you're increasing productivity for that  
12 particular type of care.

13          DR. REISCHAUER: Resources used per unit of  
14 output, and the question is what is the unit of output and  
15 what are the resources? And resources in the example  
16 they're using this time of physician only.

17          MR. HACKBARTH: And the output is a very narrow  
18 discreet service, a billing code for whatever.

19          DR. MILLER: I just want to say this because I  
20 think your question implicates this. It wasn't just a  
21 random choice to say if you assume that a time unit, the

1 RVUs, that's what they are intended to reflect: time and  
2 intensity. And so starting with that assumption, and time  
3 doesn't change in the units go up, then the assumption is  
4 that maybe that work RVU wasn't set properly.

5           If during the RUC process you sit around and say  
6 okay, the complexity of the service, given the time and  
7 intensity it takes to do it, results in a RVU of this much,  
8 and with no about to change in the amount of time that a  
9 physician spends in the office and the amount of Medicare  
10 patients they see, volume grows 11 percent in one year for  
11 that service, maybe time and intensity you were assuming  
12 about the RVU was not correct.

13           And so that RVU, in theory, should come down.  
14 This is all predicated on the assumption that the RVU is a  
15 time and intensity unit, which it is. And in a sense you're  
16 bringing in the notion of what about quality and the  
17 outcome. But that's not what the RVU --

18           MR. HACKBARTH: I think Jay is on to a really  
19 important point, though, that causes me real reservations  
20 about the type of service. We know that our current mix of  
21 services is not optimal, certainly in the aggregate. If you

1 look at Part B, a lot of what we talk about is how do we  
2 change the mix of services so that we get as good or better  
3 outcome with a lower cost set of inputs? I think that's our  
4 general goal as a society. So why would we want to, in Part  
5 B, start saying we want this current mix, we want to somehow  
6 make it more static?

7           It may be that we want more imaging to reduce  
8 major procedures. That's a good thing. Now we all have --  
9 at least I have my suspicions about whether all of the  
10 imaging we're getting is good. But we certainly don't want  
11 to say this is the right volume of imaging and we want to  
12 stop it. We want to have a fluid system that allows the mix  
13 of services to advance with medical knowledge. So why do we  
14 want to start regulating the individual silos?

15           It's sort of the old world that we're trying to  
16 get away from, not the new world where we want to go.

17           DR. KANE: I'm sharing Jay's discomfort on the  
18 notion that higher volume is higher productivity and  
19 therefore -- and that the output is the same. But I'm also  
20 concerned about things like what if we want a medical home  
21 and primary care docs to managed care and to take

1 responsibility for coordination, and we actually give fees  
2 for that, and that starts to increase the E&M visits beyond  
3 their historic trend levels or beyond their historic growth  
4 -- how do you get into this formula policy goals that are  
5 below this overall SGR target? And I think we're setting  
6 arbitrary targets.

7 I guess my other question is why is it that the  
8 physicians are the only ones being held to the GDP standard,  
9 that this is how much we can afford when it actually --  
10 they're about what, 12 or 15 percent of total expenditure?

11 I guess I just find the whole construct very hard  
12 to make logical sense of. I can see why it makes policy  
13 sense because these are targets and they're kind of  
14 measurable and you just go after what you can measure. But  
15 I don't understand why A, physicians are the ones that have  
16 to live within our means and nobody else does; and B, how do  
17 we then encourage appropriate care when we've got these  
18 arbitrary targets?

19 DR. MILLER: Those are  
20 all fair questions and gigantic questions. A  
21 couple of just things for everybody to keep in mind.

1           One is the system, as it stands, is arbitrary and  
2 there is a target and there is no variation. So it hits  
3 everybody the same. So remember that's the starting point.

4           Remember also, at least in a mandated report  
5 context, we were asked specifically to consider these  
6 specific ideas, type of service, that kind of thing, so  
7 we're trying to explore them to the best of -- and I know  
8 you know this.

9           As I think the next point I would make is some of  
10 the statements that you're making and the notion of should  
11 there be policy objectives here, should quality be part of  
12 this calculation, are also things that we need to say --  
13 whether we're talking about type of service, geography,  
14 whatever.

15           But just try and keep, as much as possible, two  
16 tracks in your mind, responding to the mandate and then the  
17 things you want to say beyond that.

18           MR. HACKBARTH: Part of our original critique of  
19 SGR was just that, that it applies to part of the system and  
20 we're not sure that that makes a lot of sense.

21           Arnie and others have said at various points maybe

1 in world we want to get to, the share of total spending  
2 going to physicians increases rather than -- even relative  
3 to the current level -- rather than decreases if it  
4 represents an efficient substitution of services.

5           The way I envision this unfolding, and I'm  
6 essentially repeating just in different words what Mark  
7 said, is that when we comment on these different options we  
8 are not bound to endorse any one of them. We are bound to  
9 analyze each of them.

10           I see the preface to all of this being our laying  
11 out some of our often stated principles about where the  
12 system ought to be going to help establish a benchmark then  
13 against which we assess the individual alternatives.

14           And so you're raising very fundamental points, as  
15 Jay did. And I see those as coming first and then we delve  
16 into option A, B and C, and so on, and assess them against  
17 those.

18           At the end of the analysis -- I won't prejudge  
19 where we end up -- but a lot of these are problematic in  
20 terms of basic long-term objectives for system change and  
21 reform.

1           That's not to say there without advantages and  
2 potential benefits but there are some real fundamental  
3 problems in looking at this as a Part B only issue, among  
4 other things.

5           DR. SCANLON: Let me first respond a little bit to  
6 the issue that Nancy raised, why are physicians different?  
7 I think part of it is that they are different. They are  
8 unique in our system in that they are the ones that we have  
9 given the power to control the use of other resources, as  
10 well as they're pretty much in charge of the resources that  
11 they are going to provide themselves, in part because we're  
12 not ever going to be in a position to review what they  
13 decide to do in a very detailed way. We've roughly got a  
14 billion claims coming in from physicians every year. And  
15 the idea that we're going to review them and be able to say  
16 yes/no is ludicrous.

17           At this point, there's huge outcries that you get  
18 from the physician community about the amount of review that  
19 goes on. It's less than 1 percent of claims. Most  
20 physicians have one claim that they're asked to turn medical  
21 records in on.

1           So we're not going to get to a point where we're  
2 going to be able to say that we're very confident these  
3 services are appropriate.

4           For other types of services we haven't had the  
5 same problems of volume and intensity that we've had in the  
6 physician area. And so there are reasons why physicians are  
7 unique. The Wennberg supply related service patterns  
8 continue to support that perspective.

9           I think we're opening up, and Jay started it, I  
10 have unease about this because I worry about the overall  
11 economic framework that we should be thinking about in terms  
12 of evaluating these things. The thing that triggers it is  
13 when we talk about this issue of mispricing because the  
14 mispricing, in some respects, and it goes back to when the  
15 volume performance standards started to create some  
16 divergence in the conversion factors.

17           The relative value units are reflective of  
18 resources. But they're not necessarily reflective of what  
19 the prices that might be paid in a market where there was  
20 good competition, people were well informed and the market  
21 was determining the prices. Because in those kinds of

1 markets prices are partly determined by the demand for  
2 different services. And if you've got to attract more  
3 resources to one type of service, you may end up having to  
4 pay higher prices.

5 In some respects in the physician fee schedule we  
6 did do something similar but we did it on a national level.  
7 We measured the relative resources. We decided that the  
8 overall amount that we were spending on physician was  
9 adequate and we used that to create the conversion factor.

10 We didn't go and measure, as we did for other  
11 services, costs because we can't. The biggest cost of a  
12 physician service is the physician's time, which we have no  
13 measure of what that "real cost" is. They may tell us what  
14 they would like to be paid but we don't necessarily have to  
15 believe that.

16 My concern is that we need to think about this a  
17 rigorous economic -- what's the rigorous economic framework?  
18 What's the prospective that a purchaser should have in this  
19 exercise? And what should a purchaser be willing to do in  
20 terms of payment for different kinds of services?

21 That may lead us to something very different than

1 the national fees that we have today. We've had all kinds  
2 of discussions over the time I've been here about the issue  
3 of the value of primary care and concerns about the future  
4 of people going into primary care. Well, that's a classic  
5 example. If it's going to take more to attract people to  
6 primary care for one reason or another how do you get there?  
7 Do you get there through the fees for the current  
8 configuration of services? Do you create new types of  
9 services so that the primary care physicians are rewarded in  
10 different ways and people will be attracted to that field?  
11 Those are the kinds of questions that we should be asking.

12 I think it also applies to all of our discussions  
13 about pay for performance. Pay for performance is going to  
14 start to distort fees as well in terms of their fees  
15 relative to costs, fees relative to the RVUs. The question  
16 is are we doing that in the right way.

17 So I hope we can think about how a broader, more  
18 rigorous economic framework can be constructed to be able to  
19 assess what these various options imply.

20 A couple of other different points. One is I  
21 think we shouldn't use the GDP plus one as a potential

1 target on the basis of the actuary using it as that. The  
2 actuary is kind of giving into reality that the increase has  
3 exceeded the GDP in health spending historically but it is  
4 by no means necessarily desirable.

5 So I think in doing this we should be thinking  
6 about what are the desirable targets that we would like to  
7 have.

8 The last thing which is something we've talked  
9 about, and I think this is area where it applies, is the  
10 issue of the administrative ability to implement options  
11 that we create. This comes to the resources that CMS is  
12 going to have to do this.

13 One thing of a historical note to remember is part  
14 of the SGR problem that we have is because of data errors  
15 that existed in 2000 and 2001 when the physician fee  
16 increases were actually larger than they should have been  
17 and then that had to be recouped. The ability to create or  
18 to assemble appropriate data on a timely basis is always a  
19 challenge in a program this large.

20 As we start to think about how we're going to cut  
21 it in various ways and ask for actually a lot more precision

1 than we've had to date it becomes even more challenging. We  
2 shouldn't raise the white flag and say okay, we can't do  
3 anything. We should be thinking about the strategy in terms  
4 of how do you complement a proposal for having a more  
5 detailed SGR like our physician fee schedule updates with an  
6 increase in the resources and the capacity of a CMS to be  
7 able to implement it.

8 MR. HACKBARTH: I'd like to invite some comments  
9 on the first part of what Bill said. What I hear you saying  
10 Bill, and correct me if I'm missing it, is that this  
11 discussion is organized as a result of a mandate around  
12 adding or altering a piece of the physician payment  
13 superstructure, the volume related piece. What are  
14 alternatives for changing SGR?

15 But you see problems in the foundation. The  
16 RBRVS, the underlying system, is based on some assumptions  
17 about how you want to price services, attach prices to the  
18 resources that go into producing them.

19 What I hear you saying well, that's one model but  
20 it may not get you where you want to be in terms of  
21 important policy goals. You may want a greater supply of

1 primary care and RBRVS won't produce it. So you need to  
2 break out of the resource-based way of thinking to achieve  
3 some of your policy goals.

4 DR. SCANLON: If what you interpret as the  
5 resource base is equal to the RVU times the conversion  
6 factor, that that's the price and that's the only way we're  
7 going to get to the price, then the answer is yes.

8 I think of the RVUs as information that is useful  
9 in terms of determining the prices that we want to play.  
10 But that single conversion factor may not be appropriate in  
11 all circumstances. And I think we're moving away from it in  
12 on a lot of our discussions.

13 MR. HACKBARTH: Any reactions to that particular  
14 point, John?

15 MR. BERTKO: Yes, I'm going to give you a  
16 completely pragmatic reaction to it. I like RVUs for a  
17 simple factor that they are a solid framework in  
18 contracting, both on the Medicare side an on the commercial  
19 side, which I think is an important consideration. The  
20 power is held by small single specialty groups and there are  
21 a number of them.

1           Having the RVU in place, let's just say no, it's  
2 going to be a flat 105 percent of Medicare. That's what our  
3 contract is. It actually is beneficial in that aspect to  
4 paying PCPs, as opposed to having to pay 150 percent to  
5 certain very demanding relatively exclusive groups in areas.  
6 To move away from that at this stage, I think, would a  
7 distraction at best and hurtful in most case.

8           MS. DePARLE: I think I followed you but I don't  
9 understand why does it keep them from saying 150? If they  
10 have the leverage, they have they leverage.

11          MR. BERTKO: If they have all of the leverage but  
12 it allows us to have a target point, again using that  
13 phrase, and we said no, that's it. We always contract at  
14 blank percent and take it or leave it.

15                It gives the payer side of it a little bit of  
16 assistance in some ways by saying we're doing this -- I'll  
17 use the fair here -- equitably across-the-board.

18          DR. SCANLON: Can't you still use Medicare as a  
19 standard? If Medicare uses a different method for setting  
20 its fees and you go into a market and you say to them here  
21 are the Medicare fees, we do 105 percent?

1           And the other thing I guess I would say is John,  
2 I'm sorry, but we can't have Medicare policy be done for the  
3 convenience of insurers. Medicare policy has got to be  
4 targeted on Medicare's needs.

5           DR. CROSSON: But I think if you were to follow  
6 Bill all the way through and assume that there was a  
7 rational and better way that came out of this, then I would  
8 assume you could still reference that better way.

9           MR. BERTKO: Yes.

10          DR. CASTELLANOS: Just to answer your question of  
11 pricing, you're concerned about the overpricing where the  
12 physician is asking for that. I can tell you in competitive  
13 markets in South Florida they're not paying Medicare rates.  
14 They're paying something discounted, 80 percent, 70 percent.  
15 I've seen them down at 60 percent. I'm telling you, managed  
16 care says take it or leave it. That's what we pay.

17          MR. BERTKO: And you prefaced it with the correct  
18 adjective, competitive markets. For every competitive  
19 market you cite for me, I can give you 10 noncompetitive  
20 markets. Smaller areas but it's a very difficult  
21 contracting issue.

1 DR. CASTELLANOS: My point is contracting is on  
2 both sides. It's not always in your pocket and it's not  
3 always in my pocket.

4 MR. HACKBARTH: Let's continue through our  
5 previous list.

6 MR. BERTKO: So let me give a couple of parts to  
7 that intro you talked about first, so I can feel better  
8 about having said them, and then directly address the  
9 questions.

10 Number one, any fix we make to the SGR is going to  
11 be very expensive in budget terms and I support the list of  
12 additional features to get more value out of whatever we're  
13 paying for.

14 Number two, I think keeping a target of some kind,  
15 in spite of all of our discussion, is important. Taking a  
16 target off would send a bad message or the wrong message at  
17 this point in time.

18 So now, getting down to specific comments, and  
19 Scott, I compliment you for showing an absolutely Byzantine  
20 method here, which I think is important to know. Jay and I,  
21 in different ways, have designed and help run systems of

1 things which are SGR-like, capitation funds, service funds,  
2 whatever you call them. I was associated with the  
3 Minneapolis mechanism here which changed essentially the  
4 RVUs on a quarterly basis, and to some degree helped make it  
5 collapse of its own weight on that.

6 And so I would say, first of all, simpler is  
7 always better.

8 Secondly, I agree with Jay's comment which I think  
9 he said quickly, some combination of these things is  
10 probably the best. But simple and broader targets divided  
11 by geography are very important.

12 In the world that I see the capitation funds for  
13 physician groups are still reasonably popular. As we heard  
14 Dr. Kaplan say yesterday, he would take capitation today,  
15 even though he got rid of it six or seven years ago.

16 In some of our markets, in some of our Florida  
17 markets, we have extremely efficient physician groups who  
18 love capitation. But the trend has been and pretty much now  
19 locked on, to capitation within the services they deliver.  
20 So in spite of the comment that we ought to include other  
21 things like inpatient, or you could put drugs in that mix,

1 the answer on a practical basis seems to be no. Let's just  
2 keep it within either primary care or, more likely, the one  
3 that is a general physician services type of thing, which is  
4 administrable.

5 Bill mentioned this a moment ago, the concept of  
6 administering anything very complex is just amazing. The  
7 amount of time and effort we put into administering a fund  
8 for 100,000 employees and dependents in Minneapolis on a  
9 quarterly basis, changing RVU schedules, it was almost  
10 beyond us at the organization I was in at the time.

11 To think of CMS having to do this, or with  
12 contractors, in 250 areas if it was geographically designed,  
13 would be just mind boggling. So simpler is much better.

14 And then lastly, I think maybe to address the  
15 correction of protections, I think it has to be cumulative.  
16 There's a bunch of ways to think about doing this. Medicare  
17 Advantage plans are subject to cumulative corrections in the  
18 way that the updates come out. I think that's for the best  
19 on both sides of the fence. If there are over projections  
20 they get corrected the next year. If there are under  
21 projections they get corrected the following year.

1           One other assumption here I've kind of made in my  
2 mind is that this involves a fresh start, that is  
3 forgiveness of the current cumulative overhang. I don't  
4 know if that needs to be a separate topic that needs to be  
5 addressed.

6           MS. DePARLE: I agree on that fresh start. We've  
7 had that discussion in here before.

8           I'm glad that Nancy took the pin out of the  
9 grenade because I was sitting here thinking, as I always do  
10 every time this comes up, that I might as well just say it.  
11 I have never understood why the volume of physician services  
12 is tied to GDP growth. Every time -- I was I guess at OMB  
13 when this thing first was implemented or right after it, and  
14 then at HCFA. Every time it came around to doing the rule I  
15 really had to go back to first principles and say why is it  
16 this way?

17           I suppose one could argue it's an elegant way to  
18 constrain health care growth. Some of you may recall during  
19 the Clinton Administration's health care reform, the  
20 discussions that we started on health care reform. There  
21 was discussion about global budgets. And there are ways of

1 doing that. But that isn't what we've chosen to do in any  
2 other area.

3 I question it frankly as our policy goal. I was  
4 amused when Bill said that the GDP plus one target that was  
5 discussed in this presentation was based on the actuaries,  
6 that they were grounded in reality. I think the actuaries  
7 would be thrilled to hear that someone thinks that they're  
8 grounded in reality.

9 It's not just historical. It's like the last 50  
10 or more years, 75 years, that health care has grown at not  
11 just one point above GDP but several points. And with other  
12 areas of health care, perhaps not as effectively as we'd  
13 like to be, but we use other policy levers. We use the  
14 update with hospitals. We use the transfer policy or  
15 whatever as ways of trying to constrain what we think is  
16 inappropriate growth or volume and intensity.

17 So I understand, Mark. You and I have had this  
18 argument too and discussion before. I understand that on  
19 this report we've been asked to look at these various ways.  
20 But if I were writing the preface I would start with I don't  
21 think this formula makes sense.

1           If we are going to look at the type of service,  
2 that's an interesting way of looking at it, I suppose. But  
3 I'd be very troubled if we didn't try to look at -- if we  
4 get drawn again into this kind of formulaic thing without  
5 looking at why is volume growing in particular areas? It  
6 may be, and others have said this, that there are things  
7 that we want to increase. It may be that Congress has  
8 enacted policies to have colorectal cancer screenings or  
9 whatever. And things are growing for that reason.

10           DR. REISCHAUER: Those are all taken out though,  
11 remember. There's an adjustment made.

12           MS. DePARLE: Is it really?. I'm not so sure that  
13 that's really -- that we've really gotten to the bottom of  
14 that.

15           MR. HACKBARTH: The statutory and regulatory  
16 changes are, in theory, adjusted for in the target. But  
17 there are other changes in health care delivery that would  
18 not be captured by those that are desirable.

19           MS. DePARLE: I'm not even sure of the other.

20           MR. HACKBARTH: For example, pay-for-performance.  
21 There are a lot of areas where there is known under service

1 and quality care requires an increase in the provision of  
2 certain sort of services. The formula doesn't adjust for  
3 those.

4 DR. REISCHAUER: But there are equally areas in  
5 which undesirable things are going on. And while we  
6 criticize the RUC because it only looks in one direction,  
7 and we can't in fact look in both directions. This is down  
8 in the level of the weeds here anyway. And what we're try  
9 to do is say as a society what can we afford? And what we  
10 can afford, we think, is something around the growth of real  
11 GDP. That could be too low. As a society we could say no,  
12 we want health care to be more robust. We could set it at  
13 two GDP. That would be fine, too.

14 MS. DePARLE: That's an elegant way to run the  
15 world but that isn't the way the world is run. And that  
16 certainly isn't the way other areas of Medicare are run.  
17 That's my concern.

18 DR. REISCHAUER: Put me in charge.

19 MS. DePARLE: I agree, if Chairman Mao/Bob were in  
20 charge, that's what we'd be doing.

21 I can go there. That's a very interesting way of

1 running health care. But that isn't what we're doing. And  
2 I think if we want to look at other policy levers, that  
3 would be open, self referral. There lots of things that  
4 need to be looked at here. I'm not saying that those things  
5 should be off the table. I just think we're shrouding all  
6 of this in some veneer of this is the way we should do it  
7 and it really isn't the way we're doing anything else. I'm  
8 not even sure it's consistent with our policy calls for the  
9 Medicare program.

10           Again, it's tilting at windmills I know because  
11 all of this would cost billions to fix. And if we start  
12 over again, it would be very difficult. But if we're going  
13 to get drawn into all these formulaic discussions again, I  
14 just felt I have to say it. And I don't think it makes  
15 sense.

16           MR. HACKBARTH: This is a very important point, I  
17 think, for the preface. Some things we get too much of.  
18 Some things we get too few of, both within the Part B realm  
19 and in the prior package of health care services. I think  
20 everybody around the table agrees with that. Everybody who  
21 pays any attention to health policy agrees with that.

1           What we need are mechanisms that give clinicians  
2           and other providers the incentives to work with their  
3           patients to get a better mix, a more efficient mix and not  
4           use efficiency to mean quality and cost in patient  
5           satisfaction.

6           The fundamental issue that I have with these Part  
7           B only approaches is they are not giving an appropriate  
8           reward, incentive, set of penalties to clinicians and  
9           providers to make better decisions. In fact, most of them,  
10          many of them, actually may lead you in the wrong direction.  
11          And looking at just the Part B part of the problem is, I  
12          think, very dangerous in that respect.

13          DR. MILLER: Can I just do one quick thing? Can  
14          you give me the third slide?. I just want to respond a  
15          little bit to Nancy-Ann because I also want the public to  
16          understand what's going on here.

17          Maybe it's the second slide. I'm sorry, maybe  
18          it's the fourth. See what the problem is?

19          I want to be very clear here. We went through and  
20          we used GDP in our examples because that's the current  
21          system. One of the issues that we can consider is what the

1 target is. And that's why, for example, we started talking  
2 about an objective versus a trend. So I just don't want you  
3 to think they we're going down the GDP road because we're  
4 saying we must do it. I also don't even think the mandate  
5 is saying you must do it. We're just doing it because it's  
6 the easiest reference point where people will go oh right,  
7 that's the current objective standard, just to illustrate  
8 some impacts here.

9           So you should know that that is on the table and a  
10 question that can be addressed of how to set the target, if  
11 at all, I suppose.

12           DR. REISCHAUER: That's a question that's well  
13 above our pay grade. That's what we elect Congress for.

14           DR. MILLER: These are all above my pay grade, let  
15 me be clear that point.

16           DR. REISCHAUER: If we want to talk about what  
17 we're paid to do...

18           DR. MILLER: Can we talk about my pay?

19           [Laughter.]

20           MS. DePARLE: You're talking to Chairman Mao  
21 there, remember. He's not the right guy to talk to.

1 DR. MILLER: Will you guys stop saying Chairman  
2 Mao. This is a public meeting.

3 [Laughter.]

4 MS. DePARLE: Just to respond to Bob. It is what  
5 we elect Congress to do. But Congress asked us to give them  
6 the best advice about this. And if we can't say -- I don't  
7 know that everyone agrees. I've been on this for a while.  
8 But if we can't say that we don't think it makes sense, I  
9 don't know who can.

10 DR. CASTELLANOS: I don't know where to begin.

11 I guess I have several issues that I'd like to  
12 bring up. One is I know we're mandated by DRA to look at  
13 these five multiple spending targets. And we need to do it  
14 and that's what we're doing. And I think we're doing a good  
15 job at it. I think these need to be discuss openly and  
16 frankly and the good points discussed and the bad points  
17 discussed.

18 But DRA also required this commission to report on  
19 other alternatives or alternatives to the SGR. I think it's  
20 important that we look also at other alternatives.

21 Nancy, I couldn't agree with you more. I don't

1 think GDP has any relationship to medical care. And why are  
2 the physicians held to that while no other provider really  
3 is? I don't know. I didn't write those rules.

4 I think a fairer index may be MEI. And I know  
5 MedPAC has looked at that before. Unfortunately, I'm new on  
6 the commission and I don't have the history that you have.  
7 But I do know that Congress has gone on record, CMS has gone  
8 on record, every medical society has gone on record that  
9 what we're doing now isn't working.

10 And I suggested that we just not look at these  
11 five alternatives but look at other alternatives, also.

12 MR. HACKBARTH: Can I just pick up on that point,  
13 Ron? There are two separate issues. MEI is an index used  
14 in helping to set the price of individual services. And the  
15 basic notion is that these prices ought to have some  
16 relationship to the increase in input cost that physician's  
17 experience in producing them.

18 GDP, in this context, is used as an aggregate  
19 target that combines both price and volume.

20 In fact, the GDP increases more rapidly than the  
21 MEI because it does increase national wealth. The GDP is

1 total -- there's real GDP growth above inflation.

2 And so physicians don't want to substitute the  
3 MEI, a lower number, for GDP, a higher number. But I think  
4 your point about MEI is for the unit prices and have a unit  
5 prices system linked to MEI; correct?

6 DR. CASTELLANOS: That's correct.

7 MR. BERTKO: Glenn, may I just add that part of  
8 our charge here is not only keeping providers equitable  
9 under this, but consumers. And broader measures tend to  
10 address the part of what should be the increase in Part B  
11 premiums here and cost sharing? And so I think broader  
12 rather than more targeted ones are important for us to  
13 consider, as well.

14 DR. SCANLON: To clarify what you're saying is to  
15 apply MEI to the unit price and ignore the volume changes.  
16 Because right now the way we do the updates is we take into  
17 account MEI and then we look at volume. And if volume were  
18 to equal GDP growth, then it will be the MEI. If it's less,  
19 it will be greater than MEI. And if it's more, it's less  
20 than.

21 DR. CASTELLANOS: I'd like to continue on the

1 issue and I'd like to continue a what is specifically  
2 volume.

3           What we're trying to do here is control costs.  
4 And the way we're trying to control costs at present is by  
5 controlling the volume of what the physician orders. You  
6 may not like it, but it's a price-fixing in my opinion.  
7 It's a way of controlling costs.

8           I've had several discussions with Mark concerning  
9 volume and, not to pat him on the back, but on his report to  
10 Congress in July he probably gave the most astute answer to  
11 volume. I think we look need to look at, as Mark said to  
12 the Congress at that time, was to look at the root causes of  
13 volume. And I don't think we've adequately done that.

14           I've looked over some of the work that MedPAC has  
15 done but I think there's a lot of other answers perhaps to  
16 volume control than what we've looked at. And there's been  
17 several newer articles concerning obesity, comorbidities,  
18 lifestyle, smoking, et cetera, that add to this.

19           So I think when we talk about volume, I think we  
20 need to look at why we have the increased volume.

21           Increase in volume isn't that bad, in some

1 respects. In some respects, it's bad. I'm not saying that  
2 doctors don't abuse it at times. I think you can show me  
3 examples of that.

4 But I think we need to really look at volume a  
5 little bit more carefully.

6 DR. REISCHAUER: Can I make a comment on the  
7 origins of all of this which really goes back to what Bill  
8 said? Let's assume there was no waste and all increased  
9 medical care was good, meaning it had some positive value to  
10 society. We wouldn't just have an infinite amount of  
11 medical care. We have limits. The limit is the size of our  
12 economy and how we want to allocate it between pet food and  
13 medicine and transportation and compact discs.

14 And in a government program, we don't have a  
15 market that will do that. We have a political system that  
16 is based on the collective judgments of society that the  
17 resources, public resources we devote to this activity  
18 should be about this much and growing at about that pace.

19 And that's what this is all about, really.

20 MR. HACKBARTH: I'm not sure that that was the  
21 origin of the SGR. If that's, in fact, what they wanted to

1 accomplish, they would have looked at total Medicare  
2 spending. I think the origin of the SGR was that they -- I  
3 think the origin of the SGR was that there was seen to be a  
4 specific problem with growth in physician spending, an  
5 increase in volume and intensity, and we needed some  
6 mechanism to change the dynamic. It wasn't well, let's  
7 think rationally about how much want to spend on Medicare.

8 DR. SCANLON: But you could be thinking in the  
9 back of your mind rationally what do we want to spend on  
10 total Medicare? And you say to yourself hospitals are under  
11 control, nursing homes are under control, home health is  
12 under control. Remember, this is back in the '80s before we  
13 had our home health and SNF explosion.

14 And you say yourself wait a minute, there's one  
15 surface that's going up volume and intensity, not price,  
16 volume and intensity, two to three times to GDP every year.  
17 What are we going to do about it? And we're not going to  
18 review claims because we can't.

19 And so therefore we're going to send this signal  
20 to say we want some control. And we had pretty good control  
21 under the volume performance standard. We had pretty good

1 control through 2001. And we did.

2 No, if you look at the data, we did.

3 MR. HACKBARTH: But it's an illusion that you had  
4 control. There were other things going on in health care  
5 that meant that that was a period of relatively low  
6 increases. You had no control.

7 DR. SCANLON: We achieved our objective even when  
8 we didn't have control. The best of both worlds.

9 [Laughter.]

10 MR. HACKBARTH: It's delusion.

11 DR. SCANLON: We cut the rate of volume and  
12 intensity growth in half.

13 MR. HACKBARTH: To the extent that anybody cut, it  
14 was John Bertko and people in private plans who were  
15 changing how the market worked temporarily, temporarily. It  
16 wasn't anything related to VPS or SGR.

17 MR. DURENBERGER: Can I add just one other point?

18 I'm only doing this because I saw George Greenberg  
19 walk in the room. George from CMS was sitting in my office  
20 the weekend we actually did this. We had Waxman and Stark  
21 and Rockefeller and myself and we're banging heads and

1 things like that.

2 I'm not going to speak to the origin. I agree  
3 with you that that was a problem. But one other important  
4 point which makes me a pin-puller on the grenade, whether  
5 we're confined to the first paragraph or the introductory  
6 chapter of all of this.

7 The other thing that a lot of us knew at the time,  
8 we're struggling with the impact of DRGs on hospitals on  
9 physician spending, we're trying to get physician spending  
10 under control. We also knew that the TEFRA risk experiment  
11 that was going on in the mid-80s told us if you've got the  
12 docs, the hospitals and the health plans together in certain  
13 areas of the country at least, you could drive down the  
14 growth of cost substantially. So we knew that at the time.

15 One vivid memory I have, besides George missing  
16 his kid's soccer game or baseball game or something, was the  
17 realities of sitting there with the then-CMS administrator  
18 and getting a promise that right off the bat she was going  
19 to find some way to deal with this problem, which of course  
20 she was never able to do from 1989 -- this was the  
21 administrator in 1989, not you.

1           So I add that because of the nature of the  
2 discussion.

3           MR. HACKBARTH: Karen has been waiting patiently.

4           DR. BORMAN: Uncharacteristic for a surgeon, too;  
5 right?

6           I'd like to just ask a technical question first.  
7 Remind me that in the differentiation of major procedure  
8 versus minor or other, is that based on global periods?

9           DR. HAYES: The distinction is based on a type of  
10 service classification scheme that CMS has developed -- this  
11 Berenson Eggers type of service classification scheme. The  
12 clinical input that CMS received prompted this distinction  
13 between major procedures and others.

14           I think it's fair to say that, for the most part,  
15 the major procedures include a global surgical period that  
16 would include the procedure itself as well as pre-and postop  
17 visits. But I can't guarantee that that's the clinical  
18 input that CMS received, but the result is that in the  
19 general that's the way it works.

20           DR. BORMAN: Because certainly at the CMS level  
21 major and minor procedure distinguishing does relate to the

1 episode, the length of the episode, which certainly kind of  
2 starts to move into some of the other things we've talked  
3 about in terms of looking at episodes and how you define  
4 them and so forth.

5           And so I think it's important not to collect  
6 apples and oranges to the best that we can control it unless  
7 we're going to say up front we've collected a fruit basket  
8 as opposed to saying we're making a valid comparison.

9           So that was helpful.

10           My observation would be, and I agree to some  
11 degree with what Bill Scanlon has said, whether you agree or  
12 believe how it was done, why it was done or whatever, there  
13 was some effect of VPS in the context and the time at which  
14 it occurred. Now you can argue up and down about what you  
15 attribute to each piece of it but I'm not sure that any of  
16 us, myself included, can wave the magic wand and say there  
17 was no impact of that or it did match up with reaching a  
18 portion of a goal. And maybe the challenge is to find out  
19 what in there helped to get to the portion of the goal and  
20 extract that out.

21           And let's be careful about throwing out the baby

1 with the bathwater here a little bit and sort of maligning  
2 VPS a little bit.

3 I'm a little puzzled, and I'm sure this is my  
4 naivete and perhaps statistical ignorance or whatever, which  
5 may be blissful, but we're talking in some significant  
6 degree about a method of controlling cost. Yes, over here  
7 we're also saying we want that to subserve advancing  
8 quality. But that out here the big gorilla is the cost.

9 If we say that's a pretty overarching target, then  
10 we send a pretty mixed message to people who did indeed  
11 control their growth, the increase in the conversion factor  
12 did, in fact, reward those people to some degree. Now you  
13 can argue whether that translated down to the individual  
14 physician level, objective or whatever. But it was  
15 controlled growth and you get something for it. If we're  
16 talking about incentivizing people, that's incentive, in my  
17 simpleminded approach to the world.

18 What we're, in part, doing is saying even if you  
19 don't control growth we're going to reward you.

20 As we broke it out into finer and finer things we  
21 then said okay oops, we're going to combine it all into one

1 conversion factor. Intentionally perhaps there was a  
2 message sent that to the subset where volume was controlled  
3 that well yes, we told you that we were going to reward you,  
4 but now we're not.

5 I think we have to be a little bit careful about  
6 mixed messages that we're sending here. Physicians don't  
7 spend huge parts of time sitting back and thinking about the  
8 wonderful policy considerations going on here. You're sort  
9 of dealing with a message from the bottom line. And you  
10 have to be a little bit careful about the message.

11 MR. HACKBARTH: The reservation that I have about  
12 that, Karen, is the rate of growth for major surgical  
13 procedures is lower now. VPS doesn't exist. There's no  
14 differential conversion factor. People aren't responding to  
15 incentives. There's something different in the dynamics of  
16 growth in major surgical procedures than there is in  
17 imaging.

18 So I absolutely do not believe for a second that  
19 the reason that surgical procedures grew less under VPS was  
20 because surgeons were responding to incentives. The  
21 incentive of the individual physician is never to control

1 volume in a fee-for-service system, even if there's an  
2 aggregate national target. The incentive is to do more.  
3 It's a classic free rider problem.

4 If you want to create real incentives for  
5 individual clinicians to change behavior, the incentives  
6 have to be way closer to home than national targets.

7 DR. BORMAN: If I could just respond to one piece  
8 of that, and to say a very academic phrase, I don't disagree  
9 with all of what you've said there, and I hate saying that,  
10 that don't disagree part.

11 But I have to also tell you that one thing that's  
12 a bit different about some chunks of major procedures,  
13 whether they're accomplished through open operation by  
14 classic surgeons or whether they are major procedures that  
15 are accomplished through other means that are not typically  
16 thought of as surgery. I would challenge anybody that  
17 angioplasty is not a major procedure. It is.

18 So I think that one thing you've got to remember  
19 is there are some pretty big chunks here of surgery that are  
20 unable to be repeated. I can only take out your appendix  
21 once. I can only take out your gall bladder once. My

1 ability to grow that pie relates to population growth. It  
2 does not relate to my ability to do more of the services  
3 that I do.

4 I would say that imputing that I will do more  
5 questionable things in order to up my growth, I would resist  
6 -- and I know you didn't mean to imply that. But I do think  
7 that we do have to be a little bit careful and think about  
8 the whole pie.

9 MR. HACKBARTH: Absolutely. Just for the record,  
10 I want to be clear that I wasn't saying that you or any  
11 other surgeon was going to try to take out the appendix  
12 twice because of fee-for-service payment.

13 My point is that there are different dynamics in  
14 the growth rates for different types of services. Under  
15 fee-for-service the economic incentive is always to do more.  
16 Obviously there are other factors, including  
17 professionalism, that affect clinical judgment. And thank  
18 God for that or we'd be in even worse shape.

19 DR. MILSTEIN: I'd like to, first of all, just  
20 very strongly endorse Glenn's original framing that what I  
21 think the nature of this opportunity is and the fundamental

1 lack of fit between this tool and any objectives that we  
2 share.

3 My view is that we want physicians to lead a  
4 transformation in quality and affordability of the Medicare  
5 program, and in doing so, the whole U.S. health care system,  
6 since Medicare is by far and away our strongest lever.

7 That said, it's important to recognize that any  
8 attempt to facilitate that goal that's limited to physicians  
9 service growth only is, I think, likely impossible to  
10 achieve. There's too much of a mismatch between the subject  
11 or the lever which is changing in physician service volume  
12 only and the quality and total affordability goal that we're  
13 after.

14 I think the only exception to the  
15 incontrovertibility of this tool to our objectives is that  
16 the current SGR results in extremely severe physician fee  
17 cutbacks across the board. This is going to sound a little  
18 counterintuitive, but that actually could be, in that way,  
19 makes it quite useful.

20 What I have in mind is for us to consider, as one  
21 option, the unaltered continuation of it as a valuable tool

1 for motivating physicians to opt out of it and into a system  
2 that rewards them robustly and overwhelmingly for the  
3 transformation we're after.

4 MR. HACKBARTH: Let

5 me pick up on that with a piece of personal  
6 history. When I was at HCFA in the mid-80s we actually  
7 looked at proposing an SGR-type system with that specific  
8 strategic objective. The idea, to put it frankly, was to  
9 make fee-for-service Medicare untenable and then give  
10 physicians an escape route that would result in better  
11 organization and delivery of care where it was total  
12 expenditures, the whole package.

13 Obviously, we got cold feet and never did propose  
14 it. One of the reasons we got cold feet was that we had  
15 doubts that, in fact, Congress would ever stick to it and  
16 ruthlessly apply the stick to get the system to change. And  
17 evidence has shown that that reservation was basically  
18 correct.

19 I think the elephant in the room in the policy  
20 debate is the fee-for-service system does not work.  
21 Originally, when the program was first devised, you could

1 say well, this was an approach that would maximize clinician  
2 autonomy, maximize patient choice, and at least what we  
3 would get out of it is access to high-quality care.

4 Well, we've run the experiment for 40 years and it  
5 doesn't even give us that. At the end of the day we're not  
6 getting consistently high quality care. We're getting lots  
7 of access. We're getting lots of technological  
8 sophistication and advancement. Those are very good things.  
9 But at the end of the day, we are not even getting  
10 consistently high quality care, let alone efficient care for  
11 our beneficiaries.

12 All of this is a dance around how we patch a  
13 system that is fundamentally mistaken in terms of its  
14 assumptions and its operation

15 Except I'm a practical enough person to know that  
16 you can't overnight legislate that there won't be any more  
17 fee-for-service. But I think the strategy needs to be to  
18 move the system strategically towards arrangements where  
19 physicians are given the incentive, the opportunity to  
20 better organize care for patients.

21 These Part B only systems just, I don't think, get

1 you there except in the very limited sense that Arnie  
2 described.

3 MS. HANSEN: I just would like to pick up on the  
4 fact that the system, this Part B, is not effective as is.  
5 And I'd like to, again, highlight the unintended  
6 consequences that have been brought up a couple of times  
7 already from the beneficiaries' perspective.

8 I'd like the story to still be visibly told of the  
9 double digit premium increase that beneficiaries are facing  
10 and have been facing, coupled by when you increase volume,  
11 regardless of what it is, there are more copays. And then  
12 looking at beneficiaries as a whole, many of the  
13 beneficiaries are older women. That's really your older  
14 geriatric population. And about two-thirds of older women  
15 rely only on about \$950 for their basic Social Security  
16 check for 90 percent of their income.

17 So when you start looking at the economic model  
18 for creating the so-called access and choice and what not,  
19 doing a practical math problem, it also potentially cuts off  
20 access without addressing some fundamental issues.

21 So I just wanted to make sure that face is really

1 portrayed in the course of the data that we present.

2 MS. BEHROOZI: Everyone else has expressed so  
3 eloquently the problem with accepting the definition of the  
4 problem as it's been presented to us. But since a lot of us  
5 spend our days working within systems that we didn't create  
6 and trying to make the best of it, I'll try to do my  
7 assignment and address what we've been given just a little  
8 bit, just a couple of points.

9 One of the questions that you ask is whether we  
10 should be looking at existing levels of volume or growth in  
11 volume. I think that that really gets back to the question  
12 of what is it that's within the physicians' control. It  
13 seems to me that something like geographic area, the factors  
14 that influence volume, are less within the physicians'  
15 control. It's got to do with the historic patterns of  
16 utilization and beneficiary demand and access and marketing  
17 and all kinds of things that may be less within the  
18 physicians' control. I could be wrong about that but that's  
19 the way it strikes me.

20 Type of service is more within their control and  
21 is also something more related to the policy judgments that

1 we might want to be supporting or suppressing or whatever,  
2 in terms of what are the types of services where we think  
3 growth is appropriate or less appropriate.

4           But I think part of our problem with our  
5 discussion today is that we've been asked to talk about only  
6 two of the five potential areas and we all know that they're  
7 all out there. I think confining ourselves to two at a time  
8 makes us all a little crazier about the exercise.

9           I would just suggest that when you look at the  
10 last one on the list, physician outliers, that's the one  
11 that says this is what's in the control of the physicians,  
12 and maybe gets a little closer to what it is that physicians  
13 can control and controlling inappropriate volume growth,  
14 something that we talked about when we had the discussion in  
15 the summer, as opposed to controlling volume growth which  
16 might be appropriate in some cases, in some overall fashion.

17           So I'm not going to say that physician outliers is  
18 the one and only place we should look, but I do think that  
19 in general thinking about this problem we should be looking  
20 more to what we can incent, what physicians can control.

21           And then, by the way, if it turns out, I just want

1 to say one thing about the physician outliers point.  
2 There's a lot of talk about the Medicare system, about state  
3 Medicaid systems, about how much waste and fraud there is.  
4 And if you just controlled the waste and fraud the problem  
5 go away and everything would be affordable. And then there  
6 are other people who say physician outliers, you're talking  
7 about outliers. It's not that big a group. There aren't  
8 that many podiatrists who bill for six toes worth of  
9 treatment or whatever. So let's look at that.

10           And if you do that, if you respond to the people  
11 who are saying oh, it's all about waste and you show that  
12 you're only going to save 0.02 percent of your total  
13 spending, then we're done with that.

14           But we have saved that 0.02 percent or whatever it  
15 is that we shouldn't be spending. Or maybe we'll find out  
16 that that's a way to provide incentives for appropriate care  
17 and appropriate volume growth and be able to look at in a  
18 little bit more refined way.

19           DR. KANE: I agree that outliers may be actually a  
20 fruitful way to go only because I think when the fraud and  
21 abuse statutes were passed, weren't they estimating that 10

1 percent of expenditures were fraudulent and if you really  
2 had good edits in the claims system -- electronic edits,  
3 that you would catch more of this. So I think that's  
4 probably a good way to look.

5           But why don't we use the technology of managed  
6 care to set limits rather than GDP? We have all of these  
7 private insurers and Medicare themselves who do estimate per  
8 capita costs in a geographic region. And they obviously  
9 have some sense of how that per capita cost breaks down by  
10 type of service, like physician, hospital, post-acute care.

11           And can't you do by region some kind of capitation  
12 guide that is the limit, rather than affordability, so it  
13 reflects the Medicare beneficiaries' health and demographics  
14 and burden of illness in any geographic area, so you have  
15 sort of an indicative capitation budget for a geographic  
16 area that's broken down. Maybe 15 percent of that is  
17 physician services and that would be the target.

18           I guess I'm trying to say why doesn't the target  
19 reflect the way HMOs set targets, which is expected per  
20 capita costs rather than affordability?

21           DR. MILLER: This is a point that Bob Reischauer

1 brought up in another discussion. We are aware of it and  
2 we're trying to troll through the thought, both conceptually  
3 and what kind of data could be used to support it. So it's  
4 something that we are trying to think through.

5 DR. KANE: But don't we already do this?

6 DR. MILLER: For Medicare managed care, yes. But  
7 some of those targets are based on fee-for-service.

8 DR. KANE: They are now, I understand. But fee-  
9 for-service hasn't gone away.

10 DR. MILLER: Let me put it this way. I think the  
11 thing that we would like to drive at is since the  
12 administrative benchmarks are, in part, driven by fee-for-  
13 service, what we'd like to look is are the bids, so that you  
14 could then go in and say am I coming in underneath that?  
15 That's the point that we're sort of thinking about.

16 DR. KANE: But there are also managed systems -- I  
17 mean, there are already managed systems of care that had  
18 people over 65 in them for decades that aren't driven by the  
19 fee-for-service. And there's also the VA has managed --  
20 there's different ways you can get these.

21 MR. HACKBARTH: So if you're running a delivery

1 system in a managed care organization, there was an era a  
2 long time ago where you build up from your costs and said  
3 this is what we're going to charge. But that changed pretty  
4 dramatically.

5 And so you're taking a market price, what the  
6 buyers are willing to pay, and then divvying that up among  
7 the delivery system. So what you would need here is a  
8 market price to serve as your guide. One place you might  
9 look for that is the bids under MA.

10 DR. KANE: Also, the actuarial science for the  
11 build up from costs didn't go away. We stopped using it.  
12 I'm not sure we have to -- why can't you go to Kaiser or  
13 Humana's -- somebody's managed care business and say here's  
14 what we think the efficient per capita amount is, maybe  
15 inflated by some amount because it's not in the managed care  
16 system, and say that's the cap.

17 In other words, base it on the demographics and  
18 health burden of the geographic area rather than on GDP.

19 MR. BERTKO: Let me only confirm what Mark and  
20 then Glenn said, that the bids which are bid on the standard  
21 Medicare package, as part of it, as one step, do incorporate

1 all of that. The difference is what Jay and I offer all the  
2 time. It's a very distinct well-defined delivery system, as  
3 opposed to the fee-for-service system. Those are apples and  
4 oranges.

5 MR. DURENBERGER: I would just mention, Mr.  
6 Chairman, what I did yesterday, that two members of this  
7 commission are involved in an application for a 646  
8 demonstration doing exactly what she has proposed. It isn't  
9 just the plan. It's the physician, the doctors, what we've  
10 been talking about all morning.

11 MR. HACKBARTH: Let me just try to make a couple  
12 of other connections here. The outlier idea that Mitra was  
13 talking about, immediately a question you ask is what are  
14 you looking at in your definition of outliers? And one  
15 approach to that is you'd need to look at it in episodes of  
16 care, as opposed to just service counts. And that has a  
17 host of complications.

18 But I'd link that back to the work that we have  
19 been doing in trying to look at tools that can actually look  
20 at efficiency in the delivery of particular clinical  
21 episodes as a way that you might start to think about

1 outliers.

2           And Mark says that may include A and B, and not  
3 just the Part B portion.

4           Geography. Set aside the SGR alternatives piece  
5 of this. We keep coming back, the health policy debate  
6 keeps coming back to these huge geographic variations. If  
7 we recommend anything in this area that makes me inclined to  
8 want to think about we might combine geography perhaps with  
9 other models to start moving the policy debate to doing  
10 something about geographic variation, as opposed to  
11 observing it. Just a reaction on my part.

12           Last, going back to the productivity model that  
13 Scott described, one potential use of that is as part of an  
14 SGR formula. But I wonder whether some elements of the  
15 thinking could not be relevant even in the unit price  
16 increase with MEI adjustment model that MedPAC has worked  
17 from in the past because we had this productivity assumption  
18 that we assumed that productivity was going to improve last  
19 year by 0.9 percent based on the 10-year moving average for  
20 the economy as a whole. And we have repeatedly said that's  
21 not an empirical estimate, that's a policy objective.

1           The sort of a productivity thinking that Scott was  
2 describing is a way of starting to introduce into that some  
3 empirical elements of what we're observing in the production  
4 of services. I'm not sure exactly how you combine it with  
5 our policy, but it gives you a benchmark.

6           We often hear from physicians well, I can't  
7 increase my productivity by that amount. Yet we see perhaps  
8 some evidence that at least some of them are. It sort of  
9 gives us some framework, empirical framework, for thinking  
10 about productivity, even if it's not linked to an SGR-type  
11 formula.

12           DR. KANE: As a way to discuss this whole topic of  
13 how we should redo the SGR, I would find it helpful if we  
14 started off by saying what should the right target be? And  
15 then say okay, therefore what is the best way to group  
16 however we went to group them. I think it's really hard to  
17 talk about these things, the groups themselves, without  
18 saying what are we trying to achieve.

19           If we all agree on a target we want to achieve,  
20 let's play along with this whole notion that physicians  
21 should be under a target and nobody else. But let's agree

1 on what's the most reasonable target and then go backwards  
2 and figure out which of these different methods gets you  
3 there best with the least amount of administrative  
4 complexity and the least amount of political resistance.

5 DR. MILLER: Just a couple of things. Can I get  
6 slide three up there? I'm pretty sure that's the one I  
7 want.

8 There are a lot of good comments here on a policy  
9 and technical. But just in the interest of clarity, and  
10 because I believe in some respects, in repetition. I really  
11 appreciated Mitra's comment about we're considering these  
12 things and it's driving us crazy. There are a number of  
13 things that are driving us crazy and I just want to lay some  
14 things out.

15 I think as a matter of procedure we're going to  
16 put this slide up and it's going to stay up in all of our  
17 conversations. Because I don't want you guys to forget this  
18 report will have a place where it will talk about the many  
19 things in all of the work that you're doing that you need to  
20 change in the system and the way things need to change. You  
21 could have this conversation entirely separate, and we have

1 come, from SGR, that we're going to include in this report.  
2 This is things like pay-for-performance, encouraging groups,  
3 cost-effectiveness.

4 And so, as you consider the difficult task of  
5 dealing with the five things that they've asked you to look  
6 at, don't forget, we have not forgotten, that there are  
7 other things that you want to say. And Dana right now is  
8 working in this part of the chapter.

9 Which brings us to Mitra's point, which is it is  
10 crazy. We have to work every month and bring to the table  
11 what we can get done from month to month. And we'll be  
12 constantly considering these things in bits and pieces. And  
13 it's very frustrating, because many of the things that  
14 you're raising might not be problems in an outlier policy or  
15 a group policy, which we're all going to consider as we come  
16 along.

17 There are things -- and if I could go to the next  
18 slide -- we were asked to deal with other ideas all together  
19 if we have them. Targets can be in play. There are other  
20 things that we need to comment on here.

21 So if we're throwing GDP around, for example, on

1 the target, it doesn't mean that we have to stick with GDP.  
2 There are other ways to think about the target. We've been  
3 thinking about the bidding but you're right, there may be  
4 other ways to think about it.

5 And again, it's frustrating for you because you  
6 don't necessarily know that we're trying to bring something  
7 to the table on that.

8 I think maybe I'll stop there. There are couple  
9 of other things, but I think they can wait.

10 MR. HACKBARTH: We are exactly on time, so thank  
11 you very much. Much more on this later.

12 Now we turn to another mandated report, this one  
13 on rural hospitals and payment provisions directed at rural  
14 hospitals.

15 DR. STENSLAND: Good morning. Today we're going  
16 to present some supplementary data on our mandated study of  
17 how certain rural provisions of the Medicare Prescription  
18 Drug Improvement and Modernization Act of 2003, the MMA,  
19 affected payments to rural and urban hospitals.

20 Our mandate states that MedPAC shall analyze the  
21 effect on total payments, total growth in cost, capital

1 spending, and other such payment effects of certain rural  
2 positions of the MMA. It should be noted that these  
3 sections of MMA called rural provisions often also affect  
4 hospitals in urban areas.

5 An interim report on how the MMA affected critical  
6 access hospitals was presented in our June 2005 report to  
7 Congress. Our final report on all the rural provisions of  
8 the MMA is due this December.

9 Today we'll discuss the effect of certain MMA  
10 provisions on inpatient payments, outpatient payments and  
11 capital expenditures and overall cost. First Tim will touch  
12 on inpatient payments, then Dan will discuss how the MMA  
13 affects outpatient payments and we'll present a policy  
14 option that could assist low-volume hospitals when they lose  
15 their outpatient hold harmless payments at the end of 2008.  
16 Finally, I will discuss how the MMA provisions and expansion  
17 of the CAH program may affect capital expenditures and  
18 overall hospital costs.

19 I think it's important first to put the impact of  
20 the MMA inpatient payment changes in context. It is  
21 important to note that most rural hospitals are not paid

1 traditional PPS payment rates. CAHs are paid 101 percent of  
2 their current costs. SCHs have the option of receiving an  
3 inpatient rate based on their historical cost of care. MDHs  
4 have the option of receiving an inpatient rate based on 75  
5 percent of their historical cost and 25 percent of PPS  
6 current rates.

7           Therefore, when the MMA adjusted traditional PPS  
8 inpatient rates, most rural hospitals were not significantly  
9 affected because their rates are primarily based on current  
10 or historical cost.

11           And now Tim will talk about the specific inpatient  
12 changes.

13           MR. GREENE: Historically hospitals in large urban  
14 areas received a base operating payment amount that was 1.6  
15 percent higher than rural and other urban hospitals  
16 received. The first row shows the effect of the MMA  
17 provision bringing rural and other urban base payments up to  
18 our large urban levels.

19           Before the MMA, rural and smaller urban hospitals  
20 had their DSH payments capped at 5.25 percent of total  
21 payments. The MMA moved the cap up to 12 percent. The

1 second row shows the effect of this change.

2 CMS increases operating payments in high wage  
3 areas and reduces payments in low-wage areas to reflect  
4 local input prices. The MMA modified this adjustment to  
5 increase payments in low-wage areas. This benefits  
6 hospitals both in urban and rural low wage areas. The third  
7 row shows the effect of this provision.

8 The MMA also increased the wage index of hospitals  
9 if they were in a county of residents of workers who commute  
10 to higher wage areas. Relatively few hospitals take  
11 advantage of this provision and it's a very modest effect on  
12 payments. The fourth row shows the effect.

13 These MMA provisions overall have a greater dollar  
14 impact on urban hospitals but a larger percent impact on  
15 rural hospitals. In total, the provisions increase overall  
16 payments by 2.5 percent and urban payments by 0.8 percent.

17 DR. ZABINSKI: The MMA also has two provisions  
18 affecting the outpatient PPS that the law requires us to  
19 examine. The first of these provisions required CMS to do  
20 an analysis that resulted in rural sole community hospitals,  
21 SCHs, receiving a 7.1 percent add-on to their standard

1 outpatient PPS payments. This policy pays the rural SCHs  
2 about \$90 million. But the policy is also budget neutral,  
3 with most of the \$90 million being transferred from urban  
4 hospitals to the rural SCHs.

5 The MMA also extended hold harmless payments for  
6 rural hospitals. The idea of the hold harmless policy is  
7 that the qualifying hospitals receive the greater of their  
8 outpatient PPS payments or the payments they received under  
9 the previous cost-based system.

10 The hold harmless payments had sunset at the end  
11 of 2005 under the MMA but the DRA, the Deficit Reduction  
12 Act, further extended them to small rural hospitals that are  
13 not SCHs through the end of 2008. This policy pays these  
14 hospitals about \$70 million per year.

15 You might recall that last year we discussed  
16 options for replacing the hold harmless payments. But when  
17 the DRA extended them through 2008 we halted those  
18 discussions. But because the hold harmless payments are  
19 again scheduled to expire in the near future, we are again  
20 looking at alternatives for replacing them as well as  
21 replacing the add-on to the rural SCHs.

1           Our motivation for considering alternatives to the  
2 hold harmless payments and add-on to the rural SCHs is that  
3 both policies do not efficiently target hospitals that are  
4 in need or that are vital to beneficiaries access to  
5 outpatient care.

6           However, we also recognize that without any  
7 supplements such as the hold harmless payments rural  
8 hospitals would have worst financial performance under the  
9 outpatient PPS than their urban counterparts.

10           So with this backdrop, we set out to accomplish  
11 two goals. The first of these goals is to identify the  
12 factors that are beyond hospitals' control that cause the  
13 rural providers to have relatively poor performance under  
14 the outpatient PPS.

15           The second goal is, based on our findings, we want  
16 to develop a payment policy that directly addresses those  
17 factors.

18           Our work in accomplishing these two goals resulted  
19 in two key findings. Our first finding is that hospitals do  
20 exhibit economies of scale in their outpatient departments,  
21 meaning that outpatient costs per service tend to decline as

1 outpatient service volume increases.

2           The second finding is that rural hospitals tend to  
3 have lower service volumes than urban hospitals. We believe  
4 that this low volume strongly contributes to the poor  
5 financial performance of the rural hospitals in the  
6 outpatient PPS.

7           And because of these findings, when the hold  
8 harmless payments sunset in 2008 you might consider  
9 replacing the add-on for the rural SCHs and the hold  
10 harmless payments with a policy that gives low-volume  
11 hospitals the percentage increase over their standard  
12 outpatient PPS payments. A low-volume adjustment would be  
13 more efficient than the hold harmless payments and the SCH  
14 add-on, first of all, because if it is designed properly it  
15 can more efficiently target hospitals that are vital to  
16 beneficiaries access to outpatient services. Also, it would  
17 directly target a factor that affects hospital financial  
18 performance, that being whether a hospital is low volume or  
19 high volume.

20           Now an effective low-volume adjustment would have  
21 the following three features: first, hospitals would be a

1 minimum distance from other hospitals in order to receive  
2 low-volume assistance. This would help avoid making  
3 additional payments to hospitals that are low volume not  
4 because of isolation but because of poor performance in  
5 relation to their competitors. Also, it would help target  
6 hospitals that are vital to beneficiaries access to care.

7 Another feature of an effect of low-volume  
8 adjustment is that the adjustment rates would decline as  
9 hospital volume increases. That would assure that the  
10 lowest volume hospitals are receiving the highest adjustment  
11 rates.

12 And finally, critical access hospitals would not  
13 be affected and would maintain their cost based payments.

14 On the next two sides we show the effects of  
15 moving from the current policies to our proposed low-volume  
16 adjustment. First, under our current policies, first the  
17 SCH add-on is a budget neutral policy that transfers about  
18 \$90 million, mostly from urban hospitals, to rural  
19 hospitals. But it does not increase total spending in the  
20 outpatient PPS because it is budget neutral.

21 Second, the hold harmless payments add \$70 million

1 to the outpatient PPS payment for small rural hospitals but  
2 those payments go down to zero when this policy expires at  
3 the end of 2008.

4 Our proposal would replace the current policies  
5 with a low-volume adjustment starting in January 2009 after  
6 the expiration of the hold harmless payments. In your  
7 briefing materials we included an illustrative example of a  
8 low-volume adjustment that has a 15 mile distance  
9 requirement and empirically-based adjustment rates that  
10 result in about \$40 million going to about 500 rural  
11 hospitals. We understand that some may be concerned about  
12 the magnitude of the assistance provided by this low-volume  
13 adjustment, so I really want to emphasize that spending  
14 under a low-volume adjustment can be increased by changing  
15 the parameters such as the distance requirement.

16 So to close this part of the discussion, I want to  
17 just present a draft recommendation where beginning in  
18 January 2009, the Congress should enact a graduated low-  
19 volume adjustment to the rates used in the outpatient PPS.  
20 This adjustment should apply only to hospitals that are more  
21 than 15 miles from another hospital offering outpatient

1 services.

2           The spending implications are pretty modest and  
3 that would add less than \$50 million to budgetary spending.  
4 The implication for beneficiaries is that it would help  
5 assure their access to hospital outpatient care.

6           Jeff is going to conclude our discussion.

7           DR. STENSLAND: While it's fairly easy to estimate  
8 the changes in Medicare payments, Congress also required  
9 that we look at the effect of MMA on capital expenditures  
10 and overall hospital cost. In the past, we've shown that  
11 hospitals tend to spend less when they're under more  
12 financial pressure and tend to spend more when they have  
13 more money to spend. So we would expect some increase in  
14 capital expenditures following the MMA.

15           However, the MMA only increases rural PPS hospital  
16 Medicare revenues by roughly 2.5 percent on average, which  
17 is roughly equivalent to a 1 percent increase in total  
18 revenues. This is probably not enough to cause a measurable  
19 increase in the average rural hospitals' cost. There's too  
20 much noise in the data to detect the impact of a 1 percent  
21 shift in revenues.

1           To test the impact of changes in IPPS payment  
2 rates, we would have to focus on hospitals that received the  
3 largest increase in payments and look at capital  
4 expenditures and hospital costs at least through 2006. That  
5 data is currently not available.

6           However, the MMA also changed the CAH program and  
7 conversion to CAH status does lead to increased expenditures  
8 as CAHs modernize their facilities. Some may be concerned  
9 with this spending growth while others may see this as a  
10 positive sign that old rural hospitals are being updated.

11           Our preliminary analysis of 2003 and 2004 data  
12 indicate that aggregate CAH capital cost, such as  
13 depreciation and interest, grew by roughly 8 percent at CAHs  
14 compared to a 5 percent growth rate at small rural hospitals  
15 that have not converted to CAH status. The difference in  
16 growth rates is statistically significant. We will be  
17 examining cost data further and plan to present more  
18 analysis during our October meeting.

19           In our June 2005 chapter on CAHs, we projected  
20 that the number of CAHs would grow to roughly 1,300 by 2006  
21 and the average CAH would receive roughly \$5 million in

1 Medicare payments, which would be approximately \$1 million  
2 above PPS rates.

3           There are currently over 1,280 CAHs and given what  
4 we see in terms of growth in payments from 2003 to 2004, and  
5 what we see in terms of increases in the size of CAH  
6 converters, our original estimates regarding CAHs appear to  
7 be on target.

8           In this slide, we examine the rate at which  
9 Medicare expenditures continue to grow after conversion.  
10 The sample is limited to CAHs that had converted before  
11 2002. In general, the trends are as you would expect given  
12 the financial incentives. We see expenditure growth focused  
13 on swing beds and outpatient payments. These are areas  
14 where cost-based rates tend to be significantly higher than  
15 PPS rates at small rural hospitals. Some observers may view  
16 expenditure growth as a positive sign, indicating that rural  
17 individuals may be receiving more health care services.  
18 Others may be concerned about the rate of payment growth  
19 given past experience with cost-based reimbursement in  
20 hospitals, SNFs, and other providers.

21           We should caution that a significant increase in

1 outpatient payments may in part reflect CAHs starting to  
2 bill jointly for physician services. CAHs are able to  
3 receive 115 percent of the physician amount if they bill for  
4 the service rather than the physician billing for the  
5 service.

6           The most important provision of the MMA was that  
7 it requires new CAHs to be 15 miles by secondary road or 35  
8 miles by primary road from the nearest alternative hospital.  
9 States can no longer waive this distance requirement for new  
10 CAHs. Most existing CAHs do not meet these criteria but  
11 were grandfathered into the program.

12           Since our preliminary report was published, CMS  
13 has published regulations governing the degree to which CAHs  
14 can be allowed to build replacement facilities in a new  
15 location. CAHs can relocate as long as they continue to  
16 serve the same patient base and have the same employee base.  
17 Some CAHs may be reluctant to significantly change their  
18 location or to merge with other facilities for fear of  
19 losing their CAH status and the cost-based reimbursement  
20 that goes along with it.

21           The current system, in essence, encourages the

1 status quo of maintaining all the current CAHs in all the  
2 current locations. In essence, the structure of rural  
3 health care delivery is, to some extent, encouraged to stay  
4 the way it witness.

5           However, rural communities continue to face some  
6 difficulty recruiting physicians to practice in towns with  
7 only one or two colleagues, and if economies of scale become  
8 important as we move towards pay for performance and  
9 electric medical records, there may be a few rural  
10 communities that consider consolidating with a neighboring  
11 hospital that is five or 10 or 15 miles away. To provide  
12 these communities with more flexibility, the Commission may  
13 want to consider the following draft recommendation.

14           The recommendation states the Secretary should  
15 allow CAHs to merge and retain their CAH status if one or  
16 both of the two CAHs closes and the new CAH serves both  
17 communities. The new CAH should be allowed to staff enough  
18 beds to meet the combined 2006 peak census of the two closed  
19 hospitals.

20           Not to be clear, this would not expand the bed  
21 limit to other hospitals that aren't merging where one or

1 both of the two hospitals closed. And I don't want to  
2 oversell the importance of this recommendation. Many rural  
3 communities feel very strongly about keeping their hospital  
4 in their town and they would be very reluctant to see a  
5 hospital closed. This recommendation would only come into  
6 play if you can find a rural hospital board that's going to  
7 agree to saying we should close the hospital that's in our  
8 town and that's going to be a rare occurrence.

9           But in some agricultural areas, farms continue to  
10 consolidate and population continue to decline and we may  
11 want to give those communities that are changing the option  
12 of changing the structure of their local health care  
13 delivery system, especially if a new health care delivery  
14 system is seen as a more efficient way to serve their  
15 communities.

16           To give you a concrete example, in my mind I think  
17 that maybe there are two hospitals, they're 14 miles apart.  
18 They each have a medical staff of three. The physicians are  
19 on call covering the ER every third night. Maybe they're  
20 getting tired of that. And they're thinking about  
21 remodeling, the hospital 14 miles down the road is thinking

1 about remodeling. And they say maybe we should just get  
2 together and have one hospital rather than two.

3 Then they talk to their CFO and he says if we move  
4 the hospital in between the two towns, Medicare is going to  
5 cut our payments by 20 percent. The concern is that maybe  
6 we don't want that to be the end of the discussion.

7 Now we'll open it up for your comments on the work  
8 so far and to hear your suggestions on the recommendations.

9 MR. HACKBARTH: Can I just pursue that last idea  
10 of allowing mergers. I understand the logic and it makes  
11 sense, at first blush at least.

12 As I said when we've talked about CAHs in the  
13 past, one of the concerns that I have is their impact on  
14 nearby PPS hospitals. We tend to look at them in isolation  
15 and not in a broader competitive context.

16 I've been worried that when we start to allow CAHs  
17 that are not really geographically removed that we start to  
18 then affect the nearby PPS hospitals. To the extent that we  
19 allow CAH hospitals to merge and become bigger, I wonder  
20 whether that would be an even greater risk, that we would  
21 start to have been adverse effects on nearby PPS hospitals.

1 DR. STENSLAND: The regulations that CMS put out,  
2 I think, were influenced by some PPS hospitals complaining  
3 that some CAHs were planning to move and move very close to  
4 their facility. So there would need to be new regulations  
5 on the part of CMS that would govern what would happen if  
6 two CAHs merged. I could foresee they could, for instance,  
7 say the new merged entity cannot be significantly closer to  
8 any PPS hospital than the current entities are, or something  
9 of that nature.

10 MR. HACKBARTH: Comments, questions?

11 MR. DURENBERGER: Number one, as usual, the work  
12 is excellent and it's also responsive, if I understand from  
13 the executive summary, what you were asked to do. So this  
14 is merely by way of suggestion to be more responsive perhaps  
15 then they asked you to be.

16 My first question is whether or not you've  
17 consulted a former commissioner at all, just in terms of the  
18 tone of the response and some of the information. But I  
19 just think it would be a great idea because Mary Wakefield  
20 puts her whole life not into to this kind of an issue, but  
21 into the service and the beneficiary-related issues. And I

1 think it would be helpful to talk to her, for other reasons  
2 too, because she has a good political sense and making sure  
3 that the way in which it's presented is helpful,  
4 particularly to the people who have sponsored a lot of this  
5 legislation, as well as those who might be a little critical  
6 of it.

7 MR. HACKBARTH: I think that's a good idea, Dave.

8 MR. DURENBERGER: The second one goes back to the  
9 discussion we had previously. In this presentation and in  
10 the paper I was reminded of the previous discussion, which  
11 mainly reflects that we're sort of on the wrong track if we  
12 only look at critical access hospitals and we look at  
13 distance and we look at things like that. That's not the  
14 way people are looking at it. The definition of medical  
15 home is a little town nobody's ever heard of in rural South  
16 Dakota where a bunch of docs have gotten together to create  
17 a medical home for people -- and Nick can do this better  
18 than I can because this is the area that he works.

19 But all of the things that we discussed when we  
20 were pulling the pin on the grenade last time is what's  
21 going on in rural America today in a white variety of ways.

1 It's probably helpful in some ways. I'm not asking you to  
2 analyze that. I'm simply saying it's helpful to reflect  
3 that it isn't just hospitals that are going to change the  
4 access, the quality and the cost. It's going to be  
5 physicians, and that's where the creativity comes.

6 My the third point is simply a question, and that  
7 is do we have information on ownership of critical access  
8 hospitals? You talked, I think, Jeff, about the  
9 consolidation and all the rest of that sort of thing. And I  
10 don't know how helpful this is. Most of us have this image  
11 of, just like the little schoolhouse on the prairie or  
12 something like that, there's this little hospital out on the  
13 prairie.

14 One of the biggest health systems in America, the  
15 Mayo Clinic, probably owns about 50 of these things in rural  
16 -- maybe not 50, maybe it's only 40 -- in rural Minnesota,  
17 Iowa and Wisconsin. I'm sure that they appreciate the  
18 financing that comes from this. But at the same token, they  
19 probably know better than we or payment system or their  
20 members of Congress how to enhance the value to the  
21 communities that are served by changes in the way certain

1 hospitals are structured and certain hospitals are served.

2 I don't know what knowing that would add to  
3 policymakers' understanding of is that a good policy or not.

4 MR. HACKBARTH: I think that's an interesting  
5 point. It makes me wonder about the ownership as well, not  
6 just the Mayo Clinics of the world. But has this become  
7 sufficiently attractive that for-profit companies are  
8 starting to enter the business? It might be interesting to  
9 know that. Or are they still largely not-for-profit  
10 governmental institutions?

11 DR. STENSLAND: I think the vast majority, almost  
12 all of them, are going to be not-for-profit or government  
13 institutions. They can be for-profit, but I've never heard  
14 of a for-profit CAH. Though some of them are owned by -- in  
15 a few cases, they are owned by a system and the system may  
16 view it more kind of as an outpost and a feeder kind of  
17 hospital to the larger system and there is a lot of system  
18 ownership of CAHs.

19 DR. KANE: And some of them are managed by for-  
20 profits and the for-profit takes a chunk off the top as  
21 their fee.

1 MR. HACKBARTH: Other questions and comments?

2 DR. BORMAN: Just one quick question. In looking  
3 at the capital add-on piece, do we have any sense of how  
4 much that can really be accounted for by true pricing cost  
5 differences to the CAH hospitals because they are in a more  
6 remote location? And we can all envision the increased  
7 costs of trucking in certain things and whatever.

8 Because as more purchasing gets done in  
9 consortiums and so forth, you kind of wonder whether or not  
10 that's a valid thing. And one of my concerns is that it  
11 then goes to capital funding of equipment that's used to  
12 initiate diagnostic events or testing or things upon which  
13 those individuals can't act and aren't going to act. And  
14 then when they move to another piece of the system, and this  
15 gets to the grouping issue about where people have been, a  
16 bunch of money has been expended on stuff that provided no  
17 benefit to the beneficiary when they next entered the next  
18 piece of the system. That wasn't done in a way that's  
19 useful, it wasn't the right, whatever.

20 And I just wonder if this capital piece fuels that  
21 at all?

1 DR. STENSLAND: There shouldn't be much of a  
2 difference in terms of the trucking distance because we  
3 compared the CAHs to other small rural hospitals that have  
4 1,000 or 900 or fewer beds. So the comparison groups are  
5 fairly similar.

6 We also were looking at growth rates as opposed to  
7 levels. So it's a growth rate issue and so it shouldn't be  
8 affected by the distance.

9 If anything, the differential might be a little  
10 bigger than what we state, and that's because at some point  
11 CAHs change the way they do their accounting a little bit  
12 when they become a CAH. For example, maybe they're buying a  
13 bed for \$4,000. Maybe they used to capitalize that and  
14 depreciate it. Now maybe they expense it rather than  
15 capitalize it and depreciate it.

16 So actually the increase in their capital costs  
17 might be even a little more than what we show there.

18 DR. KANE: We're sharing this question. But Mitra  
19 pointed out that when we looked at DSH and IME and all these  
20 other add-ons, we looked at the distribution of the Medicare  
21 profit margin, maybe even we'd like to look at the total

1 margin for each of these little benes and to see how they  
2 distribute across the population of hospitals that get them.

3           And just to be consistent, it would be nice to  
4 have the same kind of information about these hospitals and  
5 the rural hospitals. Because what we do see with, for  
6 instance, IME is that we've created a little monster of 200  
7 hospitals -- I shouldn't say that way.

8           DR. REISCHAUER: Are you planning to return to  
9 Cambridge?

10           DR. KANE: I guess my grenade thrower personality  
11 is starting to pop up again.

12           But it would be nice to be sure that these are  
13 reasonably distributed and not creating competitive  
14 advantage/disadvantage inappropriately and out of sync with  
15 what we're intending.

16           So I would just ask that we can see the same kind  
17 of distributions for how these monies would flow and the  
18 profit margin distributions that go with that for the rural  
19 hospitals just as we did when we looked at the teaching  
20 distributions.

21           DR. STENSLAND: We can do that. We could either

1 look at the dissipation of margins, which we're going to  
2 show the 1 percent margin for Medicare across the board, and  
3 then some variance in the total margins. We could also look  
4 at some variability in the cost.

5 Because in a way, at least CAHs all have 1 percent  
6 Medicare margins but they may get that very different ways,  
7 depending on what their cost structure is.

8 MR. HACKBARTH: Okay, thank you.

9 Next we turn to physician payment again, this time  
10 practice expense payments and CMS's proposed change in  
11 practice expense.

12 MS. RAY: This summer CMS proposed a major  
13 revision of the methods it uses to calculate practice  
14 expense payments. Ariel and I will take you through the  
15 impact of CMS's proposal.

16 As you will see these changes, if implemented,  
17 will result in some large changes. Some of these changes  
18 are unexpected. Ariel will also summarize three analyses we  
19 are conducting that address some of the proposed changes.

20 Just a little bit of background very quickly.  
21 This work on practice expense fits into our broad agenda to

1 examine physician payment issues, in particular the accuracy  
2 of payments. Recall that in our March 2006 report we made a  
3 series of recommendations to improve CMS's process for  
4 reviewing work RVUs. These recommendations address the  
5 concern about the mispricing of services in the physician  
6 fee schedule.

7           The Commission and others have argued that  
8 inaccurate price may be leading to increased volume for  
9 certain types of services. Inaccurate pricing is also an  
10 issue on the PE side. In our June 2006 report, we raised  
11 concerns about the age of the data CMS uses to calculate  
12 practice expense payments and some of the assumptions CMS  
13 uses to estimate the practice costs of imaging services.

14           So what are practice expense payments? Practice  
15 expense payments pay cover the costs of operating a  
16 practice. Direct practice expense payments cover the cost  
17 of non-physician clinical labor, medical equipment and  
18 medical supplies. Indirect practice expense payments cover  
19 administrative labor, rent, utilities and other expenses.  
20 Practice expense payments are important. They account for a  
21 little under half of the payments to physicians.

1           Like I said, in June CMS proposed a major overhaul  
2 of its practice expense methods. The four main changes are  
3 listed here. CMS is proposing to calculate direct practice  
4 expense RVUs using a bottom-up method instead of a top-down  
5 method. CMS is proposing to use supplemental data. That is  
6 more recent data on the total cost of operating a practice  
7 from eight specialties. There is a proposal to modify how  
8 to allocate indirect costs to specific services and CMS is  
9 proposing to eliminate the nonphysician work pool.

10           As expected, moving to a resource-based method for  
11 all services and modifying how direct and indirect practice  
12 expense RVUs are calculated results in changes. The impact  
13 of these changes varies by type of service. On average,  
14 practice expense RVUs would increase by about 5 percent for  
15 E&M services, decrease by 5 percent for imaging services and  
16 10 percent for major procedures, and increase by 4 percent  
17 for other procedures, I'm sorry, and 1.5 percent for tests.

18           Within these categories, there are a lot of large  
19 changes and some of these changes are unexpected. For  
20 example, although as a group PE RVUs for imaging services  
21 goes down, they increase by about 27 percent for certain

1 types of agography and 13 percent for certain types of CT  
2 services.

3 Please keep in mind that the practice expense  
4 accounts for different shares of total payments across these  
5 five categories.

6 So what are the factors that contribute to these  
7 changes? First is the move to a bottom-up method to  
8 calculate direct practice expense RVUs. CMS will calculate  
9 direct practice expense payments by summing the cause of  
10 nonphysician clinical labor, medical equipment and medical  
11 supplies. Moving to a bottom-up method would, not  
12 unexpectedly, move direct RVUs towards non-facility services  
13 that use costly labor, equipment and supplies such as  
14 certain tests and certain procedures performed in physician  
15 offices.

16 Under CMS's proposal, direct inputs play a greater  
17 role in determining both the direct and indirect PE RVUs. A  
18 better understanding of the process used to refine the  
19 direct inputs may help us consider ways to ensure their  
20 accuracy in the future. We contracted with the Urban  
21 Institute to interview stakeholders about the process for

1 refining the original estimates of the direct inputs and  
2 examine changes in practice expense RVUs between 1998 and  
3 2002 when CMS phased in resource-based payments and 2002 and  
4 2004 when most of the refinements were made. The appendix  
5 in your mailing summarizes the findings of this report.

6 I'm not going to go into the results right now but  
7 I'm happy to take questions from you. The take-home message  
8 is that the refinements to the direct inputs and other  
9 changes between 2002 and 2004 affected practice expense RVUs  
10 differently across the five categories of services.

11 Back to the proposed rule. Using supplemental  
12 data, that is more current data on the total cost of  
13 operating a practice, is another factor that contributes to  
14 the change in practice expense RVUs among services and  
15 specialties. Under CMS's proposal, total indirect costs are  
16 needed to calculate indirect practice expense RVUs. Keep in  
17 mind that indirect RVUs are important. They account for, on  
18 average about 67 percent of the practice expense payment.

19 As we noted in our June 2006 report, supplemental  
20 data could cause distortions in the relative practice  
21 expense payments across services. For example, practice

1 expense RVUs for coronary angioplasty increased by 38  
2 percent. By contrast, among all major procedures, practice  
3 expense RVUs declined by 10 percent. Cardiology submitted  
4 supplemental data.

5 Indeed, four of the eight specialties with  
6 supplemental data experienced some of the largest gains in  
7 practice expense.

8 In addition, supplemental data may offset some of  
9 the effect of eliminating the nonphysician work pool for  
10 these specialties.

11 Now Ariel will take you through the other factors  
12 contributing to the change in practice expense RVUs.

13 MR. WINTER: As Nancy said, indirect expenses,  
14 which include rent, utilities, and administrative staff,  
15 account for more than 60 percent of most specialties'  
16 practice costs. These costs cannot be directly associated  
17 with specific services, so CMS has to develop a way to  
18 allocate them. Under its current method CMS allocates  
19 aggregate indirect costs for each specialty to the services  
20 they perform based on the sum of the direct cost and the  
21 physician work RVU for each service.

1           The proposed method makes two changes. It adjusts  
2 the direct practice expense part of the formula based on the  
3 ratio of indirect costs to direct costs for the specialties  
4 that perform the service. This change increases the  
5 indirect cost allocation for services that are, on average,  
6 performed by specialties with higher indirect costs. It  
7 decreases the indirect cost allocation for services that are  
8 performed by specialties with lower indirect costs.

9           Second, instead of using the physician work RVU in  
10 the formula, it uses the higher of the work RVU or the  
11 clinical labor RVU, for example the cost of a nurse's time.  
12 The clinical labor RVU is also part of the direct practice  
13 expense, so it could be double counted, depending on whether  
14 it's higher or lower than the work RVU.

15           This change is designed to protect services with  
16 little or no work RVUs that might be disadvantaged by the  
17 current allocation method.

18           Nonphysician work services include services like  
19 imaging and radiation therapy that are performed by  
20 nonphysician staff. Currently, the practice expense RVUs  
21 for these services are not resource based as they are for

1 other services. Rather, they are based primarily on  
2 historical charges. CMS has now proposed to set resource-  
3 based RVUs for these services using the same method it uses  
4 for all other codes. This change will increased RVUs for  
5 some nonphysician work services and decreased RVUs for  
6 others depending on the relationship between charges and  
7 resource estimates.

8           The effect of this change is unclear for  
9 specialties that have many services in the nonphysician work  
10 pool and that have submitted supplemental data, namely  
11 radiology, cardiology and radiation oncology. Use of  
12 supplemental data for these specialties may offset sense of  
13 the reductions to their services caused by the move to a  
14 resource-based method.

15           Now I'll briefly review our proposed work plan for  
16 the coming year. First, as Nancy described, using more  
17 current practice cost data for some, but not all,  
18 specialties could cause significant distortions in relative  
19 practice expense payments. We plan to examine the impact of  
20 using supplemental data on practice expense RVUs.

21           Second, CMS's method for allocating indirect

1 expenses among services may raise equity issues. For  
2 example, CMS currently uses the cost of medical supplies to  
3 allocate indirect costs. It's part of the direct practice  
4 expense part of the formula that I showed you earlier. This  
5 approach rewards services with high cost supplies, although  
6 it is questionable whether high cost supplies are associated  
7 with higher indirect costs. So we plan to model alternative  
8 approaches for allocating indirect expenses.

9           The third issue relates to how CMS adjusts  
10 practice expense payments for geographic differences in  
11 input prices. The geographic adjuster is called the  
12 Geographic Practice Cost Index or the GPCI. When CMS  
13 constructs the GPCI, they calculate the proportion of  
14 practice expenses across all services that are related to  
15 staff wages, office space and equipment and supplies. They  
16 assume that prices for office space and staff vary  
17 geographically and that prices for equipment and supplies do  
18 not because they're purchased in a national market.

19           The problem is that CMS uses the average share of  
20 equipment and supplies in the GPCI but, in fact, this  
21 share varies widely among services, as we'll see on the next

1 slide.

2           This chart shows the distribution of direct  
3 practice expenses by clinical staff and equipment and  
4 supplies for different categories of services. Services  
5 such as E&M, which is the bar at the far left, use a lot of  
6 clinical staff resources, shown by the yellow portion of the  
7 bar, while imaging services use primarily equipment and  
8 supplies, shown by the blue portion of the bar. The average  
9 share of equipment and supplies across all services is shown  
10 by the dotted horizontal line.

11           Now remember that CMS assumes that staff wages  
12 vary geographically but that equipment and supplies do not.  
13 So using a geographic adjuster that's based on an average  
14 share of equipment and supplies means that Medicare is over-  
15 adjusting payments for imaging and under-adjusting for E&M.  
16 In other words, equipment and supply intensive services like  
17 imaging are overpaid in areas with a high cost index and  
18 underpaid in low cost areas. Conversely, E&M services are  
19 underpaid in high-cost areas and underpaid in low cost  
20 areas.

21           We plan to have our contractor model the impact of

1 applying the geographic adjuster to the portion of each  
2 service for which prices vary geographically. In other  
3 words, the labor portion of the direct expense and the  
4 entire indirect expense.

5           So to summarize, CMS has proposed a major change  
6 in the method it uses to calculate practice expense RVUs.  
7 The effects of this change are large and unexpected for some  
8 services. We're concerned that the use of supplemental data  
9 from some specialties could cause distortions in RVUs.  
10 Changing the indirect cost allocator would redistribute  
11 payments to services performed by specialties with higher  
12 indirect costs. Eliminating the nonphysician work pool  
13 means that RVUs for all services would be resource based.  
14 And finally, we described our proposal work plan for the  
15 coming year.

16           We look forward to your questions and comments.

17           DR. BORMAN: Just a couple of technical questions,  
18 because we've had some conversation off-line about some of  
19 this.

20           Number one, could you help me to understand how  
21 the in-facility/out of facility approach plays into this or

1 where it may impact this? Where does it potentially change  
2 these numbers?

3 MR. WINTER: In terms of the geographic adjuster?

4 DR. BORMAN: Currently we believe that many things  
5 that are done out of facility, that is in outpatient  
6 settings, get a much larger practice expense, sometimes very  
7 legitimately but sometimes in a seemingly artificial way.

8 Is there anything in this that will look at  
9 particularly changes that come to the out-of-facility and  
10 whether those are differential versus in-facility and  
11 whether it further widens that gap or not?

12 MR. WINTER: I was going to go back to our work  
13 plan if I can get back there.

14 The one thing is that looking at how they allocate  
15 indirect costs could play into that because under the change  
16 -- I'll go back to the formula, which I put up before.

17 So the current way it works is it's based on  
18 direct practice expense plus the work RVU. Now they propose  
19 to adjust the direct practice expense by the ratio of  
20 indirect to direct costs by the specialty. Most specialties  
21 have higher indirect costs than direct costs. So that's

1 going to increase in direct practice expense part of the  
2 formula and relatively decrease the work RVU part of the  
3 formula. And services that are done outside the office,  
4 they're more dependent on work RVUs for allocating those  
5 indirect expenses.

6 And so it could have an effect that way. And  
7 that's something we might be able to look at through our  
8 model.

9 DR. BORMAN: Because I think, particularly in the  
10 minor procedures, other procedures kinds of categories, the  
11 number of things that are done on an outpatient basis may be  
12 substantially higher and it may drive some funny things in  
13 there. I'm not sure that it does, but it might.

14 MS. RAY: Just to be clear, we presented the  
15 changes by these five broad categories of service. What  
16 you're talking about is looking at the changes facility  
17 versus non-facility.

18 DR. BORMAN: Within that is it facility verses  
19 out-of-facility? And I don't know that there is an impact  
20 there but I think if we're looking at that we ought to know.  
21 Are we enabling something that we want -- getting back to

1 the philosophic issue -- or are we disabling something that  
2 we want? That would one thing.

3 MR. WINTER: Right now our contractor is in the  
4 process of modeling the bottom-up methodology and they're  
5 going to present to us results by facility and non-facility.

6 DR. BORMAN: Great. I think that's fabulous.

7 MR. WINTER: And by type of service as well as by  
8 specialty.

9 DR. BORMAN: This is great work and I also think  
10 CMS did a much better job this time of making it to where  
11 mere mortals could understand the process a little bit and  
12 follow the calculation. So I think that's great. That was  
13 very helpful. Of course, this is wonderful staff work.

14 Another piece of it that I would bring up and it  
15 sort of relates to Nancy's comment about set a target and  
16 then figure out where it is. At least my understanding is  
17 in the rule that it's talked about that what's really being  
18 covered here is roughly one-third to two-thirds of  
19 physicians' practice expense costs. That sets an implicit  
20 target, if you will, on this little piece of the puzzle.

21 Certainly, that's influenced by the Medicare mix

1 of an individual physicians' practice or a group's practice  
2 or whatever. But you need to know you are sort of setting a  
3 target there that even though the way we measure your cost  
4 it's 100 percent, that we have decided that what we can pay  
5 you for is 35 percent, 65 percent of your directs or  
6 indirects. And that implicitly sets a target, whether you  
7 want to think about it that way or not, it does seem like it  
8 does sort of imply a target for physicians. So I think we  
9 should look to see are those the things we want to  
10 encourage.

11 The other piece, just very philosophically, is  
12 that as you get into more of the technical arcanery here,  
13 that it does bed the issue of whether or not a system that  
14 was developed in a very well-intentioned way, in terms of  
15 trying to break out what are the inputs into these costs,  
16 now it seems to be progressing way past its value by virtue  
17 of the way we've learned to slice and dice this. Being a  
18 slicer and dicer, I understand that part.

19 MR. HACKBARTH: I'm glad you're on our side.

20 DR. KANE: First of all, although it might be  
21 clear to you, I frankly don't understand the new indirect

1 allocation.

2 But before I go back there, I actually worked on  
3 this years ago as a research project, maybe in the early  
4 '90s. My main focus was what drives indirect costs and  
5 which ones are fixed and which ones are variables. And it  
6 turns out indirect costs are largely fixed, but we're paying  
7 them on a 100 percent variable basis.

8 And I'm going back down to our volume problem and  
9 I'm thinking maybe this is one way to think about the volume  
10 problem is that -- and I don't know if -- it's probably  
11 administratively impossible.

12 MR. HACKBARTH: That's never stopped us before.

13 DR. KANE: That's never stopped us before. But my  
14 recollection, because I ran around the country talking to  
15 physicians and collecting their costs and doing an analysis  
16 of what drove their overhead costs. First of all, most of  
17 them are fixed. But we're paying them on a variable basis.  
18 And I wonder if we should have some cut-off point at which  
19 you're only getting to work part instead of -- if you really  
20 want to get at volume.

21 I guess the other thing is whether -- and I know

1 this is probably too complicated. I don't understand the  
2 allocation formula but I do know it doesn't relate at all to  
3 the cost drivers for indirect costs. So I guess in  
4 traditional industrial cost accounting we try to create an  
5 allocation method that really reflects what's driving those  
6 costs. Is it more the size of the staff which is what's  
7 creating overhead or the size of the -- but this doesn't  
8 have any of that in there.

9           So I guess I'm concerned -- first of all we should  
10 throw the whole thing out, I know. I'm just wondering if we  
11 want to at least do a fixed variable consideration and in  
12 terms of indirect costs whether there should be some point  
13 at which you're getting work and you're not getting --  
14 because your volume -- and whether we can even track that at  
15 the practice level. I don't know.

16           But this is really just a totally arbitrary way of  
17 allocating indirect costs that bears no relationship to the  
18 science of cost accounting. And on top of that, I don't  
19 understand it yet.

20           MR. WINTER: I can take a stab at trying to  
21 explain how it really works. So for a given code you have a

1 direct practice expense, and that used to be derived on a  
2 top-down method and now we're doing a bottom up. So that's  
3 summing up the direct inputs, supply, staff and equipment.

4           And you add that to the work RVU for that code.  
5 And then there's a whole process where they apply a scaling  
6 factor to it, at which they relate the total indirect cost  
7 for the specialty, as derived from a survey, the SMS survey  
8 or the supplemental surveys. They relate that to the total  
9 allocation across all the specialties' codes. That is what  
10 you derive from that formula, direct PE plus the work RVU.  
11 So you try to make the two equivalent on an aggregate basis.

12           DR. KANE: If the indirect to direct relationship  
13 in surgery was two-to-one, but then you've made the one, the  
14 direct both direct cost plus physician work, do they  
15 maintain -- do they keep it two-to-one, so you're adding an  
16 indirect on to something that wasn't in the original  
17 relationship? Am I wrong?

18           MR. WINTER: That's a good point. I'd have to  
19 think about whether -- you're asking whether the  
20 relationship between direct and indirect is maintained at  
21 the specialty level.

1 DR. KANE: No, I'm saying you're allocating -- I  
2 should probably take this off-line, but just one more shot.

3 If a specialist, let's say the surgical specialty,  
4 is two-to-one indirect to direct. But you're going to  
5 allocate it two-to-one to the direct plus physician work.  
6 But that's not the original relationship.

7 DR. BORMAN: It's the effect of the scaling factor  
8 that's carried on for multiple pieces of the equation.

9 DR. KANE: I think I'll ask this separately  
10 because I don't understand it. But I will say that cost  
11 accounting is one thing I'm pretty good at, so I'm  
12 concerned.

13 MS. RAY: I'm not going to try to explain it, but  
14 it is clear and this is a point that we did make in the  
15 comment letter, that it is still not a transparent method  
16 and it is still hard to understand for us mere mortals. I  
17 think your point is well taken.

18 DR. MILLER: I also thought in your work plan  
19 there was a discussion to look at this and to look at the  
20 scaling factor.

21 MS. RAY: Right, and to look at different ways of

1 allocating indirect costs; that's correct.

2 DR. MILLER: So beyond just getting you to  
3 understand it, and we'll have this conversation by phone, we  
4 can get to that point. But we've recognized that there are  
5 some issues here and that by doing it the way they are doing  
6 it, they may be having effects that one wouldn't necessarily  
7 have anticipated. So we do understand that there's an issue  
8 there.

9 DR. BORMAN: Relative to this process I think, as  
10 Mitra brought up before, there's an assignment here. And  
11 part of the assignment is to look at what is the impact of  
12 this.

13 Just to reiterate some of the things that you  
14 pointed out, the issue of the supplemental data kind of, as  
15 everybody very quickly saw, relates to some of the earlier  
16 silo and movement discussions that have been had here. And  
17 some of you might fairly quickly think well -- because it  
18 occurred to me at first, well I can go out and get  
19 supplemental data. But in actuality, to collect this kind  
20 of information is pretty expensive and it does disadvantage  
21 smaller groups from doing it in the same kind of way to

1 present comparable data. So the supplemental data piece is  
2 an issue, I think.

3 And the SMS data that is your default data, those  
4 are now 1999 data at best. I think we would all agree that  
5 probably some things have changed in the economics since  
6 then.

7 The piece about the zero work pool I would say, as  
8 you mentioned, the issue has been raised about you're double  
9 paying. And I think it's a little hard to figure it out in  
10 any other way other than it is double paying. And if that's  
11 again a good policy goal or something we want to reward,  
12 great. But it is double payment. I would wonder what other  
13 rationale there could possibly be to do that other than this  
14 notion of trying to give back something to a group that you  
15 perceive that you've hurt. And we keep doing this patchwork  
16 stuff and it takes us further down a road that presumably we  
17 don't want to go.

18 DR. CASTELLANOS: Just to clarify the supplemental  
19 data, every specialty had the option to do this. It wasn't  
20 mandated. There were eight that did. One of them happened  
21 to be a urologists, which I am. We did it because we wanted

1 to correct some supply question problems we had. As far as  
2 the cost, it cost urology about \$60,000 to do that.

3 DR. CROSSON: I just want to talk to one item on  
4 the work plan, and that's the issue of the basis for the  
5 geographic adjuster. A few meetings ago we discussed  
6 another issue related to the GPCI and that had to do with --  
7 oh, goody. That had to do with, I think, a sense of  
8 inequity in California as at least one of the multi-locality  
9 states. That's still an active issue.

10 I think we talked about that for a while and  
11 recognized, I think, the validity of the concern and also  
12 the complexity of potentially addressing it.

13 So my question is is it likely that remodeling the  
14 factors that go into the geographic adjustment factor, as  
15 laid out here, might mitigate that problem in multi-locality  
16 states? And B, could we model, as we're doing this, the  
17 impact of this different way of doing it on that problem?

18 MR. WINTER: We had not been thinking of  
19 interacting variations, changing the way the GPCI is applied  
20 along with changing the locality areas. That was part of  
21 your question. The other part was the effect on multistate

1 areas? I'm sorry, the single state areas?

2 DR. CROSSON: I think that the sense I have here  
3 is maybe the degree of difference between the localities in  
4 multi-locality states might be made smaller if you change  
5 the calculation for the geographic adjustment factor. So  
6 that the differences that have created so much concern might  
7 not disappear but might be smaller.

8 So the question is -- you haven't done it yet.  
9 But is that likely to be the case? And if so, could we  
10 model that as an additional piece of work?

11 DR. MILLER: My sense is, I'm talking to guys  
12 here, Nancy and Ariel, my sense is there's no reason that  
13 any of these changes that you would anticipate that as you  
14 stepped across locality boundaries it would necessarily  
15 minimize. Because there would have to be -- I think there  
16 would have to be significant differences in the  
17 distributions of specialties and services across the  
18 localities in order to get that effect.

19 What you'd really be reflecting there is not so  
20 much that the methodology did anything as did the mixes in  
21 the two localities.

1           So my instinct, without doing the arithmetic, is  
2 that no, there's no reason to anticipate in advance that it  
3 would have any effect of minimizing it, that we're still  
4 stuck with the problem that we discussed a couple of  
5 meetings back about the definition of the locality and the  
6 GPCI differences between it.

7           That's my initial reaction but you guys obviously  
8 know this better than me.

9           MR. WINTER: You're on the right track and it  
10 depends on the mix of services, because with imaging if you  
11 adjusted only the portion of the practice expense where the  
12 prices varied, so you held the equipment and supplies  
13 constant -- and for imaging that's a very big portion --  
14 then you're essentially compressing the price differences  
15 across geographic areas.

16           But for E&M, you're expanding the price difference  
17 about geographic areas because they have a larger than  
18 average share of clinical staff and you'd be adjusting for -  
19 - therefore you'd be adjusting for a larger share of their  
20 direct expenses geographically.

21           So it does depend on the mix of services. If

1 you're doing a lot more E&M, then it could increase the  
2 variation. If you're doing more imaging and maybe tests  
3 where the variations are going to be compressed, then it  
4 would be compressing the variation.

5 DR. MILLER: And in the California situation, my  
6 sense -- and you're being from California, you probably have  
7 a stronger sense. But my sense of this is we're talking  
8 about localities that are next door to each other, where the  
9 differences on the GPCIs are relatively high in some  
10 instances. And I'm just speculating that rolling across  
11 that border it's not so much that you're going to get big  
12 differences in the services and the mix of specialties that  
13 you would see this compressing effect. Plus the fact that  
14 it could go in either direction. That's my sense.

15 DR. CROSSON: I've been somewhat at a loss,  
16 actually, figuring out how we can address this concern  
17 although I could certainly raise it at future meetings.  
18 Because I think I'd like to explore that.

19 So I guess I'd only ask in the modeling process if  
20 the intuition we have for it now turns out not to be the  
21 case that we could take a look at that.

1 MR. HACKBARTH: Other questions or comments?

2 Okay, thank you very much.

3 And last, Sharon is going to talk to us about  
4 building quality composites. I should say last but  
5 certainly not least.

6 MS. CHENG: I'm going to spend a little bit of  
7 time with you this morning. Really this is probably an  
8 introduction to this topic. We will talk about this again.  
9 The topic is a building quality composites.

10 What I'm going to do with the time that I have is  
11 describe what we're working on here, what is a quality  
12 composite, look at some other groups that have built these  
13 and are using them. We're going to look at a quick list of  
14 actions that we could take relating to this topic. Why are  
15 we talking about this this morning? And finally, we're  
16 going to discuss some potential criteria for how we could  
17 describe and perhaps assess different quality composites,  
18 their strengths and their weaknesses. What are the criteria  
19 of a good quality composite?

20 The first one I thought we would look at is a  
21 pretty high level quality composite. This is available on

1 the web from the Agency for Health Care Research and  
2 Quality. A lot of people call this kind of measurement a  
3 dashboard. I think this ones kind of slick, it actually  
4 looks like a speedometer or something.

5 And what this does is it is a composite of quality  
6 information, in this case for the state of Virginia. And  
7 what AHRQ has done is taken about 100 different indicators  
8 of the quality of health care in the state of Virginia and  
9 given it to you in a fairly simple graphic.

10 There are two needles up here. So the solid  
11 needle tells you where the state is in the most recent year  
12 and they dashed needle tells you where it was last year. So  
13 you get a sense of current level and also a little bit of  
14 the sense of change.

15 There's a lot of stuff going on then behind this  
16 needle. Preventive care, what's the rate of immunization in  
17 this state? How are they doing at testing for diabetes?  
18 It's got acute care. Are they dispensing aspirin in  
19 hospitals to people who present with an acute MI? It's got  
20 admissions for asthma. It's got chronic care. So there are  
21 a lot of things that have been rolled up into a single

1 score, in this case, for a state.

2 Here's another one. This is a consumer website.  
3 This is available to people who are looking for a hospital.  
4 It's a hospital level composite of quality. Actually,  
5 you're looking at several different composites here.

6 Let's look at the stars, for example. This  
7 hypothetical hospital is a five-star cardiac hospital. That  
8 is a composite of the quality of care for surgical  
9 procedures in the cardiac field. So we've got CABG in here,  
10 we've got treatment of heart failure patients. The five  
11 stars tell you this is one of the best hospitals that was  
12 graded.

13 Another composite that's also available here is up  
14 at the very top of the screen there's a little silver medal,  
15 a critical care excellence award. That gives you a somewhat  
16 different piece of information about that same hospital. It  
17 tells you it was in the top tier, and that's a composite of  
18 mortality that results from things like the complication of  
19 diabetes, sepsis, pulmonary embolism and respiratory  
20 failure. It also includes a structural component. So part  
21 of the award that this hospital has gotten is meeting

1 Leapfrog's requirements for staffing and intensive care unit  
2 with intensivists. So those are several different hospital  
3 level quality composites.

4 Let's look at just one more. This is from the  
5 state of California. This is also a public website. I just  
6 picked the area of Fresno County in California.

7 This is a rating of medical groups that are  
8 operating in Fresno. And here you've got two different  
9 composites. Again, they've used stars to compare them to  
10 their peers.

11 The first one is getting the right medical care.  
12 So that's a composite of whether the physicians in that  
13 medical group tested for blood sugar. Did they test their  
14 patients for cholesterol and composite process measures?

15 The other composite is a patient rating of care.  
16 This is sort of a collection of different pieces of  
17 information based on patient surveys. It indicates whether  
18 the docs in this group coordinated care well for their  
19 patients. Did they communicate in a clear fashion? And was  
20 the patient able to access their care in a timely way? So  
21 it's got several different pieces of information wrapped up

1 in a star rating.

2           So what each of these systems have in common is  
3 that these groups have a large number of quality indicators  
4 and they are trying to give the consumers of information a  
5 way to summarize it and a way to use that summary to  
6 compare, in one case states, in another case hospitals, and  
7 in this case medical groups, to each other on a summary  
8 score.

9           The reason that we're looking at these kinds of  
10 activities is that we have, and CMS has, similar kinds of  
11 information. We have a number of different ways to measure  
12 the quality. In our case, we've got several different ways  
13 to measure the quality of physicians, of inpatient hospital  
14 care and of home health agencies. And so we have the  
15 possibility then of also creating these summary level  
16 scores. So we can start comparing groups of physicians to  
17 each other, hospitals to one another, et cetera.

18           So this is a list of things that we could do with  
19 the quality information that we have. We could build a set  
20 of quality composites that would allow us to make these  
21 kinds of comparisons. We could describe then the strengths

1 and limitations of different approaches that we could take  
2 to building those composites. There's certainly more than  
3 one way to put this information together.

4           We could use composites in our work. This is  
5 directly relevant to the congressionally mandated report  
6 that we have on designing options for pay for performance  
7 for home health agency. It's also relevant to our own  
8 efforts to start to describe efficient providers. If we'd  
9 like to compare hospital A to hospital B, a summary of its  
10 quality, in addition to its resource use, would help us  
11 make comparisons about their relative efficiency.

12           Also, we could discuss an entity that could  
13 administer quality measurement and build a quality  
14 composite. A lot of the work that goes into a quality  
15 composite is to set priorities among things that we all  
16 probably agree are very important. But what's the relative  
17 importance? And how would we put that information together?  
18 And an entity that we could describe would also help to set  
19 these kinds of priorities and goals for a national program  
20 like Medicare for private and public payers perhaps. And we  
21 could think about with that entity would look like

1           So let's switch now and get a little bit down to  
2 brass tacks then. How would we describe what a good  
3 composite might look like? What MedPAC staff has spent the  
4 summer doing is looking at different government agencies  
5 that have put quality information together like AHRQ. We've  
6 looked at the work of various researchers that have started  
7 working in this area, notable Wennberg and the folks at Rand  
8 that have described the quality of U.S. health care.

9           We've also looked at sites and systems that were  
10 designed and are being used right now by consumers in the  
11 marketplace such as the HealthGrades we just looked at. We  
12 looked at America's Best Hospitals from U.S. News & World  
13 Report, a system that was designed by RTI and the University  
14 of Chicago. We looked at the state of California and the  
15 work at Integrated Health Care Association that's put  
16 together a lot of this information into quality composites,  
17 as well.

18           These are the criteria that emerge from looking at  
19 a body of work and we're going to run these past you to  
20 start thinking about whether or not these describe a good  
21 quality composite.

1           They are all up on the screen and what I'm going  
2 to do now, with the next couple of minutes, is go through  
3 them one by one.

4           So our first one: a good quality composite applies  
5 to most patients, most providers and most quality traits.  
6 What this really hits is what you try to do a quality  
7 composite in the first place because, first of all, any time  
8 you use a single square, the kind of scores that we have,  
9 you're going to exclude certain types of patients. If  
10 you're looking at a score for AMI, you exclude patients that  
11 don't have AMI. And so by bringing different scores  
12 together for AMI, for pneumonia and for heart failure, you  
13 get a better picture of the all the nations that a hospital  
14 or a physician group might be caring for.

15           Sample size is another thing that you get to  
16 address when you start bringing different measures of  
17 quality together. Some small hospitals do quite a bit more  
18 medical procedures than they do surgical procedures. So if  
19 we can account for both surgical quality and the quality of  
20 their medical care, we're going to be able to include some  
21 hospitals that would be excluded if we just tried to use a

1 single surgical score.

2           And finally, bringing more than one piece of  
3 quality information together in a composite lets us get at a  
4 lot of traits that we think we're going to have to measure  
5 separately but they're all pretty important. So from the  
6 Institute of Medicine we've got three key traits that we  
7 think are important. Was the quality of the care, was it  
8 safe? Was it effective? And was it patient centered?  
9 Measuring those three traits probably are going to involve  
10 different measures and we might want to bring them together  
11 to say in summary, one provider compares to another provider  
12 in this fashion.

13           A good quality composite trait is that it accounts  
14 for differences among patients. This gets really at the  
15 heart of whether or not we're making a fair comparison  
16 between hospital A and hospital B. Especially also if we  
17 thought about moving this into public reporting or attaching  
18 a financial incentive to it, you want to make sure you're  
19 not creating an access problem for patients that might be a  
20 little less easy to care for that might bring a providers  
21 score down. So you want to account for differences among

1 patients that might have an impact on your quality score.  
2 And it begins then with the adequacy of risk adjustment for  
3 each measure. If you are including an AMI mortality, you  
4 want to make sure that your risk adjustment on AMI mortality  
5 is pretty robust.

6           You want to compensate then when you bring things  
7 together for differences in patient characteristics like  
8 their age, their cognitive status and comorbidities so that  
9 you can describe the patient population adequately.

10           What it might suggest is that it might be very  
11 difficult to compare all the patients that a medical group  
12 sees to all of the patients at another medical group. What  
13 you might want to start thinking about then is  
14 stratification. Maybe you'd like to compare groups of  
15 patients to each other. And stratification can have a lot  
16 of different levels.

17           Going back to U.S. News & World Report, I am proud  
18 to say that my undergraduate alma mater was the best small,  
19 single-sex, masters level university in the Southern region  
20 of the United States in the most recent ranking of colleges  
21 and universities. I just bring that up to suggest you can

1 think of a lot of different ways you stratify. And what you  
2 want to do is compare apples to apples, but you don't want  
3 to end up with only one or two apples in your basket. So  
4 there's some balancing going on.

5 Another characteristic that we want, all that  
6 said, is that at the end of the day you'd kind of like to  
7 have a score that's easy to describe and understand. As  
8 important as it is to get these things right, the have to be  
9 useful to the people that are going to have to digest this  
10 information and use it for comparison. So something that  
11 you can at least describe is going to be more useful to the  
12 consumers of the information.

13 And also, there has to be some level of  
14 transparency. If you're going to tell a medical group that  
15 they're better or worse than the group up the street, they  
16 have to be able to understand how they were ranked and why  
17 those differences occurred in the information that you're  
18 collecting from them.

19 This is a complicated endeavor. And one of the  
20 things that is going to increase how good your composite is  
21 is the extent to which you can acknowledge and identify

1 where the areas of uncertainty are. For example, a  
2 composite could make note of the variability in individual  
3 scores. Maybe something is very sensitive to having a small  
4 sample. Maybe risk adjustment has a big impact on making a  
5 certain comparison. You might want to note that that's  
6 what's going on underneath that score.

7           You could choose, and in the couple of grades that  
8 we looked at, HealthGrades for example only includes  
9 significantly significant differences. It makes it a little  
10 bit easier for the consumer, rather than giving them two  
11 different numbers and telling them these really are the  
12 same, only include the things that you can test and you can  
13 validate as being statistically significant.

14           And finally, you could contemplate reporting a  
15 confidence interval around your score rather than just  
16 coming out with a single score and saying this score is  
17 definitely 35. You could say this is 35 plus or minus 3  
18 percent or whatever your range would be around that. There  
19 are several different ways you could imagine of building  
20 that confidence interval around a single score.

21           You want to look at the composite that you've come

1 up with and determine whether or not it reflects the  
2 relative importance of the traits that it integrates. One  
3 way you can do this is you can say these traits are all  
4 equally important to us and we're going to weight all of the  
5 things that go into this composite equally.

6           Alternatively, you could group measures within --  
7 when we looked at the California report card, for example,  
8 there were two composites that we were looking at side-by-  
9 side. So they've grouped things under those and then put  
10 them side by side. So you could have unequally numbered  
11 groups or you could assign different weights to different  
12 groups within the composite.

13           The point in the middle here, there are different  
14 ways you could use to calculate the average among similar  
15 scores. That has an effect also of reflecting what you  
16 think is important to measure about the characteristics of  
17 your provider. I'm going to hit that on the next slide.

18           Two ways that are widely used in the research to  
19 create an average of similar scores are the appropriateness  
20 model and the opportunity model. The appropriateness model  
21 is patient level and it doesn't assign partial credit. The

1 opportunity model is provider level and it does award  
2 partial credit. So let's think about this for just a second  
3 and I hope this helps.

4           Imagine a system in which you have four measures  
5 for diabetes care. You want to check the health of their  
6 eyes, the health of their feet, you want to measure their  
7 blood sugar and you want to measure their cholesterol. If  
8 two groups of doctors both did all four of those things to  
9 all of their diabetic patients, then these two models would  
10 give them the same score.

11           However, if one group, for example, was very good  
12 at giving all four measures to most of his patients but not  
13 to others, then you would start to see a difference.

14           So in the first case, if a diabetic patient got  
15 three out of the four measures, that physician group would  
16 get a score of zero for that patient. In the second one,  
17 they would get a score of 75 percent because they did three  
18 out of four things that were indicated for that patient.

19           The appropriateness model could provide a kind of  
20 a checklist for patients. It gives you an idea as a patient  
21 of all four things that probably should happen to you over a

1 year or at an encounter. It emphasizes that the care should  
2 be patient centered and that's the center of the  
3 measurement. This was a system that was used by McGlynn at  
4 Rand when she was looking at similar types of quality  
5 indicators.

6           The opportunity model would have the advantage of  
7 being able to acknowledge a very high level of performance  
8 at doing something. If there were a medical group that  
9 always checked their patients eyes and feet but didn't  
10 routinely do the blood work for sugar and cholesterol, they  
11 would get some credit under the opportunity model. And the  
12 opportunity model would then acknowledge the difference  
13 between those two groups.

14           That was kind of tough. And probably no easier  
15 then is assigning explicit weights to traits that are even  
16 less similar that are four processes of care. There are  
17 many different ways to assign weights. Several that we have  
18 to think about: Leapfrog, as a group, put a quality  
19 composite together. They used a consumer utility function.  
20 So they put greater weight on processes that had a greater  
21 impact on reducing mortality.

1           Another group of researchers proposed using excess  
2 mortality. So you might assign more weight to the adverse  
3 event of acquiring a serious blood infection than a hip  
4 fracture, because the blood infection is going to lead to  
5 more excess mortality than the other adverse event.

6           You could have consensus weights. Blue Cross-Blue  
7 Shield values its consensus system and they get all of the  
8 people that are grading and being graded together and they  
9 set the traits and they set their relative importance  
10 together. This is also flexible and it changes over time as  
11 the community feels they've hit certain goals or they want  
12 to emphasize different aspects of quality.

13           One of the things we could do to elaborate on this  
14 point a bit, if this would be of interest, would be to do a  
15 somewhat more systematic look at scorecards that are  
16 available, describe who's using them and how they set the  
17 weights on those scorecards and maybe put a matrix together  
18 for you.

19           So where to from here? Well, I'd like to bring  
20 you some real numbers and we can start looking at how these  
21 composites would go together with the kinds of quality

1 information that we've got on hand. We could apply the  
2 standards for sample size to the home health agency  
3 measures. That kind of hits our first criteria. Are we  
4 able to measure most of our providers with what we've got on  
5 hand? And if not, where are our weaker spots?

6 We're going to continue to assess risk adjustment,  
7 and especially we're going to do that with the home health  
8 outcome measures to see how that risk adjustment is working.  
9 We're going to bring you different kinds of composites,  
10 probably several different ones for home health agencies and  
11 several different ones for inpatient acute hospitals, and  
12 then we can use that criteria to compare how well they meet  
13 the different criteria and compare the alternatives to each  
14 other.

15 We'd also like to convene some stakeholder panels  
16 and get their input on the way we've put these things  
17 together and the traits that are important.

18 So what that, I'd like to turn it over to you guys  
19 to describe the actions that are relevant for this and what  
20 do you need from staff to be prepared to take some of those  
21 actions in upcoming meetings?

1 DR. REISCHAUER: I think this is terrific, Sharon.  
2 I apologize that I'm going to have to step out and  
3 go to memorial service for a close friend.

4 But I think we would serve a tremendous value to  
5 the debate and understanding if we just laid out how this is  
6 done and all of the different ramifications and variations  
7 that you have laid out here.

8 I think the value added from us trying to build  
9 additional composite indexes is quite limited and could  
10 prove to be confusing. And there's already a proliferation  
11 of these things. It's not really our area of expertise, I  
12 think.

13 So if we are considering how far to go down this  
14 path, I think our comparative advantage is really analyzing  
15 what others have done and showing the strengths and  
16 weaknesses and limitations of all of these approaches in a  
17 comparative way.

18 MR. HACKBARTH: Bob, before we lose you, what  
19 about the issue of discussing an entity that might, in fact,  
20 have the ongoing responsibility for maintaining such a  
21 system? Would you include that as something that we ought

1 to address?

2 DR. REISCHAUER: I think we should. As you all  
3 know, the Institute of Medicine issued a report on this  
4 committee that several of us are on, on this issue. I think  
5 it would be great if MedPAC expounded on the wisdom of that  
6 report and similar recommendations. There are a number of  
7 these recommendations by other groups for how this should  
8 get done.

9 I think just sort of saying composites have  
10 advantages and complexities and somebody go do it isn't  
11 really enough, because if we want to bring some kind of  
12 organization and effectiveness to this area you can't have  
13 everybody out there doing their own thing. And there has to  
14 be some kind of entity or entities that play defined roles  
15 in this.

16 That's my opinion, and if this group felt the same  
17 way, I think we'd be making a real contribution.

18 MR. HACKBARTH: I, too, would like to see that as  
19 an issue we discuss, without prejudging the outcome. My  
20 personal feelings are much like Bob's. But I think,  
21 especially given the IOM report, we ought to address whether

1 there ought to be an entity to do it and what the  
2 characteristics of that entity might be.

3 DR. MILLER: I agree with all of that, and  
4 internally we've had discussions of this kind as well in  
5 putting this together.

6 There is one complication here, and I suspect this  
7 is on Sharon's mind too. So we have a mandated report where  
8 we have to demonstrate how someone might do this. Even if  
9 it's just illustrative, we're going to have to put a couple  
10 of these things together just to show how these things work.

11 And of course, being in the position that we're  
12 in, we also to try to distance ourselves and just say this  
13 is just illustrative and everybody will forget that. So  
14 it's going to be kind of this funny walk we're going to have  
15 to walk.

16 DR. CROSSON: On that basis, that we're going to  
17 be talking about how one would model this, I'd like to talk  
18 about the criteria. Because I think I heard in the  
19 discussion of the criteria something that sounds implicit.  
20 But I wonder whether it ought to be explicit in thinking  
21 about the criteria.

1           And that has to do with -- I don't know what the  
2 right term would be, something about the subjective  
3 importance of discreteness. And it's like where on the  
4 lumber-splitter continuum do you want to be? In the text  
5 they used the automobile model, so I'll talk about the  
6 automobile model.

7           You go out to buy a car and arguably you're  
8 interested in how much it costs, something about the power,  
9 the acceleration, the fuel economy. You might or might not  
10 want to know the difference between highway and city.  
11 Comfort, safety, crash survivability, quiet, and then maybe  
12 some fancy stuff like a satellite radio or whatever.

13           I think most people who are going to buy a car are  
14 kind of interested in those things, as opposed to whether  
15 the car is rated 75 or 84.

16           I think when you get into health care, it gets a  
17 little bit more complex because some of the things that are  
18 important are not as intuitive or well known as those car  
19 characteristics.

20           MR. HACKBARTH: Jay, do you think it's also  
21 dependent on who the measures are being developed for? You

1 might have different criteria if it's being used for a P4P  
2 system versus consumer information versus provider feedback.  
3 It's just three possible purposes for the information.

4 DR. CROSSON: So as I was defining it, I said  
5 subjective -- and that would mean to the observer --  
6 importance of discreteness. So the thought is if we're  
7 going to describe the criteria that one should use to create  
8 a composite, I wonder whether or not that might be one,  
9 which is -- in your context. For the customer, the  
10 observer, the target audience, there ought to be an explicit  
11 understanding of where on that lump-split continuum it  
12 should be.

13 MS. DePARLE: Actually, I realized my question was  
14 what Bob was asking, sort of where are we going with this?  
15 So I don't need to probe that more.

16 MR. DURENBERGER: That's probably all of our  
17 questions to one degree or another.

18 I didn't want to raise it, after we learned about  
19 where her undergraduate degree came from. We probably  
20 shouldn't even be questioning Sharon.

21 [Laughter.]

1           MR. DURENBERGER: But since we're all in this  
2 together, I guess it's all right; right?

3           I think I too -- and I don't have an answer for  
4 this. I'm searching for our comparative advantage and I'm  
5 not yet clear exactly where our comparative advantage comes  
6 in.

7           I remember doing a press conference in like 1990  
8 with Sheila Leatherman, who was then at UnitedHealth Group  
9 and standing up and describing a scorecard. She was  
10 predicting the future of all of these composites, as they're  
11 now called, but she's talking to us about a scorecard for  
12 doctors and hospitals, and one of these days we'll all be  
13 buying quality. I think that was 16 years ago. So we sort  
14 of like, as a community of folks, we've been at this for a  
15 long time.

16           The community that I'm most used to though has  
17 been doing this in one way or another almost internally  
18 rather than involving the public. So you think of the  
19 Institute for Clinical Systems Improvement and the work that  
20 they've been doing, funded by health plans but principally  
21 aimed at doctors in Minnesota and the larger community.

1           They've always debated whether or not they ought  
2 to take that to consumers and things like that. As of today  
3 they haven't done it. They haven't exactly -- they felt  
4 more comfortable internalizing change than they have trying  
5 to take it to the level that I know it's important to take  
6 it.

7           The folks next door in Wisconsin, this is just a  
8 way of recommendation and maybe you're already talking to  
9 them, but I think it's probably unique in this country.  
10 Over the last four or five years now, starting with six  
11 medical groups and now it's like 70 percent of the docs in  
12 the state. Even -- well, I won't go into that.

13           It's about 70 percent of the docs in the state  
14 have been providing the leadership in Wisconsin to develop  
15 the kinds of measures that will first -- and this is the  
16 distinction I'm trying to make -- first change physician  
17 behavior and then change public behavior.

18           And I don't know where they are on that, except I  
19 know they have now involved the business community. They  
20 hired Chris Querum to come over from their employer group to  
21 run this effort.

1           I suspect if we're trying to think about what  
2 works for various -- starting with the providers -- and then  
3 going to the public, I think we might have something to  
4 learn from this because it's a collective, as opposed to  
5 going to the Society of Thoracic Surgeons who are also  
6 leading in this area or the orthopedic surgeons who believe  
7 that they're coming up with unique things and things like  
8 that.

9           It might be really interesting to go to a  
10 community that is addressing all of the service concerns  
11 that are raised in the work that we are doing.

12           I guess the last thing on the entity, I know my  
13 initial reaction to the IOM suggestion that there be a  
14 commission or a government body was oh my God, nobody will  
15 buy that. In other words, there's a yearning to have  
16 somebody set the rules for everybody. But when you think  
17 about the people whose behavior you have to change, I'm not  
18 sure how quickly it changes because some entity somewhere  
19 nationally described the way in which change ought to take  
20 place and so forth. So that only may mean what you ask that  
21 entity to do rather than whether there should be one.

1           And I'm only describing a gut instinct. One of  
2 the cochairs called me immediately and said what do you  
3 think about it. And I said this is my gut instinct. It's  
4 sort of like the cart and the horse maybe, that if we know  
5 what we're doing and for whom we're doing it and then we  
6 think about what entity does what, it might work better.

7           MR. HACKBARTH: I think a lot of people have that  
8 instinctive reaction. The other side of the coin is to what  
9 extent are we going to get clinicians or institutional  
10 providers to move if they're repeatedly inundated with  
11 different sets of measures that pull them in multiple  
12 directions and burden them with data collection. So there  
13 are trade-offs definitely to be made.

14           MR. DURENBERGER: Can I just respond to that very  
15 quickly? I thought, and maybe you all know better -- and  
16 I'm sorry I didn't raise it in the executive session so we  
17 wouldn't be taking up everyone's time.

18           But Mike Leavitt has been to Minnesota twice in  
19 the last couple of weeks and I know he's been to Wisconsin.  
20 I know they've selected these six or seven places, the AQUA  
21 [ph] places that they're going to. And they're going to

1 expand them and so forth. So it seems to me the  
2 administration is on a track right now in the implementation  
3 of MMA and some of their pay for performance. They're going  
4 to look at local committees and see what's going on. And  
5 also to try to start dealing with the issue of measures and  
6 see what you can learn at a local level about who's doing  
7 what kind of measures, as opposed to relying only on an NQF,  
8 although that is a -- anyway, I was curious as to what they  
9 are up to, other than the obvious.

10 MS. BEHROOZI: I guess whether this is to inform  
11 the work that an entity with responsibility for doing this  
12 creates from scratch or whether it's used as a threshold for  
13 judging whether other things that are being done out there  
14 meet the test of validity that Medicare beneficiaries could  
15 rely on or the Medicare program could eventually rely on.

16 It's interesting to talk about all the issues that  
17 you've identified, Sharon. It's really great that you  
18 pulled it together in one lucid paper here. So I'm just  
19 going to focus on one small thing.

20 In terms of accounting for differences among  
21 patients, whether it's risk adjustment or patient

1 characteristics or taking into account and stratification of  
2 it, I would suggest that looking at the socio-economic  
3 status of the group that the entity serves should be added  
4 to the list. It might be more important in a home care  
5 setting than in a hospital -- actually, Arnie, I should turn  
6 this over to you to talk about differences in socioeconomic  
7 status and things that don't show up as comorbidities.

8           You will find socio-economic status reflected in  
9 comorbidities and some of those other characteristics. But  
10 there are other things that are hidden that you won't find,  
11 such as family and social network connections, language, as  
12 Jenny has pointed out, things that will interfere with the  
13 ability to provide care or achieve the same outcomes.

14           So that's just a suggestion.

15           MR. HACKBARTH: Dave's mention of Sheila  
16 Leatherman reminded me of the same point. Sheila has, for a  
17 lot of years now, been toiling in the quality measurement  
18 fields and I've had the occasion to sit on a couple of  
19 groups with her recently. And she's quite concerned about  
20 this issue and whether -- I'm trying to remember the exact  
21 terminology that she applies to it.

1           But you need an adjuster that's not just morbidity  
2 and risk but social circumstances, particularly when you  
3 have measures where patient compliance is a big part of the  
4 outcome.

5           DR. HOLTZ-EAKIN: Let me just repeat some things  
6 that probably have been said at this point.

7           First of all, I am looking forward to this but I  
8 am worried about the scope just exploding on us. So to the  
9 extent that it would be possible to, within that scope,  
10 address some of the things that have come up. I'm very  
11 worried about distinguishing the purpose for which these  
12 different things are used. You could imagine all you want  
13 to do is get things in the right order and then just getting  
14 an ordinal measure is fine. Sometimes you want to know how  
15 far apart they are, and then you need to put more structure  
16 on it. And then you want to pay based on the differences.

17           So I think laying out those issues very clearly in  
18 a single set of examples might be very helpful for people.

19           And having done that, what's the purpose? You  
20 could then ask who's going to get it? Is it going to be the  
21 consumer? Is it going to the provider? Is it going to be

1 the payer?

2           And when you do that, look at the incentives it  
3 will provide for the other parties. If we're doing this for  
4 providers, it's not going to be secret. The payers are  
5 going to know about it. The consumers will eventually get  
6 their hands on it. Does it lead to bad incentives overall?

7           I'd worry about that when you do this.

8           The other thing I'd like to see us think a little  
9 bit about is the data. If you restrict yourselves to the  
10 data you've got, you will dictate the incentives for data  
11 provision. And so a good thing to think about is what data  
12 do you want to elicit from people in the construction, even  
13 if it's not currently available? I'd like to have that be  
14 part of this discussion.

15           I'll hold my fire on building the large monopoly  
16 government agency that's going to tell us how good every  
17 doctor in the country is.

18           I think we ought to, all kidding aside, be careful  
19 about that and think harder about whether you want to have  
20 something that's the standard setter. You don't want to be  
21 the accountant, you want to be the accounting standards

1 board and tell people how to do this well. I think that's a  
2 focus we might want to bring to this.

3 DR. MILSTEIN: One dimension that would be helpful  
4 to bring to bear in the next iteration of this, because it's  
5 directly relevant to what might -- at least I think down the  
6 chess board more moves, what kind of an aggregate would be  
7 most useful A, to a consumer and B, to a provider, and C, to  
8 other interested stakeholders is the issue of the user  
9 specificity of the aggregate. I think, as I imagine  
10 Medicare beneficiaries in my family, what they'd be  
11 interested in is an aggregate measure of quality for a  
12 doctor or hospital or a home health agency that was specific  
13 to their particular health conditions rather than weighted  
14 across-the-board or even weighted by category, patient  
15 experience versus effectiveness versus safety.

16 And similarly for a physician, I think if I were a  
17 physician -- if I were practicing today, I would like to see  
18 an aggregate that was weighted for the particular clinical  
19 activity that I primarily engaged in, rather than, for  
20 example if one out of a thousand of my patients is a  
21 diabetic but my diabetic measure counts as one out of 10 --

1 gets weighted 10 percent of my score.

2           So I think ultimately what you'd like is almost  
3 any stakeholder would like, if they're in the market for  
4 aggregates as a general goal, is going to be interested in  
5 an aggregate that is specific to them and especially  
6 Medicare beneficiaries.

7           If we could, maybe in the next iteration, take  
8 that as a general objective, and maybe you could share with  
9 us your thoughts on how that might be achievable or what we  
10 might put in place as a first step toward achieving that  
11 ultimate goal.

12           MR. HACKBARTH: Okay. Thank you, Sharon.

13           We'll now have a brief public comment period with  
14 the usual ground rules. No more than two minutes, no  
15 repeats. Sharon knows those ground rules very well.

16           MS. McILRATH: Except it's going to be harder this  
17 time.

18           Let me start with practice expense. I just wanted  
19 to stay on that one that, in terms of when the RUC was doing  
20 the refinement on the practice expense, actually most of it  
21 occurred before 2002. So if you're looking at that as one

1 of the factors, you need to change the way you're thinking  
2 on the timing.

3 I think you also should keep in mind when you're  
4 looking at those things that it's a four-year transition.  
5 So you're not going to see that all immediately. And when  
6 you're thinking of the supplemental surveys, just keep in  
7 mind that you would have probably two years of the  
8 transition before there was another survey that was a cross-  
9 specialty survey that would be available. The AMA is  
10 working with specialties and we're going to pilot one we  
11 hope this fall, and then it would be done in 2008 and be  
12 ready by 2009.

13 On the GDP, the volume targets, to start out with  
14 I don't think that some of us would think that GDP was an  
15 objective standard. There's a lot of subjectivity to that.

16 On productivity, the relationship to the MEI, I  
17 don't know, are you talking about not doing a productivity  
18 adjustment on the MEI if you do it on work values? Are you  
19 going to be penalizing some services twice if you do it?  
20 And also, keep in mind that BLS just changed the way that  
21 they figured the multi-factor productivity and that actually

1 has led to a lower MEI this year than was originally  
2 anticipated.

3 It's also very much at odds with the other  
4 providers in terms of how their productivity is treated.

5 On the question of overall versus physician only  
6 expenditures, in terms of looking at targets, there are  
7 other areas of the program that are growing even more  
8 rapidly than physicians. If you look at the last two years  
9 for hospital outpatient department, I think you would find  
10 that to be true.

11 On the question of regional, I do know that, for  
12 example, in Iowa, even though they have overall low  
13 expenditures, the physicians -- I think it's about the sixth  
14 highest in the country. So there does seem to be perhaps  
15 some trade-off of where you have higher physician  
16 expenditures you may have some lower other expenditures.

17 And I think that ought to be part of the  
18 discussion in terms of impact on beneficiaries, as well,  
19 because though they may have a higher premium they may avoid  
20 a hospital deductible or a hospital outpatient copayment.

21 Risk adjustment, there was some discussion about

1 that. I wonder if you wouldn't want to have some discussion  
2 of the different risk adjusters that are out there and what  
3 exactly they do include. We're hearing all this stuff  
4 recently about obesity. That does vary by area. I believe  
5 Kaiser even does a map of obesity. And you might look to  
6 see how well that lines up with some of the Wennberg maps.

7 In terms of using other tools, as Dr. Castellanos  
8 said, I think that the attitude of the profession is  
9 generally that the best way to get at volume is to try to  
10 figure out which volume is appropriate, which isn't, and  
11 address it that way. The episode groupers, of course, is  
12 one way to do that.

13 In terms of what happened in the early '90s, a lot  
14 of people think it was as much or more going to the RBRVS.  
15 And in fact, the lower volume didn't start until you began  
16 the RBRVS. There were global surgical codes. They were new  
17 CCI edits, those were coding edits. So before you assumed  
18 that it was the target that had that impact, look at some of  
19 those other things that were going on.

20 And finally, in terms of improving payment to  
21 primary care or other specialties where there are beginning

1 to also be shortage problems, there are other ways that you  
2 could go about it. For instance, there's talk about the  
3 medical home. But there are even already, in the CPT book,  
4 codes for coordinated care. Those have been valued by the  
5 RUC but they are not paid for by Medicare. So you could see  
6 some kind of way that you could use some of the existing  
7 codes to begin to get at the problem.

8           And finally just to note, as I think Dr. Borman  
9 did, that the rule that came out recently on practice  
10 expense did, for the first time, quantify that the Medicare  
11 is paying for only two-thirds of the physician's direct  
12 costs.

13           MR. HACKBARTH: Okay. We are adjourned. See you  
14 next month.

15           [Whereupon, at 12:01 p.m., the meeting was  
16 adjourned.]

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