MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

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

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
ROBERT BERENSON, MD, FACP, Vice Chair
SCOTT ARMSTRONG, MBA
KATHERINE BAICKER, PhD
MITRA BEHROOZI, JD
KAREN R. BORMAN, MD
PETER W. BUTLER, MHSA
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GEORGE N. MILLER, JR., MHSA
BRUCE STUART, PhD
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AGENDA PAGE

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

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

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

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

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

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

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

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

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

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

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

According to industry coalition's data, the volume

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

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

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

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

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

work.

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

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

MR. WINTER: Right.

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

MR. WINTER: Correct.

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

Although growth of imaging slowed between 2008 to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a prior E&M service.

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

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

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

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

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

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

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

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

authorization program to manage imaging services.

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

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

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

your paper.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. WINTER: Yes.

MR. GEORGE MILLER: Okay. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CASTELLANOS: Okay. Thank you.

MR. HACKBARTH: Clarifying questions?

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

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

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

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

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

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

the impact on the beneficiary.

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

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

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

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

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

DR. KANE: No, I -

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

but their costs would go up.

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

MR. WINTER: We're using the RVUs.

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

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

procedure coupled with a --

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

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

MR. WINTER: -- the same encounter.

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

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

MR. BUTLER: Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: When I testified on the March

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

On Recommendation 1 any further questions or comments?

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

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

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

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

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

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

DR. STUART: So it could be --

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

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

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

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

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

MR. WINTER: Correct.

MR. HACKBARTH: Is that correct?

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

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

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

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

DR. BERENSON: For the total dollars, but that

doesn't affect the specific assignment of values.

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

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

[No response.]

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

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

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

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

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

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

MS. HANSEN: Actually, this relates to 2 but

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

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

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

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

MR. WINTER: Right.

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

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

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

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

[Pause.]

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

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

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

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

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

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

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

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

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

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

this level by this group is probably not productive.

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

MS. BEHROOZI: [off microphone].

MR. HACKBARTH: Okay. Number 3.

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

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

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

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

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

DR. CASTELLANOS: I understand that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

activities are carried out.

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

Secondly -- and this has come up in our other

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

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

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

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

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

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

Thanks.

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

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

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

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

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

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

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

Texas...

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

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

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

can pursue, so I will support it.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. WINTER: Correct.

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

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

The second point about the increased use of

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

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

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

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

DR. CASTELLANOS: We're looking at --

MR. HACKBARTH: Growth rates.

DR. MARK MILLER: Growth rates.

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

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

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

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

growth --

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

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

DR. CASTELLANOS: Okay. Thank you.

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

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

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

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

But I think having said that, this is an area

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

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

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

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

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

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

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

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

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

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

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

[Pause.]

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

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

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

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

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

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

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

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

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

[Laughter.]

MR. BUTLER: Two specific points.

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

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

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

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

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

will know what, in fact, is being recommended.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Opposed? Abstentions?

Okay, Draft Recommendation 2, all in favor?

Opposed? Abstentions?

Number 3, all in favor?

Opposed? Abstentions?

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

Opposed?

Abstentions?

Okay. Thank you very much.

[Pause.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

redirection.

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

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

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

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

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

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

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

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

be a QIO.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Thank you, Anne and John.

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

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

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

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

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

MR. BUTLER: So it is --

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

MR. BUTLER: And there are 41 --

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

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

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

MR. BUTLER: Yes --

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

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

MR. HACKBARTH: Good question. I assume that the

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

MS. MUTTI: Mm-hmm.

MR. HACKBARTH: Nancy?

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

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

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

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

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

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

1 --
2 MS. MUTTI: Yes.
3 DR. KANE: -- that they are going to be revoked --
4 MS. MUTTI: Yes. In fact --
5 DR. KANE: -- as opposed to that they will go into
6 the P4P -- I mean, I guess -- how bad do you have to be
7 before you get revoked, is the --
8 MS. MUTTI: Yes. I mean, I guess that gets to
9 another point of when we talk about what is low performers,
10 and is it solely based on their adherence to the Conditions
11 of Participation or do you also want to consider their
12 performance on outcomes measures and other process measures
13 that we have as part of P4P.
14 MR. HACKBARTH: As I think of it, Nancy, we are
15 sort of working on two different vectors. One is to make
16 the Conditions of Participation more meaningful and urge the
17 Secretary to adopt some new approaches to improving the
18 performance of those that are just sort of teetering above
19 the absolute minimal level for participation in Medicare.
20 And then there is another group of providers that may be
21 well over the absolute minimum threshold, but are still,
22 relatively speaking, low-performing providers, and we have a

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

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

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

Herb?

MR. KUHN: Just an observation about Glenn and

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

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

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

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

community overall.

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

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

MR. KUHN: [Off microphone.] Right.

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

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

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

MR. KUHN: [Off microphone.] Thanks.

MR. HACKBARTH: Let the market work.

Ron, round one.

DR. CASTELLANOS: Actually, just two questions. The first one I asked you last time. This is going to apply to all Medicare providers, is that correct, because we really are just focused predominately on QIOs and hospitals, but it will --

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

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

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

DR. CASTELLANOS: Thank you.

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

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

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

MR. GEORGE MILLER: Okay. Thank you.

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

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

MS. MUTTI: Correct.

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

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

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

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

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

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

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

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

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

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

DR. CHERNEW: Right.

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

DR. CHERNEW: Right. Right.

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

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

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

DR. MARK MILLER: Well --

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

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

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

DR. CHERNEW: Okay --

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

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

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

DR. CHERNEW: -- buying EHR.

DR. MARK MILLER: Right.

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

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

DR. CHERNEW: Right.

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

DR. CHERNEW: And CMS would decide.

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

DR. CHERNEW: Right.

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

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

DR. MARK MILLER: Correct.

DR. CHERNEW: -- in the evaluation --

DR. MARK MILLER: Yes.

DR. CHERNEW: -- is what was your performance. And that's just -- okay -- clear. Okay, so that was just the clear -- so, I'll save the follow up.

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

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

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

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

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

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

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

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

DR. DEAN: Mm-hmm.

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

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

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

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

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

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

DR. DEAN: Okay.

MS. MUTTI: The services.

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

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

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

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

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

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

DR. MARK MILLER: I mean, I --

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

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

We didn't envision sort of a technical assistance

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

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

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

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

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

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

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

MR. HACKBARTH: Was this a statutory change?

MS. MUTTI: I believe it was, yes.

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

MS. MUTTI: Yes. Yes.

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

MS. MUTTI: Yes.

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

MS. MUTTI: Correct. Correct.

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

MS. MUTTI: We do.

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Scott?

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

work.

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

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

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

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

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

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

But a less extreme suggestion, and as one who was

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

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

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

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

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

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

And then, finally, I'd like to highlight

recommendation number five. I think the advancement and the conversation we have about the System Improvement Agreements here is very well done. I think this is a lot better than the conversation before on the intermediate sanctions. Again, I felt like that was kind of the notion of let's kind of count who's making mistakes and kind of get at them. I think this is more uplifting and it's a better way to go.

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

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

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

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

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

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

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

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

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

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

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

DR. BERENSON: Yes.

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

MS. MUTTI: Right.

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

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

MR. HACKBARTH: Yes, so --

DR. BERENSON: -- in the language.

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

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

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

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

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

MR. HACKBARTH: Okay.

DR. MARK MILLER: Because I got your point that

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

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

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

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

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

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

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

[Laughter.]

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

[Laughter.]

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

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

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

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

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

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

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

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

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

[Laughter.]

MS. UCCELLO: He's doing very well.

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

MS. UCCELLO: He's doing very well.

[Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

MR. GEORGE MILLER: They could do it better.

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

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

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

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

MS. MUTTI: Transplant is different, right --

MR. HACKBARTH: What about non-transplant services?

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

MR. HACKBARTH: Okay. Jennie?

MS. HANSEN: Yes. I --

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

MS. HANSEN: [Off microphone.]

DR. SOKOLOVSKY: [Off microphone.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: I agree.

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

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

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

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

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

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

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

DR. DEAN: Yes. Okay.

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

Mitra?

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

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

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

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

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

Opposed?

Abstentions?

Okay. Number two. All in favor of two?

Opposed?

Abstentions?

Number three. All in favor of three?

Opposed?

Abstentions?

And four. Mark, will you read the revised version?

DR. MARK MILLER: This is my big moment.

MR. HACKBARTH: Right.

DR. MARK MILLER: Okay.

MR. HACKBARTH: Clear your throat.

[Laughter.]

DR. MARK MILLER: All right. [Clearing throat.] The Secretary should regularly update Conditions of Participation so that the requirements incorporate and emphasize evidence-based methods of improving quality of care. Does anybody want to hear it again?

MR. HACKBARTH: No, once was enough.

[Laughter.]

MR. HACKBARTH: Okay. All in favor of that reading?

Opposed?

Abstentions?

Number five. All in favor of number five?

Opposed?

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

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

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

Opposed?

Abstentions?

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

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

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

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

DR. ROWE: Thank you.

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

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

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

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

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

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

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

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

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

referring physicians.

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

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

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

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

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

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

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

Thank you.

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

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

AFTERNOON SESSION [1:08 p.m.]

MR. HACKBARTH: Okay. So our first topic this afternoon is Medicare fee-for-service benefit design. Scott, are you going first? Okay.

DR. HARRISON: Good afternoon. Today we are continuing our discussion of Medicare's fee-for-service benefit design. Let me quickly remind where we've been on the benefit design issue. In the past, we've noted that the benefit, with its high Part A deductible and no limit on out-of-pocket spending leads to unlimited exposure to cost liability, and thus, a small group of the sickest people owe most of the cost-sharing.

Further, cost-sharing is uneven and varies by site of care. Of course, about 90 percent of beneficiaries have some form of supplemental insurance, but it is often quite expensive and not always available. However, because much supplement insurance fills in all of Medicare's cost-sharing, it hides Medicare's costs and leads to higher use of services, both necessary and unnecessary services.

Today we hope you will continue your discussion of benefit design after we address a few questions that arose during the last meeting. In response to questions, I will

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

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

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

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

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

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

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

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

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

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

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

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

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

supplemental coverage categories.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The first project using this model was the

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

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

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

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

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

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

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

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

One hospital reported substantial increases in the

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Okay.

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

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

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

MR. HACKBARTH: Ron.

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

DR. HARRISON: For the demo.

DR. CASTELLANOS: Slide 3, the last --

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

DR. CASTELLANOS: Yeah.

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

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

DR. CASTELLANOS: Okay.

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

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

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

DR. CASTELLANOS: So the low-cost providers would

still provide high-quality care?

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

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

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

DR. CASTELLANOS: Yeah, I understand that.

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

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

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

DR. CASTELLANOS: Okay, thank you.

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

DR. SOKOLOVSKY: Great.

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

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

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

So I guess my question is about sort of the

consistency of sort of Federal statements in this area.

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

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

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

really go beyond that.

MR. HACKBARTH: Can anybody on the staff?

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

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

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

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

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

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

MR. HACKBARTH: Right.

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

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

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

MR. HACKBARTH: Great. Thank you.

DR. BERENSON: Can I continue?

MR. HACKBARTH: Yeah, sure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. LEE: Yes.

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

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

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

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

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

MS. LEE: This is what beneficiaries are paying,

yeah. The beneficiaries' share of the premiums.

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

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

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

MS. LEE: Exactly.

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

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

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

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

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

premium or what does that mean?

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

DR. KANE: And not D?

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

DR. KANE: Okay, great. Thank you.

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

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

MR. BUTLER: Okay.

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

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

MS. LEE: That's correct.

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

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

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

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

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

difference was physician visits.

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

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

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

DR. SOKOLOVSKY: 2009.

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

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

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

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

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

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

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

MS. LEE: Yeah.

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

MS. LEE: That's correct.

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

And my question is, is there any secondary market

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

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

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

DR. HARRISON: Yes.

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

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

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

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

DR. STUART: Yeah, okay.

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

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

DR. HARRISON: [Shakes head.]

DR. KANE: Don't know.

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

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

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

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

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

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

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

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

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

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

DR. MARK MILLER: [Off microphone.]

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

MS. BEHROOZI: This is so interesting and there's so much to think about and talk about and think about other ways of looking at some of the questions that they material raises. The whole issue removing the out-of-pocket -- setting an out-of-pocket cap, you know, removing the catastrophic liability from the beneficiaries and shifting that to the front end by way of a combined deductible, that might be a good thing to do, or eliminating the catastrophic exposure is a good thing to do. I mean, I think it's a good

thing to do.

But doing that, paying for it, by putting it all up front in a deductible, I think doesn't really belong in kind of the analysis that we're doing about trying to encourage beneficiaries to make better decisions about high value and low value care. When there's an up front deductible that applies to all services, that doesn't distinguish between high value and low value care.

It just doesn't seem consistent with the rest of the discussion that we have, that the chapter goes into and the analysis that you've done and all the interviews that you did, Joan, with payers trying to find ways to drive value. Deductibles are the crudest -- I still don't get what the point is except to shift costs, I mean, generally in the world.

I don't just mean here in this discussion. Nobody can really articulate for me the policy value of deductibles. They neither act like premiums where people choose certainty, they choose to pay more in premiums to protect themselves from both variability and catastrophic costs, nor are they associated with being able to make good choices about what's valuable to a beneficiary.

So if we want to talk about eliminating the catastrophic exposure and paying for it some other way, I'd really like us to look at other ways. You suggested an excise tax on Medigap plans. Of course, that then finds its way into the premium, the same way that coverage of the deductible would find its way into the premium.

There are other ways to do it, too. You could just add it to the Part B premium and then let people buy policies that -- or join MA plans or engage in other behaviors that help them reduce the cost of the Part B premium. There are just a lot of ways to do that. I really think deductibles are not consistent. It's moving backward. It's not moving forward in terms of creativity and progressiveness around benefit design.

So that's about deductibles. I think I've made clear how I feel about copayments. The same dollar cost across the board means different things to different people according to their income status and -- I've said many times -- dual eligibility, eligibility for Medicaid is not co-extensive with low income.

You have a lot of references in the paper, I think particularly, Joan, in the panel that you did, where it's

clear that there will be more avoidance of appropriate care by people at the lower end of the income spectrum, or people who feel like maybe they have a lot of dependents to take care or high rent or whatever, their income isn't necessarily at a threshold that you would obviously say is low, but they think they can't afford the cost of that service.

So I think it is progressive design to try to apply costs in a way that will discourage low-value care, so that does mean copayments or exposing people to the full cost of a low-value service when a high-value service is available, reference pricing, as you said, being a good example of that.

But I also think it's important to make sure that when you're talking about that, that there are options for people to avoid those costs like reference pricing, you know, making it free or very low cost to get the high value service, or joining a Medicare Select plan where there is a narrow network that costs Medicare less, or one of a number of different types of Medicare Advantage plans where people's costs will be lower.

As you said, there are many different benefit

designs, and they can choose where they want to either expose themselves to risk or expose themselves to management techniques or limited choices, and not necessarily say everybody has to pay -- going back to an earlier discussion -- $100 or $150 for an episode of home health care use because it will have different impacts on different people and it's too crude a tool to do what we want, which is drive high-value utilization and discourage low-value utilization.

MR. HACKBARTH: So let me just try to tease out a couple different points that I hear you making, Mitra. One is that although you personally would value improved catastrophic coverage, how that's financed really matters a lot to you because of different distributive implications and the like.

Now, for any given beneficiary, how the affect of a big increase in the front end deductible, you know, combined A and B deductible at a high level, how they would experience that front end cost will be a function of their supplemental coverage. And so, they can choose a supplemental coverage that uses deductibles as a feature. Some people may welcome that. Or they could choose a supplemental plan that has much smaller copays and pay a

higher premium for it. Or they could choose a supplemental policy that has no cost-sharing at all and pay still a higher premium than that.

So that the point I'm trying to make is that even if Medicare were to say, Well, we're going to pay for catastrophic with a front end deductible, that's sort of the beginning of the tale as opposed to the end of the story. Exactly what the distributive implications are will be influenced by the array of private plan options that people could choose.

MS. BEHROOZI: Except that the people who are really exposed to the catastrophic potential costs are the ones, for the most part, without supplementary coverage, right, supplemental coverage. And so they are the ones who will experience the deductible up front, and it's that 10 percent of people.

MR. HACKBARTH: Although to the extent that they're experiencing catastrophic costs, even without supplemental coverage, they would be among the big winners from a restructuring the Medicare benefit package.

MS. BEHROOZI: But of that 10 percent that don't have Medicare coverage, I don't know the numbers, but I'm

sure that far more of them would experience the deductible than would realize the benefit of the catastrophic coverage.

MR. HACKBARTH: Oh, yeah, absolutely.

MS. BEHROOZI: So all of those people who face that deductible before they can use any services, hopefully they're all young and healthy, but they have Medicare spending. So there's going to be a lot of appropriate care that they're going to forego. All of them will be risk of that.

DR. MARK MILLER: But even absent the catastrophic discussion, the other nature of this discussion is, is we've got these two very different deductibles that exist in Medicare, 1,200 bucks and a couple hundred on the other side, and there's sort of that that formed some of this thinking, too. I mean, even if you didn't change the absolute dollar amount that anybody's facing under current law, is there some reason to discuss rationalizing, at least, who's hitting that?

MS. BEHROOZI: Yeah, but if somebody doesn't have a hospitalization during the year and they have to pay a combined deductible, they're going to face higher costs than they do now.

DR. MARK MILLER: Absolutely.

MS. BEHROOZI: I guess there was some rationale when the two different deductibles were put in place.

DR. MARK MILLER: I was trying to speak to your point for the person who faces the deductible, because the person who faces the A deductible is headed to the hospital and they have to incur that.

MR. HACKBARTH: Would you put Slide 12, the questions that you had posed for us? This is such a big and complicated topic. As we go through Round 2, if we can try to address ourselves to the questions, I think it will help us figure out how to get to the next step in this conversation.

Mitra, let me give you a chance, either now or at the end, if there are some things specific you want to say on these questions.

MS. BEHROOZI: I feel like a lot of what I said addressed a lot of the points. I think maybe -- I mean, yes, I think rationalizing cost-sharing is important, but how you do it matters. I've expressed some opinions about what I think is rational to me, anyway. Better financial protections, yes, on catastrophic. Some cost-sharing for

all services, yes, with, as I said, the option to avoid the costs by not -- well, sorry. I wonder how that's going to look in the transcript.

No. I guess the answer to that is no, I would like there to be some plan designs or networks or something where there is management as a substitute for cost-sharing in all cases.

DR. MARK MILLER: So that's the last bullet.

MS. BEHROOZI: Actually, that's three. That's the third bullet in the first section, set some cost-sharing for all services.

DR. MARK MILLER: No. You're saying you would prefer that the beneficiary, instead of that, have the ability to go into a set of providers that are more tightly managed and perhaps reduce their cost-sharing that way?

MS. BEHROOZI: Yeah, yes. I mean, provider or payer is what I think of doing the management, you know, like an MA plan I don't think of as a provider, but if you're including that in provider, then yes.

DR. MARK MILLER: I am.

MS. BEHROOZI: Okay. Then yes. I guess --

MR. HACKBARTH: What about the second major

bullet, should limits be placed on ability of supplemental coverage to cover all cost-sharing?

MS. BEHROOZI: That, I think, is related to what we were just saying, that there should be some types of plan designs that are allowed to use management instead of cost-sharing. I don't have the faith in cost-sharing that it always has to be present. So it's one or the other and you have to accept the management narrow network, or you face cost-sharing for all services except preventive services under the PPACA.

MR. HACKBARTH: Okay, thanks. Tom.

DR. DEAN: In general, I agree with most of the concerns that Mitra just raised. I'll be very brief. I was saying at lunchtime that I have really been struck how cost-sharing can really lead people to some, what I believe, are inappropriate decisions in that so often, I will recommend a service and the criteria for the decision is, does Medicare pay for it? Regardless of what, at least I see, the value of the service to be.

And coming from people who clearly have the resources. It's not an issue of them not being able to do it, but it just -- I'm troubled and, you know, it isn't all

the time, but I'm troubled how frequent -- it's almost a knee-jerk reaction. If it's covered, it's fine. If it's not covered, nope, can't do it.

So I think we need to be very careful about this. In theory, these things make a lot of sense, but on a practical level, they sometimes just don't bring about the decision-making we'd like.

MR. HACKBARTH: I'm not sure what the implication of that is. And so, does that mean there should never be cost-sharing or that there should always be cost-sharing? I'm not sure which way it should cut.

DR. DEAN: I'm as confused as you are.

[Laughter.]

MS. HANSEN: Before I get to the last page, I'd like to go back some more to Chart Number 6, or Page Number 6, and it has to do with the -- I really like how it's arrayed relative to the A and B and the out-of-pocket and premiums relative to the income. I wonder whether we have the capacity with this to kind of separate out the different age cohorts, because this is an average of all 65 and older.

MS. LEE: Actually, average of all Medicare beneficiaries. It includes under 65.

MS. HANSEN: Includes under 65. So I wonder whether or not there's a break-out possible of the different segments or whether that's too complicated.

MS. LEE: It thins out each age cell pretty quickly.

MS. HANSEN: Right.

MS. LEE: So if we are adding, in addition to the three variables and then the overlaying age cohort on the top of that, then the sample becomes pretty thin

MS. HANSEN: It does? And I appreciate that that probably will occur. I'm thinking more kind of prospectively, that as the population continues to grow in those older age cohorts, for future purposes, I think the ability to track that -- because the income level is quite different for the average 85 and above to the 65 to 74 population. And so, the percentage of out-of-pocket expenditure will be relative to those differences, even within each one of these silos.

The reason I think about that, that the benefit design side of it is that the cost-sharing side of it will be that much more significant for people whose income, net income, annual income is going to be lower over time, even

if they're only a -- if they're on the Medicare-only side. So at the moment it reflects possibly the younger population.

People who might not be able to afford supplemental insurance over time will fall into this category. So I think, again, the precious dollars that people have to spend to make choices will, you know, possibly be at greater risk just because in the meantime, right now even filing bankruptcies is highest in this older age group due to medical costs.

So going back to the last page here, I think this whole sense of rationalizing, all these concepts make total first-level sense on this. So I always use the income benchmark and I appreciate the extra chart, by the way, that the staff put -- the national chart that some of us have in color of the 12 United States groups. They show income as a factor of the country.

But going back to this point, I'd really like to jump back down to the last major bullet about incentivizing beneficiaries to see efficient providers. I definitely believe in that being a way, if we could shape behavior so that it's theoretically a win-win. My only concern is back

to an earlier conversation we had about quality improvement and the QIOs helping providers become more effective.

If there are not that many efficient providers at this point, there's going to be a limited opportunity to have places what you can be kind of guided towards. So I think it's both the behavior here, but the context of what you have to choose from as to whether or not, you know, there are physicians to choose or hospital systems that you can choose. Some communities may not have that choice right now.

MR. HACKBARTH: So Jennie, any thoughts on the issue of there being limits on the ability of supplemental coverage to cover all cost-sharing

MS. HANSEN: Back to that essential question, I'm leaning toward the fact of yes, there should be some limits to full cost-sharing entirely. I must say that that's asterisked by an article that I sent you all, an article that pointed out that even when there was no cost-sharing, sometimes beneficiaries won't get these free preventive services. So I don't know what that one tells us.

MR. HACKBARTH: This was the RAND study --

MS. HANSEN: The RAND study.

MR. HACKBARTH: -- that was recently published?

MS. HANSEN: Yeah. So I don't know whether then -- you know, my thinking that we should have some degree of cost-sharing, whether it's something nominal like a couple of dollars, just so that people are aware they're getting services, but that article certainly gave me a little bit more of a pause.

MR. HACKBARTH: Mike.

DR. CHERNEW: So, I'm going to try and be quick, not by saying a few things, just by saying it quickly. So first let me, my view of MA plans --

MR. HACKBARTH: You're off to a slow start.

DR. CHERNEW: I know.

[Laughter.]

DR. CHERNEW: My view of MA plans is they were traditionally the organization that avoided cost-sharing and tried to manage things through management and other tools. So having the fee-for-service system benefit designed juxtaposed against MA is the way you would allow people to say, I don't want to be managed through money; I want to be managed through these other tools.

In fact, now that we have ACOs and a bunch of

other things, there's even more opportunity to begin to do that. So that's sort of in response to Mitra's comments. As some of you may know, I spend a lot of time thinking about this in benefit design, and so in answering these, I think very clearly the most important thing is to rationalize cost-sharing, but I think that encompasses providing better financial protection to beneficiaries, setting some cost-sharing, not for all services, but at least for current services that we don't have.

So I think we should place limits on the ability of supplemental coverage to cover all cost-sharing, and I think that in general, I support using incentives to send Medicare beneficiaries to efficient providers, but remember, in a fixed-price world, you have to think about exactly the set up like the ACE demonstration is different than just saying, Oh, you're efficient, because the efficient ones are just getting paid the same amount. They don't have a lower price. We have to think that. So that's my sort of broad answer to these.

Regarding the general set of how -- so the real question is, what does rationalization mean, because we don't want to irrationalize cost-sharing. And so, I think

rationalization basically means we have to recognize some problems with cost-sharing, many of which have been mentioned.

One is, people don't do the right thing, (a) when it's free, and they do -- if you charge them more, they don't just cut out the bad things. They cut out the good things and you have to understand why. I was cited in the chapter, and I agree, too much cost-sharing can lead to disparities. With the chapter.

[Laughter.]

DR. CHERNEW: The chapter said it causes disparities. I agree with that. I'm glad that --

MR. GEORGE MILLER: And they quoted you.

DR. CHERNEW: Right.

[Laughter.]

DR. CHERNEW: So you have to worry about that. I also think -- it's going to just go longer.

[Laughter.]

DR. CHERNEW: I also think you have to worry about some other problems like adverse selection if you give people a lot of choices. So it's really -- that's not said much in the chapter. I think we have to worry about

cognitive problems. It's very easy to talk about how well the markets will work if we just make people pay, but if you look at some of the people that are deciding, there's all kinds of evidence that there's this sort of cognitive problem.

So the tightrope that I'm trying to walk is, I'm a big believer that we have to do a better job of designing the benefit package and allowing consumers to vote with their feet about what they want and to have incentives in the right place. But we can't do that with a blind notion that the markets are just going to work perfectly and people will just always do the right things. So it's a lot harder to rationalize.

I do think there are some places where we can do better than we're doing now, and so I think the bar should be, if we were to do this, is it better than it is now, and I think having some cost-sharing for a lot of current services would be better.

And I think -- so I have a few specific things about the employer stuff in the chapter that I just want to say. The first one is, there's a strange tone in places where sometimes it's sort of a lit review and sometimes it's

not quite a lit review. So, for example, there's a few things in the chapter that make it sound like there's not really a response to cost-sharing. And then there's the cite for this one Commission study that shows there's a huge potential financial gain if you have cost-sharing.

So the earlier stuff that was critiqued -- it's like the adverse selection potential and how those studies went, but it never really says how the study you did -- I believe and the chapter cites, which I agree with, that the RAND health insurance is a pretty good sense of what the elasticity estimates would be, and I think the chapter should go on noting that there will be behavioral changes if we charge people for stuff. We know loosely what the magnitudes might be, and some of those behavioral changes will be good and some of them will be bad.

I guess the last thing, I held back my Round 1 question so I'm going to ask it loosely now, which is, you talked about the quality measures. So, what are the typical quality measures when they're doing these various types of programs like you say, some people go to high-performing? Are they typically process measures, the ones I've seen? I know you said there were some cost ones, but the other

quality ones, are they often process-type measures?

DR. SOKOLOVSKY: The cost -- well, I guess I'm not quite sure what you're asking. To get into it in the demonstration or the measures that they now have to report?

DR. CHERNEW: In the ACE demonstration, but also in all of the other work on efficient providers and how you would identify an efficient provider, which there was a lot of discussion in the chapter about.

DR. SOKOLOVSKY: Most of the discussion in the chapter comes from the interviews, and the way in which they identified efficient providers varied by employer. And again, sometimes it was totally on quality, sometimes it was totally on cost, and sometimes it was cost and quality.

DR. CHERNEW: But the quality measures that you used, I think, the ones that I'm familiar with, are generally process measures. They're like, did you get an eye exam if you have diabetes, or did you get a -- a lot of the HEDIS measures, they tend to be process measures.

The only reason I say that is, there's some language in the chapter that makes it sound like, Well, we can't figure out what high-value services, but I think in almost everything we have done, we can't identify all the

high-value services, but almost all the time when we use the word, this is high quality, they're efficient, we're actually using quality measures that are actually things that we want to encourage people to do.

And so, I think there are measures for -- not comprehensively, but I think there are measures that you could use for identifying what's high quality, and if you can identify low quality, what I think we typically see going on in the world is everybody's raising copays anyway. So instead of saying, We're going to raise copays extra for, pick some imaging service just to keep the theme of the day going through.

Instead of saying, We're going to pick this imaging service, instead, people will say, We're just going to raise copays 5 percent. So that's a way of raising copays to align incentives systematically even though you're going to get it wrong.

DR. SOKOLOVSKY: I think just -- and I'll need to make it clear in the chapter -- although there were differences in how you measured high value, there was a lot more consensus about that and it did turn on that.

DR. CHERNEW: Right.

DR. SOKOLOVSKY: It was the low value where it was much harder to get.

DR. CHERNEW: Right. To pick particular ones.

DR. SOKOLOVSKY: Yeah.

DR. CHERNEW: But oftentimes, the alternative is, All right, we can't pick particular ones. We want to protect the high-value ones, so we're going to raise it for everything that's not in the high-value bin.

DR. SOKOLOVSKY: Yes.

DR. CHERNEW: And that could allow you to hit whatever financial goal you want. And I guess the last cautionary thing I'll say is, I would be very wary of following the evaluation that employers do to tell you the impact of their programs, because I've seen too many cases where the employers tell you how wonderful it is for this, that, and the other thing. And then when I've actually seen the evaluations, it's not just, Oh, they didn't get the standard errors right. It's more that the basic message is just wrong. There's some discussion about, you know, the employer did this in their report.

And you were very good in the presentation to point out, with a lot of caution, and I do think it's

important, not just for, you know, Medicare, we randomize people into this and we do all this evaluation, but when the chapter is written, the employers report this. Sometimes, although you don't say it, sometimes it seems as if we're endorsing that was the effect. And I'm a little more cautious. Thank you.

MR. HACKBARTH: I want to just throw out one additional thought to give people an opportunity to react to it as we go around. Implicit in my mind, and I want to make it explicit and get people to react to it, is that when we talk about rationalizing cost-sharing, my goal is not to reduce Medicare outlays in the first instance. So I'm not trying to reduce the actuarial value of the benefit package.

My own personal view is that the actuarial value of Medicare's benefit package is already pretty skimpy, and unlike employers that may have a rich benefit package and they're starting to introduce cost-sharing just to get that first order reduction in costs, I don't think that's really appropriate in Medicare given how skimpy the benefit package is already.

So when I think about changing the cost-sharing structure, I'm more focused on, you know, the distributive

burden and allocating it in a way that makes more sense is fairer. So that's one goal.

And then in addition, when I think about the possibility of saying Medigap policies cannot fill in all cost-sharing, my goal, again, would not be to reduce the Medicare line in the budget, but perhaps by changing utilization patterns, free up dollars that can be used to enrich the benefit package elsewhere. So that's just how I'm thinking about it. I welcome people to agree or disagree with that, but I wanted to make that explicit and give people a chance --

DR. CHERNEW: [Off microphone.]

MR. HACKBARTH: Yes.

MS. UCCELLO: Briefly, I agree with your description of the rationalization. I mean, that makes sense to me. I think that's needed. And also, catastrophic protection, I think, is something to pursue and I'll get back to it in a minute.

With respect to setting cost-sharing for all services, and also, should we allow supplemental coverage to cover everything, it seems to me that if there are things that we think people shouldn't have to pay -- that are high

value, that are helpful to people that are steering them toward more effective use of care, that should be for everybody, not just the people with supplemental coverage.

So the supplemental coverage should not cover all cost-sharing. So I would put the things that we think are high value, cover all of it for everybody.

Going back, kind of building on something Mitra said about how to kind of fund the catastrophic, if we pay for it solely through the deductible, then it's just hitting the people who have spending. On Table 3, it says 40 percent of beneficiaries have spending below $500. So that's a pretty big share who probably aren't going to get hit by this.

If we somehow can build it into a premium, then it's spread across everybody. But my question then is, the premium is just for Part B. It seems like this would be the case, but is most of the reason that people have high costs due to the Part B services than the Part A? It seemed like that would be the case.

MR. HACKBARTH: So your question, Cori, is for those who have catastrophically high costs, what proportion would come from Part B services as opposed to Part A?

DR. MARK MILLER: Yeah. I would have -- question? Well, I gave you a little air cover. I mean, I would have thought that -- and I'm basing this on some of our conversations of what happens when you change the structure; that a lot of the people who are hitting the catastrophic cap are having hospitalizations.

MS. UCCELLO: I think they're having hospitalizations, but their out-of-pocket spending --

DR. MARK MILLER: Oh, I see what you're saying.

MS. UCCELLO: -- yeah. Where is their high out-of-pocket spending coming from? And that seems to be Part B, right? So that, I think, supports the funding of it from the Part B premium versus trying to find a way to have it funded by everything.

MR. HACKBARTH: I understand what you're saying, although funding it through the Part B premium means it's a flat amount regardless of -- well, not even -- you can't even say that anymore -- regardless of income. But it has a different distributive impact if you fund it through Part B premium as opposed as through the payroll tax.

MS. UCCELLO: Yes, yes, right. But it was just one other thing to think about, how to kind of spread that

around.

MR. HACKBARTH: Right. George, Round 2 comment?

MR. GEORGE MILLER: Yeah. I'm going to try to make this succinct, but I want to start with Michael's comment that we can do better than we are currently doing, and I want to quote him from the chapter concerning the issue about low-income beneficiaries, and I would imagine that would include dual eligibles are certainly price sensitive -- price sensitive for increasing costs and may contribute to health care disparities.

With that said, then looking at your discussion questions, I want to frame it around -- discussion around those two issues. I think Michael was quoted and he quoted himself when he said he agreed with the chapter.

The first issue is, as a first priority, should Medicare deal with costs, rationalize cost-sharing, and I would say yes. But again, I want to emphasize that I would be concerned about low-income and then dual eligibles from the price sensitive standpoint of that cost-sharing.

And it seems to me that the discussion about the demonstration project where you can align the incentive of all the providers and the beneficiaries in the cost-sharing

or gain-sharing would be a better approach, in the fact that even the beneficiaries get back, as the demonstration said, 50 percent of their savings up to their annual Part B premium. I think that has some attraction and makes some sense.

I void that against Tom's comments that even those who could afford, if Medicare did not pay for it, they seem to not select that, and those, according to Tom, were folks who could afford to pay for it. Then you've got the issue of low-income and dual eligibles who would be faced with that same issue who can't afford to pay for it.

So for the most part, for the discussion, I can support the recommendations here, the short-term question issues that we're talking about. Yes, there should be some cost-sharing for all services with the caveat about low-income and dual eligible beneficiaries, as Jennie would certainly raise the issue.

And we certainly should incentivize beneficiaries to see efficient providers, but again, as Ron would ask, what's that definition, and make sure we can appropriately move folks into the most cost-efficient provider.

And I want to quote the New York example where --

I think it was last month, where minority beneficiaries were bypassing a better provider going to a low provider, and I wonder what the reason for that is, familiarity, if it was competencies or communication issues, that they felt more comfortable? And so, we need to explore those issues as well. Thank you.

MR. HACKBARTH: Ron.

DR. CASTELLANOS: Thank you. I live in the real world and I'd like to focus on the real world and that's the beneficiary.

MR. HACKBARTH: But you're in Washington now.

DR. CASTELLANOS: I'm not sure this is the real world, I've got to tell you. I'd like to focus a little bit on the real world of the beneficiary. You know, we're struggling ourselves to try to work out what is best. Now, my experience for Part D, where the patients had multiple decisions, they were just unable to make any clear decision themselves.

So if we're going to do something, we really need to look at it also from the beneficiary's perspective where they can understand. Now, what Tom was saying, and it's the same thing I say and I'm sure Karen will say, the consumer

or the beneficiary looks at cost. They really look at cost. Whether they have insurance or whether they have to come out-of-pocket or what, the ultimate decision is, What is it going to cost me, does insurance cover it, and is it worth me doing this?

As far as cost savings go, as far as cost-sharing goes, I think we really need -- based on the RAND study, and that's the only experience I have and what I read, that gives a good behavioral response, but we have to protect the low-income and the minority patient. And I think we can do that.

So I'm really for cost-sharing to encourage high quality procedures. I'm for it to try to prevent the unnecessary procedures. Catastrophic protection is extremely important. I see this every day in my practice where people go in bankruptcy.

In my community, 25 percent of the bankruptcies are due to health care. Now, some of these may not be Medicare patients, they may be private, but 25 percent of the bankruptcies in my community are related to health costs. So I think we do need to do something from a society viewpoint to help protect catastrophic problems.

Should Medicare incentivize beneficiaries to see more efficient providers? I mean, that's a no-brainer. Of course. But these have to be efficient providers that provide high-quality and low-cost care.

MR. HACKBARTH: Bob, just a note on the time. We are now just at the allotted time for this topic, so anything we do beyond this point we're taking out of future agenda items.

DR. BERENSON: All right. I'll try to be quick. Picking up on what Ron said, I think we need to provide better financial protection to beneficiaries and people should not go bankrupt because Medicare has an inadequate benefit package. Part of the goal then, in my view, is if we rationalize cost-sharing and provide a catastrophic coverage, that people won't feel the need to have to go buy what is not very efficiently provided, Medigap insurance, that people would be willing to actually pay the first-dollar cost-sharing without filling in with supplemental.

Whether we have to place limits on the ability to supplemental, I guess I would like to not go there unless I was convinced that that had to be done in order to prevent the costs to the program from first-dollar coverage. So I

would hope we could improve the benefit package such that people wouldn't feel the need to do that. But I would consider that. I'm intrigued by the idea of an excise tax, also, as an alternative.

I guess the final piece on, set some cost-sharing for all services, I would say set some cost-sharing for all benefit categories. I mean, we shouldn't have these anomalies for home health and hospice on the one hand, and then after a certain number of days, for SNF it's very large. Within benefit categories, then we should try to see if value-based models can work.

There might be particular services within a benefit category that we have such confidence is high value, like prevention we've done, that you would waive cost-sharing for those particular ones. I think we're way off from being able to, with any granularity, identify services that are high value or low value. Home health is usually high value and sometimes it's low value.

So I think we do have to rely, to some extent, on pruder approaches that sort of rely on the individual to make the choices. But to the extent that we can move in that direction, we should, and we should also try to

incentivize beneficiaries to see efficient providers.

DR. KANE: I think the readings made me just think that rationalizing cost-sharing is an incredible difficult thing to do because the rationale for appropriateness is specific to the individual and not the service. I just think that's -- you know, that's just a long road. Maybe we can get there someday, kind of like finding the perfect price, but I think it would be more useful to put our energies into something that has a quicker payoff.

I certainly think that better financial protection to beneficiaries is incredibly attractive, and I agree with Bob. I think if we had that, maybe people would stop buying inefficient Medigap policies or would 20 percent go for just the marketing expense?

I think maybe the other -- and that's one reason, actually, the whole idea of putting it into Part B is not a bad one because then people get that coverage and then they don't have to pay the 20 percent for the marketing if they think that's enough. If the reason that people are buying Medigap now is to get that financial protection of that from out-of-pocket costs.

So I just think that really focusing on the

financial protection, minimizing the catastrophic potential is really worth spending time on. The other cost-sharing pieces, I just think there's too much -- it's too specific to the beneficiary in their situation for any broad policy to be made at the Medicare national level.

And if we can't put the better financial protection into the Part B premium, which I know has all kinds of issues now since only a few people are paying any increase in that, the other way to think about it is to say, Let's tie getting an out-of-pocket cap to joining an ACO or a medical home, thereby pushing people into that bottom category should Medicare incentivize beneficiaries. Yeah, let's incentivize into going to medical homes and ACOs and behave themselves within that context and, you know, try to stay -- play the game that we're trying to get the providers to play.

And in return, they get out-of-pocket limits, which is kind of what managed care does. I mean, first of all, they have to have an out-of-pocket limit. I think I heard that 3,000 was kind of what most of them were at -- maybe I didn't hear that because I'm deaf in one ear, but anyway, 6,700, whatever it is, you know, they're doing that

in managed care now.

So it sounds like it's doable to have an out-of-pocket limit, but people have to accept some level of responsibility to be in a more efficient network and not go crazy, you know, seeing a specialist every time their nose itches.

So I would say take the financial protection and tie it to going into medical home, ACO, and then the other stuff will fall into place much more than if we spend hundreds of hours trying to figure out how to structure high-value cost-sharing which I think is really, really tough, and the private sector, obviously, hasn't figured it out yet and they've been experimenting with it for a long time.

MR. BUTLER: Said less elegantly, but more efficiently. I think I agree with most of the consensus of the group and that is, rationalization of cost-sharing, I think particularly if you look in the transcript as you described it, Glenn, is good. The financial protection as Bob described it, I think, is good, and others. The cost-sharing shouldn't be across every service. Of course, we want to have some limits on supplemental coverage.

Otherwise, we're not really changing much because 90 percent of the people have supplemental coverage.

Where I may differ is on incentivizing on inefficient providers. I think at the ACO or the Medicare Advantage, as stated by Nancy, yes, I think it's just a question of prioritization, and I think if we do a bunch of coronary artery bypasses and things like that, you just don't get very far very fast with a lot of effort.

The overall should be on the basic structure of how you do the copays, deductibles, et cetera, and probably less initial prioritization on steering to specific providers for specific services, which can be pretty labor-intensive without the yield, except for a pilot in Ft. Myers for a knee replacement.

DR. STUART: I'll go along with that. I obviously agree very broadly with what's been said here. I'm a little more optimistic than Nancy about being able to devise value-based designs that are going to, on average, do us well. It's true that every service can have different impacts on different patients. What we don't know is just how broad that heterogeneity is, and I think it's probably overstated in many cases. So I'd still like to go down that line.

I'd also like to point out one thing, that we're a little inconsistent in terms of incentivizing beneficiaries to see efficient providers. Everybody says that that's a no-brainer, but remember, when we looked at the overpayment of MA plans, we said, Well, it costs 117 percent of what the fee-for-service costs in MA plans. Well, another way to think about that is while we're incentivizing beneficiaries to choose these managed care plans and then, as Mike said, well, then they're subject to this management.

So I think we have to be a little careful about being consistent in our message here, and particularly when we've got these new programs coming online with ACOs and medical homes. We might end up in the same place that we ended up with this MA overpayment issue. So we need to know what we're getting when we do the incentivizing.

MR. HACKBARTH: On this issue of rewarding beneficiaries for going to efficient providers, keep in mind that the model of ACO in the proposed rule, the model of medical home that's being used in demonstration, beneficiaries retain their freedom of choice.

So they're not locking themselves into an efficient delivery system for which you can say, Oh, there's

a lower cost. Some are going of the use it exclusively, some are going to go in and out, so we're sort of combining insurance concepts with care delivery concepts in a way that doesn't entirely match up. Kate.

DR. BAICKER: I think setting cost-sharing for some or all services is clearly subsumed within rationalizing cost-sharing, and in some ways, part of incentivizing beneficiaries to see efficient providers is as well. On the cost dimension, if the cost-sharing is rationalized, that pushes people towards lower cost conditioned on value. People need ways to be able to evaluate quality and you may need to juice that a bit to drive people not just based on cost, but based on a trade-off of cost and quality.

I think it all goes back, in some ways, to providing better financial protections, because I think the real draw to the Medigap plans that undermine the cost-sharing is that they provide these backstops that the main benefit really should provide. It's hard for me to understand why we would have a main Medicare benefit that does not have catastrophic backstops.

So if you fix that, then it would be less of a

blow to amend the Medigap policies because you would already have that backstop. I would urge us to remember that financial protection in all of the discussions.

When I look at Table 6, which I think was on Slide 7, looking at how beneficiaries would be better or worse off in terms of out-of-pocket plans -- in terms of out-of-pocket spending, if they were in a plan with a catastrophic backstop, that's ignoring, in some sense -- there's nothing wrong with this, but I'd like to layer on the fact that they're also getting a benefit of the catastrophic backstop even if they don't end up using it.

So even though most beneficiaries don't end up hitting the catastrophic backstop, that doesn't mean it wasn't of value to them. And so, you want to take that into account. You may look a little worse off in terms of out-of-pocket spending this year, but it could have been a disaster and you were protected from that. So let's build that into whether people are worse off or not when thinking about the effect of moving from one plan to the other.

DR. MARK MILLER: To your insurance value point from --

DR. BAICKER: Yeah. I'm a one-trick pony.

DR. MARK MILLER: No, I didn't mean that.

[Laughter.]

MR. ARMSTRONG: But I think it's a really good point.

DR. BAICKER: If you're only going to have one joke.

MR. ARMSTRONG: We want to have a good one.

First, just a few points. First, I think this is really a very important topic for MedPAC to be focusing its attention on and I'm glad that this is -- we're basically affirming that we're going to be going forward with this work in the year ahead.

In particular, we have acknowledged in a couple of our last meetings that we really want to complement all the time we spend looking at payment policy to providers with policy around incentives directly to the beneficiaries, and I think the value of our products will be much enhanced if we're really looking at both levels and really thinking about this at both levels.

I also have to admit, the more I learn about the benefits in this fee-for-service plan, I am amazed more people don't join Medicare Advantage plans, and the fact

that 90 percent of people in fee-for-service feel compelled to either buy a Medigap plan or benefit from the plan through their employer, to me, says we really need to be looking at these benefits as this is proposed that we do.

If you look at Slide 12, the questions, I would agree we should be looking at the various ways in which we've talked about rationalizing cost-sharing. You know, one point I would make, though, is that I think there are some services where there should not be cost-sharing for, whether it's prevention or generic drugs or any visits that are scheduled visits for patients with chronic illness.

So I assume that that's really what we mean, that we wouldn't necessarily cost share for everything, but we would rationalize that. And then in particular, I also would agree that there are powerful opportunities for us to look at, incentives to change, through cost-sharing, the behavior of patients relative to different kinds of providers: Higher cost shares for specialists, lower for primary care, or even different networks.

And then finally, I live in a world where it's really not an insurance product if there isn't a cap on out-of-pocket costs, and that Medicare Advantage plans that we

have, have $3,000 out-of-pocket limits, and so we just really have to be talking about that.

DR. BORMAN: As I listen to the conversation, I think I see us having something of a problem of dichotomous thinking about this a little bit. In one respect, a lot of what we talk about is sort of at a strategic, plan-wide, somewhat depersonalized level in terms of population behaviors and that sort of thing.

But then at times, we all find ourselves thinking about that favorite geriatric relative that we know, some descriptive clinical circumstance for those of us that are health care providers, or whatever, and we come down to the individual and we can't, at the end, make policy that serves both perfectly.

And, Glenn, I support what you've said about removing this conversation from the background monetary issues, although at the end of the day, I think we have to remain cognizant that whatever we set up may, in fact, ratchet back as we try to deal with our national fiscal plight, but that's not the work of this Commission.

So I think that we have a couple of confounding factors, one of which is that the value to any given

individual of a health care service changes over time depending on what you're sick with when. And so, it's not a static thing to which we can say, This has value forever, I don't think. I don't find that my patients can do that, and I think that's partly the message you've heard from Tom's conversation with his patients.

And I think that in my view, and it's a biologic population, so it's not like managing widgets and there will always be some funny outliers, there will unpredictable things in terms of the evolution of disease and treatment that we just can't control and not all of our patients' illnesses are controllable and modifiable by them.

And so, we have a dichotomous population. Some have illnesses that they could have impacted, and we should incentivize their ability to impact, but some people have things happen to them that were absolutely outside their control, and to manage all that in one system is very difficult. So to get this down to crisp up, where can we rationally go with this?

I would just say a couple of things. Number one, I'm not sure that I'm smart enough, or any group is smart enough to say, This is clearly high value for the next 50

years for everybody. I personally would try and move that instead into an arena where there's perhaps some cost-sharing, albeit small, for everything, because you as the individual in the end have to make a value judgment about your situation over the time frame that you can predict. And maybe some small level that relates to everything, in the end, may be the most fair. I don't know.

I think in terms of ability of supplemental coverage to cover everything, I think yes, to a point. If I have the means and want to buy the Cadillac supplemental coverage, if I still view that I need it after we fix the background, I should still have that ability to do that. You can make it be a huge premium with some kind of extra tax on it or something, but I don't think that should go away if you can afford it and if you judge that you want to have it.

I think not to do that is an unfair thing to do. And we're already sort of getting into the equity business in the program by virtue of the unearned income tax that's in the Affordable Care Act by the fact that we have the premium tiering relating to when you got in the program and your income. So there's sort of already things happening in

that regard, and so I do think we shouldn't totally take away somebody's ability to buy that protection if indeed they want to buy it.

In terms of incentivizing beneficiaries to see efficient providers, I think in theory, it's a no-brainer, as has been said. I think the devil is in the details about what's efficient and what's appropriate, as Ron is constantly reminding us, a propriety here. And I think it's yes but, and I think we're a long way from knowing what that definition is.

MR. HACKBARTH: This is a really difficult, complex subject to deal with and it's sort of multi-dimensional, so we'll need to think real hard about how to structure our next conversation. We're sort of up at a very abstract level trying to wrestle with it, and I think it may be good if the next time we talk about it we can have some more concrete alternatives as a way of just sort of getting people to react, I like this, don't like that. So we'll think about that.

Even though it's a difficult conversation, a complex issue to deal with, I think it is very important that we wrestle with it for the reasons that Scott was

saying. The country has a really serious problem with the budget in general, with Medicare costs in particular, and the problem gets bigger as time goes on.

And so, in dealing with that, we need to use all available tools and opportunities. We spend a lot of time talking about the right updates and putting pressure on unit prices. I think that's part of what we need to do. The conversation we're going to have in just a few minutes is about getting relative values right and getting the signals that we send to be more accurate than they are now. That's also part of the solution.

And part of it is also new payment methods, ACOs, medical homes, that change the incentives for care delivery. But the fourth part, I think, of the solution, as it were, needs to be, how can we fairly, appropriately bring beneficiaries into the effort to make the system more efficient. And if we just work on the payment side of it and ignore the beneficiaries, I don't think we're doing the best job that we can, and I don't think we will be as successful.

Now, it is very tricky, for all the reasons that have been discussed today, to figure out how to engage

beneficiaries constructively in seeking out lower cost, high value care, but it's a well-placed effort, I think. Thank you all, and obviously more on this in the future.

So our next topic is improving the accuracy of payments to physicians and other health professionals. So, Kevin, are you leading the way?

DR. HAYES: Yes. Our topic, as you said, Glenn, is improving the accuracy of payments to physicians and other health professionals. It is a follow-up to a session you had at your meeting last October. Since then, we have worked with two contractors and have developed the issue further for your discussion today and for the June report.

As you know, the payment system for these services is Medicare's Physician Fee Schedule. It replaced a payment system that was based on charges and one believed to be inflationary and inequitable. The fee schedule is designed to account for differences among services and use of three types of resources: The work of the practitioner, practice expense, and professional liability insurance.

Commissioners have expressed concerns about this payment system. One is that it is vulnerable to mispricing, and two, it does not account for the relative effects of

different services on clinical outcomes. On this latter point, you asked us to do some research and ask private plans, integrated delivery systems, and others whether they have developed innovative approaches to paying for practitioner services, approaches that could be considered for Medicare.

So the way we have organized this presentation is that, first, Ariel will describe our work with a contractor on payment innovations. Then we will switch to mispricing and I will describe work by another contractor and some options you may wish to consider on that topic.

Ariel?

MR. WINTER: So as Kevin said, we contracted with the University of Minnesota to examine alternative approaches to valuing physician services being used by health plans, integrated delivery systems, and medical groups. The findings from this contract may help inform the Commission's work in improving the Physician Fee Schedule.

The contractor conducted structured interviews with leaders of 24 organizations. Fifteen were selected from across the United States and nine were from the Minneapolis-St. Paul market, and the researchers focused on

this market because there is significant experimentation with new payment mechanisms going on there. Because the organizations in the study were not randomly selected, the payment methods that they used do not necessarily reflect the prevalence of these approaches nationally.

So this slide summarizes the key findings from the interviews with the 15 organizations from across the United States. The most common physician compensation model within provider groups is based on the number of Medicare work RVUs provided by physicians combined with a target compensation amount. This target amount is usually linked to compensation for physicians in the same market and specialty. A small share of physician compensation is usually based on quality metrics, such as patient satisfaction, process measures, and outcome measures. Non-physician practitioners are generally paid on a salary basis.

The contractor did not find evidence that plans or providers have developed alternative approaches to valuing individual physician services, such as basing the relative weight of a service on its clinical value for patients. However, there are examples of collaborative efforts between

plans and provider groups to test innovative arrangements, such as medical homes, shared savings models, and pay-for-performance. Some of these efforts have been in existence for several years, whereas others are still in the discussion phase or in a pilot phase.

The motivation for these experiments is dissatisfaction with the fee-for-service payment system and a desire by health care providers to get an experience with ACO models that may become more prevalent in the future.

This slide is the key findings from the interviews with the organizations in the Minneapolis-St. Paul market. All of the plans and most of the integrated delivery systems in this market are developing or have implemented shared savings arrangements. In these models, the delivery system shares with the plan in the overall savings they can achieve for their patients relative to a negotiated target, assuming that quality goals are met. These approaches are based on total cost of care. In other words, they cover both physician and hospital spending.

The interview respondents identified patient attribution and data sharing between plans and providers as key issues. The high level of patient loyalty to specific

delivery systems in this market made it easier to attribute patients.

There are several factors that have contributed to the high level of innovation in this market. There is the history of collaboration among plans and providers in quality measurement and improvement. There is the presence of large integrated delivery systems. And there has also been encouragement and support from the public sector and a large organized employer group.

Because the shared savings contracts are still in their infancy, respondents were not yet able to share much empirical evidence about their effectiveness, and now I'll turn things back over to Kevin.

DR. HAYES: All right, and we will continue now with some issues having to do with mispricing. And we note here that CMS is planning to validate the fee schedule's relative value units.

The history on this is that, first, there have been concerns about the process for establishing relative values in the Fee Schedule. In 2006, for example, the Commission made a series of recommendations for improving the valuation process. In addition, contract research for

CMS and the Assistant Secretary for Planning and Evaluation has raised questions about the accuracy of the fee schedule's relative values. They depend on estimates of the amount of time that a practitioner typically spends when furnishing each service, and the research has shown that some of the estimates are likely too high.

And, as Ariel discussed this morning, there's GAO's results on efficiencies that arise when multiple services are furnished during a single encounter. Those results have implications for the pricing of services generally, but for the time estimates, too.

So there is evidence of mispricing and concerns about the time estimates in particular.

The validation process that CMS is now planning could be a step toward addressing these concerns. It would fulfill a requirement in the Patient Protection and Affordable Care Act. The law requires the Secretary to establish a process to include a sampling of services that meet criteria, criteria such as rapid volume growth, and criteria that services are potentially misvalued.

As part of the validation process, the law gives the Secretary the authority to make appropriate adjustments

to the RVUs for practitioner work. CMS sees validation of RVUs as a new requirement and one that would complement the ongoing efforts of the RUC.

As discussed at the October meeting, the fee schedule's time estimates are very important in determining RVUs. Depending on the type of service, the estimates explain from 72 percent to 90 percent of variation in the RVUs for practitioner work.

If the goal is to ensure the accuracy of these RVUs, it seems fair to say that it is necessary to ensure the accuracy of the time estimates. The estimates have their origins primarily in surveys conducted by physician specialty societies. The Commission's concern has been that the specialty societies and their members have a financial stake in the process.

To consider options for validating the fee schedule's time estimates and collecting objective time data, the Commission contracted with RTI International for a study to address two topics: One, are time data currently available from accessible sources; and two, what is the feasibility of collecting time data from practices and other facilities where practitioners work.

The project is continuing, but the primary findings are, one, with surgical services as a possible exception, we have not yet found sources of readily available data for this purpose.

Two, it appears that a data collection activity dedicated to collecting time data will be necessary. For that, the contractor is conducting interviews with representatives of integrated delivery systems and multi-specialty group practices. From what we have learned so far, time data exists within practices, but some assembly of data from different systems will be required. For example, time per service could come from electronic health records and from patient scheduling systems. Then it would be necessary to integrate these data with billing codes. However, billing codes may need to come from another system, the billing system. This issue of billing codes is important because the fee schedule's time estimates are specific to each code.

As you can see, collecting objective time data would require an organized effort. Voluntary surveys are one option. The problem with surveys, though, for a purpose such is this is that, historically, they have had low

response rates. Response rates of 20 percent or less are not uncommon.

Alternatively, participation could be mandatory for all, not unlike the cost reports submitted by institutional providers. While mandatory participation would overcome the problem of low response, it would require a change in regulation. In addition, the administrative burden on practitioners could be a problem, depending on the level of detail required.

To avoid the difficulties of voluntary surveys and mandatory cost reports, a different approach could be for CMS to collect data on a recurring basis from a cohort of practices and other facilities where practitioners work. Participation would be required among those selected. The cohort would be representative of all specialties and types of practitioners. However, the data collection could target specific types of practices, such as those that are more efficient than others. Clearly, such an activity would put demands on resources, both at CMS and practices participating.

Collecting data from a cohort of practices would present a number of issues. We list some of them here.

What number of participants would be required? Would it be necessary to compensate practices, and so on.

But let me draw your attention to the last two items on this list, the levels of data collection and estimation of time per service. With levels of data collection, there's a question of whether to collect time data at the level of each billing code or whether it's sufficient to collect the data at the level of the practitioner. It's a kind of trade-off. Collecting data at the level of the billing code has its advantages, but the difficulty is that it would put the heaviest demands on practices in terms of having to integrate data from multiple systems, their electronic health records, billing systems, and so on.

Alternatively, the data could be collected at the level of the practitioner. Here, the data collected would be limited to the volume of services by billing code for some interval, say a week, and the practitioner's total hours worked during that time period. Clearly, collecting practitioner-level data could reduce the burden for practices. However, it would then be necessary to conduct a statistical analysis of the data to answer questions about

the validity of the current time estimates and perhaps to develop new estimates. So these are some of the issues you might want to consider on this.

And that concludes our presentation. We look forward to your discussion of the points raised, in particular, your comments on the alterative approaches to valuing practitioner services, the ones that Ariel presented, and also your thoughts on next steps on validating time data. Thank you.

MR. HACKBARTH: All right. Let's see, round one clarifying questions. I can't remember. I think we're on your side this time, Karen.

DR. BORMAN: Could you just reconfirm for me that time, in addition to being the driver here, remains a significant number in generating the practice expense value, as well?

DR. HAYES: Yes, it does. It's -- there are two distinctions. There are two types of costs identified for purposes of practice expense. There are the direct costs associated with -- that are directly attributable to a service, things like staff and equipment use for a particular service. But then there is a category called

indirect costs, and so these would be the kinds of costs that are not readily identifiable as due to furnishing a specific service. This would be stuff like rent, reception, and all that kind of activity. And so it's with the indirects that the time data become important, because it's partly a function of the work RVUs, so it's kind of indirectly a function of the time estimates, but also in terms of the allocation of time of practice costs by physician specialty is also contingent on time.

DR. BORMAN: But also, for example, in the estimate of clinical staff time, for example, also often goes back to the physician time plus some increment, so it also factors into the direct expense if I recall correctly. So is that -- that's all captured in indirect, including clinical staff, clinical labor?

MR. WINTER: The non-physician clinical labor is part of the direct practice expense --

DR. BORMAN: Right, the direct. That's what I said. So it's in the direct --

MR. WINTER: It's in the direct, right.

DR. BORMAN: It impacts --

MR. WINTER: That's the non-physician clinical

staff time.

DR. BORMAN: Right. Okay. So it's important for a lot of reasons in addition -- [Off microphone.]

MR. BUTLER: So we're seeking a solution to what is an ill-defined problem, in my head a little bit. Why are we worried about accurate prices? Is it a little bit of the, do we want to make sure that there is the right supply available, which could be a longer-term question of making sure that certain specialties are reimbursed the right way. Is it a shorter-term, we are doing too much of one thing and not enough of another in the prices? Or are we just trying to make sure that the costs, the prices reflect the costs of providing the service? I'm just -- you know, a little bit more help on the definition of the problem that we're trying to solve here in the short run.

DR. HAYES: Sure, and it's, to an extent, kind of all of the above. I mean, the concern about pricing has to do partly with its effects perhaps on the volume of services, and the Commission has said that rapid growth in volume of services could be attributable, at least in part, to mispricing of services. So that's one consideration.

But also in discussions about the future of the

practitioner workforce, there's also been a connection made to the implications of mispricing for that, for what you might call the passive devaluation of some services. Services such as, we'll say, evaluation and management services are not so amenable to changes in the amount of time required because of technological advances and so on, whereas other services would be more subject to innovations, technological advances that might reduce the amount of time required.

So to the extent that those two problems, those two kind of categories of services are split, one specialty versus another, you could then see some skewing of incentives or compensation and so on. And so, as I say, it comes down to an issue of workforce over the longer term.

MR. HACKBARTH: I don't disagree with anything that Kevin said, but I want to add to it. I think this is a really important question that Peter has asked.

So our method of paying physicians now is based on the concept of a resource-based relative value scale, so what we're trying to do is estimate the resources that go into producing individual services and match our payments as best we can to the resources required to produce the

services, and the resources are practice expense and professional liability and the work involved by the physician or other practitioner.

But the concept is match payments, the prices for services to the cost of producing the services. As we've often noted in our discussions here, that's not the only way you may think about how to determine the appropriate price for services. In fact, in competitive markets, other things come into play, like shortages of supply and prices adjust to attract new people or new entrants into a marketplace. So you could imagine that even if our prices exactly match input costs for different services, that you want to introduce on another vector, another plain, considerations of supply. Still another possibility is the value of the service to the individual patient or to the broader hospital system, and we often talk about primary care as being particularly valuable.

Those last two sets of considerations, supply and value, are external to the physician payment system that we use, the resource-based relative value scale. This conversation is primarily focused on how can we better do estimates to calculate the relative values. There are other

conversations that we have that more directly attack the issues of supply and value. But it's important to keep them straight, which we're talking about at any given point in time.

Now, I agree with what Kevin said. If you don't have the prices well matched to the cost of production, you can create incentives for either over-production or under-production, or in the long run, you can affect the decisions of new physicians, whether to go into a specialty or not. Those are sort of second-order effects of mismatching prices to resource costs.

MR. BUTLER: [Off microphone.] So are you saying we're focusing on improvement in the RVUs primarily, right?

MR. HACKBARTH: [Off microphone.]

MR. BUTLER: Which may have relatively little to do, ultimately, with pricing. It could have little to do.

MR. HACKBARTH: [Off microphone.] In a subsequent conversation, we could, and, in fact --

[Fire alarm sounding.]

MR. HACKBARTH: I guess that means the emergency is over. The fire department is very efficient. They come and douse the flames.

[Laughter.]

MR. HACKBARTH: So let me stop, and Bob, I know you've got thoughts on this.

DR. BERENSON: Yes. No, I agree with what Glenn said, but I think it's going to take us a much longer time to work through issues around how does setting prices affect supply decisions, you know, career decisions that medical students and residents make or find a consensus about what services are undervalued in the sense of what beneficiaries would benefit from.

So I think this drill is about getting prices closer to the resource costs. I mean, I agree with Nancy. We can't get it perfect. But this is a narrower drill, that there are distortions that currently exist such that -- I'll just quote a medical group administrator I interviewed last year who said that, "You're telling me that under the RBRVS that a full-time orthopedist working full out is getting 16,000 work RVUs and a full-time family physician working full out is getting 7,000 RVUs. I have trouble managing a medical group with those kinds of variations."

And I guess the final point I make is until we have a different way of doing it, the inputs to bundled

payments or even to some extent the capitated or global payments, the building blocks are these relative values and DRG values, et cetera. So it just -- I mean, so there's a lot of reasons it affects the mix of services that beneficiaries get and probably the dynamics in the system and career decisions, although we have much less grounds for that, I guess is what I'd say.

MR. HACKBARTH: [Off microphone.] Round one clarifying questions?

DR. KANE: Yes, just a quick one. I read through it quickly and I'm not sure I picked up. Are we considering, when we want to look at time per HCPC or whatever, are we talking about the average time or the efficient time, and have we tried to alter the way we pick? If we end up sort of sampling, which sounds like the only feasible way, is there going to be some effort to identify the most efficient --

[Fire alarm sounding.]

DR. HAYES: The response is that it can be efficient or it can be the average. I think that's a kind of a judgment call, a decision about how to execute this kind of thing. If it were to be the efficient one, there's

still some work to be done to define what efficient means in this kind of context, but it would seem doable. This is flexible enough to accommodate either one.

MR. KUHN: Yes, Kevin, a question about the levels of data collection that you shared with us earlier, either at the practitioner level or at the billing code level. When the RUC currently reviews codes and goes through their process, how is the data presented to them and how are they reviewing it now?

DR. HAYES: [Off microphone.] How are they what --

MR. KUHN: Yes. How is it presented to them now by -- I assume the various specialty societies bring codes forward and so they have times in there. So is it at the practitioner level? Is it at the billing code level? How are they now currently reviewing time?

DR. HAYES: It's at the billing code level. This is a kind of code-by-code review process and so a specialty society would present, you know, their time estimates, their recommendation for a relative value unit for a service, and then there would be some deliberation among the RUC members and then a recommendation agreed upon, voted upon by the

RUC, and that's what goes to CMS.

MR. KUHN: And is that data generally collected through a survey, or how is it collected now by the specialty societies?

DR. HAYES: Yes. It's collected via survey --

[Fire alarm sounding.]

DR. HAYES: It's a survey conducted by the specialty societies and brought forward to the RUC.

MR. KUHN: And then one additional question. On those surveys, is that a standard format survey that they have to meet certain criteria, and if so, who sets that criteria for that survey right now?

DR. HAYES: It's a standard format adopted by the RUC and used, you know, uniformly by all the specialties.

DR. BERENSON: Yes, two round one questions. I just wanted to --

[Fire alarm announcement sounding.]

DR. BERENSON: I wanted to pick up on Karen's important issue around the multiplier effect on time and work. Recently, I think the RUC put up on its website some results of its work, that when CMS has adopted recommendations in the fee schedule, that suggests that

they've actually produced a fair amount of redistribution, up to about $400 million in reduced work, and suggesting that that -- and then finding that that produced almost $1.2 billion of savings for redistribution because the practice expense savings were almost twice as much. I mean, does that basically -- can I infer from that that the multiplier effect is that dramatic? Have you had a chance to look at that, and -- I guess that's my question.

DR. HAYES: Yes. I would say that it's worth -- we have looked at it in kind of a cursory way, and indeed, there have been some redistributions of dollars because of changes in practice expense RVUs. It's kind of difficult to pin that down, to pin that number down. And then I would also urge some caution about whether those practice expense changes are kind of a ripple effect, if you will, from the work changes, or whether they are changes that have happened because of, say, new survey data for practice expense. The Physician Practice Information Survey is, of course, being -- the data from that have become available. The practice expense RVUs based on that survey are being transitioned into use right now. So it could be that some of that -- I'd have to nail this down, and I'll get back to you on this,

but some of those savings for practice expense could be due to that --

DR. BERENSON: Okay.

DR. HAYES: -- than not.

DR. BERENSON: All right. I think that would be important to understand sort of the magnitude of this sort of spillover effect on getting time and work more accurate.

My second question has to do with Slide 6, where you've talked about the validation provision within the ACA. I'm aware that CMS in their proposed rule last year asked for comments on whether to engage in time and motion studies, and I guess got some discouraging feedback, that professionals don't like to do time and motion studies or something, and that sounds pretty resource-intensive. I guess, do you have any idea whether CMS is also looking at this issue of feasibility of using administrative data sources, or are we the ones who are sort of doing that, I guess is my question.

DR. HAYES: Well, on the matter of time and motion studies, you're correct that they did ask about this, and the comments back were -- how to characterize them -- they were not as negative as you might have thought, but there

was caution expressed, ample caution expressed about doing anything, whether it's time and motion studies or whatever, that's too narrowly focused, that concentrates on, say, one specialty or one type of service. The point that was made was that, whatever you do, it needs to pretty much apply across the board for the fee schedule.

Also on time and motion studies, I will mention that RTI in their work for us has been asking about this, about the potential for time and motion studies, and from minimal kind of interviews, what we have learned is that they are done in some cases, but they're very specific. They're done for very specific problems. Say we have a facility that's very much oriented on quality improvement, on these so-called lean production systems. They would do time and motion studies to deal with a specific, say, issue of patient safety. But that's pretty much as far as it goes. And no one that we've been able to find actually goes so far as to link the results of those studies to, say, the billing codes and such.

DR. BERENSON: And I guess, I mean, more specifically on my question, do you know if CMS is also looking at this administrative feasibility of administrative

data?

DR. HAYES: I don't know that for a fact. They have solicited comments on this and received a number of them and report back in the final rule that they are continuing to look into the matter, but they weren't specific about exactly what their activities are in this area.

DR. CASTELLANOS: Yes, I think this is important work, also. You know, the work value is time, which is the predominant one, but it's also intensity, and I haven't heard anybody talk about, are we going to be looking at the intensity, because time's intensity is the work value.

DR. HAYES: Yes. Well, we have looked at -- we have considered the issue of intensity, and if you look at Slide 7, you will see that we have tried to measure the importance of the time estimates relative to intensity as determinants of the fee schedule's relative values for practitioner work, and what we have found is that the time is really the most important factor. If you look at the correlations between the amount of time it takes and the RVUs that are set for a service, the time, you know, is very, very highly correlated. It does a lot to explain why

the RVU for a service is high or low.

So the focus here has been on the time estimates, on trying to come up with a source for validating that, and the thought would be that if we can nail that, then you've got a good metric against which you can do some analysis of intensity. You can then take the work RVU, divide it by an accurate time estimate, and now you've got a measure of intensity, of work per unit of time, which will be a very useful thing to have. So we kind of see this as time focus initially and then there's the stronger potential to go at intensity.

DR. CASTELLANOS: I agree with you. I think time is the most important. But intensity changes just like time changes when you do a procedure. It becomes common and it's not as hard to do and it becomes common sense. So I think, as time goes, I think we need to look at that, also.

MR. GEORGE MILLER: Yes, just quickly. Is it your thought in defining an efficient provider we need to get this part of the work done first and then try to define efficient provider, or can you define efficient provider now and then try to work backwards into the appropriate time?

DR. HAYES: Yes, that's an interesting question.

I would say that what would be useful here would be some research on what might constitute an efficient practice, and if you could get some consensus about those results and about their utility for work of this sort, you might be able to say on the front end, okay, we know enough about what makes an efficient practice. We want to go out and get some time data from those practices of that sort. If we could define them and conduct a data collection activity centered around that, it would be feasible to do this. But the first step is, as I say, yes.

MR. GEORGE MILLER: It would make it easier, I think, to do this modeling.

MR. HACKBARTH: Kevin, isn't a key question what unit of production you use to define efficiency? So a given practice may be very efficient in producing, say, a mid-level E&M visit, and so if that's the unit of measure, you may go to this set of practices to determine whether that's efficient. You may have another practice which is more efficient in terms of total costs but has a very different production system for producing mid-level office visits and they may look inefficient on that. And so you have to define efficiency and what you're trying to produce.

Cori, Mike, Jennie, Tom, clarifying questions, Mitra? No clarifying questions. Okay. Round two, and let me just do a time check here. We are at 3:26, so we're already about ten minutes overdue on this one, so as people make their round two comments, if you would, please be very crisp so we can not take too much time out of other topics. I'd appreciate it. Karen?

DR. BORMAN: I think that in addition to the issue about the perfect price, we have to recognize there's probably not the perfect data set, and so we have to decide how good a data set will get us at least some way down this road.

I think as Kevin alluded to, and Ariel, if I'm correct, what you're alluding to about the surgical data is the NIS-Quick data [phonetic]. It is a data set that was collected for another purpose, but as a part of it has code-specific time-associated data. I think the experience -- and Bob may have an insight into this -- from the development of the RBRVS would suggest that when practitioners know the purpose of the data collection, there is something of an incentive to potentially influence the system or certainly perhaps taint the measurements, and I

don't mean that as surgeons that we're pure in that or impure in that. I think it is true, and I think as specialties were surveyed through the Harvard process, it became apparent as the values got higher and higher that the people learned the process. I mean, they're smart people. They learn the process.

So I would encourage that a criterion of the data sets perhaps should be that to the extent that we can find ones that were collected for at least additional purposes and not solely for this purpose, they may, in fact, have enhanced validity.

The other thing that I think was in the chapter that you guys sort of alluded to in the difficulty of the collection is that it's very difficult to -- you know, a given service is believed to have three pieces, a pre-service, a post-service, and then the actual delivery of the encounter face-to-face with the patient, and whether that encounter is an operation, an office visit, or whatever. It is because efficiency demands that you multi-task, whether it is while you are with one person or doing a lot of things about different people going on at one time, it is very difficult to get to that very micro level, and I think that

the information you provided suggests that it may be nigh unto impossible. And I personally would not want us to waste a lot of time trying to get at that.

I think the more macro work back, and accepting that the statistical inferences may not be as perfect as going to somebody's office and watching it, I just think we could be making the perfect time set well after everybody in this room is dead. And so I think if we really do want to try and enhance some of the accuracy of the times, we need to look for some good data collections and good criteria and move forward and do them, because I think that's the only way we're going to make progress in this area.

And I would urge us to consider, albeit this is more about the work thing, that the estimates of some of the other times, like clinical staff time, might also have some question about their validity, and if there's a process in the data sets that we identified, to also perhaps revalidate those, that there could be value to doing that. There are some services where the clinical staff time is two and three times the actual service encounter, which may be true for some services. It's a little hard to believe that it's true for all.

And then at the end of the day, if the conclusion is, yes, they're all inflated times, then maybe it kind of doesn't matter, so that is, I guess, maybe one of the research questions to answer, is if we decide they're inflated, we can't get a perfect data set or even something close, do we have consistent inflation in the methodology and do we just have to learn to live with that piece in the background as we take the data forward. So I think those would be important.

MR. BUTLER: Just a quick reaffirmation of the Minnesota findings, and that is it's not just the payment accuracy. Most of us that have big group practices, this is the foundation and how we're compensating and incentivizing, along with, increasingly, quality metrics and the rest. So to get it right is not unimportant. Often, we'll pay very different from what we actually collect in terms of the RVUs based on payer mix, so it's an important topic.

DR. KANE: I think I asked this before, too, but are there codes for which the private sector has just decided they're so far off that they've negotiated a different, you know, substantially -- if you were to look at how their RBRVS system was, was it substantial -- I mean,

I'm just wondering if there is some signal for where you should be spending your time and adjusting, rather than just going across the board. But other than that, it's a tough task. I think Bill Hsiao switched to designing single payer systems because that's easier.

MR. WINTER: We couldn't find any examples where plans had -- plans that generally pay on a fee-for-service basis, where they altered their fees, you know, set their fees differently than Medicare, or when we looked within practices, how they compensate employed physicians, it's usually based on a combination of the Medicare work RVUs and a salary basis. They did not adjust Medicare work RVUs. We tried to find examples, worked very hard, found maybe one limited example of a plan, but it's generally shifting away from Medicare RVUs to pay its providers. So, really, no examples.

And what one respondent said, and this quote will be in the final report, is that we found Medicare work RVUs are the least bad option we have for paying physicians. So they recognize in many cases the limitations, but they have not developed alternatives.

MR. HACKBARTH: But John Bertko used to say that

what they will do, of course, is use a different conversion factor. So they'll use Medicare's RVUs and have a different conversion factor. And in some markets, they may have a separate conversion factor for a given specialty out of necessity, because there's a very powerful single specialty group that's merged and basically the only way they can get them in is to have a special conversion factor for them. But they use the Medicare RVUs as sort of the core infrastructure, is what John always used to tell me.

MR. KUHN: The area, as we continue to look at this issue, the area I was interested in is the notion of do we have to collect data on all CPT codes out there, and I think some of the information you put in the paper is going to be very helpful as we go forward, the fact that about 460 codes account for about 90 percent of the spend in the fee schedule and about something a little south of 300 codes are the ones that represent over 10,000 services per year. So as we go forward, I think that will be helpful to help us kind of in a narrowing process here so we don't overwhelm the system as we think about this.

DR. BERENSON: I will say a few things. One is that this is -- I continue to believe this is very important

work and you guys are making progress. We should just remember that the -- we do not have a terrific system now for estimating time. It's one that has a lot of bias. I think the RUC does a decent job at challenging some of the specialty societies who come up with completely implausible time estimates, but they really have no basis. So I'm concerned that even though the RUC is doing a very nice job and CMS in reviewing a whole bunch of services, and in the last year generating $1.2 billion for redistribution, that maybe some of the revaluations should have been significantly more.

And so, Ariel, this morning, you presented data that on that echo, when they combined three separate echoes that are always performed together into one, in fact, the new valuation is marginally lower, I mean, is essentially the same, has a time of over 30 minutes as we talked about, and in my view doesn't pass face validity as being correct. Obviously, there are some cardiologists who will disagree with me, but I have seen echocardiograms being the professional work associated with those and I don't believe it takes 31 minutes or whatever it takes any more than I believe that the EKG interpretation, which is currently in

the system at five minutes or seven minutes, depending on which one you use, is anywhere close to the reality of a few seconds at this point with automated EKGs that show up on your desktop with an interpretation and all the doctor has to do is say, yes, that's right.

So I think, in fact, the work that we're embarking on could improve the RUC's work rather than be seen as a threat to the RUC's work. The RUC could be the entity that takes the time data and uses it and does, Ron, what I think only a professional group can do, is address the intensity across services. There is no gold standard for that, and I think we have to rely on professionals, but I don't think they have to make up the time data. I think we could, with CMS ultimately doing it, clearly, through some administrative mechanism, get the time data. If the RUC is wedded to their current way of doing it, which is based on reviewing 30 doctors who know what the game is, what their estimates are, then we would have to have a different process, it seems to me. So I think that remains to be seen.

We need to come up with something feasible. The perfect should not be the enemy of the good. Right now, we

have a system that I don't think works very well and I think we should, as Karen suggested, try to figure out something practical that is better. If it got plugged into the RUC process, then clearly a specialty society could come forward and say, well, you got it wrong and here's why. There would still be an opportunity for correcting what came out of some administrative collection process, but the burden would now be shifted. Rather than the RUC trying to show that the specialty society was cooking the numbers, intentionally or inadvertently, that burden would now be on the specialty society to say why it is that this administrative data that came from six or eight or ten multi-specialty group practices and a few other practices was wrong, and I think that would be a great improvement to the process.

I don't remember if I said this up front, but we are spending close to $70 billion just in Medicare on physician payments and we should at least be basing them on some real data. I mean, we need -- so that is my final point, is it will cost some money, I assume, to collect this administrative data, and once we have a proposal for how to do it, I think CMS needs the resources to go contract to get it.

One advantage to the current method is that the specialists are providing free labor to CMS, but they have an interest in doing so, a self-interest in doing so. This would not be free and I think we would need to put some kind of parameters of administrative costs that would be required to collect this data, but I encourage you to keep working. You're doing -- it's a good start and I think it is not going to turn around next year, but I think over time this is the right way to be going.

DR. MARK MILLER: [Off microphone.] Can I get you just to say one more thing? So you're very clear on there's a problem that the RUC is not going -- at least as the current process is, they are not going to correct it, and very much an encouragement there should be another effort to gather this information. In an attempt to tease out questions on that, there was a slide on surveys, mandatory versus recruiting from a cohort of practices. Did you have any views on the direction to collect the data?

DR. BERENSON: I think I would be going to places that have automated data systems. The closer some of them have to CPT-level assignment of time, the better, but if that doesn't exist, then somehow backing into the allocation

to the CPT codes, but through administrative data. So if that means it's a somewhat skewed population of practices, we're talking about large multi-specialty groups with sophisticated data systems and they're the only ones who can do it, then I would take that, put it into a process where there is an opportunity for pointing out that, well, it's different for a solo doctor and here's why. Maybe the EKG is more than three seconds. Maybe it's a minute if you don't have an electronic health system.

But I think we don't make it so complex in terms of having representativeness from every kind of a practice that it makes it infeasible. I would be concentrating on practices, hospitals that have data systems that can be used to produce this kind of data and then present what the potential error might be because they are unique practices.

MR. HACKBARTH: So the way that you've expressed it to me before, Bob, is that you would go to a subset of practices that have the systems that allow the information to be collected efficiently, and then you could allow people to rebut the presumption. There would be a presumption in favor of this being the accurate measurement, but if people can produce persuasive information that it is not accurate

in certain circumstances, the door would be open to that, but you'd have to come with --

DR. BERENSON: Yes. I mean, it could even be -- I don't know exactly how it would work out. The RUC would continue asking the 30 doctors to submit their time data. Here's now a new database. The RUC has both of them and there is an engagement. CMS obviously is not obligated to -- I mean, I'm not endorsing that. I'm saying there are a number of different ways in which you could permit some, you know, the profession, the specialty societies to absolutely have input into the process, but they don't get to sort of put all of the words on the blank page first. There's another database, which I assume over time will get better and better.

And I know that there are some people on the RUC who have wanted to have this kind of information outside of relying on specialty societies and others who think that their current way is the right way. I think consulting with the RUC as to how to make this work within their process would be a useful thing. My first choice would be to have the RUC use this objective time data within their processes, have CMS do what it normally does, is review the RUC

recommendations. If the RUC doesn't want to use objective time data, then there might need to be a different system.

DR. CASTELLANOS: Let me just clarify a couple of things so I'm not misunderstood. I totally agree that we need to look at time. We need to look at it on a new perspective. There's just no question we need to do that.

I just think we need just to give a more balanced opinion of the RUC, not that I -- I guess Karen is probably the best person to talk about the RUC. She was head of the CPT Committee and she can give you more information as to their workings and that. I had the opportunity to go down after Barbara Levy invited us last spring and I was very prejudiced towards the RUC, towards the Wall Street Journal article, et cetera. I thought they were very professional. I thought it was a tremendous amount of work they were doing. I really was interested in the extent of their importance of the cross-specialty discussions and the enormous push-back that I saw.

Bob, I just want to -- you recognize there's a problem, and Mark, you asked Bob, there's a problem but they don't want to do anything about it. I don't think that's real fair, because I think the RUC has tried to do something

about it, because I brought these questions to them when I was there. I think they made every effort in their abilities to do it, but perhaps they don't have the abilities or are not looking at the right thing.

I don't want to leave here now thinking that the RUC has not tried to do something. I think they have provided a good service, and Bob, I appreciate you went from decent to very good and I appreciate those adjectives --

[Laughter.]

DR. CASTELLANOS: -- but I don't want to throw the baby out in the bathwater. I don't want anybody to leave here thinking that the RUC has not tried. I didn't say they have succeeded.

DR. BERENSON: Point of privilege. I mean, good, decent -- I mean, I gave him great credit for having a lot of activity, for producing a substantial amount of redistribution. I'm just saying I think there might even -- with more tools, they could even do better, but I'm being pretty positive here.

DR. CHERNEW: I'm very wary of these time-motion-type studies. I want to go on record as saying that. And I actually think, although I couldn't right now tell you how

to do it, there probably is some operations researcher somewhere who, if you knew the amount of time worked and you knew the set of codes billed and in a big enough sample, you could statistically try and sort this out without trying to observe exactly how much time would be spent on things, and you'd have to make assumptions on the case mix heterogeneity. But I think compared to survey stuff or time-motion stuff or those types of things, it's fraught with a whole series of errors and it would take a lot of thought to think how to do it the other way, but I'm convinced you could get a better statistical estimate using sort of macro data and statistics than trying to send someone with a clipboard and stopwatch.

MR. HACKBARTH: You would include in that drawing information from administrative systems the way Bob --

DR. CHERNEW: No, that's how I would do it.

MR. HACKBARTH: Okay.

DR. CHERNEW: The only thing you need to know is what you billed for and how long the people were working, and maybe some of the other resources, maybe some case-mix stuff --

DR. BAICKER: And you'd want to know what share of

their time was devoted to Medicare beneficiaries versus other patients.

DR. CHERNEW: Well, again, that depends on whether or not you want to know overall everything that they billed for everybody, which is a separate issue. So, yes, you'd have to sort that out, because obviously you need to know that in the amount of time for Medicare --

DR. BAICKER: I was thinking just for the denominator.

MR. HACKBARTH: Jennie?

MS. HANSEN: Yes. This is more of a question relative to, you know, besides the large database, is there a methodology being looked at, and this might be for you folks as well as with Bob, about when it comes from the beneficiary multi-morbid perspective, are there factors of waiting for looking at people who might be dealing with, you know, eight comorbidities and things like that. So my purpose in asking this is to just make sure that, over time, these more complex people that may take a lot of time but also have clinical complexity will get seen and have the clinicians paid for appropriately here.

DR. HAYES: Well, I'll just say that the purpose

of what we're talking about here is to get more accurate time estimates and to try and do the best we can within the constraints of this kind of a payment system, to do the best job possible to account for the complexity of the patient.

I would also point out that there are within the payment system provisions for the unusual cases, for the beneficiaries who, say, take an extra amount of time. Now, there's all kinds of controversy about how well the payment system accommodates those special cases, but there is some provision for that.

But anyway, in any case, I just come back to the original point that I tried to make, which is that we're trying to just do the best we can with what we've got here and so the time data seem to be part of the answer.

DR. DEAN: Yes. I'm very conflicted about this. I understand that we need this kind of a tool. I am also deeply cynical about how effective the current one is and how it fails to in any way account for at least my time. And I understand that the specialty I am in is probably -- it fits least well. If you're doing a lot of well-defined procedures, which I'm not, I suspect that there is a chance that this could work. But right now, for instance, if I sew

up a simple laceration or take off a little skin cancer, I'll get paid probably three times as much as if I spend 45 minutes with the patient that Jennie just described. It really, you know, makes you very cynical about the whole structure.

But I understand for the reasons Peter mentioned and so forth that we need some kind of a tool, but there's so much variability between individual physicians. There's experience, what kind of support staff you have, what the patient's idiosyncracies are. I mean, you can go on for a long time. I'm just not sure that we can ever get it right, although I understand there's a need to try.

MR. HACKBARTH: And this actually links to our next conversation. I don't think you need to try to get it all -- address all of those issues through the resource-based relative value scale. This is the point I was trying to make in response to Peter. This conversation is a narrow one within the construct of a resource-based relative value scale. How do we make it as accurate as possible?

Then, separate from that, we may wish to change how we pay physicians, use new methods, or establish bonuses, other mechanisms to better address the sort of

issues that you're raising.

DR. DEAN: I think the comment that you made earlier about, you know, this bases everything on input costs. It has no relationship to value --

MR. HACKBARTH: Value --

DR. DEAN: -- and that's, to me, where the real problem is.

MR. HACKBARTH: Right. And so we'll turn to that in just a second. Mitra? I think that was round two, wasn't it?

DR. MARK MILLER: Can I just add one thing?

MR. HACKBARTH: Yes.

DR. MARK MILLER: I also want both the Commissioners and the public to know that when we have these conversations, it isn't without any knowledge of the RUC. Kevin regularly goes to the RUC meetings and engages in the process and follows the process, or at least he tells me -- he disappears for a few days and says that's what he's doing.

[Laughter.]

DR. MARK MILLER: The other thing I would say, and there's something of an interaction here that works like

this. I think the RUC has taken actions over the last few years, but I also would remind this Commission -- some of you weren't here -- it was a few years back that we started looking at the RUC and that, I think, had some role in the RUC sort of changing.

And so I think there is a kind of a symbiotic relationship or a conflict relationship, whichever way you want to think about it, in order to get the best out of both sides, our work and their work. So I just don't want you to think that we're doing it completely oblivious to what actually goes on there. We do try and engage and pay attention to what they're up to.

MR. HACKBARTH: Okay. Thank you, Kevin and Ariel. More on this later.

Our next topic is the SGR system.

Okay, whenever you're ready.

MS. BOCCUTI: Okay, I'll get started. So as most of you know, policymakers face an extremely difficult challenge regarding Medicare's future fees for physician services. Under current law, Medicare's fees for these services are projected to decline more than 30 percent over the next several years under the SGR.

So we're going to start with a short summary of the Commission's assessment of the SGR system. Then we're going to review a series of discussion questions and some of the issues that you want to consider for each of them. And then given the complexity of this issue, we're going to really try to keep our presentation short and maximize your time for discussing the direction that MedPAC wants to take in the world on this area.

So on this slide, we've got a very brief review of MedPAC's assessment of the SGR. It was, of course, summarized, or this is summarized from previous discussions over the last couple years and years before that. Also, as you recall, we included this, a more detailed version of this assessment in the recent March report.

So first, there are several widely held criticisms and flaws of the SGR system. A main flaw is its inability to differentiate updates by provider. It neither rewards specific physicians who restrain unnecessary volume growth nor penalizes those who contribute most to volume increases.

Another problem is that the SGR is strictly budgetary. It has no tools to counter the volume incentives that are inherent in the fee-for-service system or to

improve quality.

And in addition to these systemic flaws, there's widespread agreement that the updates that the SGR formula has called for are problematic; that is, large unrealistic payment cuts loom in the future under current law, and these cuts threaten provider willingness to serve beneficiaries. Also, the temporary stop-gap fixes that have been implemented in recent years have created uncertainty, frustration and financial problems for medical practices, and additionally they add significant burden to CMS's claims processing activities.

And then a third issue surrounding SGR discussions, of course, is that eliminating the SGR cuts translates to a minimum CBO score of about $300 billion, and that's just for a freeze in payments for the next 10 years. So this high score carries two critical, but somewhat circular, issues. The high score makes elimination of the SGR extremely difficult, but each year that the SGR remains in place and its fee cuts are overridden the score for replacing it gets higher and the prescribed fee cuts get larger.

So with that very brief summary statement, we're

going to start with framing the series of questions for you to consider when we discuss the SGR alternatives.

So at the broadest level the first question is: Should the SGR system be eliminated or modified?

And if you answer yes to either elimination or modification, then the next question is: What alternative mechanism -- or really I think it should be pluralized there. What alternative mechanism or mechanisms will determine Medicare payments for fee schedule services?

So would it include a new expenditure target system, or does elimination of the SGR present an opportunity to institute a contingent package of tradeoffs which would include modest, but stable, updates?

And of course, these, those two options that are those bullets there aren't necessary mutually exclusive.

So following from that previous slide, we ask: Should another expenditure target system replace the SGR? We list here some general points about expenditure target systems that MedPAC has made in previous discussions.

So first, expenditure target systems are designed to constrain price growth, but their effect on total spending or volume here is really less direct. Nonetheless,

expenditure target systems, by design, do regularly alert policymakers of spending growth, and they require significant congressional action to override them. As the Commission has stated repeatedly though, expenditure target systems in their starkest form are not a mechanism necessary for improving care delivery. And finally, expenditure targets that are narrowly applied to a single sector, such as the fee schedule payments in the SGR, offer no spending flexibility across provider sectors.

So in general, expenditure target systems are formulaic, and thus, they have several parameters to consider.

So how would the parameters of a new expenditure target system be defined? The first overarching design element for an expenditure system is its scope. By that, I mean would it apply to the fee schedule only, as it's done in the SGR like I said, or would it be expanded to Parts A and B or to all of Medicare?

Next question, what would the spending growth targets be? In the SGR, it's based on GDP. But some have suggested GDP+1 or MEI, or there could be a specified percentage of growth.

A third parameter to talk about is what would the updates be if spending was at or below the target. In the SGR, for example, it's MEI -- so in the MEI, when services are supposed to get an MEI update if the cumulative spending is equal to or below the target. Another possibility for the updates would be a predetermined amount like 1 percent when spending is at or below the target.

A fourth parameter is to what degree would the system cumulate differences across years. The SGR is fully cumulative, so it's designed to recoup any and all spending over the target. In contrast, the system prior to the SGR set the rates annually, so it did not require recoupment across multiple years. Some have suggested that there's a possibility for a partial recoupment.

Moving on to a fifth parameter, would the targets and the resulting updates vary by certain factors? The SGR has one national target. In contrast, some proposals have explored different targets and updates, say, by geographic area or by types of service.

And then finally, would there be an allowance for selected entities to be exempt from an expenditure target system? And we've talked before about the possibility of

participants in ACOs or medical homes, particularly ones that are subject to other kinds of performance risks, could be exempt from expenditure target policies.

So now I'm going to switch away from the expenditure target discussion for a moment and talk about something that was discussed at the last meeting, and that's the concept that eliminating the SGR offers an opportunity for gaining other system improvements. In other words, alleviating the looming SGR cuts could be contingent on a set of tradeoffs that could have goals of improving the stability of future payments and also aligning incentives with improvements for high quality and efficient care.

You discuss several options in the package of tradeoffs including limited future updates starting in 2012. That is fairly modest, but stable, updates for several years head.

And a second option is a major realignment of this fee schedule. This effect or, excuse me, this effort of the major realignment would have a goal of enhancing overall value of nonprocedural services and balancing per hour compensation across specialties.

A third component in this contingent tradeoff list

could allow for service-specific fee increases or decreases. In this scenario, the Secretary could make changes to fees for individual services. She could make these decisions based on CMS validation activities, and that goes to the presentation that, or the session right before with Kevin. Although that's not really listed on the slide, I think we could consider that in this realm. But also she could make these individual changes based on advice from the RUC or a Secretary's expert panel. A question for discussion then is whether or not these service-specific adjustments would be budget neutral.

And then there's a final bullet on the slide that is really there for a placeholder for other ideas that you might want to discuss today, some of which may have been brought up at the last meeting.

Okay, so as you painfully know, maybe because I've been telling you so many times, eliminating the SGR's future cuts carries a very high budgetary score. At a minimum, like I said, it's $300 billion over 10 years. And although Congress has the ability to apply what's called directed score-keeping to legislation, which is basically telling CBO how to score a bill, that option is essentially a

congressional prerogative. So we're going to focus here on this slide with potential areas for finding scoring offsets.

First, we could focus on Medicare spending reductions to offset the high score. Unfortunately though, it's extremely difficult to find this amount in Medicare spending reductions. Most recently, in our March report, the Commission did recommend lower updates in several sectors, but that is really just a start, or it doesn't go to the $300 billion when I say "start."

And then the other option is to think beyond Medicare, to include all federal spending and revenue. The concept here is to widen the pool of options that are available for offsetting the score.

And of course, these two options don't need to be mutually exclusive.

Before we get to the final slide, there's one point that the Commission has raised in several meetings and in our recent March report. And that's that in the interim, while determining what to do with the SGR, should there be a minimum period of time for which overriding updates should apply, say, for a minimum of one year?

The shorter updates that occurred in recent years

were, as I said, extremely problematic on many fronts. They undermine the confidence of providers and patients. They threaten Medicare's reputation, and they burden CMS's claims processing activities.

And finally, on this last slide, for your discussion we've summarized the framework of questions that I just ran through. And as Glenn mentioned, our immediate goal is to be able to give some sense of the Commission's direction on these considerations. We're not necessary concentrating on details and specifics for each time, but really we're trying to chart, or this discussion will chart a general course for the Commission's future work.

Thank you.

MR. HACKBARTH: Okay. Thank you, Cristina.

In the interest of time, I think what we'll do is just have one round on this topic, and what I'd like to do is kick that off, repeat a little bit of what Cristina said. My goal is to give you something to react to in terms of a potential direction for it, and I'm going to try to maybe put some sharp edges on it with the specific intent of getting you to say I agree that or I disagree with that.

And I'm trying to help create the outline at least

of what our message is in our June report. You'll recall last time I said that the process that I envision is that in our June report we'll discuss the SGR and hopefully point in a broad direction, if not a detailed one. Over the course of the summer including at our July retreat, we'll talk about it in more detail, more concrete options.

Assuming all of that goes well, I would envision that we would have draft recommendations for discussion at our September meeting, and if that goes well, then potentially final votes in October. And I mean to emphasize if that all goes well. This is a difficult topic, and so I'm not sure we can assume that all will go well, but that is certainly the objective, is to find a consensus on a very difficult and controversial issue.

So I'm going to go through some sort of summary statements about SGR based on my own ideas and things I've heard commissioners say in the past, and I want you to react to these during the discussion.

The first point is that SGR and mechanism like it, formulaic across-the-board changes in unit prices based on what's happening with total expenditures, mechanisms of that sort do not create incentives for the efficient delivery of

care. In fact, arguably, they create perverse incentives for people to respond to impending future reductions in payment by increasing volume, or alternatively, they have inequitable effects by falling more harshly on some types of physicians than others. Physicians who can readily increase the volume and intensity of their service are hurt less by them, whereas specialties that are more constrained in those opportunities bear the brunt of the cuts.

So the basic mechanism of, by formula, linking unit price increases updates each year to volume, total volume of services or total expenditures is a flawed, inherently flawed mechanism.

A corollary of that is that if in fact we want to create appropriate incentives for physicians and other practitioners to focus on producing high value care, the best possible quality with the lowest possible cost, we have to change the payment system at the level of the individual provider. We can't accomplish that goal through some sort of overlay of the fee-for-service system. So we need to advance the work on medical homes and ACOs and bundling, et cetera, if we want to change the incentives that practitioners face as they care for patients, and we want to

do so in an equitable way.

Now that's not to say that SGR has been totally without benefit. There are people, including maybe some present members and certainly some past members of this Commission, who have said that if nothing else the benefit of SGR has been to create a mechanism that has applied pressure, that has held the annual updates to levels, lower levels than they would have otherwise been and some savings have resulted from that. I'm sort of agnostic on whether we have in fact saved money or not, but let's stipulate for the sake of discussion that that's correct.

My concern -- you've heard me say this before -- is that even if we assume that updates have been lower the price that we're paying for that may go up precipitously. The recurring crises about whether we're going to have very large cuts in Medicare's fees to physicians I think are taking a toll on physician, and potentially beneficiary, confidence in the program. So even if we are getting modestly lower updates than we otherwise would have gotten, we're running increasingly large risks to get that benefit.

There are other ways. If in fact our goal is, and it must be, to constrain updates in physician fees, I would

argue that at this point in time, especially in the current budget context, there are other mechanisms that can accomplish the goal of holding down updates without having this complex and threatening mechanism as the vehicle for doing that.

If, for example, there were just legislated zero updates for a period of 3 years and no more than 1 percent for the next 7 years in the 10-year budget horizon, that in and of itself in the current budget context would apply lots of pressure on Congress to keep the updates low. We don't need to threaten, in other words, 25 percent reductions to get low updates, especially in this fiscal context.

Now if we were, if the Congress were -- it's ultimately, of course, their decision. If the Congress were to repeal SGR, it seems to me that that also presents an opportunity, an opportunity to make some changes in physician payment that otherwise might be difficult to pull off.

Why is it an opportunity? Well, certainly, there is strong interest in the physician community in getting rid of SGR, and it may be an opportunity to say well, in exchange for getting SGR some other things have to happen.

And so one of the tasks I think that we ought to undertake during the next several months is to think about what that exchange might be, what changes would we want to see as part of an SGR repeal package. One example might be, as I said a minute ago, to have a legislated baseline that provides for low updates into the future.

A second element in my view might be a significant redistribution of payments among physicians. So now I want to link this conversation to the one we just had. The previous conversation is how do we make our estimates of relative values as accurate as possible. Here, I'm suggesting, as I responded to you, Tom, that in addition to that we may wish to make some other changes in the payment system that redistribute money within the system.

The existing primary care bonus that was enacted as part of PPACA is an example of that sort of outside of the RBRVS system let's change the distribution of dollars. As you know, there was a temporary 10 percent increase enacted in PPACA. Potentially, you could make that number bigger or you could even include in the package a change in method of payment for primary care. I'm not necessarily proposing those things at this point, but I'm using them as

illustrations.

Now let me turn to the very difficult problem of the budget score on this. I don't think that there are, within the Medicare program, offsets for a $300 billion-plus budget score over 10 years, particularly on the heels of significant legislative changes have happened as part of PPACA that cumulatively over 10 years are scored at $500 billion plus savings. So we would be talking about $300-plus billion beyond the $500 billion in PPACA, and I don't know where that kind of money is going to come from in Medicare.

Having said that, I think it's possible that there could be some offsets, just not of the order of magnitude of $300 billion. In fact, our March report recommendations, if you take all of them, aside from the physician update recommendation which has a big cost to it because of SGR, if you take all of the others, the net savings is about $20 billion over 5 years. So you know, that's a contribution, but it's hardly filling the entire hole.

To get really a significant contribution towards $300 billion, I think it's clear that any proposals would have to have a broadbased effect. We're not talking about

doing targeted things that add up to $300 billion. You'd have to have a broad cut that affects virtually all providers and potentially involves beneficiaries and Medicare Advantage plans as well if you're really going to try to approach something like $300 billion.

Again, I'm not advocating that, but I think that's the reality of the dollar situation. You're not going to find targeted well thought-out proposals that are going to add up to $300 billion.

So at the end of the day, my view, and I said this in response to a question at the Ways and Means Committee hearing on the March report, is that I think it's very likely that we're going to end up spending more than the SGR baseline. And I think really the question for the Congress is not whether we're going to end up spending more but how we end up spending more. The path that we've been on these last five, six, seven years is well, we spend more than SGR, but we do it through last-minute rescue operations that forestall large cuts, and we basically plow more money into the existing payment system that people have a lot of frustrations with.

I think because of the increasing risk that we're

running with SGR, we may be at the point of saying we've got to get on a different track. Spend more, hopefully not $300-and-some billion more, but we're going to spend more. But let's do it in a way that is more strategic, that for example, redistributes dollars within the physician payment system in a way that shores up our primary care system or at least slows the erosion of it, et cetera.

So I have a couple goals here. I promised that a couple of these things would be pointed, and so one notion I want to get you to react to very specifically is that if you go back through Cristina's slides the first several are about ways that we might modify SGR. Frankly, my own view is that's not where we ought to be spending our time, thinking about how to change the targets or make them noncumulative, or creating margins of error around the numbers.

The basic mechanism of linking unit price increases updates to aggregate expenditures, it's a flawed mechanism. Let's recognize that.

It's not just unproductive; in important ways, it's counterproductive. Let's be clear about that and say the path that we envision involves getting rid of that kind

of mechanism, not just altering it. So that's one thing I want your reaction to.

A second point, which is sort of less big-picture, but I think very important in the near future, is that to make a clear statement to the Congress about the risks that we see in these recurring SGR crises and have a clear statement urging them if it can't be repealed, modified immediately, that extensions, the rescue plans should be of at least one year in duration to minimize the disruption to the program.

So those are two things, particular things I'd like you to react to, and I'm going to stop there and open it up for discussion.

And Mitra, I think we're on your side first.

MS. BEHROOZI: Yeah, I was scared of going first because there was so much to react to, but thank you for sort of putting out a focus for the discussion.

On the second one first, in the interim, should there be a minimum duration of time for which the updates should apply, but as I recall it -- I might have this backwards. But the first time that I was aware of there being this crisis around the SGR update it wasn't so much

the duration for which the fix happened. It was when it happened. Or more recently actually, I guess, that was also an issue. Right? It was a short one, but it came a month late. Right?

So if we're going to say that, I think we also have to say that it has to be before the cut goes into effect, right, though I recognize that's the most political of all sort of things that we could be sort of sticking our finger into. So I don't know how much they care what we think about that, given the realities of Congress's task there. You know.

MR. HACKBARTH: In fact, I think they recognize the problem of the 11th hour rescue. I know that some of the committees are gearing up now to work on this and potentially have hearings, and their goal is to resolve this before the last minute. Now whether that will happen or not obviously involves a lot of factors.

MS. BEHROOZI: On the bigger topic, yes, I agree. I don't think that having this formulaic approach for a lot of the reasons that you said makes a lot of sense, and part of it is related to our own experience, struggling with funding deficiencies in the various -- we have different

plans for different groups of workers, and when we have -- recently, we've been facing funding crises in all of those pots of money where we had to provide benefits for workers, and we have to come up with different solutions for how to tighten things up, change the benefit design, whatever. We have to come up with what makes sense at that point in time based on evidence development, based on experiments being tried elsewhere, that kind of thing. So that's another factor that I would kind of throw in, why it doesn't make sense to say there's one way to fix it when we're spending too much.

I do think that it's important to have some kind of a measure of when things are getting out of hand. I mean when we're projected to run out of money in 12 months, in our pots of money, that's a clear signal that we have to do something. So it seems worthwhile to still have some kind of measure out there of what you think spending should not, what spending growth should not, exceed. But that's overall throughout the whole program because you need to have all the levers everywhere to be able to deal with that.

And I think that maybe what I'm talking about, starting to sound a little bit like the IPAB, that there is

some measure, that there is some threshold at which something has to happen because I also realize that if you just say well, it shouldn't cost more than X and then it goes back to Congress to come up with it, then it's subject to the same kind of political potential stalemate that you have around the SGR itself.

As to the scoring, I get that's the way it is. That's the way the rules are written. But it's also a political choice.

As you said, Glenn, you can elect to look in Medicare for that $300 billion or you can elect to leave Afghanistan a couple months early, or something like that, and find the same $300 billion elsewhere. And there are other more politically volatile things that I won't even mention.

But we're MedPAC. You know. I feel like we really need to recommend the best thing for Medicare spending and hope that they will do the right thing when it comes to the scoring and finding, figuring out how to pay for the right thing.

DR. DEAN: First of all, thanks for again bringing this up. I realize the Commission has talked about it a

number of times. But I have the same sense that you do, Glenn, that the environment is getting worse and that the hostility within the physician community is increasing and that it really is a problem that has to be fixed.

I don't believe this formula can be fixed. I think it needs to be repealed. I do think that for some of the reasons that Mitra mentioned, that some sort of expenditure targets in different sectors may be useful just as a monitoring system to alert us to when there are certain sectors that are growing faster than we anticipated, not that it dictates a response, but it calls our attention to where we are.

And in terms of if there's going to be a short-term fix, should it be at least a year? Absolutely.

MS. HANSEN: For the first one, more simply is I think yes, a minimum of a year at this point because of all the reasons cited.

I think the relative, the model of at this point, since I fully agree that tinkering with the existing SGR doesn't make sense. So I would move on the side of really saying what is the get-for if we end up doing this.

And I think in some ways -- I know this is not the

MedPAC role, but I think certainly my thinking goes to thinking of the legislative responsibility of those who govern to say what part of our GDP belongs in health care and what is a reasonable rate of inflation that should go, and then comparing it to other first-world countries that seem to get outputs that are seemingly more outcomes-driven in terms of quality.

So if we then back it into Medicare itself, the ability to have all of our providers move toward producing outputs and outcomes that are more value-based and more evidence-based toward the results, that may include both medical, which is what Medicare does do, but increasingly develop a method to understand the chronicity and the prevention to chronicity of using, say, things that are more perhaps touching other sectors, like CDC's work or AHRQ's work in terms of prevention and managing disease, so that what expenditures we have are going to be better distributed in terms of prevention that is primary, secondary and tertiary, so that we mitigate the use of tertiary.

So it's a very -- you know. We're talking about if we're going to change it that drastically in terms of being bold, let's look at using our medical resources under

Medicare, knowing what the population looks like and how then we potentially shape the value system.

There's one slide here about whether you start scoring it. Let me just quickly get to it here. I'm sorry. It's whether -- it was the second option that we had about how you might even have a redistribution to achieve the kind of outputs that you want for a Medicare population society.

So again, it was -- I am so apologetic.

MR. HACKBARTH: [Off microphone.] While you look that up, Jennie, Mike?

MS. HANSEN: Sure.

DR. CHERNEW: So I agree completely with your analysis.

MS. HANSEN: Seven. Sorry.

DR. CHERNEW: Do you want to finish?

MS. HANSEN: No, that's it.

DR. CHERNEW: So if I understand correctly, the current is for two, roughly two years from now? In other words, the current fix expires when?

MR. HACKBARTH: [Off microphone.] At the end of this calendar year.

DR. CHERNEW: Oh, so it's only basically --

MR. HACKBARTH: [Off microphone.] One year.

DR. CASTELLANOS: [Off microphone.] Nine months.

DR. CHERNEW: Right. So I think -- yeah. So then I would say we need at least a one year and probably a longer fix, and I'd like to think we'll have maybe one more fix in us, one more temporary fix in us before a longer fix. But in any case, I think it's important to say we need longer fixes as a general rule to the extent that we're in this place.

I guess my general views are if the problem is -- accepting your analysis that you can't tie -- because of the vast number of providers, you can't tie the aggregate volume increase to fees. I think the first way to think of it is if you think volume is what the problem is we should do something that attacks volume.

So find the places where volume is going up and make someone say is it appropriate, is it not appropriate, how do you deal with it, what do you put in place would be the first thing that I would generically say although I still think that is a patchwork solution towards moving to a more sensible way from the fee-for-service system. And so I would be guided in this whole debate by what can we do to

move away from the fee-for-service system towards other systems.

So a few general comments about this. First one is I do think it's very important to rebase across the fees although, again, view that as a patchwork thing.

I think it's important that as we go through all the savings of our recommendations we try and capture those savings instead of just make it budget neutral and stick it back in the physician system some other place. In other words, even if it's small potatoes, I think it's worth trying to capture some of those things.

I think we have to give some serious thought when we have our broader benefit design discussion about taking some of those savings out in order to protect the fee schedule one way or another. The funny thing is it's very easy to get agreement, and I would agree that we want catastrophic coverage, but I think we can't put money back in through the benefit design and then back in through the fee schedule. So I think we need to think about benefit design and the role of patients in how we manage the use and what patients pay.

And I think we might get -- for example, if we

eliminated first dollar co-pays, which we were discussing before, I don't know how much money is there. But if we were to save that money, I would consider using that money in other ways in the fee schedule as opposed to throwing it back. So there might be other places as we go through where there's more money on the table.

I think, going forward, getting something like a flat update is useful. Or, even a flat update minus some small productivity thing as we've put in for all the other providers, I think we might be able to live with over some intermediate point in time although, again, that will eventually explode.

And so we need to find some way to have this safe harbor in ACOs, or whatever it is, so we can get a hold of paying providers in a more comprehensive way and paying the providers right instead of treating it like we're all in one huge physician group from coast to coast. And I think if we can [sic] get the payment right in the broader sort of ACO or MA world that will make this debate a lot more difficult.

And obviously I'm with Mitra. The scoring is just a fiction, and so it's just ridiculous. And having a broader debate about how to get around the fact that you

have to recognize something you know is there is important.

And if we could bring more money in through either taxes or through some other way, that's a reasonable thing to do. But I think again I agree with Mitra that as MedPAC I don't think it's up to us to make broad fiscal recommendations.

MS. UCCELLO: Just generally, I agree with much of what you said.

I know at the last meeting I had made a point that I was maybe not -- that some of these modification things were growing on me, but I was thinking about that.

MR. HACKBARTH: [Inaudible.]

[Laughter.]

MS. UCCELLO: But I was almost thinking of it in the absence of the ability to really just get rid of it altogether. But that, I mean I think I am persuaded by this. You know. It's time that we need to bite the bullet here and any impact that it may have had in the past of holding down updates. Like you say, there may be other ways to do that, and it's time for a sharp change.

MR. GEORGE MILLER: Yes, also I want to echo that I certainly appreciate, Glenn, the way you framed the whole

discussion and put it in an appropriate context.

So going down the list, yes, I believe that the SGR system should be eliminated. I think this is an opportunity for a transformational change, and with that I would agree that -- and I think Jennie used the term -- what you get for it. We should tie things into quality and quality outcomes, deal with what -- my words, of course -- are health care disparities in that issue and tie that in as part of that quality issue, certainly get value for what we're doing and certainly do it in a way that's education and positive, that this will benefit the entire system. And then we can certainly deal with the issues that Michael talked about with benefit design and the role of the patients.

And I would also agree that it should be no less than one year. We certainly have to establish credibility within the physician community. It is very, very troubling as you've already illuminated, and Ron and Tom and Karen and the others. It is a major issue, and so I would support those things taking place.

DR. CASTELLANOS: Yes, I would agree to eliminate the SGR for the reasons you said, Glenn. I don't think I

need to comment on that.

Do I want another target? No.

What are other options? Maybe some limited future updates.

I'm really looking forward to hearing Dr. Bruce Hamory tomorrow from Geisinger Clinic. My understanding, they pay a salary, and then they pay for outcomes and quality. I'd like to see what his approach has been, and I'm going to ask him that. I know it's rural, but I'm going to ask him that.

I think we need to get -- you know. Start paying for quality and outcomes. Look at the ACO. Look at the medical homes. Look at the bundling. Look at a lot of the things that we've been talking about over the last four or five years.

What options do we have to get rid of the budget score? Simply write it off. Congress has no problems writing off bad debt from the World Bank or other countries. Why don't we start doing something for ourselves and our society?

You know Congress was the one that increased the payment rates without touching the targets. So I would just

write it off if we could.

As far as the duration of time, just what George said, we need some stability in the medical community. And I would do multiple years, not months, not one year, but multiple years. This has caused such a dissension in the medical community.

Again, I'm repeating something I've said over and over. It's like a broken record. I'm a small businessman. I run a small business. Now Tom and Karen don't; they work for company. But I run a small business with 90 employees.

And what do I have to do? If I'm not in business today, I can't take care of them.

So what has this forced me to do? It's forced me to look at other avenues of income. I'm just like any other businessman.

So we really need to stop that behavior and do what is appropriate.

MR. HACKBARTH: Bob, can I just pick up on Ron's first point about different payment systems?

I think there has been a hope that well, when we get rid of SGR, we can substitute new payment systems that create better incentives, and obviously that would be ideal.

The problem though is that we've got a mismatch in our timelines.

I am an optimist about our ability to move away from fee-for-service and develop new payment methods that improve incentives, but as we've often discussed before, the rate-limiting factor in that evolution is the care delivery system needs to change and organize to be able to receive new payment mechanisms like ACOs. And that's going to take some time, and now I fear that we are sort of out of time in the SGR game.

So we could, however, and this is the point I wanted to emphasize, is that we could think about to link the transition at least a little bit and say that among the benefits of moving into ACO is a different payment rate on the underlying physician services. So it's sort of an added inducement to try to accelerate the care delivery reorganization process.

So I just wanted to flag that as a possible idea.

DR. BERENSON: Just a few comments. One, I'm onboard. The SGR needs to be abandoned, and in a moment I'll say why I now think we should not try to replace it with a different mechanism that uses a formula, but I'll

come back to that in a second.

I think Mitra's and Mike's point is very important, that we can't deal with 300-plus billions of dollars. It's a fiscal decision for the country. There's now a proposal on the table that's in the multi-trillions of dollars of savings. In that kind of a context, you can deal with an SGR overhang, and that's not anything we're going to be doing.

We need to try to buy off as much time as we can. A year, two years would be great. I assume we won't get further than that to keep the pressure, as Ron and everybody has said. It is undermining Medicare's credibility with physicians and other providers. It provides a cloud over the program, and we need to move it down. We need to buy as much time as possible. So that actually -- you know.

The kinds of numbers you were referring to, $20 billion over 5, is the kind of number that can buy you some time. Twenty billion over five is beginning, is something real over ten, but it's not in that ballpark.

Physician payment, physician fee schedules are a little different from virtually all of the other payment systems in Medicare, which at least have some element of

prospective payment and some incentives for efficiency. There are none in a fee schedule. There is some rationale for -- I mean what we see is volume growth and some ability to deal with it.

I have, over time, been mildly attracted to a type of service approach but ultimately have decided that if it still says we're going to now reduce all imaging services by X percent to hit a target, that's formulaic, treats appropriate imaging values the same as inappropriate imaging values, and similarly for other services. It does have perverse incentives to just use a formulaic we're going to cut everybody equally.

But I do think there might be some logic in establishing a target for spending in the physician fee schedule and giving some discretion to the Secretary to figure out how to achieve it by targeting particular services, which in the Secretary's judgment can be where the prices can be reduced without harming beneficiaries.

Some work I was involved with a couple years ago with RAND in which we asked, using the RAND technique of asking clinical experts to tell us why certain services were fast growing; they were high spending and fast growing in

the physician fee schedule. Was it because of clinical breakthroughs or epidemiologic changes, or something to do with payment incentives?

And it was a process that actually helped us sort out in which cases it actually was clinical. There was a real reason for this volume increase. And in other cases, at least the experts we talked to simply said this is because the payments are too generous and people have figured out how to take advantage of it, and there are many, too many of these services being provided.

I think one could think about that kind of a process to support the Secretary to sort of target areas where if you need to make a target you can decide you're going to reduce some payments, or generate comparative effectiveness studies.

One of those areas, I'll be very specific, the epidemic of injections into the spine that are taking place with very murky evidence of what the indications are -- a perception, at least the people we interviewed, that they were very generously paid. It may be that in a refined time-based RBRVS process we would identify those being overpaid. But it also could be that it would generate, if

CER works, an NIH study which would actually give us the kind of information we need as to whether we should be even covering some of those services in the first place.

So I think that there -- and I'm not making this as a recommendation today, but I think we should think about whether there is any role for having a target which is not implemented through formula but is a forcing action of some kind to the Secretary to look for ways to live within that target.

MR. HACKBARTH: So can I just link Bob's suggestion to some other conversations that we've had today? Our previous session was talking about refining the relative values; that is a budget-neutral, redistributive exercise. What Bob is proposing here is that there be some targeted effort to reduce fees for identified overpaid services and do it in a non-budget-neutral way.

We had talked briefly this morning, Bruce, about exploring that avenue.

One of the concerns I think all of us have about the redistribution mechanism is that these are politically difficult things to do, and secretaries don't like to redistribute a lot of money for no budget savings. There's

a lot of pain for relatively little gain, and so the concept that we're trying to think through is could you use a target to sort of nudge that process along and potentially achieve some budget savings for it.

So it's very much in its embryonic phase. Whether we can figure out how to make it work, it raises a host of issues that need to be thought through carefully, but it's worth examining.

MR. KUHN: I would agree with that assessment, that it's worth examining. In fact, as many of these concepts that we can examine, we need to keep them all very much in play.

But I'm just going to join the chorus with everybody else. It's a flawed system. It doesn't work. It's got to go as we move forward.

But I think, as Glenn said at the outset, that there's got to be tradeoffs here as we continue to move forward.

And I think per the conversation we had this morning about quality health care, the way we were thinking on that one in terms of synching that up where we want the program to be five, ten years down the road. I think the

same kind of thought pattern has to go here as we think about the opportunities of the integration with ACOs, medical homes, other things out there.

And I think importantly, a chance to really rethink about primary care and how to kind of drive more activity and move that in that direction. When we look at the dwindling numbers of individuals in primary care, the age of that population of practitioners out there, a chance that we can use this policy to help move that forward is going to be pretty critical for us. So I think that's a part and will be an important part of the conversation.

The other issue that you've laid out, Glenn, that is of length of time, of course. I mean a year at a minimum, longer than that if possible.

But the other aspect of that that we have to think about too is what this has done at CMS and ultimately their contractors, the Medicare administrative contractors. With the number of overrides we've had over the last couple years, I think CMS has done a terrific job of holding claims with their contractors to minimize disruptions. And where they have gone past the 14-day minimum payment floor, CMS has taken it upon themselves to reprocess those claims.

It's been very expensive.

And as Bob was talking about this morning, there are kind of two different funds that CMS gets. They get their operational funds, and then there are the programmatic funds. That's eating away at operational funds. That shouldn't occur. That's out there. And so by holding those claims, reprocessing them, I think that's taken some of the sting from physicians, so they didn't have to do it themselves. But it's very costly for the government in more ways than we realize too.

DR. KANE: Yeah, well, this is -- I mean it's an impossible subject. But I guess I early on thought this is a volume problem; we should be coming up with volume solutions rather than price solutions.

And I think I mentioned this last time, that maybe we should look at have a three-year solution and then hopefully, once you sort of save money for three years, you've had time to rethink where you're going. I think even a one-year solution isn't going to do you much. It's a lot of work just to gear up to implement any solution -- so a three or four, or you earn your way out of the bad solution.

And the three-year solution shouldn't be pretty

because you want people to head off into the right direction, want to be in an ACO or a medical home and have a global payment. In high volume areas, you withhold 30 percent of the fees, and if they do better than expected they get a little bit back. Have it be like the old withholds used to be where you only got it back if you hit your target.

So at least you're not saying it's a 30 percent cut. You're saying you'll get it back if you keep your volume to the level of the national bottom quartile, or something, something impossible probably.

I mean I think we have to just set something in place for -- not me because it's not me, but three to five years of something that's pretty dramatic and say we have to take this seriously. This isn't -- you know. It's a flaw, that part of this flaw has given us enormous volume increases that are not easily -- I think as Bob was saying, not all well explained by clinical need. If you can highlight those as well as the geographic, that's even better. I don't know what's feasible technically.

I mean you can even put -- you could even say we're going to incentivize Medicare patients to get all

their most expensive elective surgery in India. Pay them to go. It's much cheaper. People are going to Mexico for their dental care. You know, $200 versus $2,000. I mean there are ways we could really nail costs for three years if we really had to. It wouldn't be popular, but there is no popular solution.

So I don't know whether the right thing to do is say for the next three to five years let's just find ways to cut costs that will minimize harm to beneficiaries and signal that this is not sustainable, so that people get off their complacency and stop moaning that it's all government, bad government, and just say wow, we've got to do something about this because the system is really falling apart.

Otherwise, yeah, it would be nice if we could just say well, eliminate the tax cuts, but that's not in our domain. So you know. End the war in Afghanistan. Those are all nice, but that's just not in our domain.

If people really want us to come up with a solution, I think we should just say here's 3 to 5 years of ways to keep costs $20 billion below what they would otherwise be. You pick. None of them are good. But meanwhile, the goal is by the year 6 to 10 people are moving

into these much better payment systems.

So anyway, good luck, everybody.

[Laughter.]

MR. BUTLER: So I think your strongest argument, which I know you agree with, is that the model doesn't make any sense. You know. You can't take one for the team at the national level. You can't even do it within a four-person office sometimes.

And I think you should reiterate it applies not only to Part B spending but any of the components of Medicare. It just doesn't align individual behavior.

So now if I get bolder in thinking though, I think Congress, if I were them, and I don't plan to be, I'd think they'd expect or would think that MedPAC can begin to grow to be something in between what it is today and what IPAB would do. And I think they want to see a set of recommendations that addresses the national spending a little bit more than just the unit prices that we do in March and some reform ideas that we put on the table in June.

So in a way, this is just a thought, on the spot kind of, but if you took what we do in March and more

explicitly said: Okay, here are the contributions that the unit prices are making, and we're also making some other recommendations. And here are the contributions on the volume side we think these are making. And by the way, here is the aggregate spending for this service.

Just to put it in front of them and say this is the aggregate Part A hospital, this is the hospice. And assemble it in a way that kind of draws more attention to the aggregate spending for each of the services we're making recommendations on as well as the volume recommendations.

And then I realize you get to episodes or ACOs, and they cross silos, but there may be a clever way to kind of being to more explicitly say what those are contributing to the national spending. And you're somehow getting closer to kind of us taking responsibility for the total budget as opposed to just the unit pricing.

And really, if you were to start over, you probably wouldn't say well, we were so fixated on this March and June report, and what's in one and what's in the other. Now we're redefining what our congressional responsibility is. I realize that, but if I were to think out of the box I would try to go a little more in that direction, if that

makes sense.

DR. STUART: I really like Ron's terminology. Let's write it off.

And the reason I say that is that I think there are two issues here. Glenn, you said well, there's no way that Medicare is going to be able to come up with cost savings equal to $300 billion over 10 years. It's actually worse than that because this thing grows. And the $300 billion is based upon a flat, you know, is based upon no increase, and we know there are going to be increases. So writing it off is the realistic thing to do.

Now the irony is that it's going to be easier to write it off the bigger it gets because then it's going to become obvious that there is no solution that is going to handle that particular thing. Now that doesn't make the debt go away. It just simply means that we have to be realistic about what the long-term debt is.

And if you look at the actuaries', at the trustees' report, you know they've got two lines. One that says current law, and the other one says well, let's bite the SGR bullet and just recognize that the debt is there.

I guess I like the idea of these contingent

tradeoffs, but I'd do that really quickly because I think if we go too much longer on this people are going to say: Well, you know, there's no contingency here. We're just going to have to write it off anyway. And so what are we giving up?

So then we get back into the question of having some realistic ways of constraining growth, and I don't have answers to that, but I really look forward the conversations that we're going to have around. And I'd just separate those two issues. I'd write off the SGR, have a realistic debt estimate and then really pay attention to constraining growth.

DR. BAICKER: Yeah, I think we're all agreed that the behavioral response one might hope for in physicians, where they foresee a drop in prices so they rein in their volume, is not going to operate at the aggregate level. There's just a mismatch between individual choices and then the effect on payments through this aggregate system. So it fails on that front.

And then the question is did it succeed -- and this is a rhetorical question. Did it succeed on the fiscal discipline front of exerting a cudgel because it keeps

getting worse and worse?

So there's a strong incentive to fix it now, and we've seen the patchwork solutions. And the counterfactual of what would it have looked like in the absence of the SGR, we're just not sure. It's possible that it could have been much, much worse.

But on the other hand, there's this real cost in provider uncertainty that we know is an increasing burden as the cycle gets shorter and shorter.

And I'd argue there's another cost in terms of successful budgeting in that when forced to forecast things based on a known fiction it distorts the estimates of the costs and budgetary score of all the other things that we talk about that interact with the physician system. And then there are alternative policy baselines that assume that the SGR doesn't hold any -- it really just muddies the water, and I think ties our hands, or hampers our ability to do accurate forecasting and planning across the program.

So those are two real costs that come at a potential benefit of exerting some impossible to measure fiscal discipline. It doesn't seem like that's a great -- that it's been very successful on either of the measures.

So I would be happy to see it changed along those lines.

MR. ARMSTRONG: Glenn, just briefly, I would affirm that we should write it off, or whatever it is we do, and look to design a different system.

I think your points about the timing and how our timing and the realities of our national budget -- I don't know how to reconcile that -- as well as some of our other agendas should be thought through.

At least a one-year update, but you know, I think a one-year is short. And I think we ought to ask whether it makes more sense to look more like 18 to 24 months, frankly.

And then finally, redundant to many points made, but I would just affirm too that to the degree this sets us up to look at ways of applying to this part of our payment policy. A lot of the concepts that we've been talking about in these other agendas, like breaking down the silos between different parts of a care system that should work more like a system and focusing on population health and maybe investing more aggressively in some of these areas because we know there's a return that accrues in other parts of our system, to the degree we can use this to really think in those terms, I think it would be potentially very, very

valuable.

DR. BORMAN: I would agree with the groundswell for elimination of the SGR. I think the point that was made by some folks who used be here a lot, that it was sort of linking it to the common man, if you will, through the GDP, the average taxpayer, the worker who had to increase his or her productivity, was a well-intentioned idea. But I think that the nature, as has been pointed out, doesn't get to the individual to make that point. And the formulaic nature of it prevents it from being useful.

Medical practice is changing every day and at a pace like change in all of our society, that's accelerating, and the change in medical practice will outpace the ability to update any formula that we create. So I would agree with Bob. I've moved away some from thinking about other formulas just because I think this horse -- as a colleague of mine says, this train has left the station.

And there are so many things that we'd like to do that I'm not sure we can even do, given the way that people practice coming out of medical school and residency now. So I think that formulas are not going to get us anywhere.

I do believe that a minimum of two years may be in

fact better because I think about the effects on the VA health care system, for example, by a one-year appropriation process. And while this isn't exactly the same thing, it gives me great pause to think about a system having to recalibrate even on an annual basis when the stakes are so high.

I think Mitra's point actually, about ensuring that the renewal comes in a timely fashion as opposed to the crisis, is absolutely important. So for example, a two-year system in which the renewal is six months before the expiration might in fact start to get us there.

I think in terms of some of the tradeoffs that it's time for the physician community to go back and actively work, and it's an unpopular message. And I have taken some potshots, and I'm sure Ron and Tom have as well, about one of the tradeoffs here is physicians can no longer ignore being fiscally accountable, at least to some degree.

I would argue that we're not the only people who are fiscally accountable, but that we need to undertake some fiscal accountability and that we have been insular about this, and we need to do better. And that should be one of the -- philosophically, there's a tradeoff.

I do think that another potential tradeoff on the tradeoff list is trying to push more quickly even for more limited electronic solutions. I think that things that save money that don't take a lot of nurturing and fooling with are better. And I think if we just had a simple system where you knew right away that the patient you're seeing just had a CBC two days ago, or a chest x-ray three weeks ago, would be a huge advantage.

And can we not devise some flash drive or CD or something that somebody takes with them out of every visit that at least starts to reap those savings as opposed to waiting for the perfect compliant electronic system? I'm not sure, but that's a place that's almost automated savings if we could make it work by eliminating those duplications.

And then my last point would be that I think there's -- as we've highlighted in the benefit design discussion, I think also while we take it to the physician community to say let's be more fiscally accountable, we need, our beneficiaries need to understand better what their benefits are. Whether it's that simple little table about deductibles and co-insurance, whether it's the public service announcements, that there's one a night that is

about home health and what your deductible and co-pay, or whatever, there's got to be a way to utilize various communications, media to get those messages out there better because ignorance on the part of our beneficiaries is also hurting the system in a very tangible way.

So I think that there are things to be undertaken by everybody, but I think that the elimination and at least a two-year time horizon for one or two cycles is probably a reasonable way to go.

MR. HACKBARTH: Cristina, Kevin, anything you want to say or ask?

MS. BOCCUTI: No. It's good discussion.

MR. HACKBARTH: Okay. Mark? Good.

Okay. Thank you and more on this soon.

So we are to our last presentation of the day on private sector payment rates for physician and hospital services.

MR. ZARABOZO: Good afternoon. In the interest of time, July and I are going to try to do this very quickly, so we'll be deleting a lot of information that we otherwise would have presented.

MR. HACKBARTH: Yes, and thank you, Carlos and

Julie, for helping us with our time crunch. We appreciate it.

MR. ZARABOZO: We are here to discuss the work we've been doing on private sector payment rates. The last presentation on this topic was in November. Today we'll provide additional information on variation in physician payments across areas and by type of service.

In addition, we'll present our preliminary findings on the variation in private sector hospital payments across areas, and we'll illustrate a possible method for looking at variation in hospital payments within a given area. All of our results continue to be preliminary and subject to change.

This slide serves as a reminder of why we have undertaken an examination of private payer rates. Our results so far have been consistent with the literature and with other studies of private payer rates. Generally, each study shows wide variation in payments across areas and within areas, even after adjusting for factors such as case-mix and differing costs in an area.

Our eventual goal is to understand the causes for this variation, and from a Medicare point of view, if

private payer prices are viewed as a reference point for determining an appropriate level of Medicare payments, what should the relationship be between private sector rates and Medicare rates? The answer depends on what the private sector price is and how that price was arrived at.

If, for example, the source of variation in private payments is the market power of insurers or providers, what does this mean for Medicare payment policy?

This is the outline of our presentation, which we'll skip, and we'll just do directly to telling you what we found.

We'll begin by looking at a slide that shows one way of looking at the variation in payment rates across areas. To review our methodology, for physician services we use a market basket of services that includes the majority of services, and we determined payments by HCPCS, adjusted by a geographic adjustment factor in each area.

This gives us a relative index for each area. On the left half of this slide under physician payments, you see that the index values range from 0.73 to 2.2. That is, the area with the lowest value has prices that are 73 percent of the national average level of payments, and the

2.2 area has prices that are 220 percent of the national average.

These two index values show that the area with the highest payment rates at 2.2 has payments that are 3 times the lowest area at 0.73. If you remove the lowest and highest index values for physician services, the ratio of the highest to lowest remains close to 3, at 2.8.

For hospital services, we see that after removing the single highest and lowest index value, there is a four-fold difference between the lowest and highest payments. The methodology that we use to arrive at average hospital payments in an area yields a severity-adjusted, wage index-adjusted average per stay payment in each area that is compared to the adjusted national average across all metropolitan areas.

You will note that we provide results for only 344 metropolitan areas for hospital payments while we show 432 metro areas for physician payments. For the hospital side, although we start with 432 areas, we only used areas in which there were over 200 hospital stays. The number 432 exceeds the number of metropolitan statistical areas in the United States because we are separating out metropolitan

divisions and we are dividing up multi-state metropolitan statistical areas into single state portions of such areas. We're also excluding Maryland from the data as an all-payer state for hospital services.

In November, you saw a slide like this one showing the variation in physician payments across areas. Here we're showing the same data but weighted by the overall population in an area. The highest bar in this bar graph shows that about 30 percent of the population in metropolitan areas resides in areas where the payment rates for physician services are between 95 and 105 percent of the national average. There are no areas below 0.7 and 11 percent of the population is in areas where the index value is greater than or equal to 1.2 -- that is, payments at or above 120 percent of the national average level of payments.

The last figure, 11 percent, contrasts with the hospital results where we see that 16 percent of the population resides in areas in which hospital payments are at or over 120 percent of the national average payment level compared to the 11 percent for physician services.

Here we see also that a little over 25 percent of the population resides in areas in which hospital payments

are in the 95- to 105-percent range, a smaller share than we saw for physicians at 30 percent in the preceding slide.

As indicated in the preceding slide showing the distribution of relative payments across areas, some areas have relatively high hospital payment rates or high physician payment rates and some areas have low rates. Here we show that the two do not always travel together; that is, an area with high hospital payments can have low physician payments, for example, or vice versa.

This is a collapsed version of a table in your mailing material that included a greater number of intervals, but this table illustrates the general points.

On the diagonal in the dark-shaded boxes, you see areas in which both the physician payment levels and the hospital payment levels are in the same general range, which is a total of 41 percent of areas and 45 percent of the population.

With respect to other types of areas, comparing the low end and the high end of payments, it is more likely that both physician and hospital payments are low in an area, which is the under 90 percent, the first dark-shaded area, as opposed to both being high, which is the lower

right-hand corner where 8 percent of the areas and 5 percent of the population are areas where both the hospitals and physicians are relatively high payment areas.

This slide provides information about the variation in physician payments based on our examination of the data by type of service. Among the services with the highest variation are endoscopy, lab tests, and imaging for heart conditions. We see the lowest variation in anesthesia, offices visits, and influenza immunizations. For endoscopy-bronchoscopy, the area at the 90th percentile of the average payments has payments that are almost 4 times as high as those in the area of the 10th percentile of average payments. In the case of the administration of the flu vaccine, the ratio is less than 1.5. However, as we noted in the mailing material, there can still be very high payments in flu vaccine administration in some areas in spite of the small variation across the country.

This slide is a revised version of the variation in physician payments that we presented the last time we talked about private payer issues. The slide shows PPO payment rates for a mid-level office visit in different markets along with the number of claims in each area for the

service. Each area has at least 25,000 claims for the HCPCS code.

We've also checked the data against other data to ensure that this represents differences in payments across providers rather than only differences because there are multiple insurers. The data for the markets that we show here are consistent with what we know about these markets.

In Miami, for example, the first area shown, where physicians are less likely to practice in large groups, we see that payments are relatively low in general, and the median payment is quite low. Boston has a somewhat higher median payment with wide variation, and Milwaukee has a very high median payment with some degree of variation.

Among the markets shown, the greatest variation is in the San Jose area, even though it is the area with the fewest claims for this service among the areas shown.

The next slide that we will display presents new information that was not including in your mailing material. However, before proceeding to the next slide, we should talk about the nature of the data that we are using. Our data are claims data for the year 2008 from MarketScan, a product of Thomson Reuters. It is a data set containing claims data

of primarily self-insured plans from insurers and administrators voluntarily providing data. The contributing entities can vary from one year to another. We do not know the identity of the contributing insurers and administrators, and we also do not know the identity of the providers. This makes it difficult to determine the extent of intra-area variation.

We noted in the mailing material that the data are geographically skewed towards the South, a point that we discussed in connection with the distribution of HMO claims in the data as compared to the distribution of HMO enrollment in some states. Therefore, we may have an issue as to whether or not we have a representative sample of claims in each area that we look at.

In this slide we're using one possible method of showing potential intra-market -- that is, within market variation in payment rates for a specific inpatient hospital service using the DRG for major lower extremity joint replacement, one of the most common procedures in the private payer data.

We took the top ten metropolitan areas and numbers of such procedures, and we are displaying four of the areas

here. Looking at the specific DRG is somewhat similar to looking at a particular HCPCS code, as we did in the preceding slide on physician payments. However, it is not exactly the same because HCPCS codes are universally used for physician payment. While the DRG-based payment is one possible arrangement that can exist between a hospital and an insurer, other possible arrangements include per diem payments or discounts off of charges, for example.

With that caveat and with our caveat about whether we have a representative sample in each geographic area, this slide shows the extent of variation between markets and across markets in the payment for this service. The highest median payment is for the Virginia portion of the Washington, D.C., metropolitan area, with the other areas having lower medians that are closer to each other. However, the widest range of payments is in Los Angeles and Chicago. Although we've stated several caveats, these dollar figures are internally consistent with the overall MarketScan data in that the average national payment for this DRG is about $22,000 across metropolitan areas. Given the level of the DRG weight for this particular DRG, the $22,000 figure is also consistent with the figure that we

included in the mailing material as the national average adjusted per discharge payment for all discharges across metropolitan areas.

It is likely that a couple of our Commissioners have intimate knowledge of one or two of these hospital markets and can comment on whether these data are consistent with their knowledge of the markets.

We are continuing to check our data for anomalies, and we intend to sort out the limitations in the data that we talked about, such as which areas may have non-representative samples based on the number of covered lives including in the MarketScan data in each geographic area.

We invite your comments on our methodology and the issues that we have raised. The next major task in our work is to gather information about the market conditions in each geographic area and examine the relationship between market factors and payment rates and spending, including using a case study approach to look more carefully at specific areas.

Thank you and we look forward to your questions. And I cleared this with Mark already: We will only take questions that can be answered yes, no, or no opinion.

[Laughter.]

MR. HACKBARTH: Okay. In the interest of time, we'll do just one round again. Let me start with a clarifying question. Would you put up Slide 9, please? I'm just trying to wrap my mind around this. Let's focus on Boston. Of these markets, it's the one I'm most familiar with, although my knowledge is dated. So the n here is 37,300. That's 37,000 claims for --

MR. ZARABOZO: For this particular HCPCS, mid-level.

MR. HACKBARTH: Yes, this particular service.

MR. ZARABOZO: 99214.

MR. HACKBARTH: And then we have a distribution of the payment rates for that particular service indicated by the yellow line. Now, there aren't that many different insurers in Boston.

MR. ZARABOZO: Well, see, that's one of our points here, that we believe this shows variation among providers in the payments that they received, which, of course, is also what the attorney general showed about Boston. You have a lot of variation.

DR. KANE: [off microphone] In Boston they could

show you the variation within one insurer across providers, so that is very -- and it was pretty significant.

MR. HACKBARTH: And so this particular one, this particular graph captures the variation in the payment rates, which is a function of both the number of different providers and the different rates for each provider and the number of insurers.

MR. ZARABOZO: That's correct.

MR. HACKBARTH: A combination of the two.

MR. ZARABOZO: But, again, we believe a lot of this, looking at some other data, is due to variation among providers.

MR. HACKBARTH: Providers. Yeah, okay. Got it.

So, let's see. Which side are we on to start?

DR. BORMAN: It's a very elegant analysis. I'm not smart enough to question you about it, Carlos

MR. HACKBARTH: Okay.

MR. ARMSTRONG: So I'm not smart enough to avoid asking probably a dumb question, but on page 52 of the report, you show --

MR. ZARABOZO: Do we have 52 pages?

MR. ARMSTRONG: I'm sorry. Page 22.

DR. BORMAN: Good beginning.

MR. ARMSTRONG: I'm easily overwhelmed with small numbers, actually.

[Laughter.]

MR. ARMSTRONG: But I look at this, and if I read it correctly, my sense is that private insurers are paying a lot in markets that I tend to think of as being low-cost Medicare markets, and the inverse. Am I crazy or is there some reason for seeing that?

MR. ZARABOZO: I'll answer the "am I crazy" first, and I have no opinion on that.

[Laughter.]

MR. ARMSTRONG: Thank you. Good answer.

MR. ZARABOZO: But, no, you're correct, this is -- in fact, I think Mike has looked at this, the inverse sort of relationship between -- these are the low Medicare utilization areas. They are also, as -- this is what we're showing. It's also what the GAO showed based on the 2001 data, that, for example, Wisconsin, a lot of areas in Wisconsin are very high. Unit prices is what we're talking -- again, we're talking unit prices here.

MR. ARMSTRONG: And so part of the work that we're

teeing up to go forward would be to try to understand why that is. Is that correct?

MR. ZARABOZO: Right.

MR. ARMSTRONG: Okay.

DR. BAICKER: I had a quick question on Slide 7 and the corresponding table. I had a hard time looking at that, integrating what I would expect to see if there were a high correlation versus a low correlation given that the cut points are somewhat arbitrary, not uniform across. So it would be nice to see it in a way that it's easier to --

MR. ZARABOZO: Yeah, the mailing material has --

DR. BAICKER: Had thinner slices, but non--

MR. ZARABOZO: Right, thinner slices.

DR. BAICKER: But they weren't populated in uniform ways. You could have a summary slide that showed the correlations in different quartiles versus the spending percentiles which don't slice the distribution evenly. I just had a harder time doing the math to figure out what I should expect to see if there were no correlation versus yes correlation, how I'd expect the percentiles to be distributed given that the distribution wasn't sliced in uniform tranches.

MR. HACKBARTH: [off microphone] yes/no/no opinion question for the economists in the group to address as we go around. Is this pattern of prices consistent with the existence of a competitive marketplace for these services?

DR. MARK MILLER: Not so easy, huh?

[Laughter.]

DR. CHERNEW: It depends what you think about the input price variation. So what you haven't done here is you don't have like the weight --

MR. HACKBARTH: Focus on the intra-market variation.

DR. CHERNEW: So the intra-market variation part generally would not be, unless you thought there were big quality differences or you thought there was a lot of noise in the data, because you could -- how you measure the prices, there's going to be -- a lot of this is going to be noise in there, and so you have to decide how much of it's really noise and how much of it's quality and heterogeneity of things. But the obvious general answer is this is awfully big to try and explain it away with those kind of explanations.

DR. BAICKER: But then the --

MR. HACKBARTH: [off microphone].

DR. CHERNEW: This is a longer discussion that is probably more dull, but in the claims data, you could have five claims for the same service, and then it turns out one was a reconciliation claim, and so you don't -- I don't know how you've dealt with all that yet, but in our data, for example, we find huge amounts of noise because it's not just one claims that's just clear, oh, that was the MRI.

DR. BAICKER: And also, you want to distinguish between competitive markets on the provider side versus the insurer side. There are two different problems floating around in these markets.

MR. HACKBARTH: Focused on the provider side.

DR. STUART: But that doesn't lead to an expectation of heterogeneity in terms of hospitals versus physicians. I think this is what you're suggesting. Would you expect in competitive markets that you would have -- you know, that they'd be below the mean or the median and in noncompetitive markets they'd be above the median? But there's no particular reason to presume, and we don't know -- and I think this is what Carlos is suggesting as his next step, is do we have a measure of competitiveness that looks

at both physicians and hospitals?

MR. HACKBARTH: I want to totally disrupt the flow. You will have another shot when we get around to you.

MR. BUTLER: Two questions. One, not from this, but the stunning thing when I read the chapter was the California, which did take into account the costs, the input prices, if you will, and showed a $5,000 difference per cost per stay compared to the rest of the nation. I'm curious why you didn't put that up here. That was such a major deviation. I would just...

MR. ZARABOZO: No reason.

MR. BUTLER: Okay.

[Laughter.]

MR. BUTLER: All right. Then go back to Slide 10, which gets close to home. And I liked your qualifier. I thought I was listening to a drug ad on TV on the side effects. You know, be wary of this and that.

[Laughter.]

MR. BUTLER: I had a little bit of the same question now. Is it a weak insurer that is that top tenth -- you know, you say, in my market, yeah, they're those insurers that are hanging on. There are some that just, you

know, almost billed charges. And I know the answer is -- it's more of a provider variation than insurance variation.

MR. ZARABOZO: Well, see, we're still not sure, particularly on the hospital side. We're kind of just starting to look at the hospital data in this manner. So we're not sure exactly what is happening here.

MR. BUTLER: It would be nice to have kind of a consolidation index or something like that for insurers and providers and somehow compare it to prices, so that if you have, say, a Blue Cross plan that has two-thirds of the market, or whatever it is, you know, does that have an impact or not?

MR. ZARABOZO: Which is exactly what we intend to do.

MR. BUTLER: That's where you're headed, okay.

The other is would your guess be that the mean -- you know, it would be either good to see the percentiles or the means as well, because, you know, I could say, well, in Los Angeles the top decile's way out there, but if the mean is still sitting down below everybody else, you know, you'd say, well, I don't know. A totally different conclusion.

MR. ZARABOZO: I have the means. I don't have the

wherewithal, though. No, the Chicago mean is $24,000, the wage index adjusted; Los Angeles, $23,300.

MR. BUTLER: Because those two pull up about the D.C. area, and --

MR. ZARABOZO: Yes, D.C., Virginia. The mean in D.C. is $24,400. So the means are very close except in Seattle, where it's $20,500.

MR. BUTLER: But who wants to go there, Scott.

[Laughter.]

MR. BUTLER: All right.

DR. KANE: I guess one of the things that might be hard when you try to measure market power is that it's not just consolidation. There can be brand issues, so --

MR. ZARABOZO: Which we mention in the mailing material about --

DR. KANE: Yeah, I guess I'm getting to how do you measure that. I think case studies or getting to know a market pretty deeply is the only way that you could figure that out. Anyway, this does not -- none of this is surprising to me, of course, but -- and didn't we have a study earlier that said something like 60 percent of MSAs had non-competitive markets by some metric? There was some

-- and leading up to some of this, we had some earlier stuff about the level of competition among markets, and we basically found that they were pretty highly consolidated and increasingly consolidating over time. So, you know, we know these markets aren't wildly competitive.

Then there's all these other ways hospitals distinguish themselves perfectly logically around their -- you know, whatever they advertise and whatever their brand is. So I think you can assume these aren't the most competitive markets that you've ever seen. And I don't know how much -- I'm not sure where you want to go with it, though, I guess is one question, is that you want to say that the hospitals are able to raise their prices to wherever they want, some of them? I mean, I'm not sure where you're going with this in terms of what are the implications for Medicare.

MR. HACKBARTH: Yeah, well, in fact, that's what I'm trying to get people to address and think about. Step one for me is to characterize what we found, and then step two would be to say, okay, what are the policy options for dealing with what we've found. And I'm not an economist, but this doesn't look like my Econ. 101 textbook description

of what a competitive market looks like.

Now, surely there may be some data issues, some noise issues, and I'm not qualified to comment on that. But I suspect that this is, you know, the flashing light that says, hey, policies that are based on the premise of competitive markets of these services, don't assume that, and so we then need to think about what policies to deal with non-competitive markets.

DR. KANE: Okay, so -- I'm sorry. Go ahead, Peter.

MR. BUTLER: I can't resist. Chicago, a quick comment. It's incredibly competitive. There are a hundred hospitals. The largest market share is like 13 percent. So the consolidation -- it could be the brand that gets the prices, but that doesn't mean it's not competitive. It's just -- it's on a different --

DR. KANE: It's on different attributes than cost.

MR. BUTLER: Different attributes than we're talking about.

DR. KANE: Yeah, and I think that's what -- it's on different attributes than cost.

DR. STUART: Really quick, the Health System

Change work in some but not all of these areas I think is something you really want to look at. That's going to give you a nice comparison of some of the competitive issues and how those have changed over time. And so it might be useful to look at those regions.

DR. KANE: Say in Boston, it's not just the hospitals' position, but it's how many primary care docs that also controls. So we have a couple systems that really control. You have to take their prices because you can't go without their doctors. So there is this joint physician-hospital effect that you have to put together, and that's why I think, you know, you're going to be better off with sort of case studies than trying --

DR. STUART: You've got some of that in Ginsburg's work [off microphone].

DR. KANE: You've got it everywhere, yeah -- I mean, so it's not just the hospitals separately from the docs. If you have a controlling market share in the physicians, particularly the ones with the primary care docs, you can dictate a lot of your prices because, otherwise, patients don't have access to the most -- you can't get access to most of the primary care docs. So I

think it's just hard to define, you know, where the nature of the non-competitiveness is coming from.

DR. BERENSON: Yeah, maybe I missed it in your oral presentation. I can't find it in the written. I'm just asking a sort of methodologic issue or just an issue about MarketScan. It talks about primarily self-insured employer plans. I guess my question is: How representative across hospitals -- let's pick hospitals in this one -- would those discharges be? I mean, do we think that they are sort of representing the range of hospital stays in the market? Or are they skewed towards a certain -- I guess I don't know what this median means. You know what I'm saying, what I'm asking?

MR. ZARABOZO: Yeah. I'm not sure about that issue, whether self-insured employers might be different in some way than -- I kind of think not because it's through the insurers --

DR. BERENSON: So we think this is as good as we can get, is sort of a median for all the admissions in that community?

MR. ZARABOZO: Well, yeah -- no, and what we're looking at, we're trying to look at probably is how many

covered lives are we talking about in the MarketScan data compared to the number of insured people under 65 in a given area. So we're trying to get a feel for whether it could be considered representative or not in that market.

DR. STUART: Just really quick, they're big employers, and they tend to be national employers. And so to the extent that if you look at an area that is where the employment is primarily in smaller firms, then it's going to be less representative.

DR. BERENSON: Yeah, I mean, the point I guess I'd make -- I mean, you made reference to the HSC studies. I did the one on Los Angeles, and I would have thought the -- well, there's huge variations that I witnessed in prices in Los Angeles, but I don't know to what extent this is -- I'm surprised that it's that low given what I know about the market, that the median is that low. So I don't know that you have the answer, but an issue is how representative of the market is the MarketScan data.

MR. ZARABOZO: Yeah, and, again, the average is like two other areas.

DR. BERENSON: Yeah. And the other thing I have, just to make the point, you emphasize on the physician side

that we define payment rate as the allowed payment for a particular service by a plan. That's not necessarily what the payment is to the physician who's able to be out of network and is balance billing, right?

MR. ZARABOZO: Right, but it looks like we see very little balance billing going on. Most of the claims that we see are shown as network claims.

DR. BERENSON: Oh, is that right?

MR. ZARABOZO: Yeah.

DR. BERENSON: Because I was trying to explain why Bethesda, Maryland, Arlington, Alexandria, and Washington are showing up as seemingly the least -- the lowest level of payment, and I also know there's a lot of out-of-network care going on here. But you don't think that's going on, that there's low fee schedules but maybe high actually payments to physicians.

MR. ZARABOZO: We don't seem to be seeing that. I mean, I would have expected that actually for the Washington market just on my personal experience in the Washington market.

DR. BERENSON: Yeah, no, exactly. So, okay, you don't think this data is being distorted by a growing number

of docs who go out of network. You think this is in network. Most of the services --

MR. ZARABOZO: It appears to be mostly in network, yeah.

DR. BERENSON: Okay. I appreciate that. Thanks.

DR. MARK MILLER: Just one that if [off microphone] it's out of network, it would have been caught by this data?

MR. ZARABOZO: Yes, it would be shown as out of network. It would be paid as an out-of-network claim, and so we would only show the insurer payment. The balance billing we would not be including if the numbers were in here. So some of the --

DR. BERENSON: So what kind of rates do you see of out-of-network -- I mean, sort of ball park. Is it in the 5- to 10-percent range or the 20-percent range?

MR. ZARABOZO: I can't tell you.

DR. CASTELLANOS: Slide 9, please. We're going to focus in on Miami for a second. Unfortunately, I live 125 miles from Miami -- or maybe fortunately. I had talked to John Bertko about this. Miami is a very heavily penetrated PPO market, and it has an excess amount of physicians. So

when they're talking about fees, they're negotiating contract fees somewhere around 80 or 78 percent of the Medicare fee.

Now, let me give you some reasons about what's happened. Obviously, they came across to our coast and wanted to give me 78 percent, and they said, "Take it or leave it." What did the physician do? I joined a large integrated group. And if they want to have my contract, now they have to pay the large integrated contract. And the group that I have controls the radiation therapy. I don't own radiation therapy. But if they want that person in that pool, they have to pay my rates. So that's a thing that physicians do. Okay? But this is what the insurance company does, and you can see the consolidation. What happens is -- I mean, they're big guys, and even John Bertko agreed it to me. He said, "Yeah, if we can pay 78 percent, that's what we're going to do. We're not going to pay them 100 percent."

Now, there's another point I wanted to make. Since there's such low reimbursement in Miami, I'm not saying it does, but does that account perhaps for some of the unusual behavior we see there?

[Pause.]

You know, I'm just mentioning it. That's all. I'm not suggesting that.

Now, the other one that I -- one other point. We talked about knees in Fort Myers and knees in Miami, and we said, okay, why is there such a discrepancy? Because it's really the same age group, same -- and, I mean, the reason is that I think that in a managed care program those orthopedic patients never get to the orthopod. They're treated predominantly by the medical doctor and treated conservatively, as in Fort Myers perhaps they get to the orthopedic doctor. That was just a -- you know, we tried to look at what the heck is going on, and that was one of the -- one of the orthopods mentioned that to me.

MR. GEORGE MILLER: Yes, on the same slide, my question is: Could you differentiate or tell if during the stratification if the hospitals were part of a system they got the higher payments or, conversely, if they were part of a GPO? Did you do that type of analysis?

MR. ZARABOZO: We are not able to identify the provider.

MR. GEORGE MILLER: Okay. All right. SO there's

no way to tell -- okay. You answered that question.

Then on the physician, I guess I know the answer to that question as well.

MR. ZARABOZO: The only way would be to look at an area where we are certain that, you know, if, for example, there's only one system in a area, like an MSA, let's say, then we know yes, it's a one-system situation based just on the area that the claims are coming from.

MR. GEORGE MILLER: Well, this data seems to me, at least to me, to refute the argument that a hospital system and the market could determine the price with this wide variation. They're so dominant they could determine the price from a --

MR. HACKBARTH: Determine their price [off microphone] and then the others that are weaker --

MR. GEORGE MILLER: Well, we don't know that because -- how large this data is, that if they're able to -- because they are part of a system to determine the price from the insurer and beat the insurer up and get a larger price. At least from this data the way I'm reading the data.

MR. HACKBARTH: I'm not sure I'm following,

George. So there's variation.

MR. GEORGE MILLER: Right.

MR. HACKBARTH: Some are getting high prices, some are getting low prices. The fact that there is variation is consistent with the hypothesis that those with market power can exact a higher price than others. It doesn't prove the hypothesis, but it's consistent with that hypothesis.

MR. GEORGE MILLER: It doesn't prove it.

DR. BERENSON: Yeah, and a related point is at least in our findings at Health System Change, multi-hospital systems are actually crossing geographic areas. They're using -- I mean, like Sutter Health, which we wrote about, has 27 hospitals, but not, you know, one or two within San Francisco. They're using a strategy that gives them an ability to negotiate high across markets. And so that's not a traditional sort of market power consolidation antitrust issue, but it is a negotiating strategy.

MR. GEORGE MILLER: I would agree. I was at three different systems in Texas, and the one that I was in in one particular city, because of the power of the system, I got much better prices than when I was a small independent. And the insurance said, "This is what we're going to pay" -- the

insurer said, "This is what we're going to pay. Take it or leave it, or we can ship all of your patients 60 miles away."

DR. CHERNEW: A few quick things. The first one is there's measures of hospital competition which are generally easy to construct, although this discussion we just had illustrates they're still hard to construct. But at least you can measure hospitals by system using AHA data. It doesn't say anything about competition in the market. I will say that competition is kind of a loose word. We really mean market structure. And who knows how they behave? So the theory, you know, you could have a lot of providers and have them collude or have them compete. But, in general, a competitive market would suggest that any price variation was explained by some quality variation where quality could be broadly defined. Clinical quality, you care about the reputation so that is one, tell my friends that I went to whatever hospital, or amenity quality or locational quality, or there's some other thing that describes the price variation in that there's some sort of competition.

My general view based on other things like the

attorney general's report is you don't have to look at this data to infer that there's not a lot of competition in the classic economic sense across the markets, and I think this confirms that.

The second point I would say is related to the question that Bob was asking about this. In the data, a lot of these weak insurers aren't in there. This is large firms that have sort of big administrative -- so this is not a small insurer in the individual market and now I'm being charged a really high price. This is mostly I'm a large firm, I have an administrative services contract with probably a big insurer that has a PPO. That generally is what I think would be in here, although I'm not sure that's completely what's in here.

MR. HACKBARTH: Some of it may be attributable to large national firms, but only having a small number of employees in the market. So it's a big company, but they don't have much leverage in that market because it's --

DR. CHERNEW: Yeah, but they would usually leverage off of the leverage of who is their admin -- so say you were using Aetna as your -- right. It would be Aetna's leverage because you would be using their network and their

prices. And even if you only had a relatively small number of people in that market, if Aetna had a lot of other people in the market and their PPO, it would typically be their leverage.

MR. HACKBARTH: Right

DR. CHERNEW: That's how it would generally work. But I think that to answer the question, there's going to be a ton of noise in this for just data claims noise, non-generalizable data noise. So if the point was to make sort of -- whenever you put a number up there, like Milwaukee, or pick Miami, you know, I don't think it's coincidental that Peter picked Chicago and, you know, when Glenn mentioned Boston, Nancy jumped in, and Ron mentions Miami right away. It's very difficult to look at a particular one, so you could learn from case studies, I agree completely. But the advantage of this is to look systematically across all of them and understand patterns in the data. And I do think the value is to come to some conclusion about the determinants of how prices vary. It may be related to Medicare or Medicaid prices or a whole series of other things. And that does tell us -- not directly it doesn't drive policy, but I do think it tells us something about how

we will feel later when we think about, say, competitive strategies and what happens if we make -- you know, if we unleash the power of millions of Medicare beneficiaries to get the right care, that type of phrasing of what you think would happen does rely on competition. You wouldn't want to say we're going to release the power of a ton of people to get the right cable rates always, you know? So there are competition issues, and I do think this speaks to it, but I think it's very hard to put up a report card because of all the data problems and say look how much higher the prices are in this city versus that city. But I do believe the general empirical regularities are probably telling you something despite the noise, and the within-market variation I think is much, much noisier than the between-market variation, although the between-market variation also has problems because you might not have all the hospitals in there, they might not be equally weighted, there might be a small set of employers, so it might be the employers in Los Angeles or a certain type of employer, and they have different things. There's case-mix issues here, so maybe an employer is paying a higher price because of the case-mix thing that's going on.

So there's all kinds of issues, but I think the general pictures are informative, if not definitive.

MR. HACKBARTH: I think a question for us, which I am absolutely not the right person to answer, is, you know, how far to go down this track of mining the data, analyzing the data, cutting it different ways, pursuing that path, not versus but the other path is the case study work that Health System Change has done, Bob and Paul Ginsburg's work. You know, there's a pretty clear picture, I think, developing. In fact, you also talk to insurers and you hear the same thing that, boy, these markets are working in a different way that isn't necessarily competitive as the term is usually understood. You know, how far do we have to go to document that reality?

DR. CHERNEW: Right [off microphone].

MR. HACKBARTH: Yeah.

DR. CHERNEW: I agree with that, so I think this is useful and a lot can be learned in doing this. But if you have -- obviously there's a lot of other things that people could do, and so I find this interesting work, as you know, for a bunch of reasons, and I think you guys have done a very good job. And I'm surprised how much I learned

knowing this well, even when I sit here and listen to what you've done. So I think that part is great, and I think MedPAC has a level of authority that's useful, so I think that's useful. But I wouldn't go and do this as a broad -- you know, you're going to get what you need out of the work that you're doing, and I would definitely recommend continuing to push forward. You know, I'm not sure how much further I would go beyond what you've outlined your next steps were.

DR. MARK MILLER: We've had these conversations, this exact conversation internally, and part of it is we want to keep putting things in front of you and getting reactions, and particularly if you have some specialized expertise, by bending this data, and so here's the way the conversation goes. When we started this -- and, Peter, you know, this is just your exchange a minute ago, is the idea could you construct this data set, feel that the data is relatively stable, let's pretend we're at that point, and then start asking the question of could you measure consolidation and provider strength and insurer strength using various metrics, you know, the standard consolidation measures but also things like are there ways to look at

things like branding and that type of thing.

In a perfect world, you would have 400, 300-plus observations, have a gigantic regression, and go, look, these kinds of measures of consolidation seem to move prices by this much. But if the data turn out to be too noisy to do that and the difficulty of how do I capture branding instead of consolidation, then the retreat -- and, of course, their argument was we should do this because this involves site visits, and they could go out of the office -- was to say, Do you go through the data identifying this is what I think Mike is saying in so many words? There are eight patterns, six patterns, and it will not be as clean as that, but just for the sake of discussion, eight patterns, and then those are the markets that you go to, do the case study, and come back and say, okay, I talked to everybody with red hair and everybody with black hair and here's what we found.

And so I think we're pushing the data out to get your reaction, and if it collapses and we can't do the gigantic regression, which, you know, we may not, then we do the case study approach.

DR. CHERNEW: But if you do just the case studies

and didn't do any of this work at all, then we'd go around the table and people would say, yeah, but that's one place and people just said it and you took a sample of folks. So I actually really do believe, as you said, there is some real value in being able to blend some of this work, as imperfect as it is, some of the case studies, as imperfect as it is, to come up with a conclusion, which, again, I don't think you are going to want to hang your hat on. We need to go into -- you don't want to go over to Justice and say, look, there's something wrong in Milwaukee, or whatever it happens to be. But I do when we have discussions about payment, ACOs, competitive strategies, I think the collection of evidence that you're building will end up being invaluable towards guiding that discussion because a lot of what's going to go on, I think, as we go forward, is going to have to do with a fundamental belief about how well you -- and I mean us collectively -- think markets can work in certain policy options. And my experience has been there is a wide variation in people's beliefs about that subject, some of which is informed by data and some of which is informed by something about their childhood. And so the data side is useful.

MS. BEHROOZI: It's late and we all want to go home. I'm really tired and in over my head, but I can't stop myself, mostly because of something Mike said. It figures.

Talking about how employers who are getting their benefits through an insurer might end up paying more, in a lot of cases, I mean, we rent networks, right? And those networks may have bargaining power with providers, but I don't know that we've talked about this. There's also the thing about how they can pass along their costs. That's another factor. We find that mostly the networks that we contract with don't have a lot of incentive to control the prices that they're paying providers because the people who come to them, like us, are unable to directly contract because we don't have enough density. And, yeah, they want to maximize their profit, but they can also pass along the extra cost to us.

So when you see them paying a higher rate, they may very well be the biggest game in town and they could squeeze the provider for a tighter rate, but they don't have a lot of incentive to. And that might be changing, as employers, as people, you know, the exchanges, whatever,

start collecting the purchasing power of those who are purchasing insurance. But the market power of the insurance company cuts two ways, and one of the examples that I'm thinking of is Maine, where there's like really dominant insurers, and I don't see them anywhere on the list of, you know, below 90th percentile or whatever. But we do know -- I mean, I know from the SEIU experience that those workers who are covered by those policies in Maine are worried about the tax threshold under PPACA because their policies are so expensive because of the insurer market power. So it seems to have cut that direction, not against the providers. So that might be a reason to actually look at a market and say here is a market where you have, you know, provider concentration or you have insurer concentration and let's see what's happen here, rather than just using the data to draw you to a conclusion about the concentration because it might not actually play out that way.

DR. CHERNEW: And, remember, the Blues have had historically relationships with providers and there's nonprofit/for-profit issues going on. So there's a lot you could do if you really wanted to understand all that's going on in particular areas.

MR. HACKBARTH: Well, you know, I have a strong sense that this is a really important topic, and I see it lurking just beneath the surface or maybe even poking its head above the surface in a number of key policy areas: you know, that market power is a key issue related to whether there's cost shifting and the degree of cost shifting; market power is a big point of conversation around ACOs, where you hear private insurers and employer purchasers, you know, really reacting nervously to that because their experience is these markets are already concentrated and they're having difficulty dealing with powerful providers and even more of that is frightening to them.

It's an issue that lurks just beneath the surface in all schemes, whether it's PPACA or in premium support in Medicare that depend on competition among private plans to hold down costs. So this is really important stuff to understand, but it's really hard at the same time. So that's my last word.

Thank you, Carlos and Julie, and we will now have our public comment period.

So before you begin, let me just review the rules. Please begin by identifying yourself and your organization

and keep your comments to no more than two minutes. When this red light comes back on, that will signify the end of your two minutes.

MR. ZANETTI: Okay. My name is Cole Zanetti. I'm a fourth-year medical student from Texas, and I'm representing AACOM.

I have two things I just wanted to ask a question about. I wanted to get the opinion and how the Committee also intends on addressing issues of monitoring supply-sensitive care variation and also providing incentives for shared decision-making models of care and how that ties into potential payment models.

MR. HACKBARTH: So if you want to engage in a conversation about those issues, what I'd suggest that you be in contact with our staff and do it that way. Okay?

MR. ZANETTI: Okay. Thank you.

MR. HACKBARTH: We welcome your interest.

DR. MARK MILLER: Yeah, we do welcome that.

Ariel, can you make sure that he gets your card?

MS. MCILRATH: Sharon McIlrath. I'll make it quick.

Just because the $731 million that came up in the context of the redistribution from the RUC, that is, a lot of is when they look at the work values they also then are looking again at what practice expense is built in. So if something previously took a fluoroscopy room and now that's mobile, then the equipment, that price changes in the practice's expense. So some of it is money that just flowed automatically due to the work value changes, but a lot of it is where they actually relooked at something.

And then to say also that the RUC is happy to look at any time data that anybody comes up with. For several years now, they have a subcommittee that has looked at criteria for what the time data would need to look at, or look like. It's not as easy as you might think. There are a lot of the things that are done so infrequently that there is no way you can find the people that do them unless you go through the specialties.

So what they have tried to do, and what maybe you may have other suggestions for ways to do this part of it, but they have tried to standardize a lot of things, so that when the specialty comes in there's a pre-service package, and everybody, that's what you get. I mean you can make an

appeal that you get something different than that, but that's already set in stone. So that takes a lot of the variation out of it.

There's a lot of back and forth. It is hard for somebody to come in now, much harder than it used to be, and argue for something that most people wouldn't think was reasonable.

And then the other thing is that because you really will have to limit the number of things that you're looking at, because you just can't go out and find them all in some random survey, you might want to be thinking of some generic things that you would want to look at, such things as Dr. Berenson mentioned where something has become automated over time. And certainly, the RUC staff would be and the members would be happy to talk to people about that.

And then finally, I just want to get on my horse here about the budget neutrality again. If you are going to have something that's left as the residue of the SGR and you're going to talk about having the Secretary take all the screens that the RUC is already taking, like whatever is growing fast, go back and look at new technology, all of those things, and then you have the Secretary competing for

that money as savings to the RUC trying to redistribute it within the system, I think at the very least you need to remember that the system is budget neutral at the top too.

So yes, you can have a law and regulation piece that is built in there where you try to recognize the things that have, built in, raised the expenditures, that physicians had no control over. But you better include coverage decisions on a lot of things that didn't get included in the SGR because if you have new coverage for macular degeneration and you expect the system to simply absorb that -- but then you want to take all the savings that somebody finds where okay, now something can be done more quickly than it used to be done and so we could probably reduce the value on that, but you're not going to let it be redistributed -- you're just constantly pushing down the system and expecting it to absorb everything.

MR. HACKBARTH: All right. Thank you, and we're adjourned until tomorrow morning at 8:30.

[Whereupon, at 5:59 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, April 8, 2011.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, April 8, 2011
8:35 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
ROBERT BERENSON, MD, FACP, Vice Chair
SCOTT ARMSTRONG, MBA
KATHERINE BAICKER, PhD
MITRA BEHROOZI, JD
PETER W. BUTLER, MHSA
RONALD D. CASTELLANOS, MD
MICHAEL CHERNEW, PhD
THOMAS M. DEAN, MD
JENNIE CHIN HANSEN, RN, MSN, FAAN
NANCY M. KANE, DBA
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
BRUCE STUART, PhD
CORI UCCELLO, FSA, MAAA, MPP

AGENDA PAGE

P R O C E E D I N G S [8:35 a.m.]

MR. HACKBARTH: So our first session today, we have two guests on rural patient care systems. Jeff, will you do the introductions?

DR. STENSLAND: Sure.

Good morning. As you know, MedPAC is in the middle of a Congressionally mandated study of rural health care. Over the next year, we'll be discussing access to care, quality of care, as well as Medicare payments and costs. The study is due in June of 2012.

Today we are lucky to have two leaders in rural health care organizations to come speak with us. But before I introduce them, I want to clarify a question from our 2011 discussion of access in rural areas and volumes of services in rural areas.

In February, we showed you this slide, and it indicated that urban areas had 10.1 office visits per beneficiary and there was a similar level in rural areas. This is true for micropolitan areas, which are counties with a town of 10,000, and for less populated rural areas, including those that are adjacent to an urban area or even rural counties that are not adjacent to an urban area and do

not have a town of 10,000.

Service volumes are even similar for frontier counties, which we define as an area with a population density of six or fewer people per square mile. While there's wide regional variation, the rural and urban service volumes were similar.

However, there was a concern at the meeting that a mean of 10 visits per beneficiary sounded quite high. And you also asked whether some of the outliers possibly were driving the mean upward. So today we bring you a breakdown of the distribution of visits.

As we show on this slide, the median is slightly lower the mean at between seven and eight visits per person, but the distribution is very similar across urban, rural, and even frontier areas. Finally, a median of eight visits and a mean of 10 may still appear large, so we made a few comparisons and found our numbers were similar to the literature. For example, Mia Pham, in a 2007 New England Journal article, found that among patients in her sample, beneficiaries saw a median of seven physicians in 2,000. This is seven different physicians, which could easily equate to 10 visits.

Leighton Chan, in a 2006 Journal of Rural Health study of five states found an average of between nine and 10 claims per beneficiary. Dr. Chan did not include rural health or FQHC visits, so his numbers may slightly underestimate the full volume of rural beneficiary visits.

More recently, there's an IOM panel looking at regional variation, as led by Joe Newhouse. Last month, they released CMS data on E&M visits for the over-65 population. They found an average of 12 E&M service events per person per year. Their number is slightly different than ours because, again, they didn't include RHC or FQHC visits. But they did include visits in the hospital and visits in nursing homes. That's why maybe they're at 12 and we're at 10.

So that's a long way of saying that if you look at the literature or the recent IOM work, you'll see similar levels of physicians visits per capita that we show in our data.

So we've talked about the level of care and the volume of visits in rural areas but the real point of today's meeting is to learn from some folks on the ground who are leading the effort to serve rural beneficiaries.

This is really a follow to our discussion at least February's meeting. In February, some of you asked us how large systems reach out into rural areas.

We are lucky enough to have Bruce Hamory share his experiences with us. Dr. Hamory leads Geisinger's efforts to extend its innovations in health care delivery and payments to other groups and health systems. Prior to his current physician, Dr. Hamory was Geisinger's systems chief medical officer for 10 years, where he led the growth of a 535 physician multispecialty group practice into a 750 physician multispecialty group practice in 40 locations serving 41 counties and three Geisinger hospitals in rural Pennsylvania. He will talk about how his system serves the Medicare beneficiaries in the hills of Pennsylvania.

But not all rural health care is delivered by large systems. Much of the good care in rural areas is provided by smaller organizations. Today we are also fortunate enough to have Jim Long from Hettinger, North Dakota. Mr. Long is a CPA, a hospital administrator and CEO of the West River Health Services, which is an integrated physician practice, hospital, and EMS service in Southwestern North Dakota.

Jim has a long history of serving his community and was kind enough to host the MedPAC staff when we went out to visit him a couple of years ago. We were very impressed with his ability to serve a wide geographic area with a small, cohesive medical staff of 23 providers, including physician assistants and nurse practitioners.

So intentionally, we brought you leaders from two very different systems today to talk to you about how they serve their communities. Mr. Long has about 23 providers who operate out of Hettinger, North Dakota, a town of 1,300 people. In contrast, Dr. Hamory's Geisinger system has more than 1,300 people on its clinical staff. So in terms of scale, they're very different.

But in terms of important aspects, I think they're similar. They're both integrated organizations. They both have tightly coordinated physician staffs, hospitals, and even emergency transportation to the hospital.

And I think what's very important is they both have a strategy for serving their communities and a cohesive system for executing that strategy. Those are two characteristics that aren't universal.

After Dr. Hamory and Mr. Long give their

presentations, we will have an hour for discussion. So now I will turn it over to the speakers.

Dr. Hamory, will you lead us off?

DR. HAMORY: Good morning. I want to thank the Commissioners for the opportunity to talk a little bit about how Geisinger has, over the last 12 years, really worked to develop a systematic regional approach to the delivery of health care that, believe it or not, does not depend on owning all the pieces. It does depend on concerted effort, some planning, and a very robust IT system, as I will show you.

So just briefly, the outline, a little bit about Geisinger so you understand who we are, a brief discussion of the geography and demographics, a little bit about how we support rural hospitals, use of IT, telemedicine, coordination of care, an example of an ST segment MI program that allows us to helicopter people in from considerable differences and still achieve a first medical contact to balloon time of under 90 minutes. And then a couple of the high level implications for this.

So we always start with a slide, Mrs. Geisinger founded our organization 97 years ago and she told the first

physician, Dr. Foss there on the right, to make her hospital at that time the best. But she put in her deed of trust that the purpose was to care for the working man and his family. And so we have taken that for a number of years to mean devote attention to population-based health care. In fact, Dr. Foss, in his I think second annual report to the board in about 1916, reported that at that time Geisinger had served patients from every county in Pennsylvania.

This is our conceptual set up. We have provider facilities. Our largest, Geisinger Medical Center, which is now almost 500 beds, is located in a town of 5,000 people. We employ 7,500 people at that location. We have 350 physicians, outpatient and inpatient, at that facility in a county of 17,000 people. So about one doctor for every 48 residents of the county. That does not include 350 residents and fellows in training.

Up in a more urban area, in the Scranton/Wilkes-Barre area, we have a smaller hospital, Geisinger Wyoming Valley. And then, as you see below that, a chemical dependency treatment center, ambulatory surgery. We are doing currently almost 50,000 admissions to both hospitals, a combined total of about 100,000 emergency room visits, and

so forth.

Physician group is now 860 physicians with just under 500 nurse practitioners and PAs. We run 37 primary care sites. They range in size from one doc in a PA to 19 physicians and five or six nurse practitioners and PAs. They are located in towns that range from about 700 residents up to a place like State College that has, without the university, probably 20,000 and with Penn State probably close to 60,000.

You see the outpatient visits. We are fortunate in that, as part of our organization, we have a health plan, Geisinger Health Plan. That health plan is currently a little over 260,000 members, of which almost 50,000 are Medicare Advantage patients.

They also have an extensive network of many contracted non-Geisinger doctors, 110 non-Geisinger hospitals. And so we have an area of overlap which my chief, Dr. Steele, calls the sweet spot in which the group practice and our hospitals provide care -- 28 percent of their care comes from the health plan, 28 percent of our business. We care for about 50 percent of the health plan's patients.

So we have about 130,000 people for whom we have complete clinical and financial data. We know all their care. And so, based on that number, we can do estimates of efficiency and cost reduction and all that.

In addition, we participated in the PGP demo for five years and will be part of the going forward of that.

We have invested heavily in an electronic health record, beginning in 1996, fully integrated, available everywhere our doctors work, including the roughly 25 specialty outreach sites that occur in doctor's offices and smaller hospitals throughout the region. It has a major patient portal and I will tell you the rate of use of that portal is just as frequent among our Medicare beneficiaries as it is among our 30-year-old ladies. Age does not appear to be a factor in that.

We allow about 2,600 non-Geisinger physicians read-only access into that, with patient permission, and only for the patient's records for whom they have cared and referred to us.

For the last five years, I'll show you some data on a regional health information exchange which has used AHRQ money to establish and been facilitated by FCC grants

to improve fiber optic cable access to smaller hospitals and clinics. And so we are very grateful to our Federal Government for those opportunities.

In addition, in the last year-and-a-half, we have begun an electronic ICU program, initially served our two hospitals and is now extended to some other, smaller hospitals as a way to permit them to retain appropriate patients in their facilities without the usually Friday afternoon transfers to Geisinger when the surgeon or the internist who is managing their care wants to go out of town.

We have been awarded a Beacon Community, and I'll show you a minute about that, and a lot of recognition.

This is the IT history. I'm not going to go into it. It basically shows the different phases.

I will just mention, off to the right, that a data warehouse, which combines clinical data, financial data from both the providers and the health plan, has been a major enabler of our ability to rapidly identify patients in need of care, diabetics, women who have not had a mammogram within a relevant period. For example, a year-and-a-half ago we identified 100,000 patient who had not had a tetanus

shot in 10 years. That's fixed. We use it as a way to get our immunization rates for flu and pneumococcal vaccine in our high risk elderly up to about 85 percent by pulling them in.

This is our geography. Philadelphia is down to the right, Pittsburgh off to the left. This is a mountainous area. We are in the middle of the Appalachian Mountains and the Poconos. You see, in yellow the various primary care sites, in red -- and the yellow also means that they are up on primary medical home. All 35 of our primary care sites are accredited as Level 3 medical homes by NCQA.

This service area is approximately 21,000 square miles, the area outlined in white is the provider area. It has a population of 2.3 million, of which 405,000 are Medicare beneficiaries, 422,00 are Medicaid recipients. We serve, you know, a number of those people. Overall, about one-third of the residents in our service area see a Geisinger doctor every year. So we believe we can have a substantial impact on population health.

We work with three major hubs, two of which are hospitals. There are two stars off to the right, Geisinger Wyoming Valley or GWV; and Geisinger South Wilkes-Barre, or

GSWB. That South Wilkes-Barre site has now been converted to an ambulatory center and an outpatient surgery unit because it is five miles away from GWV. So we've consolidated, closed some beds, and done more regionalization there.

This is the Keystone Health Information Exchange Network in yellow. The Beacon community is immediately around Geisinger. It's five counties. That is committed to reducing the proportion of Medicare beneficiaries admitted for congestive failure and readmitted. The other red dots are other hospitals in Pennsylvania. You can see the sparseness of the dots in our area. We have no counties that meet a frontier designation. We have several that are designated as rural, and only a few that would meet the designation of being in an around a metropolitan area. Wilkes-Barre/Scranton standard metropolitan statistical area is about 1.1 million, I think.

This shows KeyHIE. Basically, this information exchange includes data from 10 hospitals -- only two are ours -- 15 other organizations that include other hospitals, private clinics, skilled care and home health agencies, and long-term care.

The goals are here, to provide clinical information in a timely way, eliminate duplication, analyze data to identify gaps in care, as I've mentioned, and provide interoperability of data between the various systems that these organizations use.

Telemedicine, I think you have heard testimony on before. We have begun to use this fairly extensively, and particularly in the middle two bullets: integration of clinical data to support telemedicine, and to facilitate consultation between primary care doctors and specialists.

The barriers you know about. The services are generally not covered by payers, including you all. We recognize that all payers are concerned about cost control for non-face-to-face visits and physician billing.

However, I would comment that, at least in our place, in our state, there is a requirement for a doctor at each end. That does not help this. If you can have a PA or a nurse practitioner, who is a competent clinician, at the referring end, and a physician at the receiving end, that would assist this process. Our state is not a major advocate for telemedicine at this time which, with the new administration, will probably remain true.

So we believe, as my boss has said, that we are there to provide best care closest to home. Our goal is not -- not, to bring everybody into a Geisinger hospital. Our physicians admit to 15 small hospitals that are not Geisinger and they account, in the aggregate, for 10,566 admissions last year, in many of those hospitals 50 to 60 percent of total admissions, and a significant volume of surgery and deliveries. So the goal is to keep the care out if it can be done safety.

Now as a side note, we have also been party to closing a hospital that we thought was dangerous and ultimately the state agreed. So there is some element of maintaining standard of care here.

These are the telehealth services we provide: TeleEcho for children, 23 off-campus sites, immediately review of trauma CT to four other hospitals, immediate review by moving images to the neurologist or neurosurgeon's home, for CT monitoring for stroke. It allows a decision as to whether or not the patient can be managed with a protocol at the local facility or needs to be transferred to Geisinger for urgent intervention, either neurosurgical or interventional radiology.

External maternal fetal monitoring, we do have a Level 3 nursery and three or four maternal fetal medicine people. TeleEEG, TeleUltrasound, TeleEcho, and now e-ICU, which extends to two non-Geisinger hospitals and there are several more in negotiation for that. And that, you know, that is a billed service. Many of the rest of these are supported at the local hospital end by their technical fees and at our end by the professional fee.

I will tell you that a substantial amount of the stroke business, for example, does not result in a transfer to Geisinger.

These are the pediatric sub-specialty services that are provided off our campus. Our pediatric sub-specialists ride a circuit to 10 outlying sites, doctor's offices and smaller hospitals. I still don't understand how our chief of pediatrics gets them on the road. We have eight pediatric neurologists and eight pediatric GI people and six pediatric cardiologists, and on and on. And they ride a circuit. They will spend sometimes three or three-and-a-half hours getting out to a place to see a full clinic of patients in that subspecialty who need attention but don't need to have mom pack everybody in the car and drive

three-and-a-half hours to see us.

These are the medical specialties provided onsite at smaller organizations or smaller institutions. And we provide hospitalist services. The two top there, GMC and GWV, are our own institutions. The two others, one is in State College. The other is in a smaller town south of State College. We provide the hospitalist services under contract which allows, at least at Lewistown, that hospital to retain primary care doctors who do not want to be on call at night for hospital patients.

We provide OB/GYN services, do deliveries at four non-Geisinger hospitals, and have continued to do GYN surgery of certain types at hospitals where they have closed their obstetric units because of low volumes and high malpractice. That business has been moved either to Geisinger or a larger facility. What we've done is have our GYN folks go out there and do surgery, where it can be done safely, as a way to support the economics of that hospital.

Surgery, we do these kinds of things at other hospitals, similar principle.

Our lab people provide backup support to 50 sites, I think they are all hospitals, in our area for specialized

testing, things other than routine chemistries. We are currently doing telepathology between both our hospitals and for one rural, non-Geisinger hospital where, with the current technology, our pathologist can read the surgical slides to make sure somebody has gotten the margins clear for breast cancer biopsy, for example, or a lump removal. And that, we believe, will extend.

Coumadin Clinic, we've been running for a number of years six sites where we have pharmacist-managed protocols for patients on Coumadin which, as you know, is a dangerous drug. They have spectacular results, very low rates of complication, very high rates of compliance of the patient. I have been a beneficiary of those services myself and can tell you it works very well.

I will tell you, nobody wants to pay for that service and hopefully, as the new anticoagulants come into more widespread use it may not be that dangerous, that need may go away. But for now, that's an issue. We've maintained that because it does improve patient care, it is a benefit for our communities and our staff. Doctors do not manage Coumadin well, as the literature would say.

The STEMI Program, which I want to spend a minute

on, is a regional program started by our cardiology groups and our emergency medicine people based on a program that I think Abbott Northwestern in Minneapolis put out. The goal is to reduce the first medical contact to balloon time to less than 90 minutes, which is the national standard for patient hitting the emergency room to cath lab and balloon dilated in the coronary artery. The cardiology people basically say every minute is more myocardium.

So this was done by creating a network of hospitals and trained EMTs so that if an ambulance that goes out into a community or a farm, when they do an EKG, if they see ST segment elevation, they can call from the ambulance to our transport center -- and we have five helicopters out and around. I'll show you where they are in a minute. That helicopter will meet that ambulance either at the nearest hospital or the nearest high school football field, pick the patient up and bring them to Geisinger, one of our hospitals. When the helicopter is dispatched, the cath team comes in, they're called. So they generally have a helicopter flight -- if it's a near pickup from outside and comes in, maybe half an hour, 35 minutes. And the cath team literally meets the patient at the helicopter pad, and I'll

show you the times.

So this is the network, the heart in the middle is Geisinger Medical Center, right on the bank of the Susquehanna River, high up enough that we don't get flooded, by the way. And then the red dots are where the four outlying helicopters are found. You see in the blue, that's a 15 minute flight time each way. In the red it's about a 23 minute. So if you're in State College and somebody has to be picked up around there, it might take you under an hour to get out a little from State College, do the pickup, and get back.

The numbers that you have on your slides are incorrect, and I apologize for that. I had a correction come in from one of the cardiologists who runs this. These are the correct numbers. What I want to show you is that over this several years, the time for pickup to balloon at Geisinger has improved from just under three hours to under 90 minutes. And 52 percent of all those patients met a 90-minute goal in the most recent calendar year. National databases generally cite 10 to 20 percent of patients, from the time they hit the emergency room door to balloon dilated, about 10 to 20 percent of patients hit that.

So you see, even if you're helicoptered in, we're better than that. And if you come directly to our ED which, of course, is a smaller area, generally about a 20 mile radius, that percent is 95 percent. Town of 5,000 people. Now, big medical center, right? Lot of people. And I think that's a problem in that one of the smaller hospitals has an interventional cath lab but the technician that staffs that lives 40 miles away, so their response times are not nearly this rapid.

This is data from our health plan that compares the HEDIS criteria in 2009, so standard assessment, standard data, of our clinic mainly in purple there in the middle column, versus the panel physicians in terms of the use -- this demonstrates the use of teams, primary medical home, IT. The point is that health plan, in 2009, was number three in the national Medicare rankings and number seven or eight in the commercial. So well-ranked health plan in virtually every category, the group practice is statistically significantly higher than the community physicians the overall area, largely related to systems of care and reliability in care delivery.

Medical home, which we run in 35 -- in our primary

care sites, eight non-Geisinger practices. 14 percent decrease in total discharges for Medicare beneficiaries, 22 percent total Medicare decrease in Medicare readmissions, 7 percent sustained decrease in cost trend, 95 percent confidence intervals are now minus 3 percent to minus 12 percent. That data will be published. It's for your internal use. I would not cite it yet. The statisticians are massaging but they've analyzed it two different ways and they say it comes out the same.

So we think the implications are that an integrated motivated delivery system can support rural health care and can do it in a beneficial, meaningful way, deliver high quality care in combination with hospitals that are in the community and not owned and doctors who are not employed.

Many of the small rural hospitals in our area will need to reconfigure and repurpose. They are all losing money, all of them. And some, because of the ability of transportation and the lack of ability to recruit doctors into those communities. The biggest problem we've got in our area is that, according to the physician relicensure data about three years ago, at that time 30 percent of the

non-Geisinger primary care doctors in our area were already over 62. So if the stock market keeps going up, we have a real public health problem.

Now as you see, Geisinger has been very successful. We recruited 25 primary care folks last year. We are able to recruit and to continue to provide services. But we are not going to be able to recruit enough or fast enough to replace 30 percent of the primary care doctors in 35 counties. It won't happen.

So we're going to have to rely more on mid-level practitioners who support primary care physicians. And we have systematically tried to go down a path of divulging care from the doctor to the nurse practitioner, to the medical assistant, use protocols, use electronic reminders and monitoring, and have the doctor focus on the patient and family relationship and interaction and the difficult diagnostic and treatment decisions.

If you just have to write prescription refills, I mean we can do a lot of that electronically and send it to the pharmacy. If you need to manage hypertension or even simple congestive failure, a nurse or PA can do that with a protocol, and do.

But the hospitals probably will need to repurpose into emergency rooms, ambulatory surgical units, maybe a few beds for observation or perhaps an urgent deliver, although as you know changes in obstetrical care -- not pertinent to Medicare, of course, have meant that you can now predict which kids are going to need pediatric heart surgery, pediatric surgery of some other kind. And those deliveries are now elective and scheduled. So the day, when I trained, of somebody being helicoptered into Denton Cooley or Dr. Debakey or somebody with an unknown congenital heart defect are basically gone.

Last, a robust interactive health information network is essential for this. I think that one of the things that we're grateful about is that countries recognized this in terms of its investment. It will need to be continually supported by payment because one of the things we've learned, that I suspect many of you know, is that this is not plumbing. You do not put this in and walk away from it. It requires maintenance. It requires upgrading. The state of medical knowledge changes and needs to be put into that. Physicians and nurses need to review current practice and improve it. So it is a continuous

process. It takes energy. It takes time.

So with that, I appreciate the attention of the Commissioners and opportunity to present.

Thank you.

MR. LONG: Good morning. I might need a little help with your machine here first.

DR. STENSLAND: Get you to the show here.

MR. LONG: Thank you. Well, the Geisinger system is very impressive, and what I really appreciate, it sounds like they are staying true to their mission.

This is a much smaller version, but this is the service area that we serve, and what I really want you to pay attention to is looking at the populations of the counties and the distances. We are definitely not a suburb. We are not a bedroom community. We are 150 miles from the closest urban center with a whopping population of 61,000. Our home base is 1,300 in our city and 2,200 for our county, and the kind of potato-shaped area there is our service area, which is about 25,000 square miles and maybe has 20,000 people in it, probably less, so less than one person per square mile. When people talk about rural and frontier, frontier is even considered six people per square mile. We

consider ourselves wilderness.

[Laughter.]

DR. HARMORY: No trees, but wilderness.

MR. LONG: Yes, we're a little short on trees, too.

And here is just kind of recapping those -- when we were looking at it, the map was kind of busy, is the distances and the populations to different locations. For example, obstetrics, if we weren't there, there would be about a 200-mile gap at least on one direction and 300-mile gap the other direction to the next obstetric provider.

This is our home community. Hettinger is 1,300. Our home county is 2,200. This is where it started, and as your comment about trees, I don't see any.

[Laughter.]

MR. LONG: Then I threw in this just for a little historical. Our community has existed in the 1920s as we are today, typical, proud rural people enjoying the Midwestern way of life. We are really known for our pheasants. North Dakota is the second highest producer of pheasants for hunting of the nation. And this is the other thing we are known for. It is a little cold and a little

snowy in our neck of the woods.

Our organization, we are a hospital. We have a 25-bed critical access hospital. We have ICU and obstetrics. We deliver about 100 babies a year, and one of our doctors has delivered in excess of 5,000 babies and we think he's between 5,500 and 6,000 at the present, and he's soon to retire. Medical clinics, six medical clinics of which five of them are Rural Health Clinics. Then we have a foot and ankle clinic for podiatry and an eye clinic for optometrists.

We also are closely connected to a Federally Qualified Health Center out of Isabel, South Dakota, and so our medical staff supervises those mid-levels in four locations and that's -- two of the locations are -- well, one is 50, one is 75, one is 100, and the other is 120 miles away from us. We also provide staffing to two family planning clinics in the area that are operated by the Community Action Program.

We operate the EMS service that serves the residents of Adams County, plus we provide intercepts for area ambulances and both ambulance units and first responder units. Our physicians serve as the medical advisors to all

but one of those area services.

And so I just want to really make the point is that there is some concern about CAHs and close with ambulances and competitors. We have no competitors. We all work together. I cringe at the day that any of those close, because who is going to cover it? That's a difficult question.

We also operate a nursing home with skilled beds as well as basic care beds, assisted living unit. Our home health agency had to close because we could not make it under the Federal reimbursement system, but we do have the option under Rural Health Clinics for a visiting nurse program, so that's what we've installed as the option, and so when it comes to home care, we have probably a 100-mile stretch in our area that we can't reach and no other home care services reach, as well. So it's just not available. We operate a home medical equipment service. We have a wellness center.

And my number there where I said that we believe we meet 80 percent of our patient needs for 50 percent of the dollars was back when we had a health network. We contracted with Blue Cross-Blue Shield. We had a tertiary

care system as a subcontractor to us, and so we had good numbers on the total health care dollars of those patients, and that's where I got the 80 and 20 and 50-50 at the time. Since that time, that tertiary center decided they didn't want to be a subcontractor, they were going to be the prime contractor, and so I don't have that quite as readily available as I did before.

I talked about our medical staff. As you can see, primary care-driven system, with probably right in saying that 30 percent of our medical staff are approaching retirement and recruiting is a bear. This is the people, and as you can tell, there are some youngsters in the group and there are some oldsters in the group, so a blend, and we've kind of recruited from all over. Initially when the practice was in its early years, they were all through the University of North Dakota, but no more. We are about -- about a third, I would say, is University of North Dakota and the rest of them, we've recruited from elsewhere, including one from Canada.

This is the hospital as was originally constructed in 1950. It had 26 beds on the upper level and the lower level was the nursing home and other support services. The

back wing was the emergency room and a little surgery room.

By the late 1960s, you can see it's developed to be a fair amount different. By that time, the beds have been expanded with that additional wing to a total of 46 beds, and on the upper right is the clinic building, and that was the start of moving the system to being more integrated. The nursing home beds were given up and a facility was constructed up above. That's the top-level facility. I have a laser. I was not using it because I was scared of getting it in somebody's eyes. But as you're pointing that way, maybe I can -- but the nursing home is right up in there, and the clinic is up there, and then that's the addition where added the additional beds and also a new surgery area in the lower level of that.

And, of course, the interesting thing about the -- we had the nursing home, is in order to -- there was only 16 beds in the lower level and moved up there. That was an 88-bed facility that was constructed and it was by another provider, so it was no longer integrated to the system. And then three years ago, we bought it back, so now it is integrated as well as the clinic is all integrated to our system now.

And this is the facility as it existed after an 1982 project, which was supposed to work us a little bit more towards more ambulatory care as well as really updating those patient rooms that were built in 1950, which, as you would imagine, do not meet current standards.

And then here we've just recently completed our project, really worked to push the ambulatory care model. This is the new addition right in all this area here, and then a remodeling on the lower level of the existing building as well as other areas, too, as to put the high-traffic services all within easy walking distance, all on one level, at the ease for our elderly patients, which is the bulk of our patient population.

We are quite proud. Our addition cost $9 million and I thought, what a horrible, terrible amount of money to spend. But as I have compared with other facilities and they said, well, they went with a replacement facility and have spent $50 and $60 million, I think that we just got a heck of a deal.

What makes me proud and thankful -- we have a very supportive community, proud to support a staff. We have what I consider is a high level of care in a very rural

environment. Give a little plug to Dr. Gerry Sailer, the physician who came in the early 1960s who really helped orchestrate and was the visionary for creating our medical system. And, of course, I'm proud of the organization and the opportunity to be part of it. And I think it's quite incredible, what the organization has been able to do in a very small community by committed and dedicated people.

I have things that keep me awake at night. I fear that primary care is being eliminated, and it's really through our medical schools, is that doctors are saying, well, I can go into primary care and, hmm, I don't make much money. I go just a few more years, man alive, that's the big bucks, and they are just bypassing primary care right and left. I'm happy to hear that even the large systems are having a heck of a time recruiting primary care physicians because we are really having a devil of a time.

And I worry, as I had mentioned earlier in a slide about we are providing 80 percent of the care for 50 percent of the dollars, well, if the subspecialty care was 20 percent and taking over 50, what if it becomes 100 percent? Is that going to be 300 or 400 percent cost? So I worry about where it's going.

And I fear that the government believes that primary care physicians can be replaced with mid-levels, and I appreciated the comment that says, well, increasing the use of mid-levels but still understanding they still need to be supervised by a physician. They don't have the same level of education and training.

And then elimination of programs and services in rural communities because they can't operate like in an urban center, and I gave the example earlier of home health, is that in rural areas, home health agencies are closing everywhere because too many distances involved. We can't see as many people in a short period of time.

And, of course, I fear on emergency medical services, about them closing. What will happen? Whose responsibility if, like in our area, 50 miles away, an ambulance service closes. Who picks up the slack and how do they pick up the slack? To just cover it from Hettinger is not a good option. If you've got the golden hour, it's going to take that long before you even get there. You need people there. You need volunteers, and it has to be a volunteer-based system because with our sparse populations, you can't employ and have a for-profit-run system in those

areas.

I also worry that the EHR Meaningful Use Incentives established in the Electronic Health Record won't really be there, that it will be portioned out, saying that at our Critical Access Hospitals, well, this portion has to do with Rural Health Clinics. That's not covered. This part has to do with the Visiting Nurse Program. That's not covered. This has to do with the just straight clinic part. This part has to do with obstetrics and we don't have any obstetrics. So by the time it's done, we have already $3 million invested in our computer systems. We are figuring that we will invest another $2 million by the time we're done, and it will all come down and says, well, here's a couple hundred thousand dollars as incentive. So I'm worried about how those, quote, "Meaningful Use Incentives" are actually going to be applied and it's difficult to get an answer.

And I fear of becoming a trap line eliminated by a large subspecialty-driven urban health system, and that's really not because they are bad people, but it just means that our locally-controlled primary care model can't survive, and I think that would be unfortunate.

And I fear that our country's medical system will lose its purpose and mission for health care, and I think the prospective payment system was large in making a lot of systems think like a business, like make profit, high profit, and I think that focus was wrong.

And, of course, like everybody else, I worry about our growing national debt. What I'd like to see Congress do, I'd like to see a payment system to pay fairly and don't make some segments highly lucrative and other things not feasible, and I'll give an example. Under the DRG-PPS system, I felt that primary care kept getting cut at the expense of growing other services. I think we should reward quality and cost-effective providers, and too often, the system rewards those who have been taking advantage of the system. I just read recently the proposal on the Accountable Care Organizations and it says, well, you would use your existing as the base and then as you improved it, get more. It says, well, that's fine if you are a high-cost, low-quality system because now under that system you'll get paid even more. Now, if you are already a low-cost, high-quality system, it's like, oh, okay. Well, thank you. So it doesn't really reward quality and cost-effective

providers.

And then, of course, on the EMS issue is that this thing in the regulations that think in frontier areas that we have competing ambulances needs to be forgotten. That CAH ambulance 35-mile restriction has to be removed or at least modified to say if it's within 35 miles of an urban or for-profit ambulance. Then, I would agree.

And I would also like Congress to understand that true Rural Access Hospitals do not have an economic advantage and they are not profitable. The numbers of the CAHs in North Dakota are dismal, and if you think about it, if 75 percent of your business, the best you can do is break even -- the best -- now, that's because Medicare reimburses 101 percent of recognized and allowable costs, eliminating such things as, well, patient telephones are not necessary. Patient TVs are not necessary. Fundraising services are, of course, not part of the model. Other items that they subtract -- advertising. We advertise that we're putting on a wellness class, we're putting on diabetes education. That's marketing. That's not allowable. So if the best you can do on 75 percent of your business is break even, and then you have a typical ten percent of charity and bad

debts, is that you have 15 percent where you're trying to come out ahead on.

I think I'd like to see Congress support the training of primary care physicians and support continuation of primary care services, especially in rural areas, and for them to consider the United Kingdom model for development of subspecialists. It may sound crazy to you to have a primary care, or a potential specialty physician spend five years in primary care before they would even be eligible to get accepted into a subspecialty program, but I think it would be great service not only to them and the patient to really understand the primary care before they went to another level.

So I'd like to see the clearer incentives and financial assistance of getting Critical Access Hospitals to meaningful use, including the Rural Health Clinics. Protect access of the care for geographically remote Americans. I say Congress understands remote, sparsely populated, frontier and wilderness in Alaska. Well, I believe that very similar situations exist in the Lower 48 and I believe we are proof. In fact, I put on here the note about when the National Rural Health Association had a convention in

Alaska and many of the people took tours and came back and said, you won't believe it, but there are people that live 50 and 100 miles away and there's no hospital for those distances, and so they come to that community where the hospital is at and they stay there until their baby is born before they can go home. Isn't that incredible? And I thought, you should come to North Dakota. It's the same thing. We have the same thing in our area, as well.

So here, I just leave it with my map again, kind of showing you those great distances. Like I said, the obstetrics, if we weren't providing, is that huge differences there. You're talking pretty much 300 miles across throughout the entire works to get to the next OB provider if we weren't there. And so we have great open spaces and it's tough out there.

So with that, I'll leave with just one little cartoon. I probably shouldn't do this one. It says, "Let's leave California, you said. I can't stand the earthquakes, you said. I'm tired of the traffic. I can't stand the pollution. Well, at least in California, it isn't 70 below zero." Well, that's really an exaggeration. Unlike, as some people think we are the frozen tundra, and that's not

true, we typically have about a week to two weeks where it's below zero. But the picture where it shows the post office box or the mailbox and says "The Plains" and you look and there's one house and you don't see anything else, that's true. We've got a lot of distance between light bulbs.

So with that, I end my presentation. Thank you.

MR. HACKBARTH: Well, thank you, both of you, for really terrific presentations.

So what we do is we'll go around the table and give each Commissioner a chance to ask a question, and if time permits, we'll go around some more. I'm going to take the prerogative of asking the first question, and Jim, it's for you. I'm trying to understand a little bit better the issues in physician recruitment and what the issues are for physicians.

So I'm trying to get a feel for how much of it is money, versus issues of lifestyle, versus issues of going to a community where there may be issues about call coverage. Can you help me just sort of understand what the barriers are, and obviously of particular interest is to what extent they can be addressed through our lever, which is payment policy, as opposed to there are conditions that are really

beyond the issue of Medicare payment.

MR. LONG: Okay. It's pretty much all those things, but I'll kind of hit the high ones. Really, regarding call volume or call responsibility, we do compete and that is somewhat of a negative, but we are one of the lucky ones when it comes to most rurals. Most rurals have maybe two or three physicians on their staff, and so by the sharing of call is very burdensome for them. With our number of providers, we, at least, have a reasonable call schedule, so it's attractive from that standpoint if they are interested in the rural lifestyle.

When it comes to money, as I mentioned with our system is that, well, if you're Critical Access Hospitals, where's the margin? And the problem is there is a problem on money and there are places that are getting desperate and are out there offering incredible dollars. The highest I have seen so far for first-year fresh graduate going to a rural location was $290,000, and it was $190,000 guaranteed salary and a $100,000 sign-on bonus. Quite honestly, we can't afford to pay that, and so we can't compete against those kind of numbers. But it's really desperate out there and locations -- there are some rural locations that are

going without a provider. They're using locums, and they're the ones that if it's $300,000 or more to get one, they'll pay it because they're that short. And we're competing against that and there is just an incredible shortage.

Lifestyle, yes, a lot of young people want to be where the bright lights and the action are, and so that lifestyle is a problem with some. It's a plus on others, because rural is typically a very nice place and safe place to raise a family. I have relatives in Dallas, Texas, and they just couldn't believe that we let the kids walk home from school to a house that hasn't been locked all day. That is just a different lifestyle, and if you're raising young kids, some people actually recognize that and take that as a positive. Of course, you know, it's 75 miles to a McDonald's or Wal-Mart for us, but -- so some of the other lifestyle things, we work against.

Did I answer your question?

MR. HACKBARTH: Yes, that's helpful. So what I'm envisioning is that the problem you describe is pretty widespread, and so we have large, or potentially larger and larger areas that have sparser and sparser physician coverage. So my next and related question, then, is could

you just describe a little bit more about how your system deals with the needs of nearby communities -- nearby in the North Dakota sense -- that have lost the ability to have a physician close by? So these people drive to Hettinger to get to you, or do you have physicians, that as Bruce says, go out on the circuit? Could you just describe that relationship?

MR. LONG: Oh, okay, and I probably should have detailed a little bit more about our service area and our satellite sites, because what we do within that area is basically they're within 50 miles of us, each of our satellites. So those are Rural Health Clinics, and we send physicians out there as well as having mid-level practitioners there to provide local service. And then we also work with the Federally Qualified Health Center down in Isabel, so there's a total of four sites there that we also go to, as well, to provide supervision of mid-levels.

We also do the training for EMS for our entire area. We have trained paramedics, EMTs, first responders, not just for Adams County and Hettinger but throughout that entire area. Our doctors all serve as medical advisors to other area nursing homes as well as ambulance services.

And we formed an education consortium about 20 years ago that we kind of pool with the area nursing homes and clinics and other medical providers and to do joint education opportunities, where we figure that rather than the cost of traveling out, we pay to have speakers come in and then host within our service area.

And then we also subsidize some of the local transportation. There is a bus that runs between North and South Dakota, between Hettinger and Lemmon, and we help subsidize the cost of that transportation service, so allowing patients to easier get to us as well as trips back and forth for other purposes. We also provide a subsidy to the other area elderly services on their bus transportation also to assist in providing transportation to our residents.

MR. HACKBARTH: Scott?

MR. ARMSTRONG: First, thank you both. It's really impressive, the systems that you run and the care that you provide to your patients. Thanks for being here.

Bruce, a question for you. You were describing the way you've moved what you refer to as your medical home or a different primary care model into more rural medical centers. Could you just describe a little bit more how you

made that work and how -- I assume those practices are partly involved with your health plan, but only partially, and how you begin to support a primary care practice that's clearly based on different sort of principles and goals.

DR. HARMORY: Well, thank you for that question. Our primary medical home model, of course, is rooted in the chronic care model based at -- developed at Group Health by Dr. Wagner and colleagues, and was started between our health -- as a cooperative effort between our health plan and our provider group. And so it takes a basic -- a primary care site which is redesigned so patients can see their doctor same day or within 24 hours of a request, redesigns care to more routine care away from the physician, installs protocols so that diabetics all get the same stuff done and hypertensives and so forth and so on.

And then on top of that is added an in-clinic nurse case manager. The health plan literally took the nurses out of its call center and moved them into the practice site so that it does several things. That nurse then establishes a personal relationship with the high-risk patients and their families that he or she is responsible for managing, so they answer the phone. I mean, one of the

problems with the call center, as you know from some of the Medicare demonstration projects, is very few of us are willing to answer the phone and start talking about a bunch of medical care issues with the disembodied voice of somebody we've never met. And, in fact, early in the PGP demo, we could never get more than ten percent of the congestive heart failure patients to answer the phone, let alone call us every day or every other day and report a weight.

So the health plan moved those people out and they actually employ them, and the reason for that was so that the doctors would not start using those people as office nurses to do blood pressures and all that. Their job is focused on patients identified through data analysis as high risk and any Medicare patient admitted to the hospital.

Now, that model then was established in our employed groups. It was moved by the health plan to eight of their contracted primary care sites with large Medicare populations, and the health plan, of course, has an MA program. Geisinger Clinic has been participating with the PGP demo, and so we're able to support part of this through the shared savings of the PGP demo because we hit all the

quality metrics.

The third example is that the governor of Pennsylvania, Governor Rendell, about five years ago began to set up some regional projects to improve primary care home. There is one down in Philly. There's another up in the northeastern part of our geography which is an all-payer model and in which the Geisinger model of the embedded case manager has been employed.

And so we have seen repeatedly the same results in decreased utilization and improved patient satisfaction and family satisfaction, and early in the process when some of our sites were up on medical home, others were not, we actually had instances of patients transferring from one to the other because the word of mouth said, you're getting more help over here. So we've seen the same process repeatedly. We see the same in the analyses of medical home versus non-medical home, and we will see what happens in the all-payer model. So that's the difference.

MR. ARMSTRONG: So you moved a nurse into the medical centers. Did you change the payment arrangements for the providers themselves?

DR. HARMORY: Yes, key point. We did. Dr.

Gilfillan, who was the head of our health plan at the time and who is a primary care doctor by background, said he did not want this to fail for lack of money. So we do provide a monthly stipend for the doctors. It ranges according to how many patients they care for. The purpose of that stipend is to get them to do three things.

One is to be available to the patient when they need to be seen.

Secondly is to attend a monthly meeting where the case manager, all the doctors, the nurses, the front office staff get together with a lady who brings in all the data about the people admitted and having problems, and they go case by case, what could we have done differently. And then the physicians -- and there's a stipend to the practice site for the office space, telephone lines, and all that of the case manager.

Last, there is a result share, and like the PGP demo, it is based on a certain proportion of savings that are entirely paid on quality parameters, including increased numbers of visits by the beneficiaries to the practice. We expect the number of primary care visits to go up, and, in fact, they do, from an average of around, I think it was

eight or eight-and-a-half visits up to a little over ten visits a year. And, of course, there are multiple phone calls and so forth in addition.

DR. BAICKER: Mr. Long, I thought both presentations were really very helpful for us, and I'd love to hear your thoughts on the promise of some of the policy levers that people talk about to substitute for bodies in your service area, Mr. Long, versus just getting more bodies there. How much promise do you think there is from payment policies that promote the availability of remote consults that help with telephone management, et cetera, or really is there just no substituting for getting more physical people located in your service area?

MR. LONG: Looking at the option of telemedicine, and we have a connection. We have a system that was established by St. Alexis Medical Center out of Bismarck and we have connected with that. We have worked with that and found that patients are willing to work with it. It seems that physicians on both ends, not so much.

And so at our level, we have generally either had a mid-level provider there or a nurse there to assist at our end and a lot of frustration because what happens is that

the appointment is set for, say, 8:15, and we have our staff person there. We have the patient there. They sit. They're all connected, and then at the other end they say, okay, you're all set? You're all ready? Okay. Well, now I'll go notify the physician, and he might show up 20 minutes, 30 minutes later, and everybody's just a little bit dissatisfied with the service.

So there are some logistics that still have to be worked out. I would think personal care is still better than through a television or a radio system, but it is -- like I say, personal is preferred, but if it is not available, then I think then people would accept it.

DR. STUART: Thank you very much. I think it's really interesting in terms of how we define rural care. I actually was a patient of Geisinger when I lived in State College, Pennsylvania, and there are some people that think that State College is rural. But if you're right there, it's not. I mean, it's an urban area. But there are parts of the Geisinger system that really are rural, maybe not quite as rural as you have in Southwestern South Dakota, or North Dakota, but it's still very rural.

My question has to do with culture, and I was

particularly interested in what Mr. Long said about the importance of local control and how you are able to manage this thing locally. Dr. Harmory was talking about moving into areas, but also making sure that the patient contact was as local as possible.

And my question relates to the locality of the organization. In other words, how do you deal with the local doctors in the more rural practices and does this have any implications for what Jim Long is running?

DR. HARMORY: Well, thank you for your comment, and I'll pay the five bucks for the advertisement later.

[Laughter.]

DR. HARMORY: I think it's really a design difference for us, and it depends for us -- we view our primary care sites as the front door to the organization, as opposed to the emergency room or something else. We depend very much on devolving our operational responsibilities down into the organization. So we do not run to a Moscow-centric five-year plan in the primary care area, certainly.

Each of the counties that we serve -- or not all of them, but of the 35, we have people in roughly 20 counties -- we'll have a leader that will control or lead --

"influence" maybe is a better word than "control" for doctors. You don't really control doctors, you try to herd them in the same direction, in a sense. Please don't quote me on that.

[Laughter.]

DR. HARMORY: But he will oversee the activities of about 30 doctors. So it might be one really large site or it might be an aggregation of six to eight primary care sites distributed, and he or she then has the responsibility for building the relationships, along with his physician and office staffs, with those other primary care doctors. And the specialty people from Danville will also be engaged in that.

So, for example, the cardiology folks actually assign one of the cardiologists to the physicians in a county. So he does out there and does his CME and all that. They have his phone number and they call him if they've got a problem. Now, we have a central call center and it's easy to get people in. But if they're having a patient problem, they have a name to call.

And there is a lot of work with the local hospitals. We have some full-time people in our

administration who go out very regularly and somewhat frequently to visit the hospital CEOs and others to try to help them determine what are their needs. And we have an epidemiology unit which, for example, has recently done, in conjunction with some of the local hospitals, surveys of patient health needs in various counties, in addition to what the State and the Federal Government do. So there's an active attempt to do that.

There has, I would say, we've only recently -- and that mainly for the group of private practice physicians who practice at our hospital in Wilkes-Barre -- begun to try to move IT out to them that they can use in their offices.

So I don't know if that really answers your question, sir.

DR. STUART: I think there are two parts to the question. One was the delivery of service, but then the other is kind of the culture of the practices in rural areas.

DR. HARMORY: Yes, okay.

DR. STUART: What we see here is we've got two very different --

DR. HARMORY: We do --

DR. STUART: -- models --

DR. HARMORY: Yes, sir. Well, I think the culture of the primary care -- of the rural practices is very much as it would be in North Dakota. My granddad actually was one of those folks years back, and they tend to be a pretty independent group. Most of the practitioners in Pennsylvania, in our area, at least, are solo or two-person practices. For primary care, it's been very unusual to have more than two in a group. It's a little different for some of the specialties, cardiology, for example. They are having a lot of difficulty in recruiting and it is mainly lifestyle. It is somewhat spouses, either male or female, reluctant to leave an urban area, or the fact that there are two wage earners in the family and one person is in computers and the other person is in medicine and we don't have a lot of openings for computer people in many of these towns. It's that sort of thing.

I think, you know, as was said, we do find, both at our place and others, that young people are more willing to move to a rural or semi-rural area when they begin to have children. But that is influenced heavily by the quality of the schools. And so we're fortunate in parts of

our geography -- State College is one, and Danville and Lewisburg and some others are other examples where they have very good school districts -- and we can and other physicians can recruit new people to those areas and then use them to serve nearby or even somewhat distant outlying areas.

MR. HACKBARTH: We've got roughly 45 minutes and ten or 11 people, so we have to engage in some, pardon the expression, rationing here. So if we could keep our -- - right. Right. If we could keep our questions and responses as crisp as possible, that would be good. Thanks.

Peter?

MR. BUTLER: Can I ask two quick questions or just one? Just one?

DR. KANE: [Off microphone.]

MR. BUTLER: Okay, two -- well, just give me a short answer. The first one is you mentioned the sweet spot being when you have a patient in the plan with a Geisinger Group doctor in a Geisinger hospital. You showed data that showed the differences between the Geisinger doctor and the panel doctors and the significant -- what's the incremental value of being also in a Geisinger hospital, or is that less

important?

DR. HARMORY: The data I showed are ambulatory data. We believe that with the redesign of care in the Geisinger hospital, that helps, in addition. There are proven care bundles for heart surgery and so forth.

I would only add, in keeping my comments brief, that we have early evidence that even in those primary care sites where the same care is delivered to every kind of patient, no matter insurer or no insurer, that there are differences between the insurance plans in a proportion of patients that hit those metrics. And interesting, Medicare and the Geisinger Health Plan people are the two top ones, followed by a number of the other insurers and Medicaid.

MR. BUTLER: Okay. My other question, there's a challenge to answer it shortly. You have 350 residents. You didn't talk too much about your commitment to education. One view might be that most of those are sitting in the flagship campus subjected to usual ACGME rules and influenced by Medicare payment. Others may say, no, we've tailored this as a pipeline to our wide commitment to a population health and have a fundamentally different model. So --

DR. HARMORY: Very quickly, we have a family practice residency in the hospital in Wilkes-Barre that does operate largely in an ambulatory setting. We also have a DO surgery program up there, which is aimed at producing more general surgeons. In Danville, we have programs in internal medicine, med-peds, general surgery, and pediatrics, OB, as well, and then 32 subspecialty programs. We hire about 20 percent of our doctors from those various training programs.

I would tell you, our proportion of interns going into subspecialties is not significantly different from those of an academic medical center. We still have a large number of people go into subspecialties, unfortunately, but I'm a subspecialist, so --

DR. KANE: Yes. This is fascinating, and I guess I still -- I've been educated by Tom quite a bit, that the home health situation in rural Dakotas is not so great, and I guess I'm wondering what happens. So you've got these hundred square miles, you know, these barren plains with no trees and one little house with a little smoke coming out, you know --

DR. DEAN: We have trees in South Dakota.

[Laughter.]

DR. KANE: A lot of snow. You can't even see the trees. Who's living in those houses? Are they really 95-year-old single widowed people, or where do they go? So do they really stay there, or do they start changing their own living arrangements to be safe and medically -- or how many sort of single widowed over-75-year-old people are out there in that area where home health really would be totally -- you know, not having that would be really terrible, or do the people just accommodate by moving to Florida or moving in with their children in Dallas? I wonder if you have a sense of that. I'm just wondering what happens when --

MR. LONG: Is that one aimed at me, I take?

DR. KANE: Yes.

MR. LONG: All right. I don't have the statistics. All I do know is that there are ones out there, and we will only go so far. We'll go another 50 miles from any nurse's site, and we try to have nurses placed throughout our service area, trying to hire staff that are nurses -- they're also a farm wife, et cetera -- and extend our distances. And there are people outside our reach. I think at some point, they would give it up and sell the farm and move to town, but right now, they don't have the

services available.

These are pretty hardy people. One of the -- maybe I shouldn't tell the story, but there was an elderly couple and he was calving and got pushed down and broke his hip, and it was just him and his wife and there was a storm going on, and so she got the loader and got him in the loader of the tractor, used that to carry him to the house, dumped him on the doorstep and then drug him in the house and they had to wait four days before the roads were open and get an ambulance there to bring him in. So they're hardy people, but they are out there.

DR. MARK MILLER: [Off microphone.] Just on a related point, you also you had, I think, an assisted living facility and a nursing facility?

MR. LONG: Yes, we do.

DR. MARK MILLER: Is that fully occupied? Again, I'm trying to connect to your point here, in case that's not obvious. Is that fully occupied?

MR. LONG: No, there are beds available. Our assisted living is full and maintains full, and so it would be nice to be able to build an additional facility there. Actually, what we're hoping to -- there are dreams here --

one of these days -- is to replace our current skilled and basic care facility and make it adjacent to our assisted living and add some more basic care and assisted living beds at that time.

But right now, our skilled beds are not full. Our basic care and our assisted living beds actually are. And within our area, yes, we're not -- I don't think the entire area is full, but pretty well occupied. There is a nursing home also in Lemmon, one in Bowman, and they also have assisted living in those locations, as well, too.

DR. MARK MILLER: Sorry. I just -- the assisted living, how would you characterize where the finances come for that? What's the mix of payer there? How much is out of pocket and --

MR. LONG: For assisted living, the State through the Medicaid program will pay for the care part requirements, not the housing part of the requirements, so on assisted living. If they qualify for basic care, then that is through Title 19 Medicaid if they don't have the resources.

MR. KUHN: Bruce, Jim, thank you both for being here. This is a very helpful conversation.

I'd like to kind of explore kind of two notions here a little bit. One is a little bit the incentives towards integration in rural areas and the other is a little bit about the ability to transition and begin to manage population health in rural areas.

So, first of all, I'd like you to kind of comment, either one of you or both of you, if you would, kind of as you look at the Medicare program, the appropriate attributes of the Medicare program to move us into kind of the right integration models that are out there, including any observations you might have about the proposed ACO regulation that came out about a week ago.

And then the second part of that is a little bit about the competencies that you all think that we're going to need in the future in rural health as we move into these integration models, about the competencies that are going to be necessary to kind of manage population health as we go forward. Or, to put it another way, what do we lack in rural areas right now that we could use in the future to get us that direction?

DR. HARMORY: We're rushing to be first here, as you can tell.

[Laughter.]

DR. HARMORY: Well, I think those are complex questions and will probably take more than two minutes, but high level. I've spent a good part of the last five days reading and re-reading the proposed ACO regulations. I think they are complex. They will be difficult, if not impossible, for rural organizations other than a Geisinger or a Group Health that reaches out or some others to meet for many years, because lack of infrastructure, lack of data handling, lack of ability to identify high risk, and as you have heard, extreme difficulty in terms of distance and time for people to come in and even get preventive care.

So I think in terms of the ACO regulations, those will likely apply, at least initially, much more to suburban and maybe to inner-city areas, and that's subject to amendments and the way the thing is phased in and some of the payment mechanisms. I mean, one of the back-of-envelope calculations I did was that it probably still pays you more just to stay with fee-for-service and not do any of that. But I just offer that as a rapid observation. I need some more work and our actuaries and all that will look on it.

So I think it's a move and it would allow people,

if it can be tweaked a little, it would allow people to use dollars for other things. Some of the examples cited, I think, are right on. We have a lot of volunteer ambulance services in Pennsylvania. We spend a lot of time educating them. The State does, too, but the budget has just been cut out for all that in Pennsylvania, the State budget. So I think on that point.

I think Medicare support for graduate medical education is key. I think we're one of only two federally-designated rural academic health centers, and we appreciate that support. I do think some changes in the way the payments are apportioned between primary care and specialty training would be helpful, and all my subspecialist colleagues are going to kill me for saying that, but I think that would be helpful.

There are countries -- Norway, I visited -- and I know that they require all medical school graduates in Norway to serve two years in a rural area, but the government is paying the entire bill for the education, and that's a big difference. So I'll stop there.

MR. LONG: Okay, and I guess I'll try to keep mine short, too. On integration, we work really more

cooperatively and we're integrated. We've actually integrated just to protect and keep it together. For example, when we brought the clinics in in 1981, they were integrated because doctors were getting jumpy, scared that the last man standing could get stuck, and so he says, well, we've got to keep this together, so we proposed combining the clinic operations with the hospital.

And the same way with the nursing home, is that it was owned by a for-profit. The main person with that for-profit nursing home passed away. The place was put up for sale and we feared that the facility would be sold and the license for the beds moved out of our service area and leaving our patients uncovered, because they could be moved to a more populated area and easily filled up. And so we purchased the nursing home to integrate it.

So our model has really been always trying to work cooperatively with each other. We integrate when we have to.

As to the ACOs, I think in our situation, like Bruce mentioned, it would be difficult for us to -- and expensive to establish it to meet the requirements and then turn it around and say, we're already, and if you go and

look at the data regarding our facility, that we are already meeting the quality standards. We work very close with our PRO. We participate in all the studies. We do everything we can to meet them on items that -- on the services we provide. And so we think that under the present regulations is that we wouldn't get paid anything additional for it because we wouldn't have much level for improvement, no return on putting that investment into those ACOs.

DR. BERENSON: Yeah, thanks, both of you. Bruce, I want to get into the weeds on one specific topic, eICUs a little bit. Is that the Visicu product, I'm assuming?

DR. HAMORY: Yes, sir.

DR. BERENSON: For those who don't know, they're critical care nurses and doctors in a separate facility, which can be a long distance away, who have visual contact with the patient, sound, I mean, they're talking to the nurse and have real-time physiologic information coming through.

DR. HAMORY: Yes.

DR. BERENSON: You said it's a billable service, and I want to pursue that a little bit. What's billable? Because I didn't think Medicare covered at least the

professional services.

DR. HAMORY: It doesn't. It doesn't cover the professional. I think the technology at the local hospital end would be part of the cost base.

DR. BERENSON: The local hospital base. But it's still an ongoing issue about whether there should be compensation.

DR. HAMORY: Yes. And, by the way, let me mention, just at our larger hospital for 20-some years we have had 24-hour coverage in-house by intensivists. We have actually seen better results by pulling those people out, using them to man the ICU in our own intensive care unit, with falls in mortality rate, for example. So we think the physiologic monitoring, the ability to catch trends early and changes in pulse, blood pressure, whatever, physiologic things, will probably be helpful in that regard.

DR. BERENSON: And just to follow up, the last question on that is you said you have got it in two facilities or you're connected and you're talking to others. What are sort of the issues for the rural hospitals about whether to do this with you?

DR. HAMORY: I think a couple. One obviously is

the local medical staff coverage. You know, we're the 800-pound gorilla.

The second is that you really have to agree on protocols. You cannot have, you know, 50 doctors in four different institutions everybody doing his own thing.

The third issue typically is the support in the local hospital. I mean, as you know, many of the smaller hospitals, the ICU, in quotes, functions in a sense as post-op recovery and other things. And so, you know, the question is, in order to support it, you have to have people available, a PA or someone, who can put a central line in or do certain low-level or primary invasive things. If you don't have that, you don't even start.

DR. BERENSON: They would have to do that in any case.

DR. HAMORY: Yes.

DR. BERENSON: Or just refer everybody --

DR. HAMORY: Well, and that's what some of them have been doing, is just sending everybody in. And we don't view that as beneficial for the patient, family, or appropriate resource use of our really high end stuff. We're Level 1 trauma, and we never close to trauma, and we

try never to close to an admission and succeed in that, you know, 98 percent of the time.

DR. CASTELLANOS: First of all, thank you very much. It was an excellent presentation. But more important, thank you for what you're doing in your communities. We really appreciate that.

One of the things we've been struggling with is the health care delivery system changes and physician reimbursement. And just briefly, if you could tell me some of the indications you use, whether it's quality, outcomes, patient satisfaction, RVUs, briefly how you calculate and how you do physician reimbursement.

DR. HAMORY: Well, we're data rich so actually I can get a report every week of time to third available appointment for our doctors and specialists. We expect primary care to be 24 hours -- I think our chief is saying 48 now -- and the specialist to be under two weeks for a routine appointment and within 24 hours for urgent or emergent.

We get reports every month certainly on the proportion of patients seen with diabetes, with CHF, who came in for a preventive care visit, who have gotten all the

elements of that that they require. Our current numbers are about 65 to 70 percent, which is better than that 54 percent that Beth McGlynn reported, what, eight years ago now. And we pay our -- for the salaried physicians, in addition, they get -- 20 percent of their total comp is incentive. Three-quarters of that incentive is patient satisfaction, which we measure at an individual physician level, and quality metrics. A quarter of it is that their clinic is meeting their budget. Their budget can be to lose money, but they have to meet their budget.

So that's generally the way we look at it, and we do -- we are on a model where we do monitor productivity. We want people seeing patients. You know, we're not capitated. We're not a staff model HMO. We do not expect people to make money by not seeing patients.

DR. CASTELLANOS: Jim, do you have any [off microphone]?

MR. LONG: Our payment system is really very simple. We just pay on work RVUs, and we expect them to be both quality and cover the ER for call, and it's just an expectation; we don't measure and otherwise compensate. This is just a work RVU.

MR. HACKBARTH: So, Jim, your physicians are employed by the system, and so the revenue comes to the system, and then you reallocate it in the way that you base the --

MR. LONG: Kind of.

MR. HACKBARTH: Okay.

MR. LONG: It's kind of an in-between. We own the clinics, but the physicians are set up into a professional service corporation as a group, and then they contract their professional services, and so that's why I say we have the expectations. For example, with the on-call coverage, it's not specific as to physicians, just that the group will provide the on-call of the ER, and they do that for everybody. I mean, if a person comes in with an ankle injury, the podiatrist is expected to come in and take a look at that ankle.

MR. GEORGE MILLER: Again, let me thank both of you. Jim, I was president plaintiff NRHA in Alaska when we had that conference. And, in fact, just a side note, one of our guests that went as rural communities was chosen to be the graduation speaker on the spot for a graduating class of four for that trip. So it was very educational to do that.

I want to follow up on Nancy's question -- I had already written a note -- about the access issue, especially in rural care. Both of you can answer, but particularly Jim. Have you been able to measure the impact if you didn't have one of the services like home care, the impact to the system, what it costs you, and also then the outcomes -- the impact of the outcomes to the patient who then did not have that home care, what it manifested, what maybe the problem by not having home care in the community?

MR. LONG: I can't tell you right offhand. In our own situation is we had looked at the home health, and we were losing on average $100,000 a year on it, and so as I said, critical access hospitals, where do you make it up? You can't, so we made the decision to terminate it with the intention of replacing it with a visiting nurse. And so then we had a period of time without coverage. I didn't bring statistics along of how many visiting nurse and home health visits we do make, but it would have made a difference on quality of life certainly for a good number of our patients. I'm just trying to remember the numbers that we have on right now.

And for us the visiting nurse was a good

substitute. The only thing is it doesn't cover home health aides, so it's only the nurse. And there are aide services that would be beneficial, too, and presently they're also just not available.

DR. HAMORY: Very quickly, we have a home health agency also work closely with the visiting nurses groups. One of the uses that we found very beneficial in preventing readmissions is that for those patients discharged from our hospitals who do not have a Geisinger primary care doctor, we are increasingly sending the nurses out to visit the home within a couple days after discharge so they can sit at the kitchen table, run the medication list, do the med recs, go through the pharmacy stuff, pitch out all those outdated drugs, and do a quick survey of the home for fall hazards. And that's early in its progress, but we know from the medical home that reconciliation of meds avoids a lot of ED visits. So too early.

MR. GEORGE MILLER: And I guess that's my question. Those things that you do at Geisinger probably keeps additional patients coming to the ER, and so, Jim, my question is: Can you measure that since you've been able to close? Have you had a spike in falls or any other issue?

So there's a correlation to the money you lose on not have home care, the $100,000 a year, versus increase in utilization in the ER or to the hospital that may have been prevented if you had home care in the community? Would that have been a net loss?

MR. LONG: I don't have anything that I can say is a measure on that, and I'd say the nursing services have been retained through our visiting nurse program. And I did have the statistic, and we do about 2,000 visiting nurse visits a year. But I can't measure about what has been the impact.

MR. GEORGE MILLER: Thank you.

MS. UCCELLO: Thank you both so much for your presentations. They were really helpful.

Jim, you mentioned concerns related to the urban health systems, and I'm wondering if you can expand upon that and talk a little bit about concerns about residents going to the urban systems for care or the urban systems coming out to the rural areas.

MR. LONG: Okay. Presently in our neck of the Dakotas, there are really four major systems that are out there that are competing and combining potentially to become

two, and each one of them is trying to gobble up more service area in their battles, and, you know, because being independent, our physicians choose where their patients go between them and the patient. It's not dictated by a system. And so that's why I said, well, it will just be a loss of an independent.

Now, I'm not saying that any of those four systems are bad, because they're not. But it's just a loss of that independent choice. What was the second part of your question?

MS. UCCELLO: That's it [off microphone].

MR. LONG: That's it. Okay.

MS. UCCELLO: And since I don't really think I used all my four minutes, I'm going to ask quick --

MR. HACKBARTH: [off microphone].

[Laughter.]

MS. UCCELLO: Just quickly, when we had a month or two back a discussion about Part D and prescription drugs, one of the findings that I thought was surprising is that mail order usage really wasn't higher in the rural areas, and I'm wondering if you want to comment on availability of prescription drugs in the rural areas.

MR. LONG: Mail order, there are two parts to the equation. There are areas that are dependent on the mail order, and in some of those cases, it's quite difficult. Some of them have to drive a fair distance just to receive the mail order prescriptions. But in our areas you see a lot of people trying to support their local businesses, and so I think that's really the bigger factor of why they're not using mail order as much as they might in some other locations. But when the price gets to be enough difference, then they do, even in the really small areas. There's only so many dollars and how far can you spread it?

DR. CHERNEW: That was wonderful. I have a question for Bruce. So your system serves both Geisinger and non-Geisinger patients, as you pointed out. My question is: There's some concern about how systems that become bigger and in some ways even better price for insurers that aren't part of their system. So I don't know if you're willing to say in your case or talk generally, but how does the pricing work between what you would charge for access to your system for a non-Geisinger person as opposed to what, say, Geisinger would internally pay for those same services? And how much as you get bigger and stronger should we

generally worry about the sort of market position of players like you?

DR. HAMORY: It's a fair question. You know, I do work with several other health systems as well, some of them trying to do rural health care in parts of Illinois and Wisconsin. And I think the problem every hospital faces is just what Jeff said, which is that for our governmental payers, we're generally a little below cost. Now, we have made efforts at Geisinger to try to get our cost structure at or below Medicare payments. For us that's about $350 million, and we're about 130 into that over a year and a half. So we still have a ways to go.

Medicaid, of course, in Pennsylvania is worse, and so we cross-subsidize, and we cross-subsidize both from our own health plan and other commercial payers, and those rates vary, and they'll vary somewhat by volume of business.

Our rates are not extreme. I mean, if you look, for example, at health care cost containment data in Pennsylvania, we are actually one of the least expensive in charges for heart surgery and a bunch of other stuff. I mean, you know, the guys in Philadelphia are sort of two to three times what we are. So I don't think there's evidence

from that sort of thing that we are, you know, trying to pillage anybody.

In addition, we're pretty efficient in terms of utilization by most metrics, and so, you know, on a cost -- even on an overall thing, let alone cost per unit, we tend to be lower than other areas. So, you know, I think our not-for-profit status and our mission driven has ameliorated that. I'm aware of some other areas in other states where the Washington Post has, you know, featured some examples of overuse of market power.

Our health plan does see that, though, in some of the sole providers in a county where, you know, they can't do business unless, you know, certain thresholds are met. So it applies at both ends, I think.

MS. HANSEN: Again, thank you very, very much. It certainly reminds me of my days as a rural health nurse in Potlatch, Idaho. So one of the questions I'd find it really helpful if you would amplify is the person-power staffing that you both have seemingly worked out well with the relationship of the primary care physicians to your mid-levels, the nurse practitioners and the PAs and all, and just how that evolution of the culture change occurred so

that you could maximize, you know, people's performance to their level of skill and license.

MR. LONG: Okay. Well, we've been using mid-levels for really a very long period of time, even before I got there, and I've been there 28 years. So I can't say a lot about the evolution because they were already integrated to the system, and they got their start really from, as I understand it, after the war there were medics that came back, and they started the work as mid-level providers.

We use them as physician extenders, and they always have physicians available to ask questions and get assistance, and what's most important is that they know their limitations and that they send it on to the physician if they are unable to properly deal with that particular patient. Most the mid-levels are actually under the employ of our system rather than by the physicians because they're placed in our rural health clinics.

Like I say, it has been a relationship that has been ongoing for a very long period of time.

DR. HAMORY: We have, I think, had more recent experience with the culture changes needed, and some of the ways our advanced practice people are used are, of course, a

result of both the state medical and nursing practice acts, which in Pennsylvania have loosened up a little bit. But an issue we face is that the Osteopathy Board and the medical board have different rules. And so since about 25 percent of our total physician staff are osteopaths and we have osteopaths in many of our training programs, it's an administrative problem with how many people can be affiliated with or have a practice agreement with or be supervised by these different areas.

The biggest issue, I think, is not from the competence or skill of the advanced practice people. They're good folk. My wife's a nurse practitioner so I have a disclaimer I have to make. But the real issue is developing the physician confidence and, in fact, I tell our medical school colleagues -- and I used to be a professor at one time -- that we're training people the wrong way. We select doctors as star players on -- you know, a tennis player. We don't select them for their ability to get along in groups. We don't teach them how to function in a team.

You know, when I was a resident, if a mistake was made on a patient, it didn't matter what it was. I was the guy to blame. Right? And we've been doing that. So we've

not taught people how to work in these teams, and so when you bring folks in, they have to be acculturated, and it's the same, by the way, with an electronic health record. Docs don't trust electrons. Right?

So we've gone through a several-year period of getting this done. Now when we hire people it's simple because they're coming into an existing system, and they're either going to buy in when we hire them or not.

DR. DEAN: Well, like the rest of my colleagues, I certainly appreciate the perspective that both of you have brought. You've both described impressive, mission-driven organizations, and I guess obviously our challenge is how can we replicate what you folks have done, because obviously you're not the typical model. But, on the other hand, we wish you were.

I guess my question sort of follows up with some of the things that Cori and Mike mentioned. In our society we have a deep commitment to the idea that competition provides accountability and efficiency and all those other things. And yet we know that especially in trying to provide complicated professional services in relatively sparsely populated areas, competition can be your enemy.

And I'm just curious about your experiences and any thoughts you might have about, first of all, your experience working with other organizations and other providers and so forth to try to work out these relationships. And I know, Jim, in your case obviously you're the only show in your area. On the other hand, I know you've had some tensions with some of your tertiary care providers and so forth. I'm just interested what observations you have about, you know, what could Medicare do, what could the government do in general, what can payers do to try to support systems that are really focused on good care rather than just on bettering their own financial status, which unfortunately we have some of those, too.

MR. LONG: Wow, Dr. Dean. That's an excellent question, and I'm not sure that I can provide a good answer to that. What could government do in this competitive environment as to better things for the patient? That really has to be the focus, and I'm like you. I think there's elements of competition that are good. You talk about the competition with the systems. I'm a little scared of it. I really quite honestly am. I don't know what's going to shake down, that we have a lot of different things

that we're looking at coming up on this upcoming years that really keeping an eye out, and that competition, of course, is one. And the other is regarding the oil development in the state is that it's already effectiveness, we have numerous people from our community that have quit their jobs locally and are driving to work on the oil rigs. And so our employment base is dropping and getting tougher to compete for staff, and we have no additional dollars to compete for staff.

So this competition thing is a dual-edged sword, and what particular guidance I can give, I don't know. And I think about the larger systems, and I know there's government policies out there that says, well, you can't have an incentive to refer, but if they're part of that system, even if there isn't a direct, there is.

So, you know, I wish I had a good answer, a good response, but I'm sorry, that's all I got.

DR. HAMORY: I think that's a key question. I think it is difficult to answer without a lot of thought. I think for me the big drivers are a population health-based focus. And when my administrative partner and I go into an organization to -- you know, a lot of people come to

Geisinger and want to do what we've done. But the first question we ask is: What is your mission? Is your mission to grow the organization and make more money? Or are you here to actually take care of people and figure out a more efficient way to do it? So I think mission -- and, you know, I frankly don't know how you do that with money. I really don't.

I do think that alignment of the goals and some reinforcement by incentives, which I know the thing is designed to try to do, between the physicians, whether employed or private practice and other organizations, whether hospitals or nursing homes, I believe that facilitates this thing.

IT facilitates it because people are not out there spinning in their own little box not knowing -- you know, the old thing was pitch somebody over the wall when they leave the hospital and you hope there's somebody there to catch them. So I think payment mechanisms that reward coordination of care, collaboration around care, are important.

As you all know, the real difficulty is that the high-end stuff -- and that includes minimally invasive

surgery -- those things are expensive as the dickens. I mean, you can't do heart surgery without nurses and anesthesia and all this stuff. You can't do neurosurgery without that. You know, and so those things are simply going to forever be unaffordable in rural and sparsely populated areas.

I think the examples that I gave you, you know, we believe that there are ways to support necessary, frequently used, and appropriate services in smaller towns and communities. That includes home health. We have two PACE programs; one is rural. But, on the other hand, there's high-end stuff that should be done in a referral center. A referral center does not have to be in the middle of Philadelphia. I mean, we're an example; I think Dartmouth is an example. There are some others. But you have to be able in those places to have the capital, the ability to collect the appropriate specialty teams and support them in order to deliver that care.

MS. BEHROOZI: Thanks to everyone for being so disciplined. I got the last minute here, and thank you both for your --

MR. HACKBARTH: She's from the rural part of

Brooklyn [off microphone].

[Laughter.]

MS. BEHROOZI: I was going to say as many people in your entire 25,000-square-mile catchment area as in -- I can't even say my whole neighborhood, probably about five blocks of my neighborhood.

[Laughter.]

MS. BEHROOZI: So this is very interesting and informative for me, and just my quick question, I think particularly to you, Jim, is about payer mix. Mark sort of touched on it with respect to assisted living, but in general I'm just wondering about your rates of private payers, particularly employer based -- you were talking about people working on the oil rigs; maybe they get insurance that way -- and your rate of uninsured, neither Medicaid, Medicare, nor any kind of employer.

MR. LONG: Okay. And, of course, it depends whether you're talking which part of the operation, is that if you're looking at the hospital or you're looking at the clinics, you're looking at the long-term care, what are the mixes. But if you look just at the critical access hospital element, you're going to see a mix of about 70 percent

Medicare. And then you're going to see about 15 to -- between 15 and 20 percent of Blue Cross and commercial. You're going to see about 5 percent Medicaid, and then you're going to see about, I'd say, 5 percent and better that is just total self-pay or uninsured. We don't have a high percentage. And we have a good number of those that are called insured that are really underinsured, and so out of our total, we have roughly $23 million worth of revenue, and we end up with about a million and a half in bad debts and charity care.

MR. HACKBARTH: Well, this has been terrific, truly, and we really appreciate your spending your time with us. I'm sure we could go around and ask at least two or three more rounds of questions.

I do have a question that I want to ask. We don't have the time to try to answer it now, but maybe we can talk offline and give you a chance to think about it. And forgive me if this doesn't come out completely clear because this is sort of a developing thought that I'm trying to formulate.

One of the clear messages from this discussion, and other things, is that, you know, rural is really not a

very descriptive term. There's huge variety within the broad category of what Medicare classifies as rural, and it's well illustrated by the difference in circumstances of your two organizations. So we're trying to deal not with a rural problem but actually a complex of widely differing circumstances.

And a second premise of my question is that the issues aren't just really Medicare issues. They're about care delivery issues and how you maintain appropriate care delivery systems, if you will, in very different parts of the country.

Now, traditionally what Medicare has done on the rural front is have special payment adjustments or special payment systems for rural providers. As in the case of critical access hospitals, we'll use cost reimbursement 101 percent of costs. Other payment systems we have rural add-ons, as is the case for home health. We've got special rules for rural physicians or in health professional shortage areas. So we've got all these special payment adjustments within a basic Medicare payment framework.

It seems to me there's a mismatch between that approach and the diverse conditions in rural areas and the

fact that they're often not just Medicare issues. And so I'm trying to think, are there other ways that we could -- and we here being the Federal Government -- provide support for the development of needed rural systems outside of the context of trying to jigger Medicare rates, which I think are a problematic tool.

And so the question that I'm rambling towards is: Could potentially more good be done with not funneling the money through Medicare payment systems but through approaches that gives communities flexibility to deploy resources in ways that meet their unique characteristics, their unique set of preferences, so more flexibility, perhaps, frankly, fewer dollars in the aggregate but the trade-off is you get to deploy it in ways that you see fit to build a community-wide system as opposed to just getting add-ons for Medicare payments?

So that's the notion that I'm wrestling with. As I said, we don't have time to talk about it now, but maybe we could talk offline and get your reactions to that.

Incidentally, you know, this is strictly me thinking. I don't pretend to be representing anybody else's thoughts, and for people in the audience, this is not a

policy that's being hatched behind the scenes. This is truly just a question that I'm personally trying to wrestle with.

So thank you again for spending time with us, and it was really terrific.

MR. LONG: Well, thank you for the opportunity.

DR. HAMORY: Thank you.

[Applause.]

MR. HACKBARTH: Now we have a public comment period after sessions like this, and so I'll invite anybody in the audience who wants to come up and make a comment to do so. And then after the public comment period, we will be adjourned.

[No response.]

MR. HACKBARTH: Seeing no commenters, we are adjourned. Thank you very much.

[Whereupon, at 10:43 a.m., the meeting was adjourned.]