MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Wednesday, February 23, 2011
9:30 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
MARY NAYLOR, PhD, RN, FAAN
BRUCE STUART, PhD
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AGENDA PAGE

P R O C E E D I N G S [9:30 a.m.]

MR. HACKBARTH: Good morning. Welcome to those of you in the audience. We have now turned the page, having completed the work on our March report, which will be published March 15th. And now we are beginning work or continuing work for our June report, plus some sessions that are geared not just for the June report but for longer-term issues, like our report to Congress on rural issues, which is due next year, next spring as I recall.

In fact, our first session is on access to health services for rural Medicare beneficiaries. Adaeze or Jeff, who is going to start?

DR. STENSLAND: Well, good morning. Today we're going to discuss access to care in rural communities. This is part of a broad congressionally mandated study of rural health care. Before we start, I'd like to thank Matlin Gilman and our fellow analysts who contributed much of the work that you'll see today.

As part of the health care reform bill passed last year, we're required to examine access to care, quality of care, rural adjustments to Medicare payment rates, and the adequacy of rural payments. Today we'll be discussing

access. The other mandated topics will be discussed in future public meetings. The rural report, as Glenn mentioned, is due in June of 2012.

We started our discussion of rural access last November with our findings from rural focus groups. Focus groups allow us to directly listen to a set of beneficiaries, but it's a small set of beneficiaries. So this month we examine access by looking at claims for 100 percent of Medicare beneficiaries and looking at three large surveys of beneficiary satisfaction with their access to care.

One theme for today is the great diversity across rural areas of the country. One aspect we're going to pay particular attention to is how rural an area is. Therefore, we divide counties into four different types. The first types of counties are urban counties. This includes the suburbs in all of certain states, such as New Jersey. The second type of county are rural micropolitan counties. These are rural counties where there's a town of 10,000 people. The third type of county is rural counties without a city of 10,000 but that are adjacent to a metropolitan area. And the fourth are the most rural counties. These

are places that are not adjacent to urban areas and they don't have a city of 10,000 people; they have a limited population base to support medical services; and there are no metropolitan areas adjacent to the county where people would go for care.

Finally, we realize that areas with the lowest population density may face particular challenges, so we also examined frontier counties. These are counties with less than six people per square mile. Almost all of them are in Western States, such as Montana, the Dakotas, Nebraska, some parts of western Texas.

This slide examines physician supply and its role in motivating concerns over rural access to care. Rural areas have lower population densities and often simply will not be able to attract certain specialties. In addition, even recruiting primary care doctors to rural communities can be difficult. It's been a challenge for decades. The result is that rural areas usually have fewer physicians per capita. In the first two rows of this slide, we show that there's a wide range of physician supply in rural and urban areas.

Next, moving to the middle four rows of this

slide, we see that, on average, urban areas have 1.1 primary care doctors for every 1,000 residents and 1.6 specialists for every 1,000 residents. Rural areas, in contrast, have half this number, and if we go all the way to the bottom of the slide to frontier areas, those sparsely populated counties, they have less than half the number of physicians per capita as urban areas.

While we don't show it on this slide, the number of mid-level professionals per capita is about equal in rural and urban areas.

Now, given that rural areas have fewer physicians, the key question is: Do rural beneficiaries drive to urban areas for enough care so they get equal volumes of care compared to urban beneficiaries? And the second question is: Are they satisfied with their access to care given that they often have longer transportation times to the doctor?

Are we missing a slide?

DR. AKAMIGBO: [Off microphone].

DR. STENSLAND: Yes. This slide shows the level of physician visits and admissions per beneficiary in rural and urban areas. Let's start with the first column and the first two rows.

In the upper left-hand side, it shows that both rural and urban areas have physician visits ranging from seven per year to 13 or 14 per year. Now look at the second column. It has inpatient admissions. Again, we see that the urban and rural ranges are exactly the same, from 0.2 admissions per beneficiary to 0.5 admissions per beneficiary depending on the area.

Next, look below that line to the different categories of rural, and what we see is that the average number of visits and the number of admissions per capita is very similar, no matter what type of rural area you are in.

The interesting point is that while there's regional variation across urban and rural areas, the rural average and the urban average of physician visits and admissions is almost exactly the same all across the different types of rural counties, even frontier counties.

In this slide we look at overall service use, which is a composite index of service use that comes from our work on regional variation. It includes inpatient, ambulatory, and post-acute care. It is risk adjusted using variables from Medicare HCC models, such as patient diagnoses and whether the patient is dual eligible.

The first point of this slide is to show that, overall, rural and urban service use is similar. Look at the middle of the slide. Urban use, on average, is 100.5 percent of the national average. Rural use, on average, is 98.4 percent of the national average. The rural/urban difference is small.

The second point is that regional differences are large. At the top of the graphic, we see that urban Monroe, Louisiana and rural Louisiana have similar levels of service use. Likewise, at the bottom of the graphic, rural Hawaii and Honolulu have similar levels of service use.

Note we're not saying what the right level of service use should be. It may be the level of service use in Louisiana or in Hawaii. But we are saying that the volume of services in any given region is often similar amongst the rural and urban beneficiaries in the region.

Next we break down service use into three components: inpatient, ambulatory, and post-acute. The first point on this slide is that the mean use of inpatient, ambulatory, and post-acute care are all similar in rural and urban areas. The first circle shows that inpatient use is 102 percent of the national average in rural areas. The

second and third circles show that ambulatory and post-acute care use is 95 percent of the national average in rural areas.

Of course, these are just averages, and across rural areas and across urban areas, there's a wide range of use, as we see in the second row.

I've highlighted the two differences we see in the range of service use between urban and rural areas. What we have is a higher upperbound on service use in urban areas due to two outliers. Those outliers are McAllen, Texas, and Miami.

The first circle you see under urban ambulatory care use here shows that ambulatory care use has a high in urban areas of 1.5 times the national average. This is the result of Miami, Florida. If we exclude South Florida from the distribution of ambulatory service use, the rural and urban ranges of service use would be similar.

Under the post-acute care column, we see one urban area has 3.2 times the national average use of post-acute care. This is McAllen, Texas. If you remove McAllen, Texas, from the distribution, the rural and urban distributions of post-acute care service use would be quite

similar.

The takeaway point from this distribution of service use in rural and urban areas is that they are similar; however, there are no rural areas that have service use volumes to match Miami or McAllen, Texas.

Finally, I want to highlight two regions for you. The point is to illustrate that service use in a rural area is often similar to the service use in the neighboring urban area. Here I illustrate the point by first looking at post-acute care. We see a low use area of Wisconsin. The post-acute care in Madison, Wisconsin, is 77 percent of the national average. And the level of post-acute care in rural Wisconsin is 67 percent of the national average, fairly similar.

In contrast, we can look at Oklahoma. Here we show post-acute use in rural Oklahoma is exactly the same level as post-acute care use in Oklahoma City. In both cases, post-acute care use is 147 percent of the national average.

So the lessons from this slide are: first, that average service use is similar in rural and urban areas; second, the range of service use is similar in urban and

rural areas if we exclude Miami and McAllen; third, rural service use can be high or low and is generally similar to the level of service use in neighboring urban counties.

Now we shift to looking at service use of prescription drugs, and there's a concern that rural individuals may have to travel further to get their prescriptions filled, and the question is: Does this result in them having fewer prescriptions filled? And the answer is no. Rural prescription drug use is similar to urban levels. As I said before, we're not saying what the right level of prescription drug use is. We're only saying that rural service use is similar to urban service use.

Next, Adaeze will discuss the degree to which rural beneficiaries are satisfied with their access to care.

DR. AKAMIGBO: As Jeff just explained, utilization rates across a whole host of different service areas tend to be similar between rural and urban areas, but we see pronounced regional differences. Beneficiaries' perceptions of access to care and their individual characteristics are equally important as they might explain any variation we find in claims data. To assess beneficiaries' access to care from their perspective, we used data from the Medicare

Consumer Assessment of Healthcare Providers and Systems, or CAHPS; the MedPAC annual beneficiary survey; and, finally, the Medicare Current Beneficiary Survey 2008, also called the MCBS.

Before we delve into beneficiaries' responses about their access to care, we examined their broad measures of social and health status, key factors that might explain any variation in access. The actual rates are in your papers, but we've put this table up to sum up the result.

Beneficiaries were asked to rate their personal health from excellent to poor. Overall, about a quarter rated their health as fair or poor. A larger share of micropolitan and rural adjacent beneficiaries rated their health in this worst category.

Beneficiaries were also asked if they had any limitations with daily activities such as bathing, transferring, or feeding. More beneficiaries in micropolitan counties had limitations while a smaller proportion in rural adjacent and non-adjacent counties report having any ADLs.

HCC risk scores, however, reflect a pattern. Rural beneficiaries have lower risk scores, which improves

as we get more rural. This suggests that they are in better health than urban beneficiaries, on average, based on their medical records. This could also reflect rural/urban differences in the coding of diagnoses on claims which is where risk scores are derived from.

The takeaway point here is that looking at health status presents a mixed picture. When we look at self-rated health, rural areas appear to be worse off, but they appear to be doing well when we look at ADLs and risk scores. Basically, we don't see a pattern of excess burden of poor health with residents in any group of rural or metropolitan counties.

On this slide we explored any rates of supplemental insurance that might explain variation in access. From the MCBS, we were able to determine the proportion of beneficiaries who had Medicare-only insurance, dual eligibles, Medigap coverage, and employer-sponsored insurance.

First, we find that rural areas are comparable to metropolitan areas in the rates of beneficiaries who have Medicare fee-for-service as their only insurance. This holds except for beneficiaries in rural adjacent counties

where the rate is much higher at 16.2 percent.

On the second row, these are beneficiaries who dually qualify for Medicare and Medicaid. There is no pattern here, but micropolitan and rural non-adjacent counties are closer to the share of metropolitan beneficiaries who are dually eligible. However, almost a quarter of rural adjacent beneficiaries are Medicaid eligible, which is the highest proportion among the groups.

Third and fourth rows: Employer-sponsored insurance coverage is generally higher in metropolitan counties while rural areas tend to have higher rates of Medigap coverage. Again, however, rural adjacent counties tend to be the anomaly in this case, with 28 percent of beneficiaries with Medigap, which is much lower than other rural areas.

You may be wondering where respondents in rural adjacent counties come from. They mostly come from West Virginia, Alabama, Tennessee, Texas, and Kentucky where the rural populations tend to be poorer and have lower levels of education.

Given the mixed picture of beneficiaries' health needs and insurance levels, we now look at their

satisfaction with access to care.

Results from MedPAC's 2010 survey reflect urban/rural differences in unwanted delay in getting an appointment for routine care. Seventy two percent of rural beneficiaries and 76 percent of urban beneficiaries said they never had to wait longer than necessary to get an appointment for routine care. There is a statistically significant difference, with fewer rural beneficiaries responding that they never waited longer than needed.

A large majority of beneficiaries also report never waiting too long to obtain an appointment for illness or injury -- or emergency situations. An equal 83 percent of both urban and rural beneficiaries say they never wait longer than necessary. There is no meaningful difference between the two groups across the response categories.

Given that beneficiaries are able to make the necessary appointments, in the CAHPS survey they were asked how often they were seen within 15 minutes of their appointment time.

The yellow bars show that almost 60 percent in each group indicated that they usually or always see their doctor within 15 minutes.

A separate question asked if beneficiaries received immediate care once it was needed due to illness or injury. About 90 percent, as shown in blue, indicated that they received immediate access in such situations. Again, satisfaction with these two measures are comparable across the four metropolitan and rural groups. There seems to be adequate capacity to ensure that most beneficiaries are not subjected to long wait times in order to receive care.

Using the MCBS, we explored satisfaction rates with yet other dimensions of access. Among the questions beneficiaries were asked to evaluate were: the relative ease of getting to the doctor from their home; the quality of the communication from their doctors regarding their health care. This question addresses whether the health information being communicated is truly accessible to the patient.

Rates of satisfaction with access from place of residence and communication with physician tend to be very high -- over 90 percent -- regardless of where beneficiaries live.

In the 2008 MCBS, about 7 percent of rural and 3 percent of urban beneficiaries drive at least one hour to

access health care services. This is quite similar to MedPAC findings in 2001. This suggests that individuals who drive long distances to obtain care tend to live in sparsely populated counties. Residents in these areas tend to drive for most of their non-health-related services.

MCBS respondents were asked if they had experienced any trouble accessing medical care, and 4 percent said yes.

We wanted to know whether rural residents were overrepresented in this category. That's the 4 percent who had experienced some trouble. It turns out that, overall, about 4 percent of each of the rural and urban categories reported having some trouble. No group is overrepresented.

Focusing on cost and transportation as potential barriers. a few more people indicated that their problems stemmed from the cost of health care than transportation. However, nearly the exact same proportion from each group report troubles with access due to transportation and cost.

So about 1.3 percent of all beneficiaries report access problems from cost, and 0.6 percent report problems due to transportation.

The longer driving times by rural beneficiaries

appear not to lead to higher rates of dissatisfaction with care.

DR. STENSLAND: Just to summarize what we have found:

First, it is well known that recruitment is difficult in rural areas, and certain specialties such as dermatology or thoracic surgery are just unlikely to be located in small towns. Even primary care physician recruitment is a challenge. The result is fewer doctors per capita in rural areas.

Despite there being fewer doctors in rural areas, rural beneficiaries receive a similar volume of services. On average, they end up traveling further for care.

While travel times are longer on average, rural beneficiaries have roughly equal satisfaction with their access to care compared to urban beneficiaries.

Now, we did not try to determine the appropriate level of services and only state that rural beneficiaries tend to receive similar volumes of services as their neighboring urban beneficiaries.

It may be surprising that rural areas receive roughly equal volumes of care and have roughly equal

satisfaction. This may in part reflect the longstanding local, state, and federal efforts to improve access to care in rural areas.

Now we open it up for discussion.

MR. HACKBARTH: Okay, thank you. Any clarifying questions?

MR. GEORGE MILLER: Yes, please. First of all, thank you for this report. It certainly was helpful.

I've got a question on Slides 7 and 8, and my question has to do with both slides. Do you know where the service was given? I understand the graph, but if a rural person had their service given in an urban area, are you counting that? Or are you saying that the service was given in a rural area for rural populations?

DR. STENSLAND: No, this is just based on where the person lives, so it will include the care that the rural person gets locally and the care the rural person gets in the urban area.

MR. GEORGE MILLER: Or, conversely, it could be they lived in a rural area but got all their service in an urban area?

DR. STENSLAND: Correct.

MR. GEORGE MILLER: So there could be some -- okay. You answered the question. I will draw my own conclusions.

DR. BAICKER: I thought the within area versus between was really interesting.

MR. GEORGE MILLER: Right.

DR. BAICKER: And my understanding is that the rates are not risk adjusted, which I think is an informative thing to look at. You mentioned that the --

DR. STENSLAND: These are risk -- this one here is risk adjusted.

DR. BAICKER: This one. But all the overall usage ones?

DR. STENSLAND: This overall usage is risk adjusted.

DR. BAICKER: But like the earlier slide that broke down ranges for --

DR. STENSLAND: Oh, just the counts of visits is not risk adjusted. We wanted to do it both ways.

DR. BAICKER: Okay, so the others are.

DR. STENSLAND: And so whether you risk adjust or whether you don't, you get the same story.

DR. BAICKER: Great. That's what I wanted to know. I assumed the differences were small with the risk adjusters, but it's good to know that it's not that they're actually getting a lot more care because they're healthier in rural areas, relatively.

DR. NAYLOR: So Slide 17. I apologize for my voice. The first bullet has to do with the summary that fewer doctors per capita continues to be a challenge. And actually this somewhat connects to the next session, but we have a higher proportion of federally qualified health centers. About three-quarters of them are in rural areas, and you mentioned mid-level providers about equal access. But my question is: For the Medicare beneficiaries, are we capturing -- you know, given the satisfaction is relatively equal and ADL performance relatively equal between urban and rural, are we capturing the contributions of all team members in addressing access to primary and preventive services? You know, there seems to be a little disconnect in terms of the first bullet and the rest of the statement.

DR. STENSLAND: It would include visits to all different types of providers, whether it's mid-level professional or a physician in an FQHC, in a rural health

clinic, in a physician's office. Those visits would all be included in the volume and reflect in the satisfaction with access also.

DR. NAYLOR: Okay. I'm looking probably at the wrong slide. It's your summary slide. So it just says fewer doctors per capita continued to be a challenge, and I'm just wondering if it will be equally important to capture access to other primary care providers to make a full -- you know, to fully understand why we then may have equal satisfaction, et cetera.

DR. STENSLAND: Okay. Yeah, maybe I can clarify that. So there's your PAs and your nurse practitioners, and they're roughly equally distributed in rural and urban areas. So there's no excess number, really, of nurse practitioners or physician assistants in rural areas relative to the population. So they wouldn't be making up for this shortage of physicians in rural areas. It's not that there's not a need for physicians in rural areas because we have so many nurse practitioners and physician assistants. That's not the case.

DR. NAYLOR: One clarifying. Is that counting visits? Is that how you get to it?

DR. STENSLAND: [off microphone, nodding head yes.]

MR. HACKBARTH: Before we leave Mary, I just want to ask a question about the language we use to describe different types of providers. Jeff, you used the term "mid-level," which I understood to refer specifically to advanced practice nurses and PAs. Is that how you're using that term?

DR. STENSLAND: That's how I used it. I'm open to new terms other than "mid-level professional." If we want another term, that's fine.

MR. HACKBARTH: Yeah. Mary, maybe you can help us with the appropriate term.

DR. NAYLOR: I just think it's appropriate to call them what they are, so physicians, nurse practitioners, certified nurse midwives, and sometimes to classify them as physicians and non-physician health professionals.

MR. HACKBARTH: Okay. And then there is another category that's broader than those that -- other licensed health professionals. Is that right? So that's the broadest category, and then the advanced practice nurses, PAs, and certified nurse midwives are sort of a sub-

category.

DR. NAYLOR: That's correct. Yes, and I'm happy to provide the language, and that would be great. If we could use it throughout, that would be terrific. That would be great.

MR. HACKBARTH: That would be helpful. Thanks.

MR. BUTLER: So the data and the narrative suggest that the utilization is equal because the rural resident travels to the urban area to seek care. Could some of the reverse be true; that is, the providers that have an address in an urban area spending clinic time -- once a week -- out in the rural area so that the travel's not occurring, but you're capturing the data as if it were provided in the urban area?

DR. STENSLAND: That's correct.

MR. BUTLER: It could be, but you have no idea the size --

DR. STENSLAND: Well, there's definitely -- we don't have data on the share of specialty clinic visits that are going on out in rural areas, so we don't know how much of the transportation -- is the doctor going out to the rural area versus the patient going in to see the doctor in

the urban area? From just my experience talking to people, I think there's a lot more of the patient going into the urban area than there is the doctor going out to the rural area. And it's just, you know, the market value of their time I think drives a lot of that.

DR. KANE: I guess it would also be interesting to know if telemedicine was having an impact as well on access in rural areas. But my question was on page 11 on the beneficiaries' self-reported, self-rated health. When people say they're fair or poor, is that including -- or do we know whether that's including how they feel about their mental health? Or is this primarily their physical health?

DR. AKAMIGBO: This is primarily physical, rate your physical -- well, basically overall health, the standard self-rated health question.

DR. KANE: Well, overall and mental can be actually pretty -- I wonder if anybody has teased that out, because I just think that the mental health might be quite a different set of issues in terms of access than --

DR. AKAMIGBO: Yeah. We didn't tease it out with this particular data set. There's another data set that asks a separate question on rate your mental health. It

doesn't quite look the same, but this --

DR. KANE: Yes, I'm just wondering if it might explain some of these differences, that activities of daily living are physical and the HCC risk scores, I don't know, they're probably predominantly physical. I don't know. But the mental health component might be why they feel worse, but they aren't physically. I mean, I'm just trying to understand the differences in the -- you know.

MR. HACKBARTH: Does MCBS distinguish between mental and physical? Or are the questions simply about overall health?

DR. AKAMIGBO: Yeah, it's a standard question. You know, how do you feel about your overall health? It doesn't --

MR. HACKBARTH: There aren't sub-questions about physical versus mental. It's just how do you rate your overall --

DR. AKAMIGBO: No, not with respect to this question. There's are other questions that ask you if you've been diagnosed with depression or some other -

MR. HACKBARTH: In the MCBS.

DR. AKAMIGBO: In the MCBS, yes.

DR. KANE: I just think it might be useful in the long run to try to see if the differences are related to the differences in mental well-being as opposed to physical.

DR. CASTELLANOS: I think there's -- first of all, great job. I really appreciate it. I think there may be a typo in the briefing material on page 12. You said something about the rural study showing rural beneficiaries actually receive slightly more surgery per capita than rural residents. I think you probably mean urban residents.

And just to follow up on Peter's comment, in the rural adjacent areas it's not unusual, perhaps because of history, for us to go out into the rural areas to provide care, the doctor traveling to that. I know that's common in my area. It's getting less common because of the issues of economy, but it does -- and there's probably a very difficult way to track that.

MR. KUHN: Jeff, if we can go back to Slide 6. On this slide what it shows is that the utilization rates or the counts of services are pretty close to equal in terms of urban and rural areas. But yet on the previous slide, when we looked at the number of rural physicians, there was a drop of about 50 percent.

Now, some of the literature suggests that the hours worked by physicians in rural areas, the number of patients they see is far greater, so their productivity is higher. So if I look at these two slides, would that be a correct conclusion that I'm drawing? Is that one of the conclusions that Slide 6 demonstrates, that rural physicians are seeing more patients, or they're working longer hours and their productivity is higher?

DR. STENSLAND: The only actual data I've seen on that is Health System Change when they looked at different physician incomes in rural and urban areas and tried to explain it by different factors, including how many patients you see and how long do you work. There was a little bit longer hours amongst the rural physicians, on average, but I think it was like 3 percent longer hours or something of this nature. So it's nowhere close enough to explain the big difference that we see in service volume versus number of physicians.

MR. KUHN: It would be helpful, and I think there is some other literature. I think the Journal of Rural Health and some other things kind of demonstrate that. So I think this is one area that would be interesting to explore

a little further.

The other thing about this is what I would be interested if we could draw out from the data is also there's perception -- and I think some of the literature supports this as well -- that a number of the rural physicians are older than practicing in urban areas. And if that's the case, while the data we see now shows a pretty good access, if we stratified by age and we have this productivity notion here that I'm suggesting, could we do some predictive modeling that, while it looks good now, five years from now we could see a real access issue in rural areas. If that's something we could add to this research, I think it would be very helpful.

DR. BERENSON: Yeah, on Slide 7, I'm also quite intrigued by the finding of this close association in service use with the sort of contiguous urban area. Is that highly consistent across where you've looked? Are there any that go the other direction where there's just sort of not good correlation at all?

DR. STENSLAND: It's surprisingly consistent across the country. If you map it all across the country, almost always the rural area seems quite similar to the

urban area, and there's only a few exceptions where it doesn't seem to hold, places like Miami, McAllen, Las Vegas. But generally the pattern holds.

MS. HANSEN: Yeah, my comments were actually exactly as Herb's relative to the projections in the future, and I wonder if in the same vein the ability to have an overlay of some of the demographic shifts that will be reflected in kind of the future beneficiaries that are there because of some of the changing demography. I think it was -- was it Brookings that has some studies about some real significant population shifts that were occurring of older populations that were also demographically quite different than we normally see today. So that might be part of what will come up, especially with a mandated report, you know, that goes to Congress for the future planning.

DR. STUART: Thank you. This is an excellent chapter. I'm particularly taken, as Bob was, by the strong correlation between urban and rural in some very disparate parts of the country. But then I would like you to go to Slide 12 because here it strikes me that there may be an anomaly in this rural adjacent. You said that this appears different. It looks like it's South, maybe Appalachia, and

the statistic that I was taken with was the percentage of people in rural adjacent, wherever they are -- am I correct that rural adjacent is everywhere? Or is that just really concentrated in the South/Appalachian area?

DR. AKAMIGBO: It's pretty concentrated in the southeast Appalachia; a few people, about 60 people or so in Michigan, in a certain county in Michigan, but pretty well concentrated --

MR. HACKBARTH: What is the definition of rural adjacent for this purpose?

DR. AKAMIGBO: The states --

MR. HACKBARTH: What the definition of that category, rural adjacent, is. I thought it was just rural areas that are adjacent to metropolitan --

DR. AKAMIGBO: A metropolitan area.

DR. STENSLAND: Right. So they are spread all the way across the country.

MR. HACKBARTH: That's what I'm getting at.

DR. MARK MILLER: Adaeze is saying that they're concentrated -- those states are concentrated in that column, but that phenomenon can occur across the country.

DR. STENSLAND: Yeah, I think there's two -- it's

important to distinguish between two things: where are these rural adjacent counties, and they are any county adjacent to an urban area. So this is going to be all across the country. But then the other important question is: Where are the people that responded to this survey?

DR. AKAMIGBO: Right.

DR. STENSLAND: Because these are only a subset of the rural adjacent counties that are responding to the survey. And where was the sample taken from? And then it becomes heavily sampled in the South and Appalachia.

DR. STUART: I see. So this is not -- we would expect to see a little different distribution if we had a true national sample, which the MCBS is not. Is that another way to put this?

DR. AKAMIGBO: Potentially.

DR. STUART: Okay. The reason I think that's important is that we have another session that's coming up on benefit design, and if the figure that we see here of 16.2 percent of the Medicare population in these areas having Medicare only, having no supplement, then one would expect that you would see some utilization differences in those areas. And so this was the disconnect that I saw,

that you had that very strong relationship of rural to urban rates for areas that were very, very different. But then here in this rural adjacent statistic, it looks like you'd expect to see some differences. That may just be the sampling design of MCBS. If that's the case, then fine.

MR. ARMSTRONG: We work on trying to create access for patients in rural markets through a lot of different approaches. Building on a couple of comments, we are pushing very hard access through consulting nurse telephone consults, e-mail, home health visits. Do we include any of those kinds of visits in this analysis? Or is it really in-office type visits regardless of the license of the practitioner?

DR. STENSLAND: We're really limited to claims, so it's really stuff that they were able to bill for, so it's not going to be just the telephone consultation or even the home health visit, which is packaged in an episode.

MR. ARMSTRONG: Okay.

DR. STENSLAND: Though the episode will show up in that post-acute care bundle.

MR. ARMSTRONG: One other question, and I think it's not specific to this but more generally. My

understanding is this is really about volumes and access. We'll look at quality for these populations in a future report, where it may be that some of the issues around the system-ness of the care delivery really become a little bit more relevant.

DR. STENSLAND: Right.

MR. ARMSTRONG: Okay.

MS. UCCELLO: Okay. I'm just thinking through some of these prescription drug issues, and on Slide 9 it shows there's really similarity between urban and rural. But I was also thinking about on Slide 12 where you break out the supplemental coverage. Do you have information there on Part D enrollment? And in the chapter, but not here, you talked about these low-access counties, and I guess Slide 12, that would be too small of a sample size, I would guess, to look at the enrollment. But I'm just trying to think through whether there are prescription drug supplemental coverage issues that may very across these different counties.

DR. STENSLAND: Okay. I'll have to look into that, unless Joan has something off the top of her head.

DR. SOKOLOVSKY: In general -- I don't have the

numbers in my head, although we have them -- there is higher enrollment in Part B in these low-access counties than the national average. But there are still going to be people who don't have it.

MS. UCCELLO: But the mail order is still similar.

DR. STENSLAND: Yeah, it's similar or even lower.

DR. MARK MILLER: You would think there would be a lot more [off microphone].

MS. UCCELLO: Right, right.

DR. STENSLAND: Unless you're traveling anyways to the community -- you're going to Walmart for other things, and so you're there and you pick up your drugs or your --

MS. UCCELLO: Right. Okay.

DR. DEAN: Yeah, one of the things that I was questioning or concerned about, in Slide 4 you lay out the definitions, and those are, I think, a reasonable and good breakdown of the different counties. But then when you aggregate it into just urban and rural, I assume it includes the three rural categories together. Is that right?

DR. STENSLAND: Yes.

DR. DEAN: And I guess I'm concerned about that because the rural micropolitan will overwhelm the more

remote counties and will, I'm afraid, wash out and hide real differences that are there just because of the number problem. And this has been a problem that, you know, I think those of us in rural health have struggled with a long time. Our numbers are so small that, first of all, we can't get good quality data. We can't get statistical validity in a whole lot of areas. And it's a real struggle. And so trying to describe what's really happening there can be a real challenge.

But I guess I would be concerned about how the data is aggregated because it really does make a difference in how accurately it describes what's going on. So I don't know if that's a technical question or a comment.

Another one -- and I've got a number of things, and some of them we can talk about afterwards. But the one on number of visits, well, the one that's up there, that just doesn't seem right to me. You're saying that the average Medicare beneficiary sees a physician ten times a year?

DR. STENSLAND: Yeah, usually [off microphone].

DR. DEAN: I probably have maybe half a dozen patients that that applies to. I mean, people just are not

seen that often. And I guess that number just doesn't sit right.

DR. STENSLAND: This would be, if you go to the office -- if you go to the doctor, this would be a visit, or if you go to an outpatient facility or if you go see a specialist, or maybe you go see --

DR. DEAN: I understand, but that's almost a monthly visit for every Medicare beneficiary. I mean, that just doesn't jibe with my experience.

DR. BAICKER: Would the medians look different from the means? Is this just a right-tail issue?

DR. STENSLAND: I can check. You know, we have about 10 percent of the people with zero, so we can see what that turns up.

DR. DEAN: I mean, we know that, for instance, 20 percent of people account for 80 percent of the utilization, or something like that. So you've got 80 percent of people that are really relatively low users. And if that's the case, you have to get some very high users to get to those numbers. Like I say, it just doesn't feel right.

DR. BERENSON: Can I just comment on that? I'm using data that Jerry Anderson produced out of Hopkins.

This is now almost a decade old, but the patients with five or more chronic conditions have 50 visits a year, on average, Medicare beneficiaries. So there is a right tail.

DR. DEAN: Fifty visits a year?

DR. BERENSON: Fifty visits a year is the number for that.

DR. DEAN: Boy, that doesn't fit with what I see.

I would just like to follow up on Mary's concern about how we describe, you know, non-physician. This has been a struggle for years, but I think it's important that we come up with some definition and we use it consistently, because it's very confusing and it's getting worse. You know, physical therapists now have doctoral degrees. Pharmacists have doctoral degrees. And, you know, how you lump these people together -- they're all contributing. They're all important parts of the system. But how you come up with a description that both describes what's happening, is fair to the individuals, and all those things is a real challenge. But unless we do that, we just aggravate the confusion.

MR. HACKBARTH: Okay. Let's begin Round 2 comments with George.

MR. GEORGE MILLER: Yes, thank you. Tom just illuminated a couple things I wanted to talk about, particularly for me is the definition of access in rural areas. And, again, we're looking at the data by the three stratified rural areas which are quite different than if you lumped them all together for rural versus urban.

So my question is: What is our definition of access? And then access to what? What are our Medicare beneficiaries getting? And it seems from the data that the rural Medicare beneficiaries have higher out-of-pocket expense, which is a concern. And so what Bruce talked about -- and this would lead to a -- benefit design would be an issue I certainly would want to explore. And then how do we deal with the health of the population. So part of the access issue may be a perception issue.

I'll go back to my statement earlier. Access to what? And if a rural beneficiary has to travel -- I think in the chapter it gave an example that they had to travel further for prescription drug. So to me, that's an access issue if you have to travel further, although the numbers seem to indicate that they still get to use -- still get their drugs filled, but it is still an access issue.

I want to spend a little bit of time defining what access is for a rural beneficiary and across those three definitions for the Medicare beneficiary in the rural area.

Then also the concern that both Jennie and I think Herb mentioned about the aging of the rural physicians in the workforce. On study I saw is general surgeons, 52 percent of the general surgeons in rural areas are within retirement age, and so we do have a five-year window where there's a problem, and how will we address that problem going forward?

So those are a couple things that I think this report needs to tease out going forward.

MR. HACKBARTH: On the first one, George, help me understand what you're looking for. So one of the metrics used in this presentation is patient satisfaction with access.

MR. GEORGE MILLER: Right.

MR. HACKBARTH: And, broadly speaking, the results are similar. So even though they may be traveling further, the Medicare beneficiaries in rural areas are saying that they're satisfied at roughly the same level as people in urban areas who may have a shorter distance.

So you're saying you don't like that or you don't want that to be the only definition and you want objective metrics like time or distance traveled?

MR. GEORGE MILLER: What I'm saying is the definition of access could be different, and the perception of satisfaction by the beneficiaries is fine, and I don't have a problem with that definition. That's their perception of it. But are rural beneficiaries getting the same access to the same care as an urban is? Part of my definition -- and travel is an example of that. And so if you travel further, do you have the same access as an urban beneficiary? And that may be one of the metrics we want to look at.

MR. HACKBARTH: Yeah. So there is some evidence that, in fact, they are traveling further that's provided here. And yet although they're traveling somewhat further, the level of satisfaction is the same. So what's the policy implication of what you're saying, that even though they're equally satisfied, the fact that they're traveling further means that we need to provide more offices so that we equalize the distance traveled as opposed to the satisfaction? Where do we go with that analysis?

MR. GEORGE MILLER: Yeah, you raise a good question. It's something to think about. That's a good question. On the other hand -- and, again, I'm not trying to complicate it, but on the other hand, the additional issue is that that same rural beneficiary who may be traveling more are spending more out-of-pocket because they don't have Medigap coverage, and it seems to me then that's not equal access. They're spending more, traveling more. And I don't know the policy implications. You phrased that question appropriately. But it's something that I want to think about and work on.

MR. HACKBARTH: Okay.

DR. BAICKER: I thought the discussion you had about particular outlier areas was really interesting in thinking about the range comparing urban areas to non-urban areas. I wonder if, especially in light of what Tom was raising about the means, it would be interesting to look at both medians and other measures of the range, you know, the interquartile range, the coefficient of variation, whatever other measure you want to use, just because especially when you're comparing one category that has a lot more entries to a category with many fewer entries, the range is going to

look wider by chance or by particular example.

So it might be interesting to see that, and that would be informative on these issues, but would also, I think, underscore the issue that rural areas are just not going to be urban areas on a lot of different dimensions. And I would say our goal should not be to equalize access. That might not be a fair way or a politic way of putting it, but fundamentally access in rural areas is not going to be the same as urban areas if you're measuring it by distance traveled or lots of other things about convenience, and that shouldn't be our program goal.

DR. NAYLOR: So I think this is really an excellent report. I meant to say that last time. And I also think that people make choices, and so sometimes I'd like to live in a frontier, given what the opportunities might be there.

So, with that, I do think as we look at the issue of quality in the next iteration, this opportunity to unbundle overall health is a really important one. Because I think when people answer that, they do -- it is multidimensional, and they're talking about socially and cognitively and functionally and physically and emotionally.

So I think that would be a really -- and since you have other items, that would be helpful.

But on the issue that you're raising, talking about here on volumes of services, if beyond -- I don't know what is possible in terms of looking at it, but beyond looking at the volume of services for which there's billing directly from however we're going to categorize these individuals -- physicians, NPs, certified nurse midwives, PAs - can we look and should we look at the other kinds of services that others have been talking about, you know, the capacity -- the real outreach by telehealth and through home health and services like frontier nursing and so on and so forth that get to a whole range of volumes of services that might be contributing to equal satisfaction? Do you know what I'm saying? Beyond going for the medical volume of service, is there a way in the report to also say this population relative to urban has greater access to federally qualified health centers? Seventy-five percent of them are in rural communities, even though they only serve a very small proportion of Medicare beneficiaries and they get a team approach to care.

So, you know, I'm just trying to flesh out more

what volume of services there might be that a population might have access to that contributes to higher satisfaction or roughly equal satisfaction.

DR. STENSLAND: We can maybe bring some things out of our site visits.

DR. NAYLOR: Exactly.

DR. STENSLAND: To try to put some of that more into the report.

DR. NAYLOR: So people don't just look at this as medical visits and compare and say that's preventive health services, that's primary care. That isn't. That's a part of, but it's not the whole picture.

MR. BUTLER: So using our traditional metrics for access, it looks like there isn't that much of a problem except for people having to drive, maybe.

Having said that, we've alluded to the various roles that technology plays, but we don't really kind of shine any light on it as a gap closer. And it takes, as Scott on the one end says, maybe e-mails, or then there's more sophisticated telemedicine. But it would be interesting or, I think, worth kind of highlighting the role of technology in closing the gaps.

So if we knew or found that, for example, rural physicians or hospitals were not becoming meaningful users or were not equipped with PAC systems that could help communicate between ERs or -- you know, I think that would be something worth kind of shining a light on to say are they going to fall farther behind because they're not getting the right kinds of support from a technology standpoint. I think that would be -- just a little paragraph or something would be worth highlighting that.

DR. KANE: Yeah, I agree with Peter that it would be nice to have a sense of what that is and how we might measure it, because it is a way to encourage better access in the future.

A couple things. One is if we're going to look at the -- I think it's important to look at the aging of the workforce, but my sense is -- and this relates to access, too. When someone really is disabled and old, they don't stay in a rural location often, unless they have someone to help drive them around. So I'm wondering if we can't also look at the -- what happens when the very old in the rural area -- what do they really do? Do they really stay in place when they can't see and have, you know, a lot of

disabilities? Or do they migrate to other places? I'm just wondering. You know, when you're thinking, projecting out, you know, what are the needs, I'm just wondering if the truly disabled or blind -- you know, a lot of people get macular degeneration, and they can't drive anymore. And so since driving is such an essential part of access here, it would be interesting just to know what people who can't drive anymore do and how either technological solutions or moving to a city is the way they resolve that, and I think that relates then to the workforce needs, to the whole interaction of do they really stay in place when they can't see.

MR. HACKBARTH: Are you aware of data sources?

DR. KANE: I'm just trying to think of how you would tailor this. I think you could almost, you know, look at -- maybe try to stratify the access measures by ADLs or -- the fact that they're still in the rural areas is something that I'm just wondering if we're really capturing the fact that a lot of people just can't stay there. And, you know, going back to several points, it may be that's a choice people have to make. You know, you can't stay in a rural area where you have to drive if you can't see and you

have nobody to drive you around.

But I don't think we're fully capturing the access issue around when you're -- and maybe we'll accept that's going to be an issue. When you can't see and you are disabled, you can't live in a rural area unless you have a live-in companion or something. But I just don't get a sense that we've focused in on the groups that really might have an access problem, since driving is so carefully linked to it.

Then the only other piece I thought would be -- and, also, if your projecting workforce needs, I'm just wondering, you know, you might think that they're just like people who are in urban areas. But if they're leaving when they really get disabled, there's a different set of workforce requirements. So that was my link to the workforce thing.

Then on mental health, we do have the paper. In the paper there's sort of a By the way, there's this mental health issue, and By the way, it looks like rural areas have a higher incidence from some of the other data sets that you were looking at; but, by the way, we don't talk about it. And I think we really need to highlight the mental health

piece a little more. I do think some of those ratings might be influenced by, you know, mental health issues, and I think it would be a useful thing to try to tease out as a potential problem.

Otherwise, I think the urban/rural distinction, other than driving and potential mental health issues, we should be putting a lot more attention into looking at regional disparities rather than urban/rural distinctions. But the two places I think are difficult is if you can't drive or you're mentally ill, there might be some real access issues.

DR. DEAN: I was just going to say Nancy's absolutely right about -- in my experience, though they move off the farm into town, and the town is a thousand people. That's my experience. So I don't think they go to the city because actually it would be worse, because they go to where there are some support systems, and actually even in our small community, we do have a bus system, we do have a bunch of other things for limited elderly folks.

So you're right, but I don't think they -- of course, I live in a frontier county and moving to the city would be tremendously disruptive for some of these folks.

Now, if they have family in the city, then that's different.

DR. BAICKER: I was just going to jump in with a small data thought, that I think it would be very hard to do this systematically and be able to look at ranges across rural areas. But if you want to just get a vague sense of the magnitude of people moving in response to these things, you could use one of the other nationally representative data sets like, you know, the HRS or even the CPS that has as lookback period about where you lived last year and the type of county that it was, and it would give you an aggregate sense of movement from rural areas to more urban areas among people with worsening health.

DR. CASTELLANOS: You made a comment, rural areas have fewer specialists, and I think we all agree to that. Would it be worthwhile to drill down on that? Because there are certain specialists that are really needed in the rural communities. I don't think you need a pediatric endocrinologist, but you certainly need general surgeons and orthopods and cardiologists.

This may have some impact on the workforce issues, the aging issues, but also with medical education. We

haven't addressed in medical education to date the caps on specialty training slots. And even though it's hard to say you can train them, they're going to go into rural areas, we do know, at least in my specialty, that when they're over -- we have a surplus of pediatric urologists, they start to diverse and get into the smaller communities.

So I think maybe drilling down on the number of specialists and especially the needed specialists in the rural areas -- the general surgeons, the orthopods, and the cardiologists -- may be of some benefit.

MR. KUHN: Three or four points. Again, you all just did a terrific job on this paper and I thank you for the work here. One of the things, as we all know, in the rural areas there aren't for-real health care in the Medicare program. There are a number of add-on payments for certain providers out there.

Is there a way we can speculate in this work, or better than speculate, kind of document what access would be absent, those additional add-on payments? Because they have done a lot to kind of equalize, I think, access and payment in the area, and probably quality and other things. But absent those, what would it be like as we go forward? So I

think that would be an interesting work if we could do that.

The second thing that would be interesting for further work would be if we could differentiate by the source of the usual care, whether it's a physician office, whether it's the emergency department, the RHC, the FQHC, and if there's a way we can differentiate by the source of where people get their usual care in areas.

The third area, as I read the paper and thought it would be interesting to look at is access to preventive services. I know we're talking about services in general, but I think in that one, that might be pretty powerful for us to have some better information on that one. It would be useful.

And then finally, on the paper, and I think it was Page 28 here, there's an interesting bit of information where it talks about the proportion of rural beneficiaries reporting no problem with accessing a new primary care physician, improved from 66 percent in '07 to 83 percent in 2010. That's nearly a 20 percent jump over three years.

Do we have any kind of speculation why that improvement? I mean, that's extraordinary improvement, and if there's any way to replicate that, we ought to be all

over that. I'm just wondering, is there any speculation of what occurred here or what's behind those numbers?

MR. HACKBARTH: What page again?

MR. KUHN: Page 28.

DR. MARK MILLER: This is from the MedPAC survey. If I remember correctly, the way this breaks down, just so everybody knows what's being talked about, is you first ask the question, who's looking for a new physician? And then you ask, who has trouble or does not have trouble finding a new physician.

The catch with those numbers, because that number occurred to us, too. We had a little internal conversation on it. The problem is, in this survey, when you segment it down to the people who are looking for a physician, you've just gotten to a very small number. And so, while I might look at that and go, that is a great success, I suspect it's probably a fairly noisy number, rather than some indication of success.

But I'm also looking at a couple of people in case they want to stand up and say anything to back me up or dispute it.

MS. BOCCUTI: Thanks. I think improved is not

quite the statement that we would put in the publication, and these are just draft chapters. If they're not statistically significantly different, and I don't believe -- we'll have to look at that -- they are not, then I would be more comfortable saying that they are -- the best we can say is that statistically they're similar. I would not put a lot of weight in saying improvement until you can have statistical significance.

MR. KUHN: And then one final question here. I'm just curious. The data we looked at is A, B, and D data, but on the Part C side of Medicare Advantage, what's the access in rural areas to MA plans? Is it similar to urban areas? That was the data point I was kind of looking for here and didn't see that.

DR. MARK MILLER: We do have that --

DR. HARRISON: [Off microphone]

DR. STENSLAND: He said it's 99 or 100 percent.

MR. HACKBARTH: The number of plans that they have, as I recall, is smaller, but almost everybody has access to at least one MA plan.

DR. MARK MILLER: But we can include [off microphone].

MR. KUHN: I think the notion is can we include this in a report and I think it would be useful information to add to this report.

DR. BERENSON: Yeah, two comments. One is, Herb raised this interesting point about pending retirements, and it does strike me that having some better understanding of this issue is important, not just for this work, but for our physician work more generally, more detail about what is the typical retirement age and the range of retirement age, what is the relative productivity of older physicians versus newly minted physicians, et cetera.

So if we're going to do that as relevant for rural, which I think it is, I think it's also relevant for our other physician work, to have a little more detail about that, because we're not showing a lot of major access problems to physician services, but there are a lot of docs that are going to be retiring soon. I think that would be informative.

The second is to pick up, I guess, Scott was getting at this in the first round, I'd be interested -- it's sort of access, but it really goes to quality and system-ness. I'd be interested in knowing -- and I don't

think there's any systematic way to know what you could do as to what extent are there organized systems that are urban-based that formally incorporate rural delivery within their sort of delivery systems.

So what Group Health might be doing, Marshfield, Billings, Geisinger, those kinds of models. Are those the ones that exist or how broad is that versus just sort of informal relationships with a hospital or with an urban-based physician group? I'd be interested in knowing about that.

MS. HANSEN: Going back to the workforce issue, in addition to thinking about the retirement, the flip side of that is helping to identify, perhaps, a profile of those who are newly going into rural areas. I think I only, at this moment, have more anecdotal aspects, but it seems like foreign medical grads are beginning to populate some of the communities in terms of replacements.

So the ability just to describe what the shifts are would be helpful in this whole workforce analysis. And then the final other aspect of looking at the models that may work, I know the PACE review that Carol had done in a couple of meetings, that there are 12 projects, I think,

that PACE is doing in rural settings.

So if we're looking at delivery models that are somewhat different, I think Grand Junction, for example, right now in Colorado is one of the largest rural models right now with integrated capitated dual eligible care available. So that could be just another part of the profile of existing opportunities in delivery system change.

DR. STUART: I think Herb raised a really important point about Part C, and that is that when we look at these different data sources, we're restricted, obviously, to the coverage within the data source. And so, when we're looking at physician utilization, hospital utilization, we're stuck with Part A, B, and D.

I'm wondering whether there might be some unintended implications of using different data sources for different measures. My thinking here is, when we look at the relationship of utilization rates across the urban continuum, the disposition of Part C beneficiaries is not uniform. In other words, I would doubt that the disposition of Part C is similar to the disposition of fee-for-service. So that would be something that I think you should at least take a look at.

And then the question becomes, when we have satisfaction in some of these other measures that come from MCBS, in the statistics that were presented here, do those come just from people who were in fee-for-service? In other words, is it a fee-for-service/fee-for-service comparison, or is it everybody in Medicare?

DR. AKAMIGBO: From the MCBS, it's everyone. We don't extract fee-for-service.

DR. STUART: I guess I'd suggest that you try that just to see. It may turn out that it doesn't make any difference at all, but if we have an uneven distribution of C and fee-for-service, then on the MCBS, we're looking at everybody. You may find that you're going to get some differences there.

MR. HACKBARTH: The issue that we've had with the beneficiary survey that we do each year on physician access is that beneficiaries often don't distinguish readily between whether they are Part C or just traditional Medicare.

DR. STUART: Right. That's a good point. But in MCBS, we have administrative data so that we could make that distinction really clear.

MR. HACKBARTH: Yes. Mitra?

MS. BEHROOZI: Like Herb, I was really interested in the last question because it seems like if you're going to be making policy recommendations going forward or analyzing the effectiveness of policies, we ought to be able to somehow parse out a little bit what the results that we're seeing have to do with the efforts that have been made.

So I wonder if there are ways of looking at areas that have had -- then Herb focused on the additional payments, but as you note in that last bullet, there are lots of different policy efforts that have been applied, not just within Medicare, but at the state and local levels.

So I wonder if there's any way to differentiate areas by the degree of penetration, you know, of HPSA doctors or whatever, and state efforts and things like that to see if there's a way to separate out the places that then sort of deviate from the mean as to whether they've had significant penetration of these additional programs.

I don't know if I'm drawing too much of a conclusion from this, but it's interesting to me -- and I don't know a whole lot about this, but I think what I see in

the paper is that, with respect to pharmacy, the one policy lever that's been applied is that Part D plans have to have networks that afford 70 percent of their beneficiaries' access to a network pharmacy within 15 miles. That means 30 percent of people could be traveling a really long distance, and apparently they do.

And even with only that, which doesn't seem like the most aggressive lever, you have relatively similar pharmacy utilization. And as a couple of people have noted, more rural beneficiaries are not making the choice to access their prescription drugs via the mail, which you'd think -- you know, similar to telemedicine - they would do if it was -- you know, if they perceived it to be a huge burden to travel that additional distance.

I don't want to draw too much of a conclusion there, but there it seems like you've got more of a market force operating not influenced so much by the additional policy implications. And I realize that the pharmaceutical market is very different than the physician services market, but I think it might be useful to see if we can separate that out a little bit.

MR. ARMSTRONG: So given the methodology and the

number of points for this analysis and a number of the points that we made, I'm comfortable that we have an understanding of rural access issues and that, frankly, the concern I have is greater with the variation from region to region than between rural and urban areas.

Just a couple more points I would add. People have mentioned this. I think the idea of understanding how MA in these markets covers these areas, influences some of our data and/or offers a different kind of experience for these patients I think would be terrific. The same goes for how systems that organize care and are serving large rural areas also might offer some insight into some of the policy agendas that we could push forward with.

I do think, though, that care is changing and that so much of our care toward the goal of better health is not related to the things that we're measuring. Visits into our offices is a primary metric. And so, as we get into this quality chapter and as we start thinking about how we hold ourselves accountable for holding this program accountable for better health, I think we've got some really interesting questions about, well, what are some ways that we can do that?

Access through electronic mechanisms is one example. I would say that health, particularly for people with chronic illness, can be advanced tremendously through church groups and through other community forums. The list kind of goes on and on, but we're not measuring any of that as far as I know, unless it's through a survey of satisfaction of some kind.

And so, I don't have an answer, but I think it's more just a challenge for us. Our measures, I think, need to catch up with some of the evolution in how innovations and care delivery are affecting the health of our beneficiaries, and I think this issue in rural health care is a chance for us to learn about that.

Actually, one last point. In fact, my suspicion is that there is a lot about how health care gets organized in rural communities that urban markets could learn a lot from. If we had a way of kind of looking at these features of great care systems, we may be able to do what may seem counter-intuitive, but draw from great standards in rural communities and apply them more broadly to the program overall.

MS. UCCELLO: I think everybody's made a lot of

great points so I'm going to just key off of something that George said about some of the out-of-pocket issues. I was wondering -- this is more actually a Round 1 question, but in Slide 12 where you look at the access to supplemental coverage and the rural adjacent has lower. I'm wondering how much of that is actually a regional issue versus a rural adjacent?

DR. AKAMIGBO: Yeah, that's sort of what we're highlighting. The MCBS, the limitations of the MCBS sample is 13,300-some folks. It makes it difficult to -

MS. UCCELLO: To tease them out?

DR. AKAMIGBO: -- to tease that out, you know, to the extent to which this can be extrapolated to the rest of the county. But I think it's something we should probably explore.

DR. MARK MILLER: I was looking for Scott. There may also be another data source that we can look at to see about, at least availability of Medigap. There might be another way to look at that in addition to the MCBS.

DR. STENSLAND: Yeah, there is another data set and we started to look at it. It's not all firmed up yet, so we're not highlighting it here. But there is data from

CMS on other types of Medigap people have. We can look at that and look at the geographic distribution. Once again, you are going to see, in either data set, different parts of the country people have different levels of Medigap coverage.

MS. UCCELLO: Well, and I think by looking at this, I would think a lot of it is the retiree health insurance access, which I would imagine is going to vary tremendously by region.

DR. MARK MILLER: Yeah, and I wonder, and this is just speculation so you don't want to go anywhere with it. I mean, I wonder if it's more a geographic phenomenon rather than an urban and rural phenomenon, is what you may end up with sort of finding there.

DR. DEAN: Yeah, I've got several comments. There is a lot of interesting issues. First of all, on the pharmacy issue, that is, as some of you know, that's been a concern I've had for some time. As Mitra raised, this 70 percent rule, I think, is basically no rule at all because Humana came into our area and sold a whole bunch of policies and their nearest participating pharmacy was 55 miles away.

Now, that's fine if you're going to go by mail

order, but what do I do with the elderly lady who comes in at five o'clock in the afternoon and needs a prescription for antibiotics? You can't do that by mail order. And so, who's going to fill the gap? She can't drive -- she can't or won't -- this is all hypothetical, but we do face those kinds of issues.

It's a dilemma and I don't exactly know the answer. Mail order works fine for a certain segment of the pharmaceuticals we use. It doesn't work at all for the more urgently needed things. And there was a comment in the written paper that most of the pharmacies that closed were where there were competing pharmacies. There really are some data that say that's not true. I mean, there were a lot of sole providers that also closed, and I can get you the numbers, but it was a significant number over the last five or ten years.

The reason is -- not to belabor it, but they're almost all independent providers. They get squeezed real hard by the four-dollar Walmart prescriptions. They really can't compete with that because their only business is selling pharmaceuticals. Whereas, Walmart and the various other places basically use pharmaceuticals as a loss leader

to bring people into the store.

So it's a completely different business they're in and they provide an incredibly important service, but it's a threatened population. The numbers are declining and it's a concern, although, according to these data, it isn't -- it hasn't really shown up as yet, but it's something that I'm concerned about.

The whole issue of access and how we define it is important and complicated and I think I totally agree with Scott, that just counting number of visits is an inadequate way to do it. But I'm not sure I have a better way because, I mean, we're sort of locked into this structure that we've always had, and we know that things are changing. We know that that isn't necessarily the best or most efficient way to do things, and yet, that's what we have the data on.

I will say that I would certainly agree with the last point on your summary, that the access during my career has improved in many ways, and a lot of it is due to some Federal programs that -- I worked for an FQHC and it has allowed us to do things that we never could have done if it had been an independent private practice. We do things that are totally not economically viable, but they've preserved

some access. In today's budget climate, it's a little worrisome because those programs are probably going to get squeezed and it's a worry.

It's particularly a problem, as Nancy said, with mental health. There's a huge shortage among the specialists that are in shortage. We know that psychiatrists are one of them, and for the first probably 20 years of my practice, me finding an appointment, me myself, or getting an appointment with a psychiatrist was just nigh on impossible.

Actually, in our situation now, and I think ours is unique, it's certainly not a general trend, but it has improved significantly and part of it is through the telemedicine issues. Our system has a network of ten clinics that are scattered out over about 300 miles. We have a psychiatrist that comes to our clinic and does consultation in all ten clinics. So there's psychiatry consultation available to these clinics that simply wasn't available a few years ago.

But again, that is something that I'm not sure -- it is dependent on FQHC funding. The other big program that has made a huge difference over the years is the critical

access hospital program and that has been criticized. It's been abused, I'm sure. It's been subject to political manipulations and all those things.

But of all the things that have happened over the last 20 years in rural health, I think that's the single biggest contributor to stabilizing things in rural areas, because those small facilities have sort of provided the lynchpin to build other things around. It's not perfect, there are certainly problems with it.

I smiled when Scott made the comment about maybe there are lessons that can be learned from rural communities, and I've said the same thing. Probably I'm a bit biased, but I think because these small facilities have, many times, a community focus, and we tend, if somebody has an acute problem, even if our schedule is full, we tell them to come in because there isn't anybody else to do it.

If they go to the emergency room, it means I have to leave the office and go to the emergency room and see them over there, which doesn't really benefit either the patient or me. So whereas, if I was in an urban area, I think it would be much easier just to say, you know, go find some other place.

So I think our system without patting ourselves on the back, but we have sort of taken a medical home approach, not because we had any great vision of the model. It was just that there was no other way to do it. So I think there really is some truth to that.

I sort of argue both sides of the coin. I still think there are some serious problems in rural areas and I'm not sure that they've all been identified in this report. On the other hand, there are some very good things that have happened and continue to happen. So I guess we need to keep digging and keep pushing to try to define it.

Like I say, I'm not sure that the report really captured those. On the other hand, there are some positive things that have certainly gone on. Thank you.

MR. HACKBARTH: Tom, can I just ask a question about the pharmacy access issue? So you said that there are data showing a significant reduction in the number of pharmacies in rural areas, largely because they're independents that have been squeezed by Walmarts. But they can only be squeezed by Walmart if there's a Walmart around that's taking their customers.

And so, I can understand how independents could be

hurt by a Walmart, but then there wouldn't be a loss of access because their customers are going to the Walmart. See what I'm saying?

DR. DEAN: The issue is --

MR. HACKBARTH: Walmart can only hurt them if Walmart is available and people are choosing that over the independent.

DR. DEAN: Walmart is available, but it's 50 miles away. And so it works --

MR. HACKBARTH: If people are opting to go there for four-dollar copays.

DR. DEAN: It works for the chronic drugs, it works for those. It doesn't work for the acute needs that I talked about. That's where the problem comes.

MR. HACKBARTH: Okay.

DR. DEAN: And so, it still is a problem, but the four-dollar prescriptions have really put a pressure on the small guys and, I think, pushed a number of them out of bu. Part D did the same thing because they squeezed pretty hard. Like I say, for drugs for a chronic condition, it's not a problem because they can use mail order. There's a variety of options. It's the acute things that I worry about.

MR. HACKBARTH: Then a question about telemedicine. How does telemedicine show up in the claims base? Is it somehow flagged? Can you go through the claims and identify telemedicine visits?

DR. STENSLAND: Not in the data set we're using, but maybe we could go through it. It would be a big process, but we can maybe do it. I think maybe we could try to du telemedicine also in more of a descriptive nature of what we learn from the site visits and other places. I think there tends to be more broad hope for telemedicine from folks in urban areas than there often is from the folks in the rural areas with maybe the exceptions of mental health, telepharmacy, and the radiology, which I think they use a lot of that. But Tom probably can give you a better feeling on that.

MR. HACKBARTH: Yeah. Well, I don't know anything about telemedicine and what the issues are from either the urban or rural perspective. But in general, information technology, you know, it shrinks space and time and that's the value of it to the economy. It just seems so logical that it could be a tool for addressing at least some portion of these issues. I think it is worthy of some focus in this

report.

Good work. Oh, Tom. I'm sorry.

DR. DEAN: I was just going to say, telemedicine, I totally agree with what Jeff just said, that telemedicine has been proposed for at least 20 years as a solution to our problems, and we're closer now. It's better now, but it's awkward, the logistics are difficult. For certain things, radiology is the best example, and we're getting closer.

But what Ron said about -- actually this is a little different. Specialists going to rural areas, that is something that's declining. We had cardiologists coming to our community for 20 years and they just stopped six months ago. I mean, there's a vital speciality service that we don't have immediately available now.

So it needs to be promoted, but it's not there yet. It's still awkward and the specialists don't like it because it does -- it's much slower for them to do it through, we've got to go to the studio wherever that is and a whole bunch of logistics. So it still has potential. It's better now than it was a few years ago, but it's still not ready for prime time.

DR. MARK MILLER: The only thing I want to add is,

there were a lot of requests for additional information in this round, if anybody was keeping track of it, and they cut in a lot of different -- even more than average, which was all good. They cut in a lot of different directions, you know, moving from rural areas, aging of the physician population.

One that gave me the heart attack was Mitra and Herb saying the counterfactuals, what would have happened in these programs hadn't gone into place. So I assume I'm speaking on behalf of Adaeze and Jeff. I knew Jeff was under the weather, so he didn't say anything.

So here's what we're going to do. I've kept a list of questions and we're going to go through these questions and we're going to figure out what we can and cannot do, or what we can do with data and what we can do with, you know, less than data and come back to you with the notion of this is what we can back in behind.

But there were a few things here that were fairly hair raising. Since Jeff didn't react, I felt someone should. But we'll try and put that together and come back to you and give you a sense, like we regularly do. You ask these questions, we'll come back and at least tell you the

disposition of where things stand.

DR. BERENSON: At least my thought was that some of these data acquisition wouldn't be done for this chapter, but would be done for the report that we're doing in a year.

DR. MARK MILLER: I suspect there is some discussion there.

DR. BERENSON: Yeah, okay.

MR. HACKBARTH: Okay. Thank you. Next is a session on Federally Qualified Health Centers, which Kate is going to lead.

Kate, you can start whenever you are ready.

MS. BLONIARZ: Okay. So I'm going to talk to you today about Federally-qualified health centers, which are comprehensive primary care centers located in medically underserved areas.

We are presenting about FQHCs for a couple of reasons. I want to point out that our research is preliminary at this point, but we think there are some interesting features about FQHCs that bear on our discussions regarding primary care for Medicare beneficiaries.

First, FQHCs must be located in areas that lack

sufficient primary care.

Second, FQHCs must incorporate team-based primary and preventive care that makes use of mid-level professionals where appropriate.

Third, Medicare's current reimbursement structure, which is a per visit payment limit that doesn't vary by the type of services provided, is scheduled to change to a prospective payment system starting in 2015.

And to begin, I'll describe the current FQHC structure and then move on to the upcoming changes in Medicare reimbursement.

FQHCs must be located in a medically underserved area or serve a medically underserved population. Both categories are HRSA designations that merge both the lack of primary care with other confounding demographic characteristics, such as high poverty or a high share of residents over age 65.

FQHCs must provide a sliding scale reduction in cost sharing for patients with income less than 200 percent of the Federal poverty threshold and cannot charge any cost sharing for individuals below the poverty threshold.

In general, the services provided at FQHCs must

include the type of care that could be received in a physician's office, an outpatient department, or an emergency room. FQHC services can be provided in the most appropriate location, which could include another institution or a patient's home.

In addition to providing primary and preventive care, they are also required to provide any supports that would facilitate using the care, such as transportation or translation services, and many FQHCs also provide preventive dental and mental health care on site or by arrangement, and some of them also provide substance abuse treatment, depending on population need.

In 2009, FQHCs served 18.8 million people. One-point-four million were Medicare beneficiaries, and among other insurance types, Medicaid and the uninsured together makes up more than 75 percent of all patients. Ninety percent of patients have income below 200 percent of the Federal poverty threshold, and the majority, 71 percent, have income under the poverty threshold.

Sixty-three percent of patients are members of a minority group. Twenty-four percent are African American and 35 percent are Hispanic or Latino.

Patients at FQHCs are disproportionately female among all age groups except for children, which are roughly 50-50.

Studies have also found that on an age-adjusted basis, the chronic disease burden for patients at FQHCs was higher than patients at outpatient departments and physician offices. And while the share of the population with a chronic disease, as shown on the slide, generally looks small here, remember that they include the entire FQHC population, including the 35 percent that are children.

FQHCs must also provide a continuum of care by having off-hours coverage and admitting privileges with local hospitals. They make substantial use of limited license practitioners, such as nurse practitioners, physician assistants, certified nurse midwives, and others, and some FQHCs are run by limited license practitioners. Overall, limited license practitioners make up 13 percent of the medical staff and physicians make up 21 percent.

Medicare's reimbursement rate to FQHCs does not vary if a limited license practitioner provides the care instead of a physician. In contrast, in a physician's office, Medicare would pay an advanced practice nurse at 85

percent of the Physician Fee Schedule if they were billing directly.

FQHCs must also have a governance structure that hearkens back to their origins as community-based safety net providers. They have to be nonprofit and have a board made up primarily of people receiving services at the FQHC.

The Health Resources and Services Administration oversees the FQHC grant program and awards around $2 billion in grants per year to just over 1,100 FQHCs. These grant-funded FQHCs are broadly dispersed across the country, and there are 312 urban FQHCs, those that are in a Metropolitan Statistical Area, and there are 715 rural FQHCs. This will become important later when we discuss Medicare financing.

In addition, 213 centers are certified as FQHC look-alike sites. FQHC look-alikes meet the requirement for an FQHC but don't receive a Federal grant. However, they are certified to offer the Medicare and Medicaid benefit under those programs and, therefore, get reimbursed by those programs.

Total FQHC financing was about $11.4 billion in 2009, roughly half from patient-related revenue and half from grants or other sources. As you can also see from this

chart, Medicaid is the largest single payer, corresponding to 37 percent of total revenue. In 2009, Medicare paid $674 million, or about six percent of FQHCs' total operating revenue. As I mentioned before, HRSA grants generally total about $2 billion per year, and I should note that two other laws recently appropriated additional funds. The American Recovery and Reinvestment Act appropriated $2 billion for new and existing FQHCs, and PPACA will allocate -- the Patient Protection and Affordable Care Act will allocate $11 billion over the next five years for FQHCs, essentially doubling the grant funding available.

The FQHC benefit under Medicare covers primary and preventive care furnished by a physician or other practitioner. These include a wide variety of preventive screenings germane to the Medicare population. The benefit is reimbursed by Medicare using an all-inclusive payment rate, which I will describe next, and an FQHC may also bill directly under Part B for services not otherwise included in the FQHC benefit but otherwise covered by Medicare, such as ambulance services or the technical component of a diagnostic test.

I will talk a bit about Medicare's current

reimbursement structure to FQHCs because PPACA will make some fairly transformational changes in the way that they are reimbursed.

First, from a logistical standpoint, an FQHC is provided an interim payment from Medicare based on their prior year's reimbursement. Then at the end of the year, an FQHC submits a cost report that provides all of the information needed for Medicare to finalize the reimbursement to the FQHC, and this amount is reconciled with the interim payment.

Medicare's reimbursement is based on the allowable cost of the Medicare FQHC benefit and the allowable visits. Allowable costs include practitioner expenses, supplies, and overhead. Allowable visits must consist of a face-to-face encounter with a practitioner, and there is a minimum productivity threshold that may adjust the number of allowable visits in the calculation.

The FQHC is paid the lesser of their actual per visit cost or the per visit payment limit seen in this table. As you can see, the limit is different for rural and urban providers and the per visit limit is inflated by the Medicare Economic Index each year.

On this slide, I'll talk about the changes that PPACA will make in Medicare's reimbursement to FQHCs. The law requires that the Secretary establish a prospective payment system effective in 2015, and the language gives significant flexibility to the Secretary in designing the system. One feature of the PPS is that initial total payments must equal 100 percent of the FQHC's reasonable costs without applying the productivity threshold or the per visit payment amounts.

GAO in 2010 estimated that over two-thirds of FQHCs had reported costs in excess of the Medicare per visit payment amount, and the total amount in excess was $72 million, or 17 percent of payments that year. A far smaller share of FQHCs were affected by the productivity adjustment.

To wrap up the presentation, I'd like to come back to the three general reasons that we are presenting to you on FQHCs. First, by their design, they are required to be located in underserved areas or serve underserved populations. This could help address concerns about access to primary care in remote rural or otherwise isolated areas.

Second, they are community-centered, not-for-profit organizations that emphasize coordination of care and

the use of limited license practitioners, where appropriate.

Third, the change in Medicare reimbursement from an all-inclusive payment amount to a prospective payment system may change the incentive for FQHCs to treat Medicare beneficiaries.

So I'm happy to take your questions and I look forward to the discussion.

MR. HACKBARTH: Questions? Okay, Cori?

MS. UCCELLO: So payments are going to be higher?

DR. MARK MILLER: Medicare payments.

MS. UCCELLO: Medicare, and so just some background of the PPACA provisions. Was there an access issue previously for Medicare patients? Is that --

MS. BLONIARZ: It's not clear to me.

MR. HACKBARTH: So could you characterize somehow the difference -- how much more it costs for Medicare to provide care for a patient through an FQHC versus a regular physician's office? Is there some way to get a handle on that?

MS. BLONIARZ: We can absolutely do that. We haven't done it prior, but I think we could look at what a physician office visit for the fee schedule would come out

to and give a comparison.

MR. HACKBARTH: Clarifying questions? Scott and then Mitra.

MR. ARMSTRONG: I think I'm building on Cori's question, and you tried to address this both at the beginning and at the end, and that is why are we even looking at this, and so to clarify -- and the question's a good one, because we only represent seven or eight percent of their business. So to clarify, I think what you're saying is that we can learn a lot from what's happening here because FQHCs are expected to grow. They could solve some of our access problems. They could inform us about how prepayment advances, team-based care, and/or other improvements in care. So that's really why we're looking at this, is that --

MS. BLONIARZ: That's right, and I think also the change to the prospective payment system.

MR. ARMSTRONG: And so we have some responsibility to --

MS. BLONIARZ: That's right.

MR. ARMSTRONG: -- to comment on how we think that will look.

MS. BLONIARZ: That's right.

MR. ARMSTRONG: Okay. My only other question is, this may be unique to the markets I work in, but FQHCs have a terrible time building networks of relationships with specialists. Has that been a part of our evaluation?

MS. BLONIARZ: I haven't looked directly at that, but I know that that's an issue, that they have trouble with referrals, and I think it's probably going to depend on what population the FQHC is serving.

MR. ARMSTRONG: Yes.

MS. BLONIARZ: Some of them focus on women and children, and so they need to have relationships with obstetricians, so I would imagine that it varies.

MR. ARMSTRONG: It just might be, given the goals we have around what we want to learn from FQHCs, this network issue might be relevant when we get into those conversations.

MR. HACKBARTH: Is the difficulty in finding specialists for referrals particular to the FQHC, or is it a function of supply issues in the community served by the FQHC?

MR. ARMSTRONG: I was going to say, in our

experience, it has to do with the payer more than anything else.

MR. HACKBARTH: So if it's a Medicare patient served by an FQHC, then there may not be as much of a referral issue. Mitra?

MS. BEHROOZI: I'm not sure where this question is going to go, but in reading the paper, with respect to the picture of the population served at FQHCs, with respect to the rate of chronic disease, you note that the patient population at FQHCs tends to have more chronic diseases than the general public, I guess, but it just seemed a little low, what's reported here. Four percent had asthma. I think our population is closer to ten, actually, in, like, New York City in general, and six percent had diabetes. I actually just looked at an article this morning that said West Chester County in New York is the best county in New York State with respect to health status, and their best is 6.6 percent.

MS. BLONIARZ: Right.

MS. BEHROOZI: So I'm just wondering about these statistics.

MS. BLONIARZ: So, yes. I want to clarify. These

are reported by the FQHCs to HRSA. They report various metrics on what services they're providing and these are the percentage of their patients that were treated for one of these conditions. So I think in addition to the fact that it's disproportionately a population of children and mothers, and so you might expect to see a slightly lower rate of chronic illnesses than in the general population, but also they may be receiving care for their chronic conditions elsewhere. I don't want to attach too much importance to these because they are self-reported and it's what was the primary disease that the individual went to the FQHC for.

DR. STUART: Kate, could you go to Slide 6, please, and this is something that confused me a little bit in the chapter, as well, and that's these 213 FQHC look-alikes. Can you help us understand what a look-alike is? Is it big, little? Did it do something wrong and that's the reason it didn't get a grant?

MS. BLONIARZ: No. So my understanding of these look-alikes is that they either are FQHCs that are planning to apply for the Federal grant or maybe they just did not get awarded one, but they are ready and willing to provide

the Medicare and Medicaid benefit and they are basically substantially complying with the rules for the FQHC program, but they just didn't get a grant.

MR. HACKBARTH: Presumably with the PPACA expansion and the amount of money available, then the number of look-alikes might fall, at least temporarily --

MS. BLONIARZ: It may, and this is something, too, where we could do more research. I don't know whether there's some reason that they would not want to receive the grant, if there's reporting requirements they're not ready to comply with, things like that.

DR. STUART: I think that's really important, because if this is part of the supply chain, then we really want to have some sense of what the supply looks like now and what it's going to look like when we get these new entities in there.

And just one simple follow-up. Are the statistics in terms of financing, do they include these look-alikes?

MS. BLONIARZ: They don't, because they're not reported to -- they're not required to report yearly their costs and --

DR. STUART: And is there any other source of

information about them?

MS. BLONIARZ: Not that I've easily found.

MS. HANSEN: Along the same 213, is this group different still from what's called under HRSA the Nurse-Managed Health Centers, or is that a totally different category, because there are some similarities of FQHCs that they seem to perform.

MS. BLONIARZ: You know, I can't speak to that. I can look into it, and maybe Mary would know.

DR. NAYLOR: The Nurse-Managed Centers are Federally-qualified health centers, so there's overlap, and some are look-alikes.

MS. HANSEN: Right. So, yes, I think just filling that out robustly would be great, because that is part of the future supply chain.

And then relative to any of these, is this related to how medical homes or health care homes are also evolving? Is there any relationship to FQHCs and what's happening with the whole medical home demos that are moving along?

MS. BLONIARZ: I'm not sure on the demo side, but I know some research papers have talked about using FQHCs as kind of a model for a medical home. But on the demos, I

don't know whether they're part of the medical home demonstration.

DR. BERENSON: Yes, two questions. One is are you aware of any information about what the individuals who have been taken care of in FQHCs because they're either uninsured or on Medicaid, what their behavior is when they become Medicare-eligible, usually through age-ins? Do we know if they stay with the FQHC or whether they enter a different health system?

MS. BLONIARZ: That's a really good question, and I don't know.

DR. BERENSON: Okay. I'd be interested in seeing if there is any information on it.

The other goes to the PPACA funding increase. I assume that's just an authorization for greater funding, is that right?

MS. BLONIARZ: It's a mandatory appropriation, as well.

DR. BERENSON: Oh, it's a mandatory appropriation? Okay. That's interesting, because I believe, and maybe you have the answer to this one, that the Republican House bill that just passed has a substantial cut for the appropriation

for --

MS. BLONIARZ: That's right. I think the House-reported appropriations bill would reduce funding by about $1.5 billion, so it would be in the range of $500 to $700 million remaining.

DR. BERENSON: So that's more than a 50 percent cut?

MS. BLONIARZ: Yes.

DR. BERENSON: Okay. I knew it was great, but I didn't know it was that great. Okay.

MR. KUHN: Thanks for this, again, another really good paper, and FQHCs, at least as I see in Missouri, are really an excellent source of care, particularly in the St. Louis area where there's no public hospital. They have really stepped up and just done a terrific job.

The technical question I have is, again, looking at the structure, where you have the FQHCs and then the look-alikes, but also there's also an entity out there called satellites, FQHC satellites. I know in Missouri, we have 21 FQHCs, we've got two look-alikes, but then 187 satellites. And so it would be helpful if we understood what those were and if we could identify those in the paper,

and then are the satellites held to kind of the same standards that the FQHCs are, because what I see in satellites is facilities that maybe open only one day a week, two days a week. The structure isn't quite the same. So it'd be interesting just to have a better understanding of what the satellites are all about.

DR. CASTELLANOS: A really good paper, and I deal with FQHCs and they do a good job. In the population that they practice in my community, they do an excellent job. It's underserved and I congratulate the nurse practitioners and physicians for doing the work they do.

One of the things that concern me is that on page 15 in the material that you sent out, you said that the chronic care management of FQHCs are found to be equal in comparable facilities serving this underserved population, but when you compare it to community-served population, it was a lot less, and that concerns me about quality. Any information, clarification on that?

MS. BLONIARZ: Sure. I think -- so there were a couple of studies that have been done comparing quality, and because of the population that they serve, often the patients are at a more advanced stage of illness and

compliance may be more difficult. And so one of the studies found that it was -- this was a couple of years old, but that preventive care for chronic conditions was about comparable to a physician office that primarily treats Medicaid patients, for example.

What we did look at was the reported levels of -- the reported outcomes that FQHCs said they were achieving for their patients as compared with Medicare Advantage reported rates, and this is on blood sugar and management of hypertension, and there, we actually found that it was pretty comparable. I mean, of course, the populations are completely different, but that gives a little bit of a benchmark. But quality is definitely something we could look at going forward.

DR. CASTELLANOS: Thank you.

DR. KANE: Yes, I had a couple questions. One was do we know -- do they any medical education? What's their medical education role, and is that something that we might want to think more about when I'm not having to worry about this anymore, but going forward?

And then the second one was that the board structure, do we have a sense or has anybody done any

studies yet on the relative effectiveness of a primarily consumer-driven board and how well they are governed in terms of efficiency and financial viability versus providing a lot of services? I know, for instance, in Massachusetts, about half the FQHCs don't make -- I mean, actually lose quite a bit of money. So I'm just wondering if there's anybody who's looked at the board impact, this kind of board and what the effect is, not that it should be different, I just don't know.

And then the last thing is, I think there's a lot of hospital-based and I think they might be some of the look-alikes.

MR. HACKBARTH: In fact, I was going to ask you about that. When I was in Boston --

DR. KANE: Yes, there's hospitals --

MR. HACKBARTH: -- a lot of the then-community health centers were affiliated with teaching hospitals --

DR. KANE: Yes, and they're hospital-based and I don't think they're FQHCs, but --

MS. BLONIARZ: So no new FQHCs can be facility-based.

DR. KANE: Yes.

MS. BLONIARZ: They can be grandfathered in, but there can be no new awards, so --

DR. KANE: Because I know we can't get data on the hospital-based ones anymore through HRSA, so --

MR. HACKBARTH: So I'm not sure what it means to be hospital-based. If they have a relationship and the hospital is providing non-Federal sources of funding, is that forbidden for some -- and why would it be forbidden?

DR. KANE: It's the governance piece.

MR. GEORGE MILLER: When I was in Springfield, we started a community health center and it became first a look-alike, because they went through the process and they didn't qualify, or didn't get granted funding from HRSA, so they were a look-alike, but we funded that community health center until they got the FQHC status, and we gave them pretty close to a million dollars a year, and they lost money, even giving them a million dollars a year. But once they converted to an FQHC, they were able to pretty much break even.

And the clear thing for them is the fact that they had tort reform that the physicians didn't have to have malpractice because they were Federally employed and the

tort reform is just $100,000, so that was part of the way they saved money.

MR. HACKBARTH: Yes. Well, if I'm interpreting the pie chart correctly, even after they qualify for the Federal grants -- they're not just look-alikes but they're actually FQHCs and they get Federal grants -- they have shortfalls in funding that they meet through other sources -

MS. BLONIARZ: That's right.

MR. HACKBARTH: -- and so one question I have based on my experience is to what extent do hospital relationships contribute to that "other" category?

MS. BLONIARZ: Yes, and it may be, and the point I was just making about the prohibition is that an FQHC that is part of a hospital, you know, will not get a Federal grant.

MR. HACKBARTH: Okay.

DR. KANE: Yes.

MR. HACKBARTH: And on Nancy's first question about teaching, my recollection is that FQHCs are one of the categories eligible for the teaching health center provisions of PPACA -

MS. BLONIARZ: [Off microphone.] Yes.

MR. HACKBARTH: -- and so that's funded through HRSA, as I recall.

MS. BLONIARZ: [Off microphone.] Yes.

MR. HACKBARTH: Those grants would come through HRSA and could fund teaching activities in FQHCs.

DR. KANE: So it wouldn't be linked to Medicare, it would actually come without being linked to some Medicare --

MR. HACKBARTH: Yes, that's my understanding, is that though it's GME, it's going through HRSA, much like the children's pediatric teaching activity has been funded through HRSA in the past.

MS. BLONIARZ: Right.

MR. HACKBARTH: Peter?

MR. BUTLER: So there are 18 million people. In this slide, on Slide 6, the split between rural and urban, do we have a sense of the percentage of those 18 million that are in each?

MS. BLONIARZ: Actually, when HRSA does its grant awards, they basically try to keep an equal share of population in either rural or urban. So it's roughly half.

MR. BUTLER: Okay. So the urban ones are twice as

big, or something like that.

MS. BLONIARZ: Something, or serving twice as many patients.

MR. BUTLER: And in terms of geographic distribution nationally, would it surprise us?

MS. BLONIARZ: You know, there's a lot of them on the coasts. There's a number of them in the center in the country. I mean, it's basically where the population is.

MR. BUTLER: And my last question is the, really, the $11 billion -- you have got $1.5 billion in the National Health Services Corps, additional funding that may get cut, and then you have the $11 billion, the doubling of the overall, over five years. Does that mean they're trying to serve as many as 36 million people? That would be one way to look at it. What's the goal? If you're doubling the funding, is that -- because that's a lot. That's over ten percent of the population. That gets my attention --

MS. BLONIARZ: Right. I'm not quite sure what the intent is exactly, but it's both existing sites and new sites, so yes, you could draw that conclusion.

MR. HACKBARTH: My vague recollection is that, actually, there was in the PPACA discussion, there was the

specific target for how many people would be served through the expanded FQHC effort. I don't remember the number off the top of my head, but that was a metric that they used in thinking about the funding.

MR. GEORGE MILLER: Well, the MUA and the MUPs -

MR. HACKBARTH: I'm sorry, George?

MR. GEORGE MILLER: It would be the MUAs and the MUPs. Medically Underserved Areas and Medically Underserved Populations would be the targeted group.

MR. HACKBARTH: In terms of what the specific goal was for enhanced access.

MR. GEORGE MILLER: Right.

MR. HACKBARTH: My recollection was that they did have a target for that. I just can't remember what their number was. Mary?

DR. NAYLOR: Another great report, Kate. On the issue about what would we anticipate in terms of increased Medicare reimbursement under Federally-qualified health centers, you talk about moving from the per visit and what's on slide -- I never have the right number, I think it's 9, payment limit. So the motivation would be reasonable costs. Would we be expecting increasing from the 72 percent of

covering costs now to 100 percent, so these numbers to grow about 38 percent each? I'm just trying to get a sense of what are we looking toward.

MS. BLONIARZ: I think the key thing is that the GAO found that the amount that -- the difference between the per visit payment amount and the FQHC's costs was 17 percent. So that's kind of the number to keep in your head. But it's also in aggregate, so there may be shifts in some FQHCs getting paid more and some getting paid less.

DR. NAYLOR: Right.

MS. BLONIARZ: But that's the aggregate number for the first year of the PPS.

DR. NAYLOR: Thanks.

MR. HACKBARTH: The new rates will be higher because they don't have the productivity and visit limits. Kate? George?

MR. GEORGE MILLER: Since this is a significant population, and I appreciate the demographic information, do you have a sense if these centers are on target to deal with electronic health records and if they are investing in HIT? And then secondarily, will they be a player in ACOs? Are they preparing for ACOs and being involved with them going

forward?

MS. BLONIARZ: Those are both two things that we should look into.

MR. GEORGE MILLER: Okay.

MS. BLONIARZ: Yes.

DR. BORMAN: Just as a piece of yours and Nancy's comments about relationship to GME and other medical health professional education, is there any overlap in these groups with the area of health education centers, the AHECs, because a fair number of the, at least, university-sponsoring GME programs will have relationships, particularly in family medicine and other primary care specialties with the AHECs, and Tom may know the answer, but I know there's a fair number of those out there and I would think there could be some substantial -- if there's not overlap, there certainly could be synergy, and if there's already a mechanism to do that, then rather than reinventing the wheel with sort of moving around monies in other pots and other agencies, it might be helpful to just identify that as an opportunity for streamlining synergy.

MR. HACKBARTH: Do FQHCs ever dispense pharmaceuticals?

MS. BLONIARZ: Yes, they can, and they're part of the 340B program, as well, to receive reduced price.

MR. HACKBARTH: Round two comments? Tom?

DR. DEAN: Yes, a couple comments. I think it might be useful to split up the data, this data on an urban-rural basis, because I think there is a different population served between the urban and the rural centers. In other words, our particular center serves a much higher population of Medicare than six percent. I mean, my practice is about probably 70 percent Medicare, and we serve kids, as well, but it's a relatively small number. So I would guess our -- I meant to get this before I came, but it's way more than six percent.

I agree with Mitra's questions about the diagnoses. Those just don't quite seem right. I mean, I think our numbers -- our proportions are higher than that. I think it'd be useful to -- and I suspect it wouldn't be all that hard to do.

Ron's question about the quality data and the concern of that comment that's in the mailing material, I was bothered by that, as well, because there are some studies that show that, overall, the quality is pretty good

in community health centers across the country, and I think part of the difficulty is that there's data available for CHCs or FQHCs and that probably is not available frequently for the private practice community. In other words, the performance data with regard to diabetes and so forth, there isn't a consistent source, I don't think, for most independent private practices. And my understanding was that, for the most part, even though FQHCs deal in many cases with a relatively challenging population, that their numbers were as good as a lot of HMO numbers and so forth.

So I think their track record is pretty good. I'm biased, but it's partly because there has been pressure -- I mean, this is something I think the Feds have done right. They pressured us a long time ago. We've had a diabetes register in place for at least ten years. So we know what our diabetics are doing. We can track every single one and every single hemoglobin A1, and those things. So we have reasonably good data, even though it was a fairly primitive system, but it produced some very useful data. I think we need to be careful about some of those comments because I think it's a question of what they're compared with and so forth.

With regard to the teaching issues, there's been a push for a long time to involve CHCs or FQHCs in especially GME, and there's been a great reluctance on the part of teaching hospitals because they don't want to share the money. There's a very interesting new program, an osteopathic program in Arizona, where the first year of medical school will be in, I think it's in Tucson, I'm not -- I believe it's in Tucson, anyway, it's in Arizona -- and then the last three years is exclusively in community health centers. They've picked 11 or 12 fairly large CHCs across the country and the students will be sent to -- and they will spend all three years in that particular institution. I think it has tremendous promise as a new model for really giving students a broad perspective and a real positive introduction to primary care. It's new. I think they're in about their third or fourth year, so as far as I know, they don't have any graduates yet.

But I think if we could change -- and some of the changes that exist in the reform law that encourage these kind of changes, I think, are terribly important, because there are some wonderful models out there and an approach to care that, for the most part, just doesn't exist in academic

centers and that we desperately need.

MR. ARMSTRONG: Just one point that I would make would be back to the three goals that we have for doing this work. It just seems to me that they are good goals. It seems to me, too, that there's this serendipitous kind of convergence of other Federal policies, changing Federally-qualified health centers and prospective payment expectations, things like that, and so we should be involved with this.

But it still for me begs questions about what are the features of whether it's primary care or more broadly a care delivery system that we're trying to advance, because a few of those are presumed in here, team-based care and primary care as an example. And I think as we go into the summer and look to the next couple of years, we ought to be thinking about do we have five or six basic features of what we think makes a care system deliver exceptionally good results so that we can be using this along with several other experiments or pilots through which we test those assumptions.

The last point I would make is that considering doing this with Federally-qualified health centers,

prospective payment as an example, is great. I think we ought to consider other health systems where you might try doing some of the same kinds of things, as well.

MS. BEHROOZI: Thanks, Kate. This was really helpful and very timely, actually, for work that we're doing in New York, trying to find new places to send our members to get coordinated care, quality care, and I was really excited by the section that a lot of people have referred to where you look at the quality of FQHCs compared to the Medicare Advantage population. I mean, we're supposed to -- we're used to thinking of FQHCs as only serving very poor people. And, I mean, in urban areas, in particular. I think there are somewhat different issues of access in rural areas. But in urban areas, or in our urban area, these have sort of been perceived as providers of last resort kind of thing and I think this is really important work to kind of help change that mindset, drive people toward better systems of care, and use it as a laboratory but also use it as access to really good care as opposed to access to any kind of care at all and not just for the very poor. So I think it's really great work.

DR. BERENSON: Just to pick up a couple of

comments that have been made. I'm aware that at least a number of FQHCs are fully electronic and have adopted EHRs and a number of the medical home demos are going on in CHCs. But I don't have a good sense of how systematic, or, I guess to pick up Scott's point, how core to the model are some of these things.

I think it would be useful to pursue that, because there is a structure, there's 1,147 grant-funded, and if you are giving out grants, you can have expectations about performance. And so I think it would be useful. My hunch is it's going to turn up pretty positive about that virtually all FQHCs are sort of moving to sort of new integrated models of care, team-based care, et cetera. But I think it would be helpful as we go forward to really understand that.

MR. KUHN: A couple quick questions. One is a little bit what others have kind of spoken to as we move to 2015 and the new PPS system, and if I heard right, it will probably pay more than is currently there. So in this transition period between now and then, are there any incentives for FQHCs to try to constrain costs in Medicare, or what happens between now and 2015?

MS. BLONIARZ: Not as far as I know in terms of the legislative language.

MR. KUHN: Okay. And then the second thing is, in the paper, there were some references to RHCs, Rural Health Care Centers, and it looked like their payment rates were maybe about 60 percent of what an FQHC gets for Medicare patients out there. Do we know -- I mean, is the services they're providing similar? I mean, why the big delta that we see there? And I guess what I'm hearkening back to is our conversation when we were getting ready for the March report when we were looking at ambulatory surgical centers versus hospital-based centers. Are the services similar but there's just a payment differential there, and why is that?

MS. BLONIARZ: Well, a couple of points. The programs were developed and created at different times, so there's that. And under the Rural Health Clinics, the primary care is that primary care that is otherwise covered under Part B. So the FQHC benefit is broader. But I think it's also historical, why there's a different payment rate.

DR. MARK MILLER: Just one thing on his first question, and we can follow up on this. There was no statement in the legislation about the base year for the

PPS?

MS. BLONIARZ: I don't believe so.

DR. MARK MILLER: So then it does mean that it is sort of an open-ended run until they actually get to the year.

MR. HACKBARTH: But they're still subject to the limits, so it's not like it's pure cost reimbursement without constraint --

DR. MARK MILLER: No, but the amount of money that will be available in the PPS will include the amount that exceeds the limit.

MR. HACKBARTH: Right. Right.

DR. MARK MILLER: I think that's his point.

MR. HACKBARTH: Yes, I see. Yes, right.

DR. MARK MILLER: Did I misstate that?

MS. BLONIARZ: No, that's right.

MR. HACKBARTH: That's a good point. Ron?

DR. CASTELLANOS: First of all, I think this is a great job. The National Health Service Corps provides grants both to medical students and to other professional students where they can get the grant and then they have to agree to work in certain safety net areas. I know this

works in our area because I know a lot of the nurse practitioners and the physicians where they have got the grants are in our area practicing, and some of them actually stayed on after they had that obligation. Do we have any idea of the numbers that are provided under the National Health Service Corps and the dollar value and whether this is an ongoing program and whether it's going to be increased by PPACA?

MS. BLONIARZ: I can't give specifics on the dollars, but there was additional money in PPACA for the Corps and it's a yearly appropriation. I don't think that changed. The FQHCs are the largest site. They receive the largest number of Corps students, graduates out of ME of any site. The other stuff, I can get back to you.

DR. CASTELLANOS: Can you try to get the numbers, just to --

MS. BLONIARZ: Sure. Absolutely.

DR. CASTELLANOS: I would appreciate it.

MS. BLONIARZ: Absolutely.

DR. CASTELLANOS: Thank you.

DR. KANE: Yes. I think -- this is going to maybe sound inappropriate, but I think that a lot of these FQHCs

are not really geared toward Medicare patients. I mean, they're a small share now. And what they're really geared for are taking care of people who are underinsured, uninsured, and low-income, and there's going to be 22 million people left over, by the way, even if PPACA ever does get implemented.

And so I'm just wondering if it's wise to think about this as some great place for Medicare people, which historically this has not been, or whether it's really -- okay, it's good that Medicare is finally going to pay more than at least its cost, given that otherwise we're subsidizing with these grants that are meant to serve the uninsured, but do we really want to encourage more Medicare people to go to FQHCs or do we just want to make sure Medicare is not adding to the burden? I mean, I think we just need to think about what's the goal of having Medicare patients in FQHCs, because they really aren't, except for maybe in rural areas -- and I think Tom's right. There's a difference, maybe, between rural and urban, but I know that --

DR. DEAN: I think there's a real difference between rural and urban here.

DR. KANE: I think the urbans are different.

DR. DEAN: Urban CHCs are primarily safety net providers

DR. KANE: They really are.

DR. DEAN: Rurals are the only providers, so we serve -

DR. KANE: Yes.

DR. DEAN: The income range in rural practices is huge.

DR. KANE: Yes.

DR. DEAN: I mean, I have millionaires and people that are destitute, so --

DR. KANE: Yes, and it's kind of -- I don't want to say anything about subsidizing millionaires, but --

[Laughter.]

DR. KANE: I think we already do a lot of that. I'm not sure we need to do more of it. But I just think we have to -- I mean, we might want to rethink, what do we want to encourage for Medicare beneficiaries, and that goes along with also their system-ness. And I think where there aren't a lot of Medicare beneficiaries, where they're mostly providing care for uninsured and Medicaid, they do have

terrible referral problems and they also have not such great relationships sometimes with the hospital and the other specialists. So if you're a Medicare person in that context, that may not be the best place for you.

So I just think we need to think about -- and I think there is this urban-rural distinction that maybe needs to -- even more important to be made in terms of where should Medicare patients be encouraged to go versus maybe that's not the right place for them.

DR. DEAN: There's a lot of variability in terms of the relationships, but there's been some serious problems between CHCs and hospitals. In our particular area, we've had a wonderful relationship. In fact, we've been singled out. But it's highly variable and it is a concern, because the private practice community in areas even where there was a significant need have often seen CHCs as a threat, and it's been really unfortunate.

DR. BERENSON: Yes, I was just going to say, that's why I had asked earlier whether we know anything about the behavior of people who go into Medicare, whether they actually, as soon as they can leave, do they, or maybe not. I think if it were possible to get some information

about that rather than us sort of pontificating, it would be nice to know what Medicare beneficiaries are actually doing with their own feet.

DR. KANE: And it's not just that, but it's what are they really good at doing. Managing chronically ill elders and the cross-silo care may not be what they're really particularly expert at. I think the comprehensive primary care, preventive care for an under-65 population who have terrible access to the rest of the system anyway is a different kind of care than what we're talking about for most of our -- so I just think we ought to think about that as part of the discussion about the role that Medicare patients might -- or FQHCs might play for Medicare.

MR. BUTLER: So it's not like if you've seen one FQHC, you've seen one FQHC, but there's a little bit of that. I know in our market, they're well-funded by Medicaid. As Bob said, they tend to have electronic health records and balance. They have good relationships with their providers and are a source for graduate medical education.

This strikes me as an area, if it's a priority, that it could either be -- our information could be enhanced

by a panel that came forward with different models and/or maybe some site visits by the staff that kind of highlighted models that are working and the reasons why so that we had a little bit, not just the data, but maybe some lessons learned.

DR. NAYLOR: I agree with the last two comments, but just a couple other thoughts. One is if there is a way that we could better characterize the complexity of people served in these centers, and not just medical complexity, and I know this wasn't intentional, but this notion of chronic conditions equals complexity when it's the poverty and the living conditions and the family situation and so on. And so whether or not this evolves as a family-centered model of care in which people aging in place can continue to get care as part of their community, I think depends on how we get at that.

I think the issue around evidence, it was interesting to hear the different perspectives. I mean, you had only one study, Hicks, that raised any questions about care, and then that was bundled around a number that talked about improvements in or the same quality in really big outcomes, like blood pressure and hemoglobin A1C, reducing

emergency room, reducing rehospitalization. So I think that I don't know what happened in the framing of it, but I didn't interpret it in the way that others did and so maybe that's just a --

But then looking beyond that evidence, I think maybe we don't have the robust evidence on Federally-qualified health centers compared to others, but we do have really robust evidence on medically underserved people living with complexity and what we know about care delivery models that really get at that, including the use of other providers other than physicians and why team-based approaches are so important. So it may be a way to get at the evidence.

The last thing is maybe to make more explicit what the Affordable Care Act or PPACA really could do in terms of improving access, meaning how many people are we expected to add explicitly and what might be the direct cost implications.

But thanks again for a great report.

MR. GEORGE MILLER: Yes. Just to add to the dialogue here, Tom is exactly correct. I've run two rural hospitals that supported and helped fund FQHCs, and the

reason we did it, one was to be good citizens for our community, but when I was in Texas, there was a long distance driving from one part to the other of the county and so it just made good economic sense. Those folks would have ended up in the ER and it made sense to help support it and they got federally funded. And what we found is that whole families would go to an FQHC, and some that had no money, some were on Medicare, some were on Medicaid, and they liked that as a home. So it's a complex issue.

When I was in Springfield, Ohio, we funded it because it was a good business decision along with a good community service because those folks were coming to our ER and it just made economic sense to have them treated in a community health center, then a look-alike, and then finally the FQHC than coming to our ER. And we encourage our physicians to partner with the FQHC and take care of those patients. But that is an issue, because a portion of those patients don't have any way to pay for the services and it becomes an issue and that's why we helped fund it to take care of some of those referral sources.

I think that, as Ron said, we've got to be very, very careful about lumping them all into one. They have a

different impact on where they are. Or, as Peter said, you've seen one, you've seen one. It's a complex issue and they're dealing with a very vulnerable population demographically. I was surprised that 63 percent of them, if this statistic is correct, are minorities, which is a huge issue if that many -- if that percentage of the population are minority in FQHCs all across America, and particularly since a good number of them are in rural areas, it's a high concentration probably in urban areas that they're taking care of. So I think there's a lot to learn from them.

MR. HACKBARTH: [Off microphone.] Good work. Thank you very much.

And now we'll have our public comment period.

[No response.]

MR. HACKBARTH: Seeing none, we are adjourned until 1:00 p.m.

[Whereupon, at 11:56 a.m., the meeting was recessed, to reconvene at 1:02 p.m., this same day.]

AFTERNOON SESSION [1:02 p.m.]

MR. HACKBARTH: Okay. It is time to begin. First up this afternoon is reforming Medicare's fee-for-service benefit design, and who is leading the way? Joan? Thank you.

DR. SOKOLOVSKY: Good afternoon. The Commission has been talking about problems with the traditional fee-for-service benefit design for a number of years now. In the past, you have said that the benefit, with its high Part A deductible, comparatively low Part B deductible, and no limit on out-of-pocket spending, is a problem. It leads to a small group of people, the sickest, owing most of the cost sharing. Cost sharing is uneven and varies by site of care. Most people get supplemental insurance, but if you have to buy it yourself, it is often quite expensive and not always available. In addition, because the most common supplemental insurance fills in all of Medicare's cost sharing, it hides prices and leads to higher use of services, both necessary and unnecessary services.

Two things stood out in your previous discussions on this issue. First, what do you want to do about supplemental coverage, and if you want to add some cost

sharing for all services. How would you deal with the duals population? You may want to discuss this issue later this afternoon.

In our presentation, Julie will describe how the current benefit affects people with different levels of supplemental insurance, income, and health status. We will describe recent changes that affect future Medigap policies and briefly remind you of the literature on the effects of cost sharing. Next, I will describe some innovative benefit designs currently being tested by public and private payers.

MS. LEE: In your mailing material, there are two tables that summarize the various cost sharing rules under Parts A and B of Medicare. Rather than repeating them here, we hope the following example will highlight some of those rules and how they might work for the beneficiaries. The example is taken from 2007 MCBS.

The beneficiary had one hospital admission during the summer of 2007, followed by a SNF stay and many home visits until the end of the year. She also had numerous physician and outpatient visits throughout 2007. The summary table of her service use on the slide illustrates three key aspects of the current fee-for-service benefit

design.

First, cost sharing requirements vary by type of service. For example, her inpatient stay had a deductible of almost $1,000, but her SNF stay and home health services had no cost sharing.

Second, cost sharing liability can be significant and there is no upper limit on the total amount.

Finally, cost sharing liability might not equal out-of-pocket costs for the beneficiary.

In this example, she had over $6,500 in cost sharing liability for A and B services, but because she had the supplemental coverage in addition to Medicare, almost all of her cost sharing liability was paid for by her Medigap insurance. Overall, she had only $460-some in beneficiary out-of-pocket compared to $6,500 in total cost sharing liability.

Moving from one specific beneficiary to the overall fee-for-service population, this slide shows the distribution of cost sharing liability under fee-for-service Medicare. In 2008, about three-quarters of Medicare fee-for-service beneficiaries had less than $2,000 in cost sharing liability. Because there is no catastrophic cap on

those expenses, a small share of Medicare beneficiaries had more than $10,000 in cost sharing liability.

I want to emphasize here that those amounts on the slide are not what beneficiaries actually paid out of pocket. They reflect what the beneficiaries would have paid if they had no secondary insurance. But as we see in the next slide, most fee-for-service beneficiaries do have supplemental coverage that covers some or all their Medicare cost sharing.

In fact, among fee-for-service beneficiaries who are not institutionalized and were not working, so that Medicare was not a secondary payer, only about ten percent of them had just Medicare. More than half of them had Medigap or employer-sponsored retiree plans or both, and 12 percent had Medicaid.

This slide provides more detail on one popular form of supplemental coverage, Medigap plans. As we saw in the previous slide, almost a quarter of fee-for-service beneficiaries have them. The most popular type of Medigap policies extend their Plans C and F, which, as you see on the table, fill in nearly all of Medicare's cost sharing requirements, including the Part A and Part B deductibles.

As a result, any price signals that Medicare sharing might present to the beneficiary at the point of service, supplemental coverage can mask their effects and change beneficiaries' choices about whether to seek care and which types of providers and treatments to use.

There have been some changes in Medigap policies recently that try to address this very issue. In June of last year, Medigap insurers introduced two new types of policies, Plan M and Plan N, that do not fill in all of Medicare's cost sharing.

In addition, PPACA directs the NAIC to revise the Plan C and Plan F standards to include nominal cost sharing to encourage the use of appropriate physician services under Part B.

In this slide, we show the distribution of beneficiary income by supplemental coverage. In 2007, a little less than half of fee-for-service beneficiaries had incomes below 200 percent of the Federal poverty level, but the distribution looks quite different by beneficiary supplemental coverage. Given the eligibility requirements of the program, it is not surprising that almost all of Medicaid beneficiaries had incomes below 200 percent of the

poverty. Among those who had no supplemental coverage, the analogous number was two-thirds. At the other end of the distribution, those beneficiaries with employer-sponsored retiree coverage had the highest income, with about a quarter of them below 200 percent of poverty.

As we saw previously, current fee-for-service benefit design can impose a heavy financial burden on relatively few individuals. In this slide, we show the extent of that burden by different groups of beneficiaries. These numbers are from 2005 MCBS and we are currently updating our analysis with 2007 data.

The measure of financial burden used here is the median share of income spent on out-of-pocket costs and premiums related to Medicare A and B services and we show this measure by supplemental coverage, fee-for-service spending, and beneficiary income. So let me briefly go over how to read this slide.

Let's take the first bar in the chart. There are actually three separate data points packed in there. The height of the bright yellow part of the bar is the median share for high-income beneficiaries, defined here as above 200 percent of poverty, and that's about four percent. If

you get the total height of the bar, so it's the sum of the two yellow parts, that's the median share of income for low-income beneficiaries, and that's about 11 percent. And if you look very closely, there is a small red star. That actually shows the median share for all income groups combined, and that's about eight percent.

And you have two sets of bars. The first set of bars on the left side of the chart is for those three data points in terms of median share of income by supplemental coverage for the lowest quartile in terms of beneficiary fee-for-service spending, and you have the analogous set on the right side that is for the beneficiaries int eh highest quartile of spending.

Overall, the financial burden is higher for lower-income beneficiaries and those with high fee-for-service spending. However, the burden varies widely by supplemental coverage. Among the highest spending beneficiaries, the Medicare-only group experienced the heaviest burden, whereas among the lowest spending beneficiaries, it was the Medigap group that had the heaviest burden.

As we consider Medicare's benefit design, we will be mindful of how cost sharing changes with the financial

burden of individuals who have the greatest need for services and who currently have very high cost sharing.

Next, Joan will briefly review the literature on the effects of cost sharing and present the findings from our recent interviews on innovative benefit designs in the public and private sector.

DR. SOKOLOVSKY: There is an extensive literature on the effects of cost sharing on the use of health care services. The RAND Health Insurance Experiment remains the gold standard on the subject. This was a large-scale randomized trial conducted between 1971 and 1982. More than 7,700 people participated in it, all of them under 65. Among the most important conclusions, cost sharing reduces the use of both necessary and unnecessary services. Cost sharing had no adverse effect on most participants, but there were exceptions among the poorest and the sickest. Once individuals decided to get care, cost sharing had only a small effect on the extent or cost of an episode of care. Later research that focused on Medicare beneficiaries found that those with supplemental coverage tended to have higher service use. However, the effect of the increased use remains controversial.

When Medicare began in 1965, its benefit design was quite similar to that available in the commercial market. That is no longer the case. Benefit designs have continued to evolve. This year, we sought out payers implementing innovative benefit designs to improve enrollees' health and control cost. Working with researchers from NORC, we conducted over 70 interviews and site visits with private and public payers. Although each plan was unique, we noted four broad categories of design strategies. Those were lowering cost sharing for high-value services, raising cost sharing for low-value services, providing incentives for enrollees to see high-performing and low-cost providers, and providing incentives for enrollees to adopt healthy behaviors. No interviewee employed all four strategies, but no interviewee relied on a single strategy, either.

The Commission spent some time last year talking about value-based insurance, where payers lower cost sharing for services considered high-value. Many of our interviewees lowered or eliminated cost sharing for preventive services and for prescription drugs used to treat some chronic conditions. Diabetes was most frequent.

Along with drugs, some also eliminated copayments for other services that diabetics should use to control their condition. Eliminating cost sharing for drugs, the most common strategy, tends to increase adherence. Whether these programs are cost savings depends on how good the plan is at targeting the reduced cost sharing of those most likely to increase their medication adherence, meaning those people who were not taking their medication because of cost considerations.

Many payers only reduced cost sharing if the enrollee participates in a disease management or other program designed to supplement and teach them self-care. One program described significant improvements in health outcomes and savings for diabetics in their program. Then they reduced oversight of their management of disease management programs and they found that outcomes worsened and the program no longer produced savings. When they increased management again, they told us that overall medical costs began to drop.

The other part of value-based design, increasing cost sharing for low-value services, can protect individuals from potentially unnecessary and even harmful procedures.

But this approach has been less widely adopted. I will take you through a few examples, and several interviewees told us that they hoped to adopt some of these versions in the future.

Several interviewees used reference pricing. One plan fully covers the cost of preferred drugs on its formulary. However, if an enrollee chooses a more expensive drug when there is a preferred drug available, the enrollee pays for the full additional price of the drug.

Another rather unique example, one employer decided to end cost sharing for colonoscopies. They discovered that providers were charging a wide range of prices within their local market. They decided to fully cover the cost of the procedure up to $1,500. Above that, enrollees who needed a routine screening were responsible for any additional costs. They also provided enrollees with a list of providers who would charge $1,500 or less.

The State of Oregon has gone the farthest to work to identify low-value services and increase cost sharing for them. In one effort, several insurers developed a benefit package with three tiers. The first tier, which is similar to the value-based one we described earlier, has no cost

sharing. The second tier, which includes the majority of services, had typical coinsurance or copayments. The third level is for preference sensitive services. This includes the usual copayment plus an additional $500 charge that doesn't count for the overall deductible. Some of the examples that fit into this tier would be some back surgery, knee replacement, and non-cancer related hysterectomies.

Some plans and employers tier providers based on their cost and quality. Enrollees who go to tier one providers face lower copayments. One plan is planning to further develop this program by providing a yet higher tier for tier one physicians who refer their patients to tier one hospitals. One challenge that they have to deal with is to make sure that there are enough tier one providers to meet the access needs of their enrollees.

Some plans are giving members incentives to use the most appropriate site of care. This ranges from charging lower copayments for primary care visits compared to specialty visits. Another example is getting enrollees to go to centers of excellence for more complex things, such as transplant surgeries.

Two interviewees pay for enrollees with serious

health conditions to get second opinions, and both programs find many instances where diagnosis or treatment changes based on the second opinion. Interviewees using any of these strategies provide education and often share decision making materials for enrollees to help them make decisions about where to go for care.

Some interviewees provide incentives to enrollees to engage in activities like health risk assessments, exercising, and quitting smoking. Many interviewees offer care management or disease management to help enrollees better manage their chronic conditions, often in conjunction with some of these other strategies.

One of the most complex programs has been developed by a supermarket chain and contains two strategies. In the first year of the program, an enrollee who took a health risk assessment and said that they would abstain from smoking got a $20 weekly credit. In the second year of the program, in order to keep that $20 credit, they had to accept a call from a nurse care manager if there was anything on their health risk assessment that suggested the need for intervention. Finally, in the third year, which is coming up now, in order to keep that $20 credit, they need

to collaborate with the case manager to establish goals related to their risk factors. In addition, they have to receive recommended preventive care.

There is a lot more that I could say about these programs and I will be happy to address on question, but a few results stand out. All interviewees used more than one innovation and stressed the need to coordinate multiple strategies and align enrollee and provider incentives. However, this also means that it is hard to evaluate the effect of any one strategy.

Sometimes we heard results, and I have reported some of them to you, but independent research is limited, although we have heard that there is some ongoing work being done, and many of these programs are too new to evaluate. Outcomes also depend on the population and the plan's ability to implement the programs.

To give you one example, if your plan has a population of diabetics who are not taking their medication, again, because of cost, eliminating cost sharing could produce one set of results that would not be replicated in a population that was largely adherent or where people were not taking their medications for other reasons.

In addition, and this is an issue we heard about from several interviewees, implementing these plans depends on their IT systems and physician coding practices. For example, plans have to be able to tell whether an enrollee is having a routine preventive screening, which could involve no copayment, or having a diagnostic screening where copayments would be charged.

In the next few slides, I've tried to organize possible discussion questions around issues that can be addressed in the short-term, those that would take some time, which I've called intermediate-level issues, and finally, there are long-term issues that you might want to address.

In the short-term, should Medicare modify the benefit design to rationalize cost sharing across Part A and Part B and across different silos of payment? Should it set an out-of-pocket limit to provide better protection for beneficiaries? And should it set some cost sharing for all services? And if that is where you want to go, then should limits be placed on the ability of supplemental coverage to cover all cost sharing? How would dual eligibles be affected by this? Would there be some nominal cost sharing

added, and if so, would it be covered by the Federal Government, the States, or the beneficiaries themselves?

On a more intermediate track, should Medicare simplify its cost sharing by moving from coinsurance to copayments, as many private plans do? Should Medicare give beneficiaries incentives to use efficient provider arrangements? For example, if you want to encourage beneficiaries to use ACOs, would you charge them lower copayments if they stay within the ACO? In general, in fact, should Medicare use cost sharing to encourage beneficiaries to choose efficient providers? And should Medicare vary copays based on whether they are for high- or low-value services?

Lastly, there are some long-term issues to think about. For example, are there some benefit strategies that can be used in a managed environment but not in a fee-for-service setting? Secondly, when beneficiaries become eligible for Medicare, they have to choose between more and less managed plans. Should the government subsidy be affected by what the beneficiary chooses?

And that concludes our presentation and we're hoping to hear from you on how you would like us to go

forward.

MR. HACKBARTH: Thanks, Julie and Joan. I think you gave us enough to chew on for a while.

[Laughter.]

MR. HACKBARTH: Okay, so let's do round one clarifying questions beginning on Karen's side, so Karen, George, Kate.

DR. BAICKER: I had a quick question on Slide 9, and I loved how much information was packed into that one picture. So I would imagine that what puts people in those different bins is partly their choices about which plans to elect and that their knowledge about their health needs might affect those choices. Do you have information about the underlying health of the people who are enrolled? Do you have any risk adjustors that we could use to know how much of the differences are accounted for by behaviors because of being in the plan versus plan choice because of underlying health risk?

MS. LEE: Your observation is correct. It does include the insurance fact of having higher utilization that results from the insurance, the supplemental coverage, and what you see. We haven't got that data in such a way. MCBS

does contain some health information, but we have not used those variables to adjust for health status. We can look at the data by very broad levels of health status, but something like risk adjustment probably will be difficult for MCBS.

DR. MARK MILLER: I'm sorry, can I just say one thing? There was also some discussion in the paper where some of the research literature has tried to parse, and you got all that.

MR. BUTLER: [Off microphone.] Can we go to Slide 10? You know, we've heard the RAND study cited many times here and I haven't read it. But we know that the copays work and coinsurance work, but I'm less clear about how they define what's necessary and unnecessary services. Can you talk a little bit more about how that's done?

DR. SOKOLOVSKY: I think that no matter who does it, and remember, when they did it, what they would say was necessary and unnecessary, given how long ago it was, may well be different than what we would say now. I think it's always a fuzzy distinction that we're only now beginning to get a handle on just little parts of it. So I don't think that we can easily divide it that way.

DR. MARK MILLER: What I would say, and anybody who is deeper than this over there can speak up, but they used clinical consultants to sort of look at vignettes of services and then classified them from necessary to unnecessary. The difficult thing about it is if you look at it very carefully, there is like a small band that was defined as clearly necessary, clearly unnecessary, and then a bunch of stuff that was defined as not so clear. But I think, and this is where I could use some help, the assertion that it affects both necessary and unnecessary were the effects on tails or it was that it had pretty much an effect across the band of services. But Kate, maybe you --

DR. BAICKER: Well, one other commonly used metric when looking at that study has been the effect on health, that if you see reductions in spending and no change in health outcomes, you say, oh, spending wasn't doing that much, whereas if you see substantial changes in health, then you wouldn't conclude that, and most of the population didn't see much change in health, but there were some exceptions that you've mentioned, looking at, for example, low-income people with chronic conditions. You did see

changes in their health associated with the utilization. But most other populations, it was too small to observe.

MR. BUTLER: Okay. Here's the reason I'm asking, among others. We have a slide, also, that shows how there are no -- this ridiculous copay for hospital care the first day, which seems like it is necessary, yet, you know, and so we -- I'm trying to think ahead and where you would put your copays and deductibles, and if we kind of just take, for example, hospital off the list, I could say, well, what about a joint replacement that maybe is questionable for a 90-year-old that goes into the hospital. How do we factor those kinds of things into it? My guess is that RAND didn't get into that kind of differentiation.

MR. HACKBARTH: It sort of gets into the value-based insurance design and distinguishing between low-value and high-value services. More of the work has been on the high -- rewarding people for going to high-value only if you, as Julie and Joan have reported, have bit off the task of increasing copays for low-value services.

DR. SOKOLOVSKY: I mean, one thing that RAND did find was that the biggest change was in physician outpatient visits, hospital much less affected.

MR. HACKBARTH: Yes. And I think that goes hand-in-hand with the finding that the biggest effect is on initiation of care. Once a person is in the system, cost sharing has less of an effect.

MR. BUTLER: And, of course, the RAND didn't -- is under 65, so all the end-of-life issues are probably not as well addressed by that study. Is that fair?

MR. HACKBARTH: Yes, and I think the fact that RAND did not include Medicare beneficiaries is a significant limitation on the -- potential limitation on the applicability of results for this population. Nancy?

DR. KANE: Yes. I think going to that point, that a lot of even the studies you are citing are not on Medicare people, the only place I can think of where there would be significant experimentation around cost sharing design would be in the MA population, but do we know anything from them about what they've tried and might that not be a good place to look for innovative cost sharing -- if, indeed, there is some. I don't --

MR. HACKBARTH: This is where Bruce asks about when we are going to have encounter data --

DR. KANE: Encounter data.

[Laughter.]

DR. KANE: But this isn't asking so much about encounter data as what are the MA plans -- do we know something about what the MA plans are doing around -- because I'm sure they're pretty smart about it --

MR. HACKBARTH: Yes.

DR. KANE: -- and I wonder if we can even --

MR. HACKBARTH: In terms of trying to assess its effect on utilization --

DR. KANE: Exactly. I didn't even want to go there, because I knew Bruce would.

And I guess the other question is, are there any pilots or demos at this point using any kind of cost sharing, or is that -- are all these demos and pilots, you know, there's hundreds of them, it seems like, but is anybody trying to do anything with cost sharing or is it all provider payment pilot demo experimenting?

DR. SOKOLOVSKY: I'm certainly not an expert on that, but I don't know of demos that are specifically addressing beneficiary copayments.

DR. KANE: And we don't know anything from MA plans about how they're using cost sharing?

DR. SOKOLOVSKY: I'm looking at Scott, and he doesn't seem to want to get up here and say anything, so --

[Laughter.]

DR. CASTELLANOS: Just on slide 16, you talked about these interviewers. Is this the same panel that you discussed in the --

DR. SOKOLOVSKY: No, that was a separate project. I think that the results from the panelists were very complementary to the results we heard in these interviews, but those were much more about addressing how you identify high- and low-value services was the main topic of the panel, although they ended up getting into many of these same issues. And in the chapter, I'll try to integrate both of those sets of findings.

DR. CASTELLANOS: I just had a problem with the panel because I didn't see any physician representative or hospital representative on that panel, and I was just wondering, in the interviews, did that involve some physicians or hospital people?

DR. SOKOLOVSKY: Actually, about half of the panelists were physicians. In terms of the interviewees, there were physicians that we interviewed, but most of them

were connected to payers because what we were talking about was the benefit designs that payers were developing.

DR. CASTELLANOS: Okay.

DR. SOKOLOVSKY: But we would -- I mean, the physicians that we tended to talk to were, say, the medical director of an insurer.

DR. CASTELLANOS: Okay. I have some other questions for round two.

MR. HACKBARTH: Herb?

MR. KUHN: I have two quick clarifying questions. One is at the end, when you were talking about the discussion questions, you were referencing high- and low-value services, but hasn't the Medicare program already begun that process of differentiating? For example, preventive services don't have a copayment, correct?

DR. SOKOLOVSKY: Yes.

MR. KUHN: So the Medicare program has already kind of put its toe in the water in that area.

DR. SOKOLOVSKY: Yes.

MR. KUHN: Okay. And the second thing is when you were talking about incentivizing enrollees to seek high-performing providers, you were talking about different

strategies that different payers were pursuing, and I was curious, with the preferred provider network strategy that some of them were looking at, did they share with you the detail that when there are certain providers that might be providing very high-quality care but it's a very difficult population that they have? Maybe it's inner-city clinic or hospital or a teaching hospital that happens to be in an inner-city area. Did they have any kind of adjustments to kind of account for other associated costs that might be part of that? The care could be extraordinarily high quality, but there could be additional costs just because of the difficulty of that population they serve.

DR. SOKOLOVSKY: Yes. They obviously didn't share their algorithms with us, but they did say that they could not use the same algorithm across their entire book of business, that they had to adjust for things like that and also things for if it was in an area where there was a low volume of providers, they had to make sure that there were enough providers that their enrollees would have access.

MR. KUHN: I hadn't thought about that one, but also the sufficiency of network that they could choose from.

DR. SOKOLOVSKY: Yes.

MR. KUHN: Thank you.

DR. BERENSON: I have a couple of questions around supplemental insurance. If you could go to Slide 6, I want to focus on Plans K and L, which, from the written material, they were introduced in 2003 and have cost sharing, 50 percent and 75 percent of the Part B coinsurance amounts, and the slide suggests they also have a 50 percent coverage of the deductible, and nobody picks it even though they have lower premiums. And it would appear that this would be a smart choice for a low-income, low-utilizer person, and yet the market isn't rewarding -- isn't sort of producing that result.

So I guess my question is, is this instructive for us as to the willingness of Medicare beneficiaries in general to be told that they have to have cost sharing in their Medigap plans? Have these been around long enough? Is there some reason related to marketing or something else as to why fewer than one percent of the population is actually selecting plans that would seem to be rational choices for some people? Do we have any explanation for that?

DR. SOKOLOVSKY: Once again, I don't see --

DR. MARK MILLER: Scott, can you get a microphone?

DR. SOKOLOVSKY: -- Scott rushing up here --

DR. HARRISON: Joan, you introduced K and L, though. K and L are yours.

DR. SOKOLOVSKY: That's true. I did.

DR. HARRISON: I think K and L are seen as very complicated. When people try to sell them to the beneficiaries, it's a very complicated design structure and they don't know what 25 percent of usual coinsurance is. I think there's more hope in the new Plans M and N, particularly N, which is a set copay for physician services, $20 for a physician office visit and up to $50 for an emergency room visit, and I believe the industry is optimistic that those are going to be selling.

DR. BERENSON: Okay. That helps. My second question goes to -- this was in the written materials, I don't think there's a slide about it -- which is real important in terms of deciding whether to -- in my view, whether to recommend more rationalizing cost sharing and covering catastrophic, which is the evidence around whether having supplemental insurance affects basic spending in the Medicare program. I mean, in the written materials there's

the citation to Atherly, which discusses studies that attribute at least a portion of higher spending to an insurance effect find a spending increase of about 25 percent with a range of six to 44 percent. But then you cite a couple of studies that were actually done before Atherly which says, oh, no, it's mostly selection bias.

Do you have sort of a global judgment about what the truth is in this area, about what are we supposed to do with conflicting sort of studies about whether or not if we actually had people not have first dollar supplemental insurance, would that affect spending in the traditional program?

DR. SOKOLOVSKY: I think that the reason we keep falling back on RAND is because it's the only experimental random -- where you can clearly say this is not about selection. But what Atherly, as I understand it, what he's trying to say is that studies don't take sufficiently into account the heterogeneity of the population and that the effect of cost sharing is really different for people in good health versus people in bad health, that it has much less effect on people in bad health than people in good health, for example. And there is a big range. And he says

there are ranges that affect other things, like ethnic status, for example, and that the number that you would come up with would vary within that range based on how you take into account the population. I think that he's probably right, but I also think that even at his lower bound, it's probably a lot of money.

DR. BERENSON: No, I -- I mean, that's right, but the suggestion was that a couple of other authors didn't even think the lower bound -- they thought the lower bound was too high, and so should we have confidence, I guess, for our deliberations in sort of even the lower bound, I guess, and you're suggesting, yes, we should, I think.

DR. SOKOLOVSKY: I guess that's what I'm saying.

DR. BERENSON: Okay.

DR. MARK MILLER: And just so that Joan doesn't feel that she's carrying that all herself, there is some conflict in this literature, but I think what does come through is there is an insurance effect. It's not small. I saw the Atherly stuff as sort of expressing the difference along the continuum, but by and large, he came up with the same effect that other researchers had come up with. Is that right, Joan, roughly?

DR. SOKOLOVSKY: Yes.

DR. MARK MILLER: But he was saying, bear in mind, it's not always one number, you know. It varies through the population. So I don't want to go too far, Joan. I would even say Atherly thinks that there is an insurance effect here. It's not nominal. But it may vary depending on service, person, health, you know, that type of thing.

DR. SOKOLOVSKY: Yes.

DR. STUART: I'm not going to ask my favorite question here.

[Laughter.]

DR. STUART: No. I want to follow up on a point that Bob made because I think it's really important, and that is you've got two kinds of price responsiveness here. One is price response to the actual cost of the service at the time of service use, and then the other is price responsiveness to the insurance that covers these things.

So Bob was asking, well, how come nobody gets K and L when it looks like they have a lower premium and lower coverage. Scott was suggesting that that's because these are complex policies. It's difficult for people to figure out what they are.

But I think the other point is how good a deal are they relative to the premium, and what we know is that there's a lot of variation in premiums for the same coverage across markets. And so I think that's something that we really should understand, and it may well be, and I don't know whether these services are out there currently, but providing more information to people, particularly in light of complex design so that individuals could make a rational decision in terms of whether something that had a higher copayment but a lower premium, whether that was a good deal or not, it might or it may not be a good deal.

MR. HACKBARTH: The other possibility here is that people are willing to spend a little bit more if it's predictable as a way of smoothing out their expenditures. Basically, they're buying insurance against variability in their out-of-pocket costs. And if you're on a fixed income, that kind of insurance may be something you're willing to pay extra for.

DR. STUART: Well, and I think -- I'm not familiar with research on this, but I would think that would certainly be a research area that one would certainly want to look at. You're right. I think having that stability is

really important.

MR. HACKBARTH: Now, having said that, even if that is understandable, logical, rational behavior for individual Medicare beneficiaries, it still raises the question of whether that is in the interest of the program. It may or may not be.

DR. STUART: Right. Well, I think as long as we have an iPhone app for that, we'll --

[Laughter.]

MS. BEHROOZI: Thanks. Can you please turn to Slide 4, and this information may be somewhere in the paper or in what you've described for us before. I wonder if we can set up another column that says what percentage of each of the people in that band have supplemental coverage or not, right, because this just tells us what the cost sharing would be if they didn't have supplemental coverage, right. So it's, I guess, a little related to what Kate was asking about in terms of are we -- does it end up that the people who would have the high cost sharing are, whether it's because of the insurance effect or because they are sicker so there's selection bias, do they end up being more covered by supplemental coverage, because between this and Slide 9,

which tells us how much people in these categories spend, I'm not sure I feel like I understand how many of the people who would be subject to these high payments, and also the overlay of what their socioeconomic status is, which you also have in here as a separate factor, what that overlay is, what the sort of more composite picture is. So I don't know if it's in there and I couldn't find it or if it's even possible to do that.

MS. LEE: With respect to your first question on Slide 4, with our upcoming analysis of 2009 data, we should be able to get some -- or it won't be perfect, but most of their supplemental -- yes. So we should be able to get a cut at that. It's not going to be as internally consistent as the data coming out of MCBS, but we should be able to get some idea.

MS. BEHROOZI: And so I guess my question then on this slide is, like, so what's the distribution in terms of numbers over each of those columns, each of those bars? You know, in that highest 25 percent spending, we see people spend a lot of money if they have Medicare only, but is that relative -- is the portion of people who occupy that space, that very high-spending space, how does that compare to the

relative proportion of people who are poor or the relative proportion of people who are Medicare-only people? Do you know what I mean? That could be over-representative or under-representative of Medicare-only people in the population.

MS. LEE: I am not quite sure, but I can follow up with you on the specific requirements. We should be able to look at that data by various income spending levels and supplemental coverage.

DR. MARK MILLER: [Off microphone.] The benchmark you are looking for, the benchmark to the broader population to figure out how representative that particular slice is.

MS. BEHROOZI: Right. Clearly, it's a huge problem for the individuals who fall in that column there. How big a problem is it over the whole program?

DR. MARK MILLER: Yes.

MS. BEHROOZI: It could be bigger than it looks there or it could be smaller, quote-unquote, than it looks there, and I think it might be helpful to know.

DR. MARK MILLER: Well, we'll talk. I might have an idea. I think I understand what she's saying. And then we'll also have to connect back on Kate's point about

adjusting this for income, because that, I think, was what Kate was asking for. Are you with me?

MS. LEE: Actually, I did not get that last point.

DR. MARK MILLER: All right. Well, then don't worry about it. It's this. This is an incredibly complicated chart, every time we try to put the damn thing together, and you're asking us to, like, I think, have a benchmark for these populations relative to the total population, and I think there was an earlier question over here what it looks like -- oh, by health status. That's what you were asking, by health status. So we're going to have to go back in on this thing again, as much as -- as difficult as it is.

MR. HACKBARTH: Scott?

MR. ARMSTRONG: So given that this is still my first year through this cycle, I still reserve the right to be shocked every once in a while, or surprised. I have to say I was really unaware of how enormous the out-of-pocket costs are to some of our beneficiaries. The question that I have, and Nancy may have been going here or this may have been what Bruce registered as his question but didn't have to say it, is whether we have ever tried to compare these

out-of-pocket costs or other benefit features of straight-up Medicare fee-for-service, Medicare plus Medigap, and Medicare Advantage, and for me, it raises questions about the comparability in both overall cost, but out-of-pocket costs and then benefits of those as three different slices on the populations that we serve. So is that a look that we have seen before or do we think that that would be valuable to us as we're considering some of these?

MR. HACKBARTH: Are you asking what the actuarial value of Medicare is versus Medicare plus typical supplemental coverage versus Medicare Advantage? What percentage of projected expenses are paid by each of the three types?

MR. ARMSTRONG: I think so. I'm not sure exactly what I'm asking for, except that the Medigap policies neutralize a lot of what we're trying to do through our payment, or through our incentive structure --

MR. HACKBARTH: Right.

MR. ARMSTRONG: -- and yet they don't add any of the incentives around how care is organized. And I'm not sure exactly, but I think they probably also have a similar effect on the out-of-pocket risk of the beneficiaries

1 themselves, although I don't know.
2 I mean, we've talked about some of this benefit
3 design work may be informed by looking at what MA plans are
4 already doing, but it seems to me you'd want to start out
5 with just some slightly more objective comparator between MA
6 on these bases with the way in which we've done this
7 analysis already. So --
8 DR. BERENSON: I would just point out that I'm all
9 for doing the analysis, but MA plan has had a lot more money
10 to play with to have a more generous benefit package, so
11 that has to be taken into account with any comparison like
12 that.
13 MR. ARMSTRONG: Well, you're talking about a ten
14 percent or so cost differential. Well, I think it would be
15 interesting to see how that compares with straight-up fee-
16 for-service or straight-up fee-for-service with the cost of
17 the Medigap premium.
18 MR. HACKBARTH: I'm not sure if this is what
19 you're getting at, Scott. When we do our comparisons of MA
20 plans to traditional Medicare, what we use is the bids for
21 the standard Medicare benefit package. So we don't compare
22 different benefit packages. So we compare HMOs as a type of

MA plan, what is their bid on the basic Part A and B benefit --

MR. ARMSTRONG: Right.

MR. HACKBARTH: -- to what it costs Medicare to provide that same basic A and B benefit, and the answer comes out, like, HMOs, on average, have 97 -- their bids are 97 percent of the cost of traditional Medicare. That is an apples-to-apples comparison. Is that what you're trying to get at?

MR. ARMSTRONG: Yes, I think so. I'm not sure how to ask the question. It's just that this chapter led me to understand not just the cost to the Medicare program of the fee-for-service benefits, but also the out-of-pocket structure for beneficiaries, the incentives that exist to spend thousands of dollars out-of-pocket for a Medigap policy, and it just made me wonder how net from the program perspective but also from a beneficiary perspective does that compare to the experience of someone in an MA plan.

And it's also influenced by a bias that you have real problems with fee-for-service supplemented with these Medigap plans because it neutralizes so much of what we're trying to do, whereas we turn to MA as a point of reference

for trying to replicate these things. Maybe the difference isn't as big as ten percent.

So it's not a very well formulated question. You may be saying, well, we do this analysis all the time and then maybe I should just look at it, or --

MR. HACKBARTH: [Off microphone.]

MR. ARMSTRONG: Okay.

MR. HACKBARTH: [Off microphone.]

MR. ARMSTRONG: Okay.

MS. UCCELLO: Okay. I'm looking at Slide 9, and I know there's a lot going on here, so I'm trying to make sure I'm interpreting what it's showing correctly. So presumably, the rationale behind getting a Medigap plan is that you're getting more certainty in what your total out-of-pocket costs are going to be. So you're paying a premium in exchange for certainty.

But now if we look at moving from the lowest 25 percent to the highest 25 percent, there's still a pretty big shoot-up in the total cost as a share of income. So I'm trying to kind of figure out, is this a consequence of lower, perhaps lower average income among the people who are in the highest spending, or is it just not providing as much

protection as you would think? I'm just trying to figure out --

MR. HACKBARTH: Comparing, say, the Medigap bars in the two sets, and why is the increase in the second group for the high spenders so high relative to the first group.

MS. UCCELLO: Right. And even if we look at the Medigap in the graph on the right compared to Medicare only, you know, it doesn't seem like it's that big of a savings.

MR. HACKBARTH: Right.

MS. UCCELLO: And I'm wondering, maybe if we looked at the top five or ten percent of spenders, would that show a larger gap between those, or is it like the income effect, because these are different -- these are not the same people. So I don't know how to think about this.

MS. LEE: Among the lowest spending beneficiaries, in Medigap, the burden is high because it's the premiums that makes a big share for that group. In terms of income, that group is somewhere in the middle, between low-income and high-income. So I don't think that is skewing the numbers in any particular direction.

In the highest-spending quartile, it's still -- the out-of-pocket, it's big because they are spending a lot.

Now, in terms of it compared with something like ESI, where it seems to have a much better protection at the upper end, I actually do not know that except reason the benefits packages for those ESI types of benefits, that that is quite different. So we can look into that in more detail.

DR. SOKOLOVSKY: Can I add something? Julie is still in the process of updating this, but this is from MCBS. They don't really separate out A-B from other services. This is 2005, so there's a lot of prescription drugs in the out-of-pocket spending that we may not see when she updates it.

MS. UCCELLO: Well, I'm wondering if another way to look at this is also partly an actuarial value, or if you have prototypical people, maybe instead, and say, okay, if this person is a low spender versus a high spender, what their relative -- because I'm kind of surprised to hear that out-of-pocket spending can still be really high for people with Medigap given we keep talking about how they cover everything. But if it's drugs, well, that could be -- I mean, maybe that's just the whole story, but --

DR. BAICKER: A quick point on that. The income question -- the fact that they're different people seems

really important. The income differences seem like they should be exaggerated among those with income greater than 200 percent because that's such a big range. So then if you just look at the income below 200 percent, you're still seeing that surprising gap in Medigap protection, which is part of why I was wondering if it's more about health selection. If it's not selection based on income, because we've made a pretty narrow income range, maybe it's selection based on health.

DR. STUART: [Off microphone.] That includes --

DR. BAICKER: Sure, but I think what's puzzling both me and Cori is the big different in -- among those with Medigap, why should there be such a big jump in expenses relative to income for the lowest 25 percent of spenders to the highest 25 percent of spenders if Medigap coverage were really comprehensive, and it could be it's not because of Part D. It could be that it's different people who are in each of those bins, so either they have a different denominator for income or they have a different underlying risk for health. But I think that's the fact that we're trying to understand.

DR. STUART: But I think, again, we need to be

really careful here about who these plans are being marketed to, and I, for one, would be very hesitant to make the assumption that this is an actuarially fair market, that people that have a particular expected spend are going to pay the same premium. It may well be that there is selection by the -- screening by the insurers so that people that have a high expected spend end up paying more premiums. I don't know. But if I were selling this insurance, that's sure what I'd want to do.

MS. UCCELLO: Can I ask a follow-up to that? The underwriting rules -- is it guaranteed issue when you're first eligible or can they even be underwritten then?

DR. MARK MILLER: Scott?

DR. HARRISON: You get a guarantee issue period. I think it's two months when you first join Medicare that they cannot underwrite. But as you get older, your premiums can go up, so --

MR. HACKBARTH: If you are continuously enrolled, the only increase is due to age bands as opposed to health status.

DR. HARRISON: Right. Right. Now, actually, if the higher spenders were older, they would have higher

premiums. They might also have lower incomes. Maybe that's part of this, too.

DR. MARK MILLER: Scott, I also wanted to ask you, as long as I've got you now at the table, the most popular Medigap policies, how extensive is the catastrophic coverage?

DR. HARRISON: They don't have catastrophic, but there's no out-of-pocket, either, because they cover everything.

DR. MARK MILLER: So --

DR. KANE: [Off microphone.]

DR. HARRISON: For A and B, right. No, there's no out-of-pocket cap because there's no out-of-pocket, right? They fill in everything for Medicare-covered services.

MR. HACKBARTH: But they also cover days beyond the hospital day limits and SNF day limits?

DR. HARRISON: They do. They go up to 365.

MR. HACKBARTH: So in that sense, there is catastrophic coverage that isn't --

DR. HARRISON: Right. Now, actually, I guess I could go back to Nancy's question about the MA plans. MA plans now have to have a catastrophic cap. CMS required all

plans to have a catastrophic cap. Now, they're pretty high, but they now all have them, I believe as of 2011.

DR. MARK MILLER: We've identified a number of things that could explain the Part D, the fact that somebody may be choosing their way into this based on their expected needs. But what I'm trying to pin down is the benefit design in any way related to this. I'm just confused with the last exchange. So there is a catastrophic cap or there is not?

DR. HARRISON: There is not. Some of the waiver states have some catastrophic caps because they include drugs.

DR. MARK MILLER: Yeah, but I'm thinking like the most popular plans.

DR. HARRISON: Right. You're not paying any cost sharing so there's no catastrophe to get to really.

DR. MARK MILLER: Okay.

DR. KANE: If this is pre-Part D, and I know is still paying, it's about 80 percent drugs. So I think it's harder to understand what's really going on.

MR. HACKBARTH: It could be a significant factor here. Let's see. Tom, any clarifying questions? My

clarifying question was going to be the same as Bob's about the Atherly Study and what's our bottom line on the effect of supplemental coverage on total cost. I was, frankly, surprised to read the chapter, and it seemed quite equivocal to me compared to things we've previously written.

I remember when Chris Hogan did his analysis and we wrote that up in a chapter, what, two years ago now, something like that. We had a paragraph mentioning some of the studies suggesting selection of facts and maybe analyses like Chris's or over-statements, but we seem to give much less weight to them than we do now.

This is a central premise of much of the work that we're talking about. If you're not confident that, in fact, you save money by introducing copays and requiring that they not be covered -- preventing them from being covered by supplemental coverage, that's a really core issue for us.

So I, for one, want to go back and look at the language here some more and study it and maybe ask some additional questions about the studies so I have more confidence in my own judgment about what the analysis shows.

Round 2 comments, beginning with Karen.

DR. BORMAN: I guess I have two really. One is

just sort of a procedural question, as we delve into this particular piece, since we're now starting to really look at a Medicaid effect, is there reason that we should be dialoguing about this with the MACPAC and trying to make sure that we work toward shared understanding? Is there something that -- I'm confident that Mark and the director from MACPAC are sharing whatever we need to share, but is this an area that as we continue to move forward, that at least for this piece of it, that we should have a shared strategy so that we're just kind of not off in parallel worlds?

Then my other piece is, I'm certainly not smart enough to dissect the economics and statistics of this graph, but I think as I step back and think about this issue, it strikes me to have some similarities with some other things that we talked about.

I think, as Scott points out, we all get moved by the recognition of the financial burden that a -- the intense financial burden that a relatively small subset of people may bear and we want to make that go away. It's sort of part of being American and wanting to do the right thing.

I think in that discussion, however, in fairness

to our job to look at the program, we need to make sure we don't lose sight of where we're shifting that to and what is the level of burden that we're putting on people that perhaps are making good choices who have utilized whatever benefits of their environment, albeit earned or unearned, to get to certain places.

We just want to make sure that we don't get emotionally driven to deal only with one part of this or acknowledge only one part of this, and make sure that we have a clear understanding of some of the things that are happening to newer beneficiaries, to people that are already in it in income tiers, and some of those kind of things, and make sure that we have protections on both ends in some fairness.

But I will say that I think this conversation about benefit design and the conversation about what the 21st century beneficiary looks like and what that population is are the two most important things at the end of the day that we probably work on as longer term issues. And so, I fully support this and staff is coming at it in the usual wonderful way.

I just think we need to make sure that as we

identify an outlier that went in, let's make sure we understand what the other end is, and maybe the best we can do is build in some protections for everybody. We can't make everybody whole or make everybody equal.

MR. HACKBARTH: Let me pick up on that and ask a question and give people a chance to react to it as we go through Round 2. To me, in talking about redesign of the benefit package, it's important to be clear at the front end what your goal is. One goal for redesigning the benefit package might be to update it, rationalize it, restructure it so that new elements could be added like catastrophic coverage or maybe other things that I haven't thought of.

But you're working within a fixed amount of money and saying, Let's get the most bang for the buck for the beneficiaries out of this pool of dollars. That's one type of exercise. Now, when you do that, there are going to be winners and losers within the beneficiary population. It's important to think about that. But the goal would be to, on average, come up with a benefit package that made more sense for Medicare beneficiaries given the fixed sum of dollars available.

Of course, a very different sort of exercise is,

Well, let's figure out ways to reduce Medicare expenditures, reduce inappropriate utilization, dah, dah, dah. I think if you sort of bounce back and forth willy-nilly between those two, you really confuse your analysis and your thinking. My hunch is, we'll be a lot more effective in our work if we figure out at the front end which of those exercises we're trying to do. George?

MR. GEORGE MILLER: Thank you and with that in mind, my comments will try to address that. You mentioned about the goal. It would seem to me that we have three distinct parties in this transaction or this issue. You have the patient, the consumer; you've got the provider; and you have the insured, or the Federal Government. Somehow it seems to me that we ought to try to marry the incentives of all three together into one effective unit so that they're all coming at it the same standpoint, from a goal perspective.

And so, from my perspective, one of the goals ought to be, as the paper so clearly pointed out, I wanted to highlight one of the examples that was in the paper dealing with the joint replacement, that one group talked about taking the patients to Singapore, procedures including

paying for a spouse to go or a friend to go with them, but they never had to use that because the providers in the community didn't lower their price.

So one of the goals should be to try to incentivize high performers and/or low cost providers in a way that's unique. In some ways, what works in one community may be different than what works in a different community. So part of that goal has to be improving the outcomes in the community so that we give people the freedom to be creative and not be prescriptive that everybody must do the same thing.

And then the second part of that, and it was in the paper also, which I thought was very well done is -- and again, I mentioned earlier that the consumer has to take a role in this in providing incentives to have healthier behaviors, and if they don't choose to follow evidence-based medicine like stop smoking, lower weight, and dealing with those other issues, then no matter where the income is they pay a higher premium for that to help incentivize and align those theories. So those are some of my thoughts here.

DR. BAICKER: So you've obviously given us a great deal to think about, and Mike's not here to talk about

value-based insurance designs so I feel like I need to put in just a tiny extra plug. I thought there was great discussion thinking about moving towards promoting higher value use, but as you harken back to the expert panel, it's so hard to say a particular service is of high value to a particular subset of the population, and even in the Rand Study where there was an attempt to figure this out in other contexts, too, you've got a small slice that you can say this is low value and a small slice you can say this is high value and a whole bunch of stuff in the middle that you say, uh-uh, and that's not a great way to -- it's not a great platform on which to restructure benefits.

So I'm very much in favor of moving towards value-based insurance design, but the implementation challenges seem substantial enough that I don't know whether the answer can be a list of copayments that vary for different services for different patients at different ages with different comorbidities at different providers, or whether there has to be some other mechanism for injecting that value-based copayment into the system that isn't by an inevitably immediately outdated list that I'd like to try to avoid.

And it reminds me of some patient reactions to

tiering of providers in private insurance plans where they're the lower copayment, higher value providers that are supposed to be higher quality and lower cost. And, of course, enrollees, not unreasonably, think, well, if the insurer told me that this provider is higher value, that means cheaper. It doesn't mean better. And people may react very differently.

It's natural, as an economist, to think of value, you know, benefit per cost. But people are reacting very differently to the benefit part than they are to the cost part, even though the ratio might look the same, and we would have to be cognizant of that as well in thinking about more flexible insurance designs.

DR. NAYLOR: Thank you. This provoked a lot, and honestly, before anybody even said it, I think the first thing we need to do is update the Rand experiments. We quickly rely -- call on it all the time, so it seems it needs to be done with the Medicare population, et cetera.

MR. HACKBARTH: After 15 years.

DR. NAYLOR: After 15 years, and let's include the population that we're interested in really focusing on. Certainly, as we try to uncover what problems are causing

certain people to bear certain burdens, I think we should work toward, you know, even in the short-term, protection.

So one of your questions was, how important is that as a priority? I think that's a priority. The other message is -- this is not my world, but it sounds as if this multi-pronged approach that everybody else is thinking about ought to be something we think about. So as we talk about cost-sharing, how then might we link it not just to efficient providers, but effective providers. I think it has to "and," not "or."

And the other notion of high value/low value services, I'm wondering how this work aligns with the benefit redesign recommendations of the IOM Committee going forward. So the question about how we can -- I mean, it sounds like there's already natural work already going on with CMS saying preventive services have no copay. But then we have another group that's really looking at this. So how could our work and efforts align with some of their recommendations?

MR. BUTLER: I don't have an easy answer, but I think to begin with, the way you clearly laid out at the beginning that first this is a big problem, that there's no

method to -- it's just very educational saying, this doesn't make any sense, look what we have, and throw Part D in there on top of it. You've made a good statement.

Then second, I think most of the consumer engagement now, including like means testing, is at the premium level, and the general point that if it's only at that level, you're not taking advantage of tools available, no matter what your goal is. So the next step then is how do you then address below the premium level, whether even inject means test there or how do you use those?

If you kind of use that in recognizing this third piece we're not too clear on yet, at least you've educated, you've said, the only place you're applying the consumer at the premium level now, we need to get to work more on the copay. I don't know how far we'll get in this round other than in the June chapter, but it lays the groundwork for future work, I think.

DR. KANE: Well, I was talking at lunch about being on an employer's benefit committee around what to do about our post-retirement benefit package, which we self-insure and self-fund and so I kind of know what's in it. I think we have these consultants who are constantly telling

us, Well, if you had a copayment here, this will happen to your costs. If you had a cost share there, this -- so there's a bunch of people who have some knowledge of the Medicare population who are advising employers. And it might be interesting to get a panel of the Mercers and Hewitts and four or five of these actuarial employer post-retirement benefit and consultants to get in here and tell us at least what they know about behavior under different types of cost-sharing arrangements.

And there's one more type of cost-sharing arrangement, by the way, that's getting very popular these days in the employer post-retirement benefit which is defined contributions, which leaves all the value definitions up to the consumer entirely, I think. You know, you get MR. HACKBARTH: amount of money and go out and see you later. Hope it covers something.

So anyway, it might be useful to help us understand our own handle on what does all these cost stuff do to behavior to get people who have actually experimented with it quite a bit, which is the employer market.

MR. HACKBARTH: And, in fact, one of the reasons that we're having this conversation is because of John

Bertko. John was absolutely convinced that based on his experience with Humana, that changing the copay structure would affect behavior to the point that he regularly said that he wanted to outlaw complete coverage of the copays and deductibles because he thought we were missing an opportunity. So that's example one, but there's -

DR. KANE: There's other data. There's huge employer data sets out there that we are constantly looking at on this committee so I know they're out there, and I should think they would be willing to come and talk about what they know about it. I think it's based on the population that we're talking about and not some under-65 population of 20 years ago, 30 years ago.

MR. HACKBARTH: Ron?

DR. CASTELLANOS: Being a surgeon, and in my field, I think a lot of things about surgery, and I think there's a great Medicare experiment that's been done on reference pricing that works and that's the presbyopic lens that cataract doctors use. They pay a certain amount of money for an excellent lens and if the physician or the patient feels something else is needed, the patient can pay the difference, and that's reference pricing.

I'm just curious why that hasn't been applied to knees and hips and pacemakers and all that stuff. I know we briefly talked about reference pricing, but we never went any further than just mentioning it as something. But it's something that I think is working in Medicare. Maybe you can give us some background about the presbyopic lens and how successful it's been and whether patients are using that or are they paying the difference. I think that's a great experiment that has been used and we should maybe gather some information from it.

There's another point that I kind of wanted to mention, and we'll talk a little bit about it tomorrow, something that, Glenn, you and I have talked about. When we defined efficient providers, we talk about high performance/low cost providers. But the care has to be consistent with clinical appropriate guidelines.

I'm going to be asking tomorrow that perhaps the societies can get some help with this clinical appropriate guidelines, but we can talk about that tomorrow.

DR. BERENSON: Yeah, a few things. First, I wanted to make a comment about the Oregon approach in value-based purchasing, if you could put up whatever slide, 13. I

mean, I think -- and this I'm taking from the written material. Level 3 focuses on "services that are nationally recognized as overused and driven by provider preference or supply rather than evidence-based need."

I think the flaw in this sort of logic is the assumption -- I mean, this came out of Jack Wennberg in pointing out different kinds of services, but it assumed that these categories are mutually exclusive when, in fact, in one patient, a CABG is absolutely evidence-based. In another patient, it may be preference sensitive. In another case, it may be supply sensitive.

The problem of applying Level 3 is -- I mean, the examples you've got in the paper, upper endoscopy, outpatient MRI, CT/PET, spine surgery, CABG, angioplasty -- is in probably the majority of cases. It's appropriate and necessary for the patient even though there's a lot of misuse of the services. So I don't know how you operationalize a higher cost share and be able to distinguish. It would require one to have to get the specific clinical indications in each case.

So I just don't think we're ready. I'm attracted to going towards models that have decreased cost-sharing for

things that have higher evidence of positive effect, but I don't know how to operationalize except where in those circumstances where a service isn't of -- doesn't provide a benefit in any case, but it is truly preference sensitive, and I would say that's a brand name drug in place of a generic. I don't know how you operationalize it.

And so, I don't think we want to spend a lot of time on that, but I'm happy to -- I mean, the world is exploring this and I think the world should explore it. I don't think we should spend a lot of our own time on that.

My second point, I wanted to pick up on Scott. I think Scott's suggestions are helpful. I think what we do now is a comparison of the actuarial -- to provide the Medicare statutory benefit package, we do an analysis of different kinds of MA plans compared to traditional Medicare, and we typically find that HMOs do it slightly less expensive and GAO actually just did it and has a different number than we do, a little bit different. They suggest that HMOs are even a little more efficient than not.

PPOs are less efficient and then private fee-for-service is way off at the end. But you're asking, also, since we are talking about how do you fill in cost-sharing,

how do you provide extra benefits, I think there is possibly a useful analysis which compares Medicare with Medigap versus Medicare and Medicare Advantage, recognizing that Medicare Advantage has more money so we would have to do that.

I don't think the Medigap option is going to hold up very well. I believe that kind of analysis has been done. It sort of comes out of -- Ken Thorpe does this kind of an analysis - as the explanation for why disproportionate numbers of low-income people above Medicaid select Medicare Advantage, because it's, in fact, a better deal than going into Medigap.

But then that brings up a third area which you guys didn't really talk about, to make a simple problem a little more complicated, is Medicare savings programs, QIMBs and SLMBs, and the program that actually does fill in cost-sharing for a sliver of the population and putting them in the analysis.

So I don't know. So I think it's possible that such an analysis could be done. I don't know how you adjust for the extra money that MA plans have at this moment. There was a time in which they didn't have extra money.

So in any case, let me make the final point I wanted to do. On the discussion questions you asked us, let me answer them from my point of view. It was on Slide 17. Should Medicare rationalize cost-sharing? I have been one who thinks yes, that as we've pointed out in previous meetings, we have no cost-sharing in some areas, zero cost-sharing in other places. We have substantial cost-sharing. We have no cost-sharing in SNF for the first 20 days and then a big jump in the cost-sharing.

I think there's some logic to that and that brings me to the second bullet, which is, if we could also rationalize cost-sharing and provide financial protection to beneficiaries and if it doesn't cost extra money, because we believe that having a more rational package of benefits would mean that people don't have to go into the Medigap market and buy first dollar coverage. We could accomplish everything that we want to do.

If we came out and said, well, yes, we could provide financial protection and it's going to cost a bunch more money, I don't think the current world would accept that. But I think it's worth exploring whether we could rationalize cost-sharing, provide financial protection, and

not spend any more money.

And then the question on, should we set some cost-sharing for all services, part of that comes out of the literature, and Glenn has pushed a little bit on that. I've raised this at previous meetings. I'd be interested if there's any information, even amongst experts, on whether facing nominal cost-sharing makes somebody more vigilant around fraud and abuse, whether they get an EOB that says that they've got a $20 obligation to pay for a service that never occurred produces a different response from receiving an EOB that says, you received a service that you don't owe anything for.

I'd be interested in getting some judgment from people who might know whether having some kind of cost-sharing associated with a service, even $20 for a home health episode, would make somebody report to somebody if, in fact, no home health episode even occurred. I just think that's a factual thing that I'd be interested in, even again, expert judgment on whether that happens.

I know in the '90s, AARP had a campaign going on around reviewing your claims and reporting and all of that, so I'd love to get informed on that. That's it.

MS. HANSEN: Probably picking up again on -- Karen started off with this whole comment about perhaps where we would coordinate with MACPAC a little bit, so this is probably one of my final comments that I'll bring up during this last couple of meetings I'm going to be at, relative to just how the low-income dual eligible population, whether they are the typical dual eligible or the SLMB/QIMB population that Bob just brought up.

I've had some personal conflict about if the income is this low and any kind of cost-sharing would be difficult, on the flip side is, I think, Bob, just what you said, is there some modest trigger that is engaged with cost-sharing that doesn't cause people to not get needed services.

So it's a complicated side on the beneficiary side, but on the provider side, I'll just raise this. I've raised this before, that when you think of Part D services now, how when there is no cost-sharing or no consideration, it's totally opaque to the beneficiary, there's just some watch-dogging about use of certain -- they brand name pharmaceuticals as compared to generic pharmaceuticals that doesn't get felt by a dual eligible population versus

somebody who is price-sensitive and has to purchase a medication. They will pick, oftentimes, the generic just because the price is different.

So this is more on the part of the program savings that has to do with "cost-sharing" but from a different angle. So I just wanted to just have a final statement about just being focused on kind of how the dual eligible program operates now that also MACPAC is starting to get up and running.

It just seems like that segment of our population, be it rather small, I think we all know that the expenditures to the program are high and the needs are high, but is there a whole way of looking at the beneficiary side of this coupled with the payment side of it that could make a big difference in how that program has oversight and implementation?

DR. STUART: Well, we could spend the rest of the day on this. I have three quick points. One point that goes back to what Nancy said in the first round, and also Scott, about the variation in cost-sharing that Medicare Advantage plans use. I mean, we have a database that contains that information. It comes from Medicare Compare,

the Health Systems Management Plan database.

I don't know whether you have access to that, but it should be relatively easy to lay out the distribution of alternative plan designs that MA plans offer, and I think that would be particularly interesting with respect to how they have responded to this new requirement that they have catastrophic coverage. I can't imagine they've all done it the same way, so it would be interesting to see what that variation is.

The second point is, to a point that Ron was raising on reference pricing. We do have -- and it actually follows on what Jennie said, too. We have an example of reference pricing in LIS payments for Part D drugs. LIS charges currently for a generic, it's about $2.50, I think, and for a preferred brand it's $6.50. LIS does not cover the cost of non-preferred drug brands. And so, in essence, what you've got is that they pay the reference price. The reference price is $6.50 and then everything else is covered on that.

And then the final point, following up on Bob, how do you differentiate low and high value. I agree. I think doing the low value side is very, very difficult, but I

think one way that one might do this is, there's a lot more consensus on the value side. I mean, we've got preventive services, whether they're for primary prevention or whether they're for secondary prevention using drugs for chronic conditions.

Implement value there. In other words, reduce the costs there and then just raise the copayments for everything else. Don't make a distinction at that higher level and then we'll take our actuaries and figure out how much it has to go up to at least cover the extra cost.

MR. HACKBARTH: Let me ask you about that, Bruce. So in the preventive side, there have been significant steps taken towards reducing the cost-sharing on preventive services. The other big area is Part D, but Medicare doesn't control the benefit design there. Private contractors do.

So that's not really in the option set for what Medicare can test in terms of rewarding high value services. That's the plan's decision and we have this anomaly that the money comes out of different pockets. If they reduce the cost-sharing for some drug and they increase the utilization of that, the savings don't accrue to them and their plan.

They may accrue in reduced hospital days or emergency department visits to another insurer. So we've got potentially a disruption in the economic incentives to make prudent choices around benefit structure in Part D because of the wall between the two programs.

DR. STUART: Well, I guess my point -- I'd make two points. One is, let's learn about variation in cost-sharing in the MA market --

MR. HACKBARTH: Yes.

DR. STUART: And we can do Part D, too, but particularly in the MA market. I think that's important. And then the second thing is that the plans don't have control over what the cost-sharing is for LIS.

MR. HACKBARTH: That's true.

DR. STUART: That's standard for everybody.

MS. BEHROOZI: Thanks. Wow, this is really great. Thanks. So to your question, Glenn, about whether we should be looking, what should be our primary goal, I think that while I have a lot of concern for the people who face the tremendous costs without catastrophic coverage, I think that -- I'm not an economist nor really a business person, but I think that if you take the 90 percent of people who have

chosen to pay for or qualified for other people to pay for that additional coverage and you essentially bring them back into the Medicare program, so that you can cover the 10 percent who don't have additional coverage.

I'm not sure that that's economically like the right balance because yes, there's some induced demand. Medicare is paying some more because of the additional coverage that those people have, although we're very confused now about how much more Medicare is paying because of that induced demand, and the amount of cost that's offset by people paying for their own Medigap coverage or their contributions towards their employer-sponsored coverage or whatever, is costs that the program is not bearing and we'd have to figure out a way to reshuffle if it made catastrophic coverage available for everyone.

Instead, perhaps, the program could consider expanding the support, like in the exchanges for the people who are going to be newly insured, some kind of sliding scale of subsidies that goes beyond Medicaid, because, you know, my little wagon, dual eligible is not co-extensive with low-income and even the maximum level, I was reminded in the paper, for SLMB support is 135 percent of poverty,

and we keep talking about 200 percent of poverty as sort of a break point where we would think of the people under 200 percent of poverty as being low-income, not the 201 percent is such high income.

And, you know, on the non-Medicare side now, under PPACA, it's up to 400 percent of the poverty level where people could get a subsidy to pay for -- to put some of their own resources into getting that coverage. So I think that yeah, bringing it back into Medicare's design to address the problem of catastrophic coverage is not the most efficient way of doing it, but address the problem for that 10 percent of people.

And then the issue of induced demand and the insurance effect. I think that -- I feel like it's been sort of a catechism that I didn't grow up with and I've kind of had to learn it while I've been here. What I keep hearing, when people talk about the RAND experiment, is that the baby gets thrown out with the bath water; that both necessary and unnecessary service utilization was diminished by the imposition of copayments.

So I don't know. Does that lead to a good result or a bad result? I don't see that that necessarily leads to

a good result when you say that it's across the board the same. And then in RAND, they acknowledge that that effect tends toward the reduction of good utilization, good utilization, for poorer and sicker people.

We always use those terms, poorer and sicker, and like Peter, I haven't read it either and I should. I've read many things about it, but I don't know what that's relative to. Poorer than what? Are they talking about 200 percent of poverty or only before the Federal poverty level? You know, how did they examine that?

But I think that there is more evidence emerging and people are focusing on it differently. There's a passing reference to one of the articles written by Amitahb Chandra in 2010. I'm not sure which it is because it's actually not in the back, but I can tell you about that later. But one of them was a study, and we've talked about it before, of MA plan participants in California, which I think goes to Nancy's point about has anyone looked at what happens to Medicare-covered beneficiaries when copayments are increased.

I think that is hugely significant. There's a difference between talking about the existence of copayments

and increases in copayments. That is not the only study that has come out very recently, like over the last year-and-a-half, to look at the impact of increasing copayments, particularly for ambulatory services, front-end services, where you find a hospital offset.

I found it very interesting in Atul Gawande's recent article, The Hot Spotters, which I'm sure everybody read, that he made a passing reference like, Well, of course, this is logical, where he said something about employers are trying to offset their cost increases by adding more cost-sharing, cost-shifting to the employee side, but then they find that their hospitalization costs are on a population basis, not necessarily on an individual health outcomes basis, but on a population basis.

Their hospital costs go up. So, well, that backfired, didn't it? Well, I'm not sure the catechism remains unshaken, at least when you talk about increasing copayments to be the only point of having copayments is to be able to waive them or to be able to impose them in order to drive behavior. So I would say that the purpose of looking at this would be for the value proposition.

But I would caution against getting too

complicated about it. I mean, Mike and his colleagues have done a lot of great work about looking at very specifically which people benefit the most from which. I'd say, you know, start with the easy stuff. Start with the things that are well known.

The team has talked about the limited tools that are available like reference pricing or coverage decisions, right? But that's sort of an extreme, like medically necessary is a pretty low threshold. I think that we are moving toward knowing, at least at the ends of really high value and really crummy value, but maybe doesn't quite fall below the medical necessity threshold, some of the places where we could start using -- the program could use copayments to drive behavior or to providers in the ACO context, medical home context. That's a policy choice. It's not necessarily totally evidence -- like, well, this ACO is better than that other group of providers, but rather, a policy choice that we want to incent the development of comprehensive team-based integrated care.

So I would say there should always be a free option because people might think of themselves as unable to afford something, whether or not they fall below a certain

threshold of relation to the poverty level and they might avoid needed care that could end up costing more later, and those things that are free should be the things that we think the program should pay for.

MR. ARMSTRONG: So just a couple of quick points. First, Bob, I want to thank you for making sense out of my question from before and actually explaining in a way that made sense to me. So whatever you said, I agree with.

I echo the sentiment that we should -- I really do believe we should be looking both at payment provider-inspired incentives as well as the benefit structures and how they affect individuals. I really believe that you have to do it well, to your points about copayments, but to the degree patients are involved in their care and advancing their health, they're going to be healthier.

There are a lot of organizations with a lot of experience. It may not be a RAND study, but there's a lot of experience that I think we can look at and learn from. My own comes from not just as an insurer, but as a large employer where we are doing a lot to involve our insured lives, our patients and their family members, in very creative incentive programs like this and we're not ahead of

the curve. We're just right in the middle of the ball game.

So for that reason, on Pages 17, 18, and 19, I would, frankly, say yes to all of those questions, and I think the real issue is how do we organize the work and make sense out of this as we go forward. I'll stop there.

MS. UCCELLO: I'll agree with a lot of what's been said and kind of echo Bob and the answer to your question, Glenn, about what should our goal be. It should be both. We should be rationalizing spending, but trying to -- with maybe a smaller pot of money, or at least reducing the trend. So we'll try to be wise, but I think we could try to do both.

I also want to build off the discussions that we've had over the past two months about the Home Health copay and how we tried to think about it with respect to the other potential sites of care, and that we still need to, as we're thinking about all stuff, does it complicate things, but make sure that the cost-sharing is providing the appropriate incentives for the different sites that - people have options, you know, whether they go to an ambulatory surgical center or a hospital outpatient, you know, making sure that it's a rational way of -- that that cost-sharing

is lined up right. I'll leave it there.

DR. DEAN: Obviously this is a terribly important and obviously very interesting issue. I would just -- most of the concerns I had or questions I had have been answered. I would just make the comment on the reference pricing, it's a very attractive concept and it's one that I've thought for a long time we should be promoting.

But it also is not nearly as easy as it may appear on the surface, for some of the reasons that Bob raised. I mean, there are certain procedures and things that are totally equivalent in many situations and not in the others, and it's also true of drugs, that there are a few classes of drugs where there is a class effect and any one of the drugs will do what you need to have it do.

The other -- in other cases, there are drugs which are in a given class, they're categorized in a particular way, but they have -- one drug will have some unique properties that another one doesn't, and it's really hard for those of us who are prescribers because the industry does a very good job of confusing us and emphasizing that particular aspects of their particular product, which may or may not be really significant -- I guess what I'm getting to

is it just, again, emphasizes the terribly crucial role that comparative effectiveness has to play in all this, because once we have that data, we can really have a working market. Up until that time, we're really at the mercy of the producers.

MR. HACKBARTH: Okay. Well, you've got us thinking and thanks for that, Julie and Joan. My big concern is that the array of topics that we've raised here is too complex for us to try to tackle as a mass. If we try that approach, we will get really bogged down and not get anywhere.

For me, I think a really important point -- and not everybody may agree with this -- is I think if we're going to get a more efficient effective health care system, we've got to figure out ways to more effectively engage patients in seeking out high value, efficiently delivered quality care. Our current structures don't do that. Julie and Joan have elucidated a lot of different ways that you might approach the problem of trying to more effectively engage patients.

But again, I don't think we can tackle them all at once. I actually liked the way you raid the short-term,

intermediate, and long-term questions. I think we could tackle them in that order and say, you know, let's work on these short-term questions, see if we think there is grounds here for some recommendations, and then if not or even if the answer is yes, then move on to the intermediate issues and so on.

But I think we can't jump around these lists. The issues are too complex to try to do that. I see some people nodding that that makes sense. I see Mitra pursing her lips.

MS. BEHROOZI: I just feel like when we do the updates, we rail against the silos and so I get that there's a lot of complex issues, but I guess maybe it's a matter of staging things or whatever. But I feel like you can't analyze them separately. You know what I mean? And having a discussion about them separately is difficult.

MR. HACKBARTH: Yeah, yeah, well, there certainly is inner play among them. Part of my thinking here is this is the March meeting, albeit in February. We have one more meeting this cycle and then we don't see each other for several months. We have the retreat and then another month-and-a-half, almost two months, before we meet again.

It's very difficult on a multi-faceted set of topics to maintain continuity in the conversation. I would think that we will get more traction and move more quickly if we bite off a piece, focus on it, acknowledge that it relates to other issues and we can say, we want to flag that and pick it up next time when we get to intermediate issues, but I think we've got to break this somehow.

MR. ARMSTRONG: Just a brief comment on your proposal. If you look at Pages 17, 18, and 19, or whatever they are, it will be hard to really focus on the short-term without talking about -- if you're trying to rationalize cost-sharing without talking about, well, are we talking about cost-sharing that relates to different providers or different benefits?

I mean, I think when we get in a little bit more specific, we'll be able to structure the starting with the short-term stuff, but it will get into some of the second page and third page issues as we do it.

MR. HACKBARTH: Yeah.

MR. ARMSTRONG: So I would avoid trying to be too precise about how we structure right now, and as we get into it, I think we'll solve some of those.

MR. HACKBARTH: Okay. Well, let us put our heads together and think about what might be an orderly approach into this array of topics. Thank you, Joan and Julie. Very provocative stuff and a productive discussion.

Next up today is the Sustainable Growth Rate system. We have Cristina and Kate and Kevin.

[Pause.]

MS. BOCCUTI: Okay. Well, as most of you know, policymakers are facing an extremely difficult challenge regarding Medicare's payments for physician and other health professional services.

Under the current law, Medicare's fees for these services are scheduled to decline more than 30 percent over the next several years, as required by the SGR.

So today we're going to give a very brief background on the SGR, and then we're going to raise some policy issues that are associated with it, namely, discussing problems with the SGR, examining issues related to expenditure targets in general, and, finally, discuss some alternatives that have been proposed. And Kate and Kevin have a little bit of new data to bring for a couple of those proposals, so we'll spend a little more time on that,

and then, of course, open it up for you all to discuss some of the issues and possible directions.

So starting with a quick definition of the SGR, it's Medicare's formulaic method for annually updating services furnished by physicians and other health professionals. It was designed to keep aggregate Medicare spending for these services on a "sustainable" or affordable trajectory. So in doing that, it tied allowed volume growth to our nation's GDP and set a target that way.

The SGR was established by the BBA, but keep in mind that expenditure targets have been a part of the physician fee schedule since its inception. And we went over a lot of the details about how the SGR formula works, and we can answer questions about that. But it was in your chapter or draft.

Moving on, to discuss what updates the SGR formula has produced. In early years, volume growth was below per capita GDP, so updates were at or above MEI, in accordance with the formula. In later years, volume growth increased and per capita GDP slowed, creating an ever-increasing discrepancy between the actual and the target spending.

So, given that, the SGR has called for rate cuts

every year since 2002. But since 2003, Congress has passed a series of bills to override these cuts, and the resulting annual updates from these overrides have been fairly modest. And I would say although this year we had a payment increase of a little more than 2 percent for half the year, the overrides have all been under 2 percent.

The next scheduled cut, of course, is for January 2012, and that will be likely 25 percent or greater. Certainly not less than that.

So why does it cost so much to "fix" the SGR? Given the widespread agreement that such a deep cut -- and multiple cuts over consecutive years -- can have detrimental effects on access it does seem counterintuitive that Congress has not been able to make long-term adjustments to the SGR to bring it more in line with realistic updates. But as you recall from the previous discussions, the main obstacle is budget scoring.

So, for example, a ten-year freeze -- that is, a 0 percent update for 10 years -- scores at about $276 billion. It's even more for a ten-year MEI update. And these numbers are expected to grow when CBO releases new scores. The upshot is that fixes with these kinds of updates would have

to be paired with offsets in federal spending.

So what's driving these costs? First, future positive updates or even freezes have to make up for deep cuts each and every future year in the ten-year window. And, second, the formula requires previous excess spending to be recouped also caused issues, particularly for the first three years of overrides. It compounded the amount that the SGR had to recoup.

And, finally, there are other cost ramifications for higher updates. You've got spending for the Medicare Advantage program and TRICARE would also increase because their payment levels are tied to the fee schedule and other fee-for-service spending. And, also, Medicare Part B premiums would increase to cover the share of Part B expenditures.

Moving on to broader policy implications, previous Commission discussions have reiterated 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 or other health professionals who restrain unnecessary volume growth nor penalizes those who contribute most to volume increases. And a second

problem is that the SGR is strictly budgetary. It has no tools to counter the volume incentives inherent in fee-for-service payment systems or improve quality.

So in addition to these systemic flaws, there is widespread agreement that the updates that the SGR formula has produced are also problematic. Large, looming negative updates threaten provider willingness to serve Medicare beneficiaries and, thus, also threaten beneficiary access. Also, the temporary, stop-gap "fixes" that have been implemented create uncertainty, frustration, and financial problems for medical providers. And, additionally, these stop-gap measures add significant burden to CMS resources and their claims-processing activities.

I also want to bring up some considerations for expenditure target issues in general. So when examining the concept of expenditure target systems, the Commission has stated several points:

First, expenditure targets may constrain price growth, but their effect on spending, or volume, is less direct.

Nonetheless, expenditure target systems, by design, regularly alert policymakers of spending growth, and

they do require significant congressional effort to override them. And as the Commission has stated repeatedly, expenditure target systems in their starkest form are not a mechanism for improving care quality or even care efficiency.

And, finally, expenditure targets that are narrowly applied to a single sector, such as fee schedule spending, offer no spending flexibility across provider sectors.

So now we're going to discuss several proposals that policymaker and analysts have raised in the past several years regarding SGR alternatives. I'll start with two proposals for technical changes to reconfigure the SGR formula. In general, their goals are to: smooth out the updates and reduce the extent of negative updates.

The first change would amend or eliminate the cumulative aspect of the SGR which led to, of course, the growing "hole" that takes multiple years of negative updates to recoup.

If annual targets instead were used, excess spending that is not recouped within one year would be forgiven. We would have a different picture with regard to

the hole.

Another option is to implement an additional allowance corridor around the spending target line. This option would relax the precision of the spending target and only trigger a negative update when the difference between actual and target spending exceeds a specified corridor. I usually have a hand diagram for "corridor." I'm bumping the microphone here.

But moving on to the advantages and the disadvantages -- the disadvantage, of course, is my hand motion, but I'll leave that aside. The main advantage of the technical adjustments that I just mentioned is that they suppress the extent of negative and positive updates, but they also would restrain spending and have expenditure control mechanism as part of them. And they could be implemented relatively quickly -- that is, compared to some of the other alternatives that we will be discussing in a minute.

However, the disadvantages of these approaches is that to the extent that they forgive any spending above the target, they will be more costly than current law. And, also, the technical changes don't offer incentives for

improving care quality or efficiency.

Kevin is going to move on to talk about some types of service.

DR. HAYES: A type-of-service SGR is one in which a target growth rate and update are calculated and applied separately for each service category. A rationale for a type-of-service SGR would be, one, that it accounts for volume growth that varies by type of service; and, two, it might also restrain prices for services that are overpriced.

Different strategies have been developed for structuring a type-of-service SGR. In terms of how services would be grouped, we see that one proposal had two categories. E&M and preventive services were in a category, and then all other services were in another category.

Then previously there had been a proposal to look at a category scheme that included six types of services, so we would have primary care separated out from other E&M services and then four other categories: imaging and tests in a category, major procedures, minor procedures, and anesthesia.

Note that by itself a type-of-service SGR would not solve the SGR scoring problem. For example, if the

decision was to have a hold harmless, say, for one type of service while still meeting the current requirement of an overall reduction of at least 25 percent; other services would have to make up for the hold harmless. Their reduction would become larger than minus 25 percent.

Rebasing would reset the spending targets and avoid the negative update for 2012, but the cost would be considerable. CBO has scored the ten-year cost of rebasing at $194 billion. Beyond rebasing, a decision for a type-of-service SGR is where to set the volume allowances. Options considered have included the current allowance of growth in real GDP per capita. Another option considered has been to raise that allowance by a percentage point or two. Of course, raising the allowance has spending implications.

To analyze the type-of-service SGR, we asked: One, how might the updates vary by type of service? And, two, how might the updates change depending on the allowance for volume growth?

For the analysis, we put practitioner services into five categories, the ones that you see here on the slide: E&M, imaging, major procedures, other procedures, and tests. Of course, other structures are possible,

including a separate category, say, for primary care.

We considered different levels for the volume allowances. The one shown on the slide is growth in real GDP per capita plus a percentage point. That's for all services. Comparing that allowance to recent growth in the volume of services, we see that volume growth for all services exceeded the allowance.

In the case of E&M and major procedures, the differences were between 1 and 1.5 percentage points. In the case of other services, the differences were between 3 and 4 percentage points.

For a rough approximation of updates, we can subtract these amounts from the MEI of 1 percent. That's the preliminary forecast of the MEI for 2012. Doing so, we get updates in a range from 0 to minus 3 percent.

The takeaway is that with rebasing, with the volume allowance greater than growth in real GDP per capita, negative updates are still possible is volume growth exceeds the volume allowances.

From the Commission's 2007 SGR report, one advantage of a type-of-service SGR is that it recognizes that volume growth varies by type of service. Another

advantage is that type-of-service targets and deviations from them may signal that practitioner services are mispriced. A disadvantage is that an update adjustment would be applied to services regardless of who ordered them, an issue of accountability.

A second concern might be that physicians will shift their provision of services from one type of service to another to avoid negative payment adjustments.

And a third issue to be aware of is that spending in a service category could go up for reasons other than volume growth. For example, CMS changes relative values in a fee schedule periodically because of changes in methods and data. When that occurs, spending for a service category may go up. Should the type of service SGR then reduce payments for the service category? Probably not.

Cristina will now address some other SGR alternatives.

MS. BOCCUTI: So another alternative that has been getting some attention is to exempt certain providers from the current SGR target. The providers that would be eligible under this kind of policy might be affiliated with organizations that have structures that are very well suited

to manage the health and spending for a population. So, for example, physicians and other professionals who are affiliated with an ACO or a medical home might be candidates for this kind of exemption policy.

Of course, CMS is right now in the process of determining how to measure quality and spending for these organizations. But think about it as having the SGR exemption for practitioners only granted if their affiliated ACO or medical home did share some risk. So, of course, they would be affiliated with organizations that could get bonuses or penalties based on performance.

Advantages of these kinds of policies are that with them there is the opportunity of escaping the SGR for those eligible, and that may be an important factor in gaining provider participation in needed delivery system reforms. Also, in exempting these providers, these policies would promote efficient, team-based care and comprehensive patient care management.

And third is that another advantage is that the policy creates a somewhat more individualized spending target and result in this model. But, of course, there are some disadvantages that come to mind.

These exemption policies would be complex to administer; they would require layers of further operational issues, such as provider eligibility, selecting performance measures, et cetera.

Also it's hard to predict, participation rates, which, of course, has implications on the available funding for those that are exempt and for those who would not be exempt.

We're moving on to Kate.

MS. BLONIARZ: I'll talk about an outlier alternative that would identify physicians who, as compared with their peers, use significantly more resources.

At a very granular level, the variation in physician resource use is quite notable, exceeding the variation seen when comparing Medicare service use across MSAs. Even when physicians are compared only to others in their specialty and MSA who treat the same type of case, resource use at the 90th percentile can range from 40 to 90 percent above the average for their specialty in an MSA.

An illustrative outlier policy could have the following general structure:

First, a physician's resource use would be

compared to their peers within the same MSA and specialty.

Second, the outlier policy could focus on physicians who persistently use more resources than their peers. Using an episode-based analysis, we found that among those physicians in the top ten percentile of resource use in 2007, 27 percent were outliers for the second year in a row. However, 9 percent were outliers for the fourth year in a row. The outlier policy could, therefore, focus on these persistent outliers.

Third, the policy could use both low- and high-impact interventions for outlier physicians. For example, the policy could provide actionable feedback to the outlier physician that their resource use is higher than their peers. If the outlier physicians' patterns did not change, a high-impact intervention, such as a penalty, could be applied.

We know that one significant concern with episode-based analyses of resource use is that an individual physician may appear to be very efficient on an episode basis, but may be generating a lot of episodes.

We looked at the overlap between per capita measures and episode-based measures and found that between

60 and 70 percent of physicians identified as outliers based on an episode analysis were also outliers based on per capitas. The outlier policy should use both episode and per capita measures to ensure that the full picture of physician resource use is being captured.

The advantage to having an outlier policy is that it targets the interventions to those physicians who are contributing the most to Medicare spending growth. spending growth unlike the SGR which applies a reduction to all physicians. And using both episode and per capita methods can give a more complete picture of resource use.

Among the disadvantages of an outlier policy are that, first, there are a number of methodological issues in designing an episode-based analysis of physician resource use.

Second, resources will be required to build and maintain a transparent Medicare-specific episode grouper that holds sufficient validity with physicians and other stakeholders.

And, third, while outlier physicians may correspond to a disproportionate share of spending, by their definition they only constitute a small share of the

physician workforce.

Turning back to Cristina.

MS. BOCCUTI: Okay. I'm going to take just a minute to talk about some ongoing work that we're doing because you all have raised a number of these issues.

So before we get back to the SGR, I'm going to note that we have ongoing contracts with two contractors on the topic of valuation of practitioner services. One project is about validating the fee schedule time estimates and related data collection issues. And the second project explores alternative approaches to valuing practitioner services rather than straightforward RVU-based payments. We're going to have more to say about those projects at the April meeting, so stay tuned. But we can answer questions about that, if you like.

So here's the final slide we have for our presentation that lists these two issues. We've sort of whittled them down to two fundamental issues here, of course, the first being scoring, and even though future cuts of more than 25 percent and beyond are unrealistic, eliminating them requires significant offsets in federal spending.

The other fundamental issue is creating better policy. Medicare needs to structure a payment system for physicians and health professionals that rewards quality and efficiency, while also improving payment equity among providers. And, of course, there's the question of whether expenditure targets should be a piece of future policy. And finally, of course, you may want to weigh the advantages and disadvantages of the proposals that we have just brought up today.

Thank you.

MR. HACKBARTH: Okay. Thank you all for that.

Before we start the rounds of questions and comments, I wanted to add a little bit more about the context for this issue and also a way -- I don't have specific proposals about how to solve this very difficult problem, but I do have some thoughts about how to think about a possible direction to move out. And I'll ask Bob to chime in on this as well. But let me just quickly review some history here.

Of course, the SGR was enacted in 1997 as part of BBA. In 2001, MedPAC recommended repeal of SGR, citing the sort of problems that Cristina describes, fundamental

problems in the design that we thought at the time meant that it would be unlikely to achieve the desired results and inevitably cause problems. In fact, things have played out in that way.

Of course, the issue very quickly became the rapidly increasing budget score attached to repeal, and even with the problems starting to manifest themselves, many of us thought that potentially the benefit of SGR, despite its manifest problems, was that it did create some pressure to hold down the year-to-year increases in the conversion factor, and that was a budgetary benefit to the program.

The way I've been inclined to look at SGR is look at the costs and benefits of the system as it has rolled along these past ten years. And, okay, on the benefit side, some pressure to hold down increases and updates, we'll chalk that up as a potential benefit. What worries me is that the cost side of the ledger is growing, and in previous conversations that we've had as a commercial, sort of the chief concern is that the instability in the system threatens access to quality care for Medicare beneficiaries; that the increasingly rapid cycle of having to wrestle with how to offset the costs and what's going to happen if we

can't come up with a package to avoid the next 25-percent cut, that drama as it plays out here has ramifications for the Medicare patient population and for the physicians who serve them. In short, this increasingly rapid cycle is undermining confidence in the program, both among beneficiaries and physicians.

So that's a very significant cost of continuing on year after year as we are against the benefit, potential benefit of lower increases in the updates.

Well, that situation I think is destined to deteriorate still further in the future. The benefit of pressure on updates, frankly, there's going to be pressure on updates even if SGR doesn't exist because of the overall budgetary situation. There will be other ways, other reasons to be very cautious and conservative about updates in the fee schedule. I don't think we're any longer, for better or worse, dependent on the SGR for that sort of pressure.

As this score increases, what that means is that finding the offsets to allow even short-term extensions becomes more and more difficult in each cycle, which is one of the reasons why the extensions seem to have gotten

shorter and shorter and we go through this drama more and more frequently all the time. These scores are just going to keep going up and up and up, and so that problem is going to become worse and worse over time.

So my fear -- and based on previous conversation, I think it's one shared by the group -- is that we're in a deteriorating situation here. We're spiraling down. This isn't going to get better. This is destined to get worse.

The score, however, is a huge problem. In a way, it, too -- that problem has gotten worse recently. In PPACA, there is a long list of Medicare savings to the tune of roughly $500 billion over ten years, some of which are based on previous MedPAC recommendations.

Basically, all of the prominent Medicare savings opportunities were used in PPACA for a different purpose -- to fund the extension of benefits or move towards universal coverage. So those dollars are not now -- those Medicare savings ideas are not now available as potential offsets to the SGR score. So what was always a steep climb to find offsets has become steeper still because so many of the ideas have been used.

I fear that the bottom line is that there are not

Medicare offsets, at least that I can think of, for this large and rapidly growing score attributable to repeal. And that bothers me because if it doesn't come from Medicare, that means it's going to come from someplace else, and I already worry about how our health programs are eating up the Federal budget and devouring resources that are needed for other programs. And so this is very troubling to me.

Having said that, if we choose as a group to recommend if not a repeal of SGR, a major restructuring or resetting of SGR, and we can't come up with all of the offsets necessary, I think it is possible to use that legislative event as an opportunity to achieve some major goals in physician payment that might be difficult to achieve otherwise, and let me speak frankly here. Physicians, many physicians, value highly getting rid of SGR. They might be willing to accept some changes in physician payment that otherwise would be politically infeasible if it were a part of a desirable package. So even if we can't offset the score, this may be an opportunity to achieve some very important ends in restructuring the physician payment system that would otherwise be beyond our reach. So in that sense, you know,

always looking for the pony in the manure, that's my pony in this particular pile of manure.

So what are some examples of those things? I'm going to lay out some ideas. Certainly I'm not speaking for the Commission here. In fact, I'm not even sure I'm speaking for myself on all of these ideas, but they are ideas that come to mind.

So you can imagine a repeal bill becoming an opportunity to say let's do a major reset in terms of the structure of Medicare physician fees. We often talk about the need to reward some specialties that are critically important, more than they are now. MedPAC has always advocated doing that in a budget-neutral way, so it means more for some, less for others. This kind of legislative vehicle could be a rare opportunity to do that sort of significant redistribution of payments within the physician system.

One way to do that would be a cut in the conversion factor with significant bonuses for some specialties and services. It would be very difficult to do that in other contexts. It may be possible to do it in this context.

Another category of ideas has to do with volume restraints. Our next topic is in-office ancillary expenses and our concern about what has been happening there. Incidentally, some people would say some of what has been happening here is a by-product of SGR to some extent. If we could have a package that went aggressively after some of the issues that have arisen in in-office ancillary as part of that, it would be very difficult to enact in a different context, but maybe as part of an SGR package that might be much more feasible as part of a quid pro quo.

Another idea would be -- and here, Bob, I'm going to turn to you -- that you could keep some fashion of a target, perhaps reset with a new rate of growth target as an action-forcing tool in the physician payment system. As opposed to it being a trigger for formulaic across-the-board cuts, it could be an action-forcing tool for changes in relative values. So the Secretary could be compelled to act in order to try to hit this new target, and so it's not an automatic thing. You have a decisionmaker who says if that's the target, here's what I need to do to revalue fees, restructure the physician payment system.

DR. BERENSON: Well, you've basically said what I

would say, but let me just do it in a few different words.

One of the problems that I've had with the SGR-type mechanism, and before that the volume performance standard, was that it was a mechanistic, formula-driven reduction across the board, regardless of which services were driving volume and regardless of where informed people thought that there were distortions in the payment rates.

So I think the suggestion that Glenn is making, which I think makes some sense, is there is some logic to having a target, but that there should be some discretion in how that target is being achieved. And here I'd make one minor disagreement. I wouldn't change the relative values. I would change the prices. You want the relative values to still have a relationship to the underlying resource costs, which is a whole elaborate process. But it may well be that that's where you use some policy judgment about what are the services that are most crucial and should not be reduced and which ones is there a lot of information from various sources that they are probably overpriced, or at the very least, there's no difficulty getting a large volume of those services produced on behalf of beneficiaries. So they could be sort of selectively identified as the way to achieve

living within the target.

My own experience on the RUC and viewing the RUC's work is that the fact that they actually live in a budget-neutral world creates a discipline. When new services are coming in every year, they can't simply say, oh, yeah, let's value these regardless of the impact on the program because they have a budget neutrality requirement that everything else gets modified. So that creates some discipline. I think there are some other problems that we're trying to address around the accuracy of these services, but that's one discipline that I think works well.

And so I do think, whether it was an overall expenditure target or moving to what Kevin suggested as maybe a few large categories, having some process to actually pick and choose where to achieve the savings I think could be much more palatable than simply across-the-board cuts. And so that would be the point I'd make.

MR. HACKBARTH: Yeah, just two other ideas, and, again, what I'm trying to do is get us thinking expansively about how an opportunity might be used here. There are two other ideas that occur to me. One is malpractice reform, which at least some of us, I know, are concerned is not a

constructive force in terms of appropriate utilization of Medicare resources. Another concern that I know some of us have had about the ACO movement, if you will allow me that term, is the risk that hospitals, by virtue of being the organizations that have the capital and the management infrastructure will sort of quickly come to dominate the ACO world. And what about physician-based options? Well, an idea that I picked up from Jeff Goldsmith is that there's money in PPACA for development of co-ops. And, Scott, I love co-ops, but I'm not sure that they're going to be a rapid solution to any of our health care problems. That money could be redirected to help support development of physician IPAs that can start to have organizational infrastructure to be leaders of or at least very active participants in ACOs, and we won't just go into the automatic hospital track.

Again, these are just ideas, but if we think about broadly the problem of how do we change physician payment in constructive ways, more effectively engage physicians in controlling costs, and see that as the opportunity in SGR repeal, I think maybe we could come up with a constructive package.

You had a summary slide, Cristina, that has at least some of these ideas. Do you want to put that up? The GH slide I think it is. I'm not going to go through this again, but it references some of the things that I just listed.

Tom, I think we're starting on your side. Let's do Round 1 clarifying questions before we leap into the deeper discussion.

DR. DEAN: I'll pass [off microphone].

MR. HACKBARTH: Okay.

MS. UCCELLO: First of all, if it makes Cristina feel any better, I use lots of hand gestures, and I have knocked over my fair share of microphones.

A quick question. For the exemption policies, would that mean higher reductions for non-ACO physicians? Or is it just a whole separate -- we're only doing the analysis or the target for the non-ACO folks?

MS. BOCCUTI: That's a very good methodological question. You could ask that of other types of services, too. So that has to do with predicting who's going to participate and whether you start from zero or whether you start from the current status of the SGR. But that's the

right question to ask if it were starting to be operationalized.

DR. STUART: This builds on same of the same. One of the problems with SGR is that when that first negative update hit Congress, it really wasn't that difficult to override it. The extra cost to the debt was relatively modest, and it would be easy to say, well, we'll fix it next year. And then it happened again, and then we had the compounding.

So one of the problems was that it has gotten to the point where it can't be -- you know, it just can't be stuffed back into the bottle. And the question I raise is when PPACA was enacted, Congress included a mechanism in the Independent Payment Advisory Board that would apply primarily -- well, at least originally -- to Part D and Part C that would require that the board come up with some mechanism or some policy by which an expenditure target would be overcome, and then Congress would have to vote up and down on this in terms of a fast-track legislation. So I'm wondering whether staff has considered whatever the alternative to SGR is. If there is some kind of a limit that's imposed, have you examined what the implications

would be for Congress putting that kind of a constraint on its own actions?

DR. MARK MILLER: Yeah, I mean, I guess the way I'd start to try and answer this -- and, Cristina, you can pick up here -- is that in the 2007 report, one of the things that the Commission ended up talking about as one of the ways you could go is just to keep an expenditure target but not have it peculiar to a physician, have an expenditure target across the entire program.

What we could do -- and we can move in that direction if the Commission wants to think about things that way. In that kind of a context, the kinds of things we could play around with to give you a feel is if we have a target for the entire program, whether it's using the stuff that's in the legislation or a different target that you discuss, we could simulate what impact it would have across the entire program and make the assumption that the SGR is not restraining the physician expenditures and then build that into the impact. Is that the kind of thing that you're asking?

DR. STUART: That's part of it, but I think having a target and then whether that target is a real target or

something that can be easily overridden, and the IPAB example is one where Congress itself said, well, we have trouble keeping to targets, and so we'll write something in the legislation that's going to make it harder for us to override a target.

MS. HANSEN: On Slide 17, where we talked about outlier policy for some of this, this is more on the profile of the beneficiary side as to whether or not in looking at outliers was they're a risk-adjusted consideration of the beneficiary. In other words, there's some physicians who practice and care for people who tend to cost a lot year over year by their profile, not because of billing practices.

MS. BLONIARZ: Yeah, and I think in the past the Commission has supported risk-adjusted methods of resource use. For the studies that we looked at in the paper, two of them used risk adjustment and one didn't, but generally I think that's something the Commission has supported.

DR. BERENSON: First, for Kate, could you just clarify? When you're referring to per capita spending, are you referring to the spending attributable to that practice for a period of time a year, not the overall spending for

that beneficiary? Or are you?

MS. BLONIARZ: So what we -- it was very simple. It was just the charges that that beneficiary incurred with that physician.

DR. BERENSON: With that physician.

MS. BLONIARZ: Over the year.

DR. BERENSON: Okay. So you are dealing with the number of episodes, you're not -- that's how you're trying to sort of account for those physicians who have lots more episodes is to look -- okay. But it is attributable to that physician for the year as per capita. Okay.

MS. BLONIARZ: In that episode, that's right.

DR. BERENSON: And, Cristina, I just want to go back to -- could you go to Slide 14? I'm picking up the question that Cori asked, and I just want to understand it. When you say exempt certain providers from current SGR target or some substitute, how meaningful is that? If, in fact, the ACO goes the route that MedPAC has recommended, which is sort of risk taking on behalf -- to some extent, not completely, the payments are sort of cash flow, and ultimately the organization is functioning under a different set of incentives and are almost -- I mean, what would be

the alternative? Let's say we had an expenditure target that was a zero update and so they're exempt from that, what then becomes what would be used for them? And does it matter, I guess is my question.

MS. BOCCUTI: Right, so it depends on how painful the alternative -- you know, staying in the SGR is. Right? So that's -- if it's used -- if this exemption policy, one of the goals is to accelerate acceptance of delivery system reforms, the theory would be that what remains, so those in the regular fee schedule payment system wouldn't be as -- you wouldn't have the opportunities for bonus payments, and you would essentially -- if a provider were weighing his or her options would think that the delivery system reform mechanism -- that's in this example ACOs or medical homes -- might get them the opportunity for higher payments if they have good performance, which would not be available -- that opportunity wouldn't even be there in the regular fee schedule SGR

Of course, your question is whether you're looking at an SGR mode of a 25-percent cut or an SGR mode of a freeze. And I think that does affect participation.

MR. HACKBARTH: So I think I had the same question

as Bob. So if you're going to exempt an ACO, say, from SGR, you've got to say, okay, they're not going to get the 25-percent cut. What are they going to get? Because they're going to be paid fee-for-service --

MS. BOCCUTI: Well, it's not the ACO itself, because that's going to have its own -- you know, that's going to be determining its own payment mechanism. It's the providers that are affiliated with -- the physicians and the health --

MR. HACKBARTH: Correct. So I'm an ACO physician, and by virtue of my participation in the ACO, I'm not subject to the SGR cut. What do I get for an increase in my fees? You have to create an alternative.

MS. BOCCUTI: Right. We can discuss that, and I would imagine that possibilities would be freeze plus. It could also be determined by some of the ACO policies. Maybe that ACO is developing incentives within its own structure. Isn't that some of the idea there?

MR. HACKBARTH: Sure, sure. Is that what you were getting at?

DR. BERENSON: Yeah, I was getting at that, and it may well be that let's say we went to a type-of-service

expenditure target and imaging was reduced 3 percent or 5 percent. The ACO might not even mind that as a -- because it's actually functioning, if, again, we went to a two-sided or partial capitation approach. But it might. So we would have to work through that issue of what the alternative payment system would be to those individual components of the ACO.

I guess my general sense is being able to go into the ACO is the real attraction, but you are right, the more Draconian the alternative is, the more likely organizations will want to be off on their own, and I get that point. But I think we have a mechanistic issue to determine what would be the fee schedule.

MR. HACKBARTH: And in addition, to the extent that the ACO's success or failure is based on, you know, are they holding their costs below what's happening elsewhere, the fact that they're getting fee increases puts them behind the 8-ball compared to people outside who are having fee cuts. And so you've got to think through what the implications are for how you set the ACO target as well as what they get in cash flow and fee payments.

Suffice it to say that, you know, it's easy to say

we're going to exempt ACO, but there are some fairly complicated design issues that need to be worked through.

MR. KUHN: A couple different questions here. One, I'd go back to the SGR expenditure target, and that can change for three reasons, as I recall. One is population, one is changes in physician practice expense, and the third is change in law and regulation. Two parts to that last one.

When will we know the changes particularly in law that as part of PPACA will impact the target? Will that be something that will get from CMS in that kind of annual letter that they send us? And presumably they'll be coming in the next month or two. Is that where we'll see what the CMS Office of the Actuary projects will be the change as a result of PPACA changes on the target?

MS. BOCCUTI: Yes, we usually get that in the springtime, so upcoming, and they do delineate on all the factors that affect the SGR formula and predicted update.

MR. KUHN: And on that projection, the one -- I keep getting different stories on this, and even after my time at CMS, I have to admit I'm still not clear on this one. But, again, law and regulation, but there are national

coverage determinations, which are neither. They're neither law nor regulation. They're kind of a creation within CMS. How does OACT -- do we know OACT scores those in terms of the target?

MS. BOCCUTI: Kevin, in your experience?

[Laughter.]

DR. MARK MILLER: I actually remember us having a conversation with them.

MS. BOCCUTI: You and me?

DR. MARK MILLER: No, Kevin and I.

DR. HAYES: Right

DR. MARK MILLER: But for the life of me, I can't dredge it up.

DR. HAYES: Right. What I recall of that conversation, lo these many years ago, was that a lot of times the national coverage decisions are institutionalizing local coverage decisions, and that the spending associated with these coverage decisions is already pretty well built into the base. It just sort of arrives there organically. And so there is no provision for coverage decisions in that law and regulations factor; rather, the law and regulations factor tends to be things like new benefits that are in law,

floors on the GPCI, and that kind of thing.

MR. HACKBARTH: Clarifying questions?

MR. KUHN: Yeah, just one more, if I could. As we think about it and getting into this, you know, part of the overall discussion continues to be the refinements of the RVUs out there for both practice expense as well as work. And as we all know, the work of the RUC has begun to evolve and change over time so that this whole notion of the five-year review doesn't really exist anymore; it's more of an iterative process, and they're keeping up on a regular basis. And they seem to be working, from as near as I can tell, real good on the work side, but I'm curious where we think we're going to see any adjustments on the practice expense side. Will that continue to kind of follow a five-year review kind of model? Or was that something that CMS will probably take up more aggressively in regulatory action?

DR. HAYES: The rolling review process is picking up practice expense changes, too. The practice expense data are improved along the way. The effects of those changes then are picked up in the budget neutrality adjustment that happens within CMS' practice expense methodology. So we

wouldn't see any separate identification of those things, those effects, those changes that we could point to and say, oh, well, that's what the effect of it was. But it is getting picked up in that methodology. There's budget neutrality mechanisms built right into the methodology itself.

DR. KANE: Yeah, so one question I had is in the early years the SGR was above the spending, and so there's really -- aren't there kind of two things going on? One is the spending is accelerating, but the other is that the economy is decelerating. And I guess one question I have is if you just took our historic acceleration rates for Part B spending and then assume the economy kind of grew faster or at least at the rate that it grew in the first three or four years there, you know, then what would we be left with? How much excess spend -- I mean, is there a way to sort of say, well, let's take -- some of this is because the economy crashed, and that's not fair, but, you know -- and some of it's because you guys, you know, maybe spent more than you should have because your rates didn't grow.

I guess I don't have any sense of how much of the total deficit we're incurring now is related to the fact

that GDP hasn't been growing relative to historic levels as opposed to the fact that spending has exceeded GDP in some outrageous -- does that make sense?

MR. HACKBARTH: You're certainly right that it's the combination of the two factors that determines what the gap is.

DR. KANE: Right.

MR. HACKBARTH: It's both the rate of spending and how fast GDP's growing.

DR. KANE: And this is just a question, not to necessarily solve anything, but I'm just trying to get a sense of equity of how you want to sell this idea of what really should fall on the backs of the docs and what might fall on the backs of something else.

MR. HACKBARTH: Long before the recent recession, the score was huge for repealing SGR, and it's a rolling average used on the GDP. Is it three years?

DR. HAYES: Ten [off microphone].

MR. HACKBARTH: No, ten years. That's right. They changed it. So the effect of the recent recession on this is muted because of the ten-year moving average.

DR. KANE: But if you left -- I mean, we really

have had one of the worst recessions in the history of the Nation, and that's built into that.

DR. MARK MILLER: That's just in the last year [off microphone].

DR. KANE: So that's not the biggest piece.

DR. MARK MILLER: The volume is.

DR. KANE: Yeah, I'm sure it doesn't erase it. I'm just wondering if we assumed a more normal growth in GDP, what would the ultimate deficit be that we -- relative to -- you know, is it 10 percent, 2 percent?

MR. HACKBARTH: Yeah, okay.

MR. BUTLER: So, Glenn, I just want to make sure I understand your framework, and so let me restate it in my own words. One could say that a month ago we voted for a 1-percent increase for physicians because we felt that that was required for access and, you know, being a good, efficient provider, which doesn't exactly close the hole.

Then you said normally we would have a lot of offsets to that. But, in fact, you already stole them all and used them for the health care reform and counted them as offsets already for the most part -- ACOs, bundling, and so forth.

So if we're going to contribute more to closing the gap, so to speak, or fixing this, one could say we'll go back to those ideas and accelerate them and put them on steroids or whatever and say doom and doom faster. Another would be to say let's come up with some additional ones between now and next fall, including the topic we're going to talk about next. And then a third may be your payment reform, things that may not have money necessarily with them but, you know, kind of resets the way you look at it. Is that kind of what -- so when I make my comments, that's kind of how I heard you approaching it.

MR. HACKBARTH: Yeah.

MR. BUTLER: Okay.

DR. BERENSON: Could I just weigh in? But the major offsets were in Medicare Advantage reductions and in hospital --

MR. BUTLER: Updates.

DR. BERENSON: -- updates, not in sort of guesses about what ACOs are going to do.

MR. BUTLER: Which is a reason why you could go back and say could you somehow get a little more teeth, double-sided, whatever it is to kind of accelerate --

DR. BERENSON: I see.

MR. BUTLER: -- scorable offsets by kind following our philosophy of bundling and getting utilization out of the system.

MR. GEORGE MILLER: Yeah, just a quick clarification on the outlier alternative, Slide 16. Do we know where these physicians are practicing? For example, can we stratify them working at FQHCs or rural areas or urban areas? Do we have a feel for that? Or is this just across the board?

MS. BLONIARZ: I would clarify first that most of the studies use 100 percent data from six MSAs.

MR. GEORGE MILLER: Okay, sure.

MS. BLONIARZ: We could look at where they're practicing, but that would be drilling down pretty far.

MR. GEORGE MILLER: Okay. Thank you.

DR. BORMAN: This whole topic sort of goes to prove that it takes 50 acres of ocean to turn a battleship, and I think in your nice reprising of the history, I'd like to hear from you and our expert folks who are truly here. Just how much of this at its inception was an experiment and a prediction? I mean, this has gone so fundamentally

poorly, and it exemplifies that, albeit we make big decisions about lots of money with relatively limited data, and a lot of the time it works, but this seems to me one of the times that exemplifies how catastrophically it can fail.

So in order to avoid repeating that mistake, as I go back, what really convinced us that this would work? Was there some thought process or thinking that we don't want to repeat in figuring out the solution that you recall historically or you analytically can identify?

MR. HACKBARTH: Well, to be frank, I came to MedPAC in 2000, and so it was very shortly after I arrived that we recommended repeal because we thought the system was fundamentally flawed and would not achieve its goals. So I'm not the right person to say, you know, who thought this would work and why. I don't know, Cristina, Kevin, whether you have insight on that that I don't have.

MS. BOCCUTI: I was just going to say the rationale -- Kevin, maybe you could mention about going from VPS to SGR, and maybe that is just one rationale that was out there, because if the fee schedule started with an expenditure target but it was under VPS and then moved to SGR, maybe Kevin studied this.

[Laughter.]

DR. MARK MILLER: Can I just ask one thing before you -- were you asking what the logic was that built it? I didn't think you were. I think what she was --

DR. BORMAN: Go ahead, Mark [off microphone].

DR. MARK MILLER: I think what you were asking was this was put in place. We've now arrived at a point in our discussions where, you know, people are convinced that it doesn't work. What are the key signals that have brought us to that point so that we don't repeat them?

DR. BORMAN: Yeah [off microphone].

DR. MARK MILLER: Okay. I don't know.

[Laughter.]

DR. MARK MILLER: My job is just to be clear on the question. But, I mean, I think --

MR. HACKBARTH: The question is: What do we think the design flaws were in SGR so we don't repeat them?

DR. BORMAN: What got us to the -- I understand the part that relating it in some way to the average worker productivity, the productivity of the economy as a whole, whatever. I understand all that in terms of linking the fee schedule to that as some measure of making sure that

physician payment is reality grounded and all those kinds of things. There just had to be something other than the fact that the GDP hasn't grown. You know, we were wrong. The economics didn't work out in the trend pattern that perhaps we thought there would be.

MR. HACKBARTH: Yeah.

DR. BORMAN: And there were all these perverse incentives that perhaps we didn't envision that have played out. Are there any other sort of assumptions or thinking that we should look at to avoid? And it may be an unanswerable question, Glenn, and I don't want to belabor this. I'm just bothered by we've got such a very large failure now that it's going to be so hard to meaningfully correct, and to correct in a fair way in a very difficult environment of being a bankrupt nation. You know, I'm with you, and I worry about that a lot.

MR. HACKBARTH: Yeah.

DR. BORMAN: So I'm just trying to -- is there something we can tease out that will help us inform this conversation better? And is that something we need to think about maybe going forward?

MR. HACKBARTH: So let me try this, and this may

not be 100 percent based on facts. Some of it is speculation on my part. And this happened in the 1990s, first with the VPS system, which was '91, '92, Kevin, thereabouts. And then it was modified to SGR in '97. This was the year of managed care, and, you know, a common sort of structure among IPA-type HMOs was to say we're going to pay you fee-for-service, but as a plan we're subject to some total cost constraint, and so we've got to hit that target. Your share of the target is this. If you miss your share of the target, we've got to take it out of your fees. Ad IPA/HMOs had lots of variations in how they tried to do that, but that was sort of a common thing that happened in a lot of different places in the '90s. And so this was an effort to sort of apply in some sense similar thinking to Medicare.

Well, in point of fact, many IPAs blew up for the very reason that SGR blew up. You know, you can say, oh, we're going to pay you fee-for-service and there's an aggregate constraint. That doesn't alter the incentives of the individual practicing physician. They still have fee-for-service incentives. And, in fact, if they're worried about a cut coming because you missed the target, oh, even

do more. You increase your volume so that after the cut comes, your damage is minimal. And there were IPAs all over the country that -- well, that structure blew up, and they tired different physician payment formulas.

Well, we've had the exact same problems in Medicare. We've got an aggregate target, but the incentives for individual physicians are not tied to the target, and you get not just tension, you get a fundamental breakdown of the system.

And so I think, you know, the enduring lesson, which we've talked about often over the years here, is it's not just enough to establish a cap on something. You've got to figure out how to more fundamentally rewire the system to change incentives at the level of decisionmakers, whether they be physicians or hospitals or other providers.

Does that help?

DR. BERENSON: Could I?

MR. HACKBARTH: Go ahead.

DR. BERENSON: I've done a little bit of historical reading on this topic, and the initial thought around an expenditure target actually I think was informed somewhat by the German health care system, and I know GAO

had a whole report about their expenditure target mechanism. I still remember an '89 PPRC report which identified the problem with an overall expenditure target, but then had this optimistic statement saying that this will hopefully encourage physician specialty societies to develop clinical practice guidelines and be able to inform practicing physicians about how to live within an expenditure target, because they would no longer be doing unnecessary things. There's some reason that this worked somewhere, and there's some logic of what they anticipated might happen.

So the first years of the VPS, nothing was blowing up in particular. Volume wasn't going through the roof. There were three targets in those days, and, in fact, surgery got a very nice increase because volume was not exploding in surgery, and so I think the BBA was really sort of -- we can even do this better. It hasn't really failed. It's actually been a partial success, with some problems. And even in the first couple of years of the SGR, it hadn't blown up even though MedPAC was beginning to see the problem with it.

So I do think there was obviously the environment of managed care going on at the time, and I think it has

some spillover effect also about not generating lots of volume increases. I think there's probably a spillover effect when the managed care backlash occurred, and I think that also probably let the restraints off, which also then got translated in Medicare as well. This is my speculation. But I can point to that '89 PPRC report which had a whole chapter on the logic of having an expenditure target, acknowledged the problem but thought that the physician community would address it somehow.

DR. BORMAN: Thanks [off microphone].

MR. HACKBARTH: Okay, so that was Round 1. We need to, as quickly and effectively as possible, go through Round 2. Tom, will you be an exemplar of concise comment?

DR. DEAN: I will try. I think I can. I appreciate the attempts to try and possibly make this flawed structure more attractive, but I think we get back to the point that it's just a fundamentally flawed structure, and I don't see any way to fix it.

I think the proper approach is to repeal it. If we can use that as a tool to bring about some other desired changes, fine. But as hard -- and like I say, I appreciate the work you folks have done, but I just don't think there's

any way to fix this. The fundamentally flawed structure for the very reason, Glenn, that you talked about, it doesn't give the incentive to the individual physician to change behavior. And I think we have far more promising and efficient ways to do that, and we should -- this is a failure, we should acknowledge it, and move on.

MS. UCCELLO: I want to react somehow to that, but I don't -- I'm not as kind of pessimistic. I actually started off, you know, several months ago when we started these -- or at least in my term started these, I went from almost having negative views of all of the options to almost having positive views of all of them and focusing on, well, they can at least do something, they're at least better than what we have now.

Two quick points. Thinking about the idea of trying to properly incent the individual physicians would lead to this outlier policy and potentially this exemption policy. But I think those are just really small kind of things that aren't going to get us very far.

The more I think about it, the more I like the different targets by the type of service, and one part of that or something that was said is an advantage of that is

that it can help kind of partly adjust for price inaccuracies. And I was kind of bothered by that, thinking, well, if there are price accuracy problems shouldn't we just fix the prices somehow? So I think instead tying it to the way that Glenn said of, you know, having a different SGR policy and tying that to a reset of fees would be the way to do that, and I think that that would be appropriate.

MR. HACKBARTH: Let me just contrast the two comments. Tom is much more in "repeal, wipe the slate clean, start over." What I hear you saying is that you want to at least explore further some of the "well, let's fix it without scrapping it" sort of options.

MR. ARMSTRONG: Yeah, I guess I'm kind of in the middle. First, I just want to say I think we're doing a better and better job of describing the problem, and it is sobering. I think in many ways this epitomizes so many of the other issues that we're dealing with in a system that's so built around these silos. And it reinforces or pays for things that really aren't as important as, you know, better health and lower trends and so forth.

It's also frustrating and sobering because we know there are hundreds of billions of dollars worth of trim that

need to be taken out of this at the same time. And so it leads me to -- I'm not sure that there are constructs laid out in your alternatives that I like better or worse, but to the degree we look at what do we want providers to be paying attention to, and we've got ideas that have been developed through ACOs or medical homes or other ways of bundling payments to promote different results and hook this resolution into those ideas, I think per your advice. I like going forward with it. That seems like a constructive way of leveraging the pressure we're all feeling around this to try to move this agenda forward.

MS. BEHROOZI: I share Tom's sentiments, but I don't know that just repealing it -- forget political realities -- produces anything for having had it in place all this time. I guess that we do sort of have to acknowledge that it's not going -- the hole's not going to be filled, certainly not in one fell swoop by, you know, any recommendation we make or an act of Congress. And I am concerned that it's dealt with in this crisis-oriented, year-by-year fashion where you can't do any of the more interesting things. So I'm not sure where that leaves me either.

I think that we absolutely should be pushing forward the other alternatives, not even necessarily in the SGR context, though, kind of, you know? So that's why I so agree with Tom's sentiments because it's almost irrelevant, except that it keeps creating all these crises. What is relevant is trying to find the right kind of payment policy, and, you know, I find some appeal, Glenn, to what you say about maybe using it as a bit of a stick to try to encourage more support for better payment policy, not necessarily as alternatives to the SGR but, you know, a better comprehensive payment policy.

DR. STUART: Repeal. Failing, repeal. As far as tying it to the other, I think this is essentially a political call in terms of whether these things that we're in favor of in any event could be pushed forward. And if there was an assumption that that would work, then I'd be in favor of that.

MS. HANSEN: Yeah, I think it has to be consider "repeal but for." I think what Scott was saying earlier about having the product that we're trying to achieve -- and that is, for example, if there's unintended iatrogenic care -- in other words, a lot of this stuff is because of

duplicative things, the fact that we're seeing multiple specialties that end up crashing into one another with the beneficiary having a quality outcome that's not good, then we need to hook in a performance-based outcome of what happens to the beneficiary when there are known clinical guidelines. There are many places where it's not known, but whether it's diabetes, whether it's congestive heart failure, whether it's arthritis, things need to be practiced with evidence from an earlier RAND study about things that aren't necessarily done that should be done. So something has to be demanded if we're going to let go of this so that the outcome on the part of the beneficiary is better off. In other words, we may not use as much services then in acute care because people's steady state is maintained. So that's where the hook is if we are going to repeal it.

DR. BERENSON: Well, I agree with your sentiments and the others around the table that the SGR has become a real problem at this point. It's not just a legislative issue. It really affects the trust that physicians have in working with Medicare, and more specifically it is very hard to get anybody's attention to correct the distortions in the fee schedule as long as this thing is hanging over

everybody's head.

I am attracted -- as Bruce said, if we can figure out a package that works politically and offers something up, that sounds attractive to me rather than simply telling the Congress to bite the bullet and pay for the SGR to disappear.

I think in any of our work we should not use the term "SGR" if we're talking about alternatives. The SGR is a specific thing which, I mean, in a sense you can't use the word "capitation" anymore. Even though most of us know what capitation means, you have to call it "global payment." I understand why one has to do that. We are not talking about a modified SGR. We, I think, need to talk about eliminating the SGR, but then maybe having a new process, reconstruct volume performance standard or something else. But it will get misinterpreted just like I wasn't sure what you meant in terms of exempting ACOs from the SGR. Is that the old SGR? The new SGR? Whatever we're going to describe, we got to use some different terminology for it.

I think most of the action -- I'm with Cori -- should be correcting distortions, but there's 6,000 codes, and we've got a lot of impediments to getting there. I

would much rather go right to the overpriced services and reduce those prices. But I see a type of service approach as a potential fallback to discipline that process. And what's real important is that it wouldn't have some of the same characteristics that the current SGR system has, such as the cumulative nature. So when you get to 25 percent, it's a trigger that can't be pulled. If it's a potential 2-percent or 4-percent reduction in something that has a basis to it, that trigger can be pulled. And so I think doing it with some political reality about what is achievable I think would be a very different approach to what's being done right now.

And I guess my final point, two final points, is I like the outlier approach, but it seems to me that's not going to raise much money, and it seems sort of it's part of the whole value index work. I mean, CMS is supposed to be able to measure the value of a physician. I'm quite skeptical that there is a numerator there that we're going to measure the quality. If we're good enough to be able to identify outliers on resource use, that's a terrific thing, and I will do the work. Whether it's best to put it into this discussion or whether it's part of the ongoing

discussion about how we sort of move towards a value index, I'm not sure. But since it doesn't raise a lot of money, I'm not sure it belongs here if we do it right.

And the final thing is in modeling any alternatives to the current SGR, whatever we call it, I think we need some that don't hook off GDP. I see some logic in macro budget discussions of deciding how much can society spend on Medicare, having a relationship to GDP makes some sense. When we're talking about a sector within Medicare, I don't see the logic of tying that to GDP. So I'd be looking at some other things like MEI or zero updates. I mean, I wouldn't just do GDP, I guess, because that's what they did in 1997. I'd be a little more -- I'd be thinking of some other hooks to base an update on other than GDP. That can be part of the analysis. But I really think it's a flawed concept to update physician payment based on GDP.

MR. KUHN: As I get to travel around Missouri and a lot of the Midwest, particularly since PPACA was passed, and talk to a lot of hospital boards, hospital leadership teams, a lot of physician groups across the Midwest, I can tell you that there's probably nothing more destructive in

terms of the opinions of where we're going in health care than this albatross that just hangs across all our heads. And so this discussion is very helpful that we're continuing to move forward as we look at these issues.

Just two thoughts here as we go forward. One, I think the menu of options of the various items out there, whether it's the cumulative aspect, the type of service, the exemption altogether, or the outlier exemption, all those are interesting, and I'd like to continue those conversations on those. But one thing Glenn said and one additional thing is that the idea of linkage to other kinds of reforms as part of this is absolutely critical. I mean, this is, you know, a chance to really make some of those changes that are probably long overdue and need to be made.

But the other thing is what we can't lose sight of this whole conversation is whatever we decide to do here or recommendations that we ultimately put forward, we still have the fundamental issue on the physician fee side, just like we have in all parts of Medicare, is volume and intensity. And whatever we put in place, what kinds of incentives are they going to put in place to deal with volume and intensity? Because that's the route that SGR was

put in place to deal with, because on all the other prospective payment systems you get a predetermined amount for a bundle of services. They had utilization control there. You didn't have it with a fee schedule. And so what ultimately is going to be the utilization control here on a go-forward basis, one that we hope will work effectively?

So to be continued, I guess.

DR. CASTELLANOS: Most of what I was going to say has already been said. Can we get to number 21? I think that was it. There's a couple of good points here.

We have got to consider the budgetary issues. I mean, sure, I want to get rid of the SGR because it hasn't worked. It really hasn't. But, again, we have a significant issue with the budget, and we really need to look at and find out how we can do something that really doesn't upset the problems that we're seeing in our nation today of being further in debt and further in debt.

As far as the policy goes, you know, I'm very proud of a lot of the work that MedPAC has done. We really want to reward efficiency. We want to help reward quality. We want to improve outcomes. And the only way we're going to do that is to get the individual physician responsible

for what he or she does. And that's what the SGR does. So whatever system we go to, whether it's ACO concept, whether physicians are responsible for quality and outcomes and at-risk, or whether it's bundling, or whether it's a Geisinger model where you get a salary plus you get paid as a bonus for outcomes and quality, we need to go somewhere where we stress some of the things that we as MedPAC have always cherished.

I can't tell you -- and Herb mentioned it -- the pervasiveness of the destruction of what the SGR does in the medical community. I've never seen it so much, and we saw it quite a bit in December. And, fortunately, we have a reprieve for a year. So we really need to do something this year. We really need to do something.

One-third of the physicians in the United States are over 55, and with the economy coming back and the more hindrance you're putting on the physician with HIT, MR, workforce issues, penalties for not doing e-prescription, penalties for not doing PQRI, you're going to have a lot of the physicians saying, you know, maybe it's not worth it anymore. We can't afford that because we have a real workforce problem.

So I kind of agree that we should not use the word "SGR." We have to use something else, and I'm not sure what you guys have to say, but we need to hide that under the sheets.

Now, as a physician -- I can't speak for the physician group, but as a physician, I'm more than willing to consider other options, whether it's a package like Bruce or Bob mentioned, but I'm more than willing to do that. And I think realistically the physician community wants to solve this problem just as much as we want to solve the problem.

Now, we talked about volume restraints. I'm just mentioning it. If you look at the volume that's happened over the last couple years, there has been a decrease in the growth of volume. I'm really not sure why, but I think a lot of it can be from the Deficit Reduction Act by cutting back reimbursements. And I know you've mentioned that, too. When we cut back and pay appropriately, maybe we take that impetus away from this fee-for-service.

The last point I really want to make is fee-for-service. You know, we had to get away from that model somehow. I agree with Bob, we need to consider and continue some of the RUC's policies where we look at the cost of

providing the different treatments. But don't use it as a payment model or a pricing mechanism.

I agree about the defensive medicine and tort reform. I think that would be a significant improvement.

We just need to put some key signals out there where we recognize there's a problem with the SGR, we want to solve it, and that it's important not just for health policy people but for the physician community and sit together and see if we can work out something that's workable for society and our beneficiaries.

DR. KANE: Yeah, well, this is the topic that makes me want to, you know, retire the meeting early, but SGR, it seems to me that it's a volume problem that we have that we're trying to solve with a fee solution. That just doesn't even get near what you're trying to get to. And when you look at that figure that shows you where we went off, in '03, '04, '05, and if you look at what services were going through the roof growth-wise back then and a volume way, it was imaging, it was tests, and it was those other procedure type things.

And so I guess I have sort of a volume solution. It's a little bit Third World-y, because I know what they do

in the Third World when they have a budget. They just stop paying for the services at the end of the month until they get a new budget. This is kind of on that idea but a little bit more sophisticated, perhaps. But it seems to me we need a volume solution that -- and I frankly think tort reform would help that volume solution at some level. I don't know how much defensive medicine is contributing to all the tests and imaging. But, you know, perhaps that could be combined, some type of tort reform that says, okay, because we're passing it, we are expecting volume to drop by blah, blah, blah. And for each health resource area, you have an imagine and a testing and an other procedure limit. And each month you're tracking the claims up to that limit, and when you hit it you stop paying. You might create a little withhold out of the amount you think you owe. You know, talk about funny accounting. You could also do that. You can call it a payable maybe, and you just wait and see if the volume goes below those targets for that HRR. You're kind of keeping it at least within the referral regions that people practice, have common practice patterns, and you may have a lower limit, by the way, in high-volume areas and a higher limit in low. And you just create -- over time the

signal starts coming through monthly, that, you know, you're not going to get paid for that because you hit your target.

And I'm guessing that and getting rid a lot of the -- especially if you combine it with tort reform -- people will get that message after a while that I should be more judicious in the use of tests, imaging, and other procedures, and so I can stop having this withhold. And the withhold stays until they go down below the volume level or are at the volume level you want. And if they go below it, they get it paid back. If they don't, it gets applied against what is owed on the SGR, which is going to be called something else, whatever you want to call it.

But I just think you have to do -- I think I'm agreeing ultimately. You need multiple things. It can't just be one thing to get at it. It's really got to be targeted at volume, not rates. I agree rates need to be fixed, but I think that's a whole other -- keeping up with the RBRVS and keeping it modern is just, you know, a very hard task. But for a quicker task, I think we just go for the volume. And we know where the excess was, and we just start saying those are the things, you know, that we're going to -- you're going to run out of being paid for those

on some periodic basis, quarterly maybe, that's meaningful, that people say, yeah, I just ran out.

Again, they do this in the Third World. They do this in a lot of county-run hospitals. You're out of money; we're not paying for that. And people pretty quickly learn how to hit the right level of volume and service to not run out of money.

So, anyway, that's my Third World solution, but, again, I think we have to think about this as how do we fix the volume and stop messing with -- the rates is not the issue. It's the volume. The whole payment mechanism, fee-for-service, is the problem. But, you know, fiddling around with lowering everybody's rates does not solve the volume problem. It makes it worse, I think. I just think people should just not be paid for the whole thing if the volume exceeds the targets, and the target should be at a level that's local enough that people can sort of be responsible for it, can be given feedback on it, but to take collective responsibility for it. And then you can obviously opt out once you get into a risk-bearing ACO or something like that.

So that's my -- you know, I've been listening to this for a long, long time, and we did that report to

Congress, and it wasn't enough for them, and they wanted the solution. So, you know, come up with something totally arbitrary, but that links in some really good things. And the arbitrariness will go away once we get these really good things underway.

MR. BUTLER: So in managed care, I think physicians demonstrated a lot of leadership in the early days about being leaders of the reform of the system. Ultimately, Glenn, you'd say they were the leaders of the backlash maybe to some extent as well. So in the last year, I've seen health systems and insurers, maybe out of fear, maybe out of other reasons, suddenly think, I've got a value proposition out here that is significantly different. And they're working hard on it, insurers and health systems, while physicians are kind of on the sidelines wrapped up in SGR. I just don't see the leadership.

So I agree with Bob and with what the rest of you are saying. Really futzing around with SGR as we know it is just a fruitless exercise. But I really like your idea of even a broader concept of the payment reform for physicians, somehow using this as the catalyst to get them not just not angry but in a leadership role, because we're going to need

them. There's not an easy way to solve the budget, but I think, you know, Deficit Reduction Commission, IPAB, all these things are going to kind of trump this SGR question pretty quickly anyway. So let's use the opportunity to get the physicians back at the table in leadership roles, and so I like that theme.

DR. BAICKER: I'll try not to retread ground that has been very carefully covered. This is probably overly simplistic, but I understand the goal of the original SGR to be twofold:

One, to have a global budget guarantee. We don't want to spend more than this, so if quantity goes up, price is going down, because here's our budget.

But then another twin goal of trying to instill in the people who are making those decisions the right incentives to not exceed that.

It seems like it failed on both dimensions for different reasons. The reason it failed on promoting higher value use was that the incentives weren't tied to any individual physician. The extra test I order has no incremental effect on my future payment, it's so small. So it doesn't create any incentive for me as a physician.

And then on the other side, my understanding of requiring making back the gap from previous years was to give the incentive some real bite. But it was too much bite because then no one could ever do it. And once you get in this hole, it's politically untenable to try to make back the whole thing. So then once that part is not binding, you've lost any real cudgel to make the thing move.

So I really liked the ideas of bringing the incentives down to the physician level, and, you know, any step in that direction seems promising to me, whether it's type of service or type of specialty or area-specific, and the smaller the area the better; even better, at the individual physician level so that individuals can see some consequences from those actions. And the challenge there seems like balancing insurance versus incentives. It comes up all over the place when we're talking about patient incentives or how insurers are operating in that. We don't want individual physicians to bear the risk of getting a bad draw of expensive, unhealthy patients, and we certainly don't want physicians to face a disincentive to persistently enroll high-cost patients. I could imagine that some of the people who are in the persistently high costs are people who

would declare that they're specializing in treating the hardest-to-treat patients, and, of course, it's high every year because every year I've got the sickest.

We've made this joke before, but it seems like the reverse Lake Wobegon effect that every physician's panel is sicker than average. But I would think with sufficient risk adjusters, you could try to combat that and create an incentive that gives physicians some stake in managing that volume while at the same time not asking them to bear the risk that the program should be bearing. We should be insuring them against expensive patients. It shouldn't be the individual's responsibility. And that's a very difficult formula to write down.

Then you, I would hope, could broaden the discussion of the global budget constraint issue beyond the physician silos. We've talked about why would you want to set your global program budget just on the backs of one segment of care. So thinking about that second -- divorcing those two goals and thinking about how can we get Medicare spending under control more broadly, well, that may involve some sort of global budget that goes across silos. That's one discussion. How can we line of physician incentives?

Let's do that in a way that balances incentives and insurance, et cetera. Those may not go together the way they are supposed to now, but clearly fail on both dimensions.

MR. GEORGE MILLER: Yes, we've a very rich discussion. I'll try to be brief. And some wonderful ideas and comments have been said, and I agree with a great deal of what has been said already.

I don't know what to call it since Bob said we can't say that, so I'm going to say "this new thing." I think the new thing certainly needs to have physician leadership, as was just said. And I think as leaders we need to pick a date out in the future saying that the old thing will go away, the new thing will start at some point in the future, and these are the goals of that new thing that we will work to. But it certainly has to be all-inclusive globally. We need to go down to the physician level for quality and outcomes and then tie the beneficiaries in with that also, because the physician says you need to stop smoking, and if that beneficiary doesn't stop smoking, then maybe they should pay more, and to link everything together in the system.

I certainly like what you said about medical malpractice reform. I think that should be part of that and possibly even insurance reform to deal with this. Bob mentioned about the cumulative nature. It's too big, you can't pull the trigger as we're dealing with it today, so making it a yearly reckoning has a positive aspect and should not be volume driven. And, again, linking it all to the same -- all of us across the silos or the entire spectrum of health care should be linked in together versus separately as we're dealing with it now. And, again, I think we need to have the physicians at the table.

I'm interested, as Tom said, we need to get rid of it. Short of that, I think picking a date in the future and working toward that goal makes some sense.

DR. BORMAN: I think that the first thing is I agree with the notion that repeal is the necessary step.

In terms of thinking about the technical alternatives that have been offered, I would say what can we salvage out of that. I think that notion of risk corridors is something that's worth retaining as we think about whatever comes next.

In terms of what we think about next, I think that

we need to make sure that whatever we do we're not going to reward people with more money. We haven't figured out a way to give them more discretionary time in their lives. So one thing we need to make sure we don't do is sure not add to the hassle.

So I think that, number one, we should make sure that every effort is being made to simplify any regulatory burden and minimize physician hassle and we don't create new physician hassles, because things like EMR and so forth are already creating a sense of hassle.

I think also hassle really relates to CMS. Some of the things we've talked about here, particularly the outlier piece, in my view, starts to create an impediment for CMS and other implementation pieces far beyond what probably we would get back in the end. And I think that as much as I like the outlier piece personally, education and things like that can be very short-lived, and the data are pretty clear about that. And I think the hassle is probably not worthwhile.

What is worthwhile? Two things, I think probably. Number one is that tort reform resonates well, and it is a real problem. For people who practice medicine you know

that it's a problem. And it's a problem in subtle ways, not just overt ways. And, for example, when you get the test report or imaging report that says likely X, next test image could allow better characterization, many people feel they're being dangled out on a limb in our current society. So how do you then leverage that with all the other positive things you talked about? Well, tort reform needs to get linked with an accelerated comparative effectiveness process, and if five societies have guidelines about how best to use nuclear cardiology -- I'm just picking on that as an example -- make it that if you follow any one of those guidelines, you get some sort of protection by virtue of doing that. I think that would go a huge way. It will also give more teeth to the CE process, and we need to -- I think the CE process is probably philosophically perhaps where some of our greatest value comes.

I think the second piece of it -- and we need to accelerate it, and we need to make sure that the Patient Center for Outcomes Research -- whatever -- Institute gets adequately funded and moves forward post haste.

I think the other piece is that we really need to give some thought -- and I liked the action-forcing and

type-of-service as tools because they are a bridge between trying to characterize in some neutral way what various physicians do versus politics and policy. And so I think you have to have some of those, and I think Bob said that very eloquently.

I personally would also argue that at the end of the day there needs to be some fundamental think-tanking here. We're smart people. There's lots of smart people thinking about this. We really need to reach outside the box. And Hsiao and that activity is aging, just like the RAND study is aging. It does worry you about their relevance and applicability to planning for a future in which we're imperiling our whole budget and children and grandchildren and all that kind of thing.

So I think that some sort of mechanism to encourage think-tanking and do we need to be looking at utility rate-setting models, do we need to be looking at is there a way to enable cost reporting for physicians or some analog of that, or as Nancy described -- I mean, maybe there's off-the-wall ways to do this, but I really think that we need to make some effort.

Now, I will say that what Nancy described sounded

a lot to me like the VA and Canada, and with no aspersions on the systems, I will say that they each have their difficulties. So I'm not sure I'm ready to jump on that particular bandwagon, but I do think that sort of some blue-sky thinking here, a dedicated effort to do some blue-sky thinking would also serve us well at this juncture.

MR. HACKBARTH: Okay, thank you for the presentation. Let me just say a quick word about next steps. Our plan, subject to change as always, is that we'll have a chapter in the June report. We'll have a discussion on this at the April meeting, and in all likelihood I'll be talking to each of you between now and April. Hopefully we'll have enough agreement on ideas that in the June report we can not make definitive recommendations but perhaps more clearly point in certain directions.

Then we can discuss this more during our retreat in July, and then assuming all that goes well and we're starting to gel around some ideas, we could work towards draft recommendations for discussion in December and, if all continues to go really well, final recommendations in October. As everybody knows, the current extension expires at year-end.

So that's the tentative plan. Lots of work to do to make it happen. Thank you all.

And our last session for today is on in-office ancillary services.

And let's see. We are roughly a half-hour behind, and so I think it's quite likely that we're going to run over at least a little bit, hopefully not the full half-hour, but probably in the neighborhood of 5:45 to 6:00, I would guess.

Ariel, when you're ready, you can begin.

MR. WINTER: Thank you. Good afternoon, almost good evening. I want to begin by thanking Carol Frost, Dan Zabinski, Kevin Hayes, Kelly Miller, and Matlin Gilman for their help with this presentation.

In last year's June report and at least year's September meeting, we talked, discussed the growth of ancillary services in physicians' offices and potential strategies to address this growth. Over the last several years, there's been an increase in imaging, other diagnostic tests, physical therapy and radiation therapy provided in physicians' offices. From 2000 to 2009, the cumulative growth of imaging and tests was faster than all other

categories of physician services. Imaging rose by 85 percent during this period, compared with 47 percent growth in all physician services. Although the volume growth of imaging slowed to 2 percent per beneficiary from 2008 to 2009, this was preceded by several years of rapid increases.

In addition, there is evidence from the literature that imaging services are sometimes ordered inappropriately. The rapid growth of ancillary services has led to questions about payment accuracy, and there are also concerns about physician self-referral of these services. The In-Office Ancillary Services Exception to the Physician Self-Referral Law allows physicians to provide these services in their offices, and we have talked about options to narrow this exception. However, several commissioners have expressed concern that limiting the types of services or physician groups that are covered by the in-office exception could have unintended consequences such as inhibiting the development of integrated delivery systems.

Several commissioners have expressed interest in pursuing strategies that are focused on improving payment accuracy and ensuring the appropriate use of services. So we are shifting our focus to these approaches. We plan, or

hope, to include a chapter on this topic in the upcoming June report.

Before we explore these strategies, I want to first address an issue raised by Mike at the September meeting. He asked us to compare payment rates for ancillary services under the physician fee schedule and the outpatient Prospective Payment System.

First, outpatient therapy services -- which includes physical therapy, occupational therapy and speech language pathology -- received the same payment rates regardless of setting, and these rates are established under the physician fee schedule.

Next, on average, services in the category of radiation therapy were paid 7 percent more under the physician fee schedule than the outpatient PPS in 2010.

With regards to imaging, Medicare makes two payments for imaging studies. First is the professional component which covers the physician's work involved in supervising the test, interpreting the results and writing a report, and second is the technical component which covers the non-physician staff, equipment, supplies and overhead costs.

The professional component is paid under the physician fee schedule and is the same across settings. Imaging services provided in physicians' offices receive a technical component payment under the physician fee schedule while studies furnished in hospital outpatient departments receive a facility payment under the outpatient PPS.

For most imaging services, the outpatient PPS facility payment is higher than the comparable payment under the fee schedule. However, some imaging services are paid the same amount in both settings due to a provision in the Deficit Reduction Act that caps the physician fee schedule rates for the technical component of imaging at the level of the outpatient PPS rates. We hope to further examine payment rate differences for imaging in the April meeting.

Several factors appear to be driving the growth of ancillary services, as listed on this slide, and many of these factors are interrelated. For example, physician self-referral creates incentives to drive higher volume under a system that pays separately for each discrete service. However, a system that pays for services at a more aggregated level, such as on a per-episode basis, would encourage providers to use resources more efficiently.

Therefore, the first policy option is aimed at moving Medicare in this direction, and this option is to combine discrete services often furnished together during the same encounter or episode of care into a single payment rate. The second option we're going to talk about is to reduce payment rates for the professional component of multiple imaging studies done in the same session. The third option is reduce payment rates for imaging and other diagnostic tests performed by self-referring physicians. And the fourth option is to require prior authorization for physicians who order many more advanced imaging services than their peers.

The first option can be divided into two related approaches. First is packaging, and this refers to combining multiple services provided during one encounter with a provider into a single payment. And second is bundling which refers to combining services furnished during multiple encounters into a single payment. These approaches are designed to improve payment accuracy and also to encourage efficiency in the delivery of care.

Packaging could eventually serve as building blocks for bundled payments. With regards to packaging, the

AMA/Specialty Society Relative Value Scale Update Committee, or RUC, has established a process to combine codes frequently performed together into a single comprehensive code.

A RUC work group has been reviewing services that are billed together at least 75 percent of the time to determine if these services should be combined to account for duplication in physician work. After the RUC work group identifies pairs of services, it refers these codes to the CPT editorial panel for the development of comprehensive codes. Once these comprehensive codes have been created, the RUC recommends work RVUs and practice expense inputs for the new codes to CMS. CMS must then review and approve the new values through its rule-making process.

For 2011, for example, CMS adopted RVUs for a new comprehensive code that includes 2 component services -- CT of the abdomen and CT of the pelvis. The work and practice expense RVUs for this new comprehensive code are lower than the sum of the RVUs for the component codes that it includes.

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 this process is methodical and deliberative and is occurring over the course of several years.

Now I'll briefly describe bundling. One type of bundled payment includes services furnished by a single provider across multiple encounters. For example, under the physician fee schedule's global surgical policy, physicians receive a global payment rate for many surgical procedures that include some preoperative care, the surgery itself and a set of postoperative visits.

Another type of bundled payment includes services delivered by multiple providers. For example, based on a Commission recommendation, PPACA directed the Secretary to establish a pilot program to test bundled payments for all services associated with a hospitalization.

CMS could also explore creating bundled payments for ambulatory services provided during an episode of care.

Bundled payments could perhaps be developed for short-term acute episodes, like low back pain, or common high-cost chronic conditions.

We do recognize there would need to be a fair amount of work to identify and price cohesive bundles of

services, and to address situations in which multiple providers furnish services within a bundle. This leads us to the Chairman's first draft recommendation: The Secretary should request that the RUC and CPT editorial panel accelerate and expand their efforts to combine discrete services into comprehensive codes, and should develop bundled payments that include multiple ambulatory services furnished during an episode of care.

With regards to the implications, we expect this would decrease program and beneficiary spending unless the policy changes were budget neutral. For example, under current law, reductions to RVUs for comprehensive codes are offset by increases for other codes. We do not anticipate a reduction in beneficiaries' access to services or providers' willingness, or ability, to furnish those services.

Because the process of creating package and bundled payment rates is a long-term effort, you may wish to consider interim approaches that could be accomplished more rapidly. The Commission has previously observed that savings of physician time are likely when multiple services are provided together instead of independently, for example, when a physician performs an interpretation of two imaging

studies that occurred during the same session. Certain activities such as reviewing the patient's history and discussing the findings with the referring physician likely occur only once. However, the current RVUs assume that these services are provided independently and that each activity is performed twice.

The Commission has also noted that there are likely to be efficiencies in physician work when diagnostic tests are ordered and performed by the same physician. In both of these cases, the RVUs could be adjusted to capture duplications in physician work. One way to accomplish this is to create comprehensive codes with new RVUs that reflect these efficiencies, which is something we just talked about. But because this process is proceeding on a code-by-code basis and is time consuming, CMS could take action sooner by reducing RVUs for these services until comprehensive codes are developed.

The first of these approaches would reduce payment rates for the professional component of multiple imaging studies performed in the same session. Medicare currently applies a multiple procedure payment reduction to the technical component of imaging studies but not to the

professional component. The way this works is CMS reduces the payment rate for the second and subsequent services in the same session by 50 percent. This is meant to account for efficiencies in practice expense; that is the clinical labor, equipment, supplies and overhead costs.

In a 2009 report, GAO found efficiencies in the professional component when two imaging services are performed together because certain activities, such as reviewing the patient's history and symptoms, are not duplicated. They estimated that Medicare could save over $175 million per year if the program accounted for these efficiencies in physician work.

Thus, to account for duplications in physician work, CMS could expand the multiple procedure reduction to the professional component of imaging services, and this would align the policy for both components of an imaging study. So the second draft recommendation reads: The Congress should direct the Secretary to apply the multiple procedure payment reduction to the professional component of diagnostic imaging services provided in a single session.

Regarding the implications, we expect this would decrease program and beneficiary spending unless the policy

change was budget neutral. Under current law, the savings from this policy would be redistributed to other fee schedule services, but you could consider recommending that the savings be returned to the trust fund. We do not anticipate that this would reduce beneficiaries' access to clinically appropriate services. We do expect this would reduce revenue for providers who perform the professional component of multiple imaging studies in the same session.

A related approach would reduce payment rates for imaging and other diagnostic tests done by self-referring physicians. A key difference from the previous option is that this would apply not only to imaging but also to other diagnostic tests such as anatomic pathology and cardiac stress tests. The rationale for this policy is that there are likely to be efficiencies in physician work when a diagnostic test is ordered and performed by the same physician.

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

information during a prior E&M service.

The work RVU for the test also includes discussing findings with the referring physician, and this is unnecessary if the referring physician is the same one who performed the test. Therefore, it may be appropriate to reduce the payment rate to account for these duplicative activities.

We examined the potential impact of this policy option on imaging services although we do recognize that it would also apply to other diagnostic tests paid under the fee schedule. This table shows the share of office-based imaging services in 2008 in which the professional component was performed by the same physician who ordered the study. We excluded services performed in independent diagnostic testing facilities and hospitals. Across all office-based imaging services, we found that 37 percent of studies were performed by the same individual physician who ordered the service.

The third draft recommendation reads: 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 physician.

An important issue to keep in mind is that this recommendation would only apply to cases in which the physician who bills for performing the service is also listed on the claim as the ordering physician. Thus, there would be an incentive for a group practice to make sure that the ordering physician on a claim is different than the performing physician even if they are in fact the same person. To discourage this type of behavior, you may want to discuss whether to expand this policy to cases in which the physician who orders the service shares a practice with a physician who performs it.

With regards to the implications, this would decrease program and beneficiary spending unless the policy change was budget neutral. We do not anticipate a reduction in beneficiaries' access to clinically appropriate services. We do expect this would reduce revenue for physicians who both order and perform imaging or other diagnostic tests.

And now we'll move on to the fourth approach. Under this option, Medicare would require physicians who order significantly more advanced imaging services than their peers to participate in a prior authorization program. And by "advanced imaging," we're referring to MRI, CT and

nuclear medicine studies.

This policy would focus on outlier physicians who order many imaging services and ensure that they are using imaging appropriately. Because both self-referring and non-self-referring physicians may be high utilizers, this approach would apply to both types of physicians.

And we're not saying that all physicians who order a lot of imaging are using imaging inappropriately. Instead, we're trying to limit the burden of prior authorization by focusing it on a subset of physicians.

In 2008, GAO recommended that CMS examine the feasibility of adopting a prior authorization program to manage imaging services, and a prior authorization policy in Medicare would likely involve three steps. First, CMS would identify physicians who are outliers in terms of their use of advanced imaging. Second, these physicians would have to submit their request for ambulatory, non-emergency imaging services to CMS or a contractor for review. And third, if the imaging request is clinically appropriate, CMS would approve it for payment, but if not, the payment would be denied.

As an interim step before prior authorization, CMS

could provide confidential feedback to outlier physicians on whether they are using imaging appropriately.

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

Some plans use prior notification instead of prior authorization. In this case, the plan or the RBM reviews imaging requests and provides feedback on whether the studies are appropriate, but it does not deny payment.

Unfortunately, there are no independent studies that measure the long-term impact of prior authorization programs using a control group. Plans interviewed by GAO as part of their study reported that the annual growth of imaging services slowed down significantly after these

programs were implemented, with most of the decrease occurring in the first year.

A published case study of three health plans that adopted prior authorization found that the number of CT and MRI studies declined in the first year after the program was implemented. However, results for the second year of the program are mixed. Volume continued to decline in one of the plans but increased in the other two plans.

There would be several challenges involved in developing a prior authorization program for Medicare. I'm going to describe a couple of them, but they are all discussed in more detail in your paper.

A key issue is the administrative burden on physicians who would be required to participate in such a program, and the perceived challenge to their clinical autonomy.

Next, there are concerns about the quality of clinical guidelines that are used to approve imaging studies. There is often a lack of empirical information on the impact of imaging, on clinical decision-making and patient outcomes. Because of this information gap, efforts to develop guidelines often rely on clinical judgment and

expert consensus.

Another issue is that prior authorization would require significant administrative resources for CMS, and it's difficult to predict whether prior authorization would reduce imaging spending by a large enough margin to offset these administrative costs.

In 2008, CBO estimated that prior authorization would reduce Medicare spending by about $1 billion over 10 years, accounting for administrative costs. It is important to note that CBO assumed that such a program would apply to all physicians rather than a targeted subset of physicians.

Finally, CMS would have to determine how to identify physicians who order significantly more advanced imaging services than their peers. One method would be to measure the amount of imaging used by physicians on a per-episode basis. Another approach would be to measure the level of imaging used on a per-patient or per-capita basis by physician. Or, CMS could develop a combination of these two approaches.

The fourth draft recommendation reads: The Congress should direct the Secretary to establish a prior authorization program for physicians who order substantially

more advanced imaging services than their peers.

With regards to the implications, we expect this would decrease program and beneficiary spending. We do not anticipate a reduction in beneficiaries' access to appropriate imaging services. And we expect, anticipate there would be an administrative burden on providers who are required to obtain prior approval under this program.

So to sum up, we've described four approaches for improving payment accuracy and appropriate use of ancillary services. We'd like to get your feedback on these approaches and on the draft recommendations we've presented. And of course, I'd be happy to take any questions.

MR. HACKBARTH: Thank you. Good job.

There ought to be a rule against having this on the heels of SGR.

[Laughter.]

MR. KUHN: [Inaudible.]

MR. HACKBARTH: Yeah, right, poor leadership.

This is a topic that fills me with ambivalence. On the one hand, I am convinced that self-referral has contributed to our problems with growing volume, including some of it inappropriate. I think the evidence, at least to

me, is pretty persuasive on that. Incidentally, my hunch is also that SGR has contributed to self-referral by causing physicians to want to find other ways to generate income. So some of these things are linked to one another.

On the other hand, I am wary of sweeping solutions to the problem of self-referral, like outright bans, because I don't think the problem is, strictly speaking, self-referral per se. The problem is the toxic combination of self-referral, fee-for-service payment and mispricing of services so that some services present really rich profit opportunities. It's those things together that get us into trouble.

You heard me say often, all too often probably, my health care management experience is in a group that had all the services in-house, and we were self-referring for everything. We thought that was good for patients for a variety of different reasons. But on the other hand, we operated under a global payment system and had a salaried clinical staff where the incentives were not to overuse the services but use them in an appropriate way. So the dynamics were very, very different.

I'm wary of potential solutions to self-referral

that could damage organizations that are organized to do things the right way. That would be really unfortunate from my perspective.

So in trying to steer between my concerns about self-referral on the one hand and my concerns about too sweeping approaches on the other, I came, with help from Ariel and Mark and others, to this list of four recommendations, several of which -- let's see.

The first and the fourth are sort of targeted at the basic issue of fee-for-service incentives. If you have small, discrete units of service and separate payments for each one, you tend to get more of them. By bundling, packaging services together, that's a common tool we've used in many contexts to try to diminish, if not eliminate, those incentives. Prior authorization applies an administrative check on the fee-for-service incentives to do more.

The two middle options go at the issue of mispricing the services and try to better match the amount we pay to the actual costs incurred, thus potentially wringing out some of the excess profit opportunity. So rather than ban self-referral, let's try to target the problems per se.

So that's the thinking behind this set of four.

Some people may think it's medicine is too weak for the problem. I invite your comments on that.

Just one last thought before we start the comment or question, clarifying question round. Recently, all of the talk about ACOs has caused me to think a little bit differently about this, not come to different conclusions, but it gives me sort of a different vantage point on this.

Let's say we were to go more aggressively at self-referral, go beyond these options, to the extent that ACOs really become a common form of organization of care. Set aside the payment for a second. Then you could perhaps be more aggressive on self-referral and say if you're organized as part of an ACO and under a payment system where you have better financial incentives, we will exempt you from the tougher self-referral rules. So that's just another thought that's rattling around in my head.

So let's begin the round one clarifying questions. I can't remember which side we're starting on. Tom looks really eager to start the clarifying questions.

DR. DEAN: Do we know where the whole concept of prior authorization stands in the private community because

there's a number or private plans that actually tried it for a while and then backed away from it because of just the hassle factor? Do you know?

MR. WINTER: So as far as I know, it's still fairly prevalent, and this is based on GAO's study which is a couple of years old. But they interviewed 17 plans and RBMs, and they found it to be fairly prevalent.

I've seen an estimate that about 90 million covered commercial lives are subject to some form of RBM which might be prior authorization. It might be privileging. It might be something else. And I'll try to find that citation for you.

Then HSC did a study which also found it to be fairly prevalent in the markets where they visit, that they cover.

MR. HACKBARTH: So Tom, in the '90s, 1990s, prior authorization was a widely used tool. Some would say an indiscriminately used tool.

And I think you're right. As we went through the decade, many health plans scaled back their prior authorization programs; in some cases, eliminated them altogether.

DR. DEAN: [Inaudible.]

MR. HACKBARTH: They concluded that the administrative costs and the damage to their reputations and relationships with physicians and patients, the costs were too high relative to the benefits.

I think what we've seen in more recent years is much more targeted use of prior authorization, not the sweeping programs that existed in the '90s.

DR. DEAN: [Off microphone.] Okay.

Do you think that's a fair statement, Bob?

DR. BERENSON: Yeah. I would just emphasize that there's still a lot of prior auth going on, and I'm pretty sure that this is the one area that the health plans feel they're getting a good return -- is in imaging. So I hadn't heard that they had been abandoning this particular approach.

DR. DEAN: There was some publicity a few years ago. I think United Healthcare stopped prior authorization on -- and I can't remember the details. [Off microphone.] It was a big thing.

MR. HACKBARTH: Scott.

MR. ARMSTRONG: Just anecdotally, around imaging

in the Puget Sound marketplace, we've recently turned back on prior authorization, but it's really been complemented with fairly transparent reporting of volumes and comparing different groups, use rates and so forth, so that we can refine it and get it more focused. But I would say it's not what it used to be, but it's still alive.

DR. DEAN: Okay.

MS. UCCELLO: A quick clarification of how the independent imaging facilities are paid. Physician fee schedule? Is that --

MR. WINTER: Yes. Correct.

MS. UCCELLO: Okay. So there's no difference.

MR. WINTER: There is no difference between an independent diagnostic testing facility which is a free-standing imaging center and a physician's office.

MS. UCCELLO: Okay.

MR. WINTER: They're subject to different rules to get into the program, but the payments are equivalent.

MR. ARMSTRONG: It may be in here. Did this evaluation consider any kind of quality reporting or quality information relating utilization either inversely or not to quality outcomes?

MR. WINTER: No, that's not something that we considered explicitly in terms of the relationship between the use of ancillary service and downstream outcomes.

MR. ARMSTRONG: Well, I think downstream would be ideal and probably most impossible, but just there's -- you answered my question.

MR. WINTER: With regards to physical therapy, which we haven't talked about much today but we've talked about in prior sessions, on this topic in our 2006 report -- June, I believe -- we did talk about different options for payment reform, and one of those was trying to get more clinical information and more information about outcomes, so that the payment could be better related to the improvements in functional ability and those kinds of outcomes. But it's not something we've talked about in this chapter.

MR. ARMSTRONG: Okay.

MS. BEHROOZI: It might be in the paper, and I can't find it. What is the overlap in terms of Recommendation 4, I guess it is, the outlier prior authorization? Anyway, whichever number it is.

I understand that the recommendation is to apply it both self-referring and non-self-referring physicians.

Do you know what the overlap of a sort of robust outlier group and self-referring physicians is? I mean is it mostly self-referring physicians? Is it, you know, really a small overlap?

MR. WINTER: Right. So it depends on how you define outlier of course. In our prior work and other studies found that self-referring physicians order more imaging studies than non-self-referring physicians for an episode of care, on a per-patient basis. So you'd expect to find them over-represented, you know, in an outlier pool, but I don't have specific numbers.

But I can go back and try to look at that and perhaps bring something back for you next time.

MS. BEHROOZI: And I'll just say the next round comment, it just seems like if you would say that it would only apply to self-referring physicians then it somewhat insulates the recommendation from some criticisms about the methodology that you use to get to it. If you're starting with self-referring physicians, it's sort of built in. You know.

DR. STUART: In the old days, one of the ways to get around this was to use certificate of need, and I didn't

see anything in the chapter about certificate of need. I know that the State of Maryland has had a prohibition on physician purchase of imaging equipment since 2006. I don't know what's happening in other states. So that would be a question.

And then kind of a follow-on, if you have looked at that, do you have any sense about whether that's successful in terms of constraining increases in utilization?

MR. WINTER: It's not something I've looked at recently. Many states have been loosening or repealing their certificate of need laws, and where they do exist there are often exceptions. So sometimes they just apply to a hospital and not to a physician practice or a free-standing center. They really vary a lot. So it's hard to do, you know, an analysis of their impact when there are so many differences between states.

I wasn't aware of the change to the Maryland CON law. So it's something I'll look into and see if I can talk to the state officials about what the impact has been.

DR. STUART: The only reason that that might be interesting is that it's currently being debated in the

legislature to get rid of it.

MR. KUHN: Just one quick question. Kind of the -- you touched on this a little bit in the written material that came in advance, but just a little bit more clarification of impact on beneficiaries. That is if my understanding -- and I've talked to an RBM over the last couple of weeks. You know.

They turn this around pretty fast. You know.

They make a request for a prior authorization. They can get back to them within some of them 15 minutes. Some of them, it's four hours. But they pretty much adjudicated the whole process within 24 hours, at least some of them have performance metrics at 95 percent adjudication in 24 hours. So they move pretty quickly.

But I guess within the Medicare program and with beneficiaries, there is an additional penal right I assume Medicare beneficiaries have where they could ultimately go to an ALJ. So I guess one question is how long would this carry out and could it delay the imaging function for the beneficiary and how does the current appeal process work for beneficiaries?

Then the second question, and you kind of raised

this in the paper a little bit, is the various compliance programs CMS has going on. For example, say an RBM approves it, and then six months later a RAC contractor comes along and says sorry, we think that was inappropriate. How do they sync up all their processes as they go forward?

MR. WINTER: Both excellent points. There were concerns raised by CMS in response to the GAO recommendation. In the response, CMS raised the issue that their appeals process could be more favorable to Medicare beneficiaries than a commercial plan's appeals process and therefore could lead to if a service was denied through a prior authorization process that was appealed farther down the line. There could be more. More of those denials could be overturned than in a commercial setting.

My understanding of the appeals process is that it goes into effect when payment for a claim is denied, and so I think the way it would interact with the prior authorization program is if the program denied -- the way it generally works is the plan denies payment if it doesn't meet the criteria. So if the provider went ahead and did the service anyway, then they would have the basis for an appeal by the beneficiary, and then it would work its way

through the process.

So I think it would be sort of sequential, that you would have the prior authorization process first, and then claims that were denied but the service was actually provided would then go through the appeals process.

With regards to the post-payment review question, there was another issue raised by CMS, which is if the RBM or if the program denies payment initially through prior authorization -- I'm sorry -- approves payment for a service, can it come along later and deny it retroactively. And that certainly is a very big question, and I don't have an answer for that.

MR. KUHN: So on the -- I'm sorry.

MR. HACKBARTH: Go ahead.

MR. KUHN: But I was going to say on the beneficiary.

So presumably what would happen there is that a physician wants to do a scan or some kind of imaging procedure. The RBM, or whoever, denies it. And then they go to the beneficiary and say, I really think this ought to be done; will you sign an ABN, advance beneficiary notice? Then they do it. The beneficiary is liable potentially, but

they go through the process, and that would then trigger the beneficiary appeal process, I assume.

MR. WINTER: I think that's how it would work.

Now just within the prior authorization process itself there are different levels, as you're probably aware. So there's the initial process where they will either call up, or you use a web-based interface, and answer a series of questions, and based on the answers the test will be approved or not. But then if it's denied, then the next level would be talking to usually a nurse reviewer. And then beyond that, the requesting physician can talk to a physician reviewer, and argue, make the case. Sort of within the prior authorization process, there's a series of steps that can be pursued.

MR. HACKBARTH: So check that CMS responds to the GAO report. I think he signed it. I think it's not a coincidence that --

[Laughter.]

MR. WINTER: That's why I read it carefully before the meeting.

DR. MARK MILLER: I was just going to say that's why Ariel read it.

[Laughter.]

DR. CASTELLANOS: Ariel really gave us a lot of information and thought. Some of my comments may be one or two, but I'll try to separate.

You talk about the share of the office space imaging services ordered and performed by the same physician. Now in the text or the material that was given to us -- I think it's on 15 -- you talked about physicians also who share a practice. Is that the same?

MR. WINTER: Yeah. So in your mailing materials, it's on page 24, the more complete table, if you want to refer to that.

What we've shown here are the share of cases of office-based imaging where it was the same, identical physician who ordered the service and billed for the professional component. That's what we're focused on here.

The additional column in the table in your paper refers to cases where the ordering physician is in the same practice as the physician who performed the professional component. So they shared a tax number, basically. That's how we identified the same practice. And that was because we were still debating how expansive do we want this

recommendation to be, or this policy option to be.

DR. CASTELLANOS: So to make it clear, it's the doctor who orders it and does it himself that this applies to; it does not apply to physicians who share this practice. Is that correct?

MR. WINTER: The way the draft recommendation reads, that's correct, and we've raised for your discussion whether you want to think about making it more expansive.

DR. CASTELLANOS: On slide 15, you -- I know we've -- I've asked you in the past, and I think Bob has asked you in the past. Since about 40 percent of the doctors are now hospital-employed, and that's a big number, why don't we include IDFs and hospitals? You're just using offices here.

I mean 40 percent of the doctors in the United States are hospital-based or employed. So shouldn't they come under that too?

MR. WINTER: Okay. So in terms as an analytical exercise, I don't have, and there are no data, on the claims indicating whether a physician is employed by a hospital. I'm not aware of any administrative data set that would tell us this. So in terms of analytically I can't give you a percentage the way I can for physicians who are both

ordering and performing.

In terms of a policy recommendation, that's something you all can talk about -- whether you want to make it more expansive and apply it to physicians who are employed by a hospital and the test is billed by that hospital.

[Off microphone.] I'll stop there.

DR. CASTELLANOS: I just think it's I hate to use the word "discriminatory," but you're leaving out 40 percent of the doctors in the United States, and you're forcing people now to go from private practice into the hospital to avoid this. So I don't think that's the fairest way to do it.

MR. HACKBARTH: I see your point to a degree, Ron. Presumably, people who are employed, physicians who are employed want their employer to do well, and so even a physician who's employed and paid on a salary basis might be tempted to help his or her hospital employer by saying, oh, you know, order the extra test at the margin. So in that sense, you've got potentially a similar problem.

Whether it's exactly the same problem comes down to how the physician is compensated. If the physician is

compensated on a salary, it might be a weaker incentive in the hospital. If they're paid on some productivity basis, where in essence they're rewarded for volume in the hospital, then it might be more like the office practice. So that's just a question of how things work at the --

DR. BERENSON: And increasingly, they're being paid on productivity is what's going on.

MR. HACKBARTH: Right.

DR. CASTELLANOS: And that's exactly what happens. I think if you're going to do this I think you need to include the hospital too. That's my point.

Prior authorization, prior notification, just a clarification. There is a recent AMA survey that shows their experience with that.

You know, I like prior notification for everybody because you get a feedback to everybody who is using the service, and you may identify some people who are high users or perhaps not high users but inappropriately ordering, and that physician gets that feedback from prior notification, and then he, if he or she doesn't deal with it, then you can go to prior authorization.

But I like prior notification. I really do.

That's enough for round one.

DR. KANE: Yeah, just one quick question on slide 6, that the RUC has been reviewing services billed together. By "billed together," does that mean it's the same doctor performing the same service or does it mean --

MR. WINTER: Yes,

DR. KANE: Okay, so it's all the same.

MR. WINTER: Same physician, same patient, same date of service.

DR. KANE: So there's another potentially up to 25 percent of people who are not. For that combined service, there's two people involved, and how would they deal with a combined payment? I'm just trying to understand how it would work.

MR. WINTER: When they create a comprehensive code?

DR. KANE: Yeah.

MR. WINTER: Okay. You can still bill separately for let's say the example of CT of the pelvis, CT of the abdomen which were recently combined into a comprehensive code. If you do both together, you have to bill for the comprehensive code. If you just do one, you just bill for

the individual component code.

DR. KANE: But if you do one and somebody else does the other, I mean -- well, I don't know.

MR. WINTER: If a different physician does the other?

DR. KANE: Yeah.

MR. WINTER: Well, then they each bill separately for the component code.

DR. KANE: So I guess that could be a little bit of an issue if they're both -- unless they're in the same, if they're in the same practice?

MR. WINTER: I believe even if they're in the same practice, if it's a different -- it's a good actually. I'll look into this, but I suspect if it's a different NPI on a claim then they can bill under the component code, under each component code. So it's a separate claim for each rather than a single claim for the comprehensive code.

MR. HACKBARTH: So what you're suggesting, Nancy, is this is a way it can be avoided.

DR. KANE: Yeah.

MR. HACKBARTH: Peter.

MR. BUTLER: Okay, so go back to 15 again. I'm

still not sure I'm clear on this.

So if an orthopod in an orthopedic practice where they own their own MRI orders an MRI, but the radiologist reads the image, so is the billing physician, it wouldn't be -- they would not -- it wouldn't apply to them.

MR. WINTER: Correct. They would not be shown. They're not included in these percentages, and they would not be included in the draft recommendation.

MR. BUTLER: Yeah, that's a problem for me, but I'll get to that in round two. Okay.

Secondly, we've let physical therapy and radiation therapy, oncology, kind of -- they're not a part of any of this. We've had concerns about those in the past, but they're not part of these recommendations, right?

MR. WINTER: Not explicitly though you could think about doing packaged, creating packaged or bundled payments that include physical therapy services or radiation therapy services.

And one reason we didn't have the second and third recommendations relate to payment accuracy, we did not have one for physical therapy or occupational therapy because CMS just made a change where they applied the multiple procedure

reduction to multiple outpatient therapy services provided on the same day to the same patient, and the reduction is 25 -- actually, now it's 20 percent. So they've addressed some of those concerns through rule-making.

MR. BUTLER: They would be another good candidate for prior authorization -- physical therapy -- but I'll let that go.

Third is on page 41 of the text and just kind of it shows the top quarter and then the top tenth percentile in terms of users, and then the percentage of spending that they represent. So go to the bottom right-hand corner and see if I'm reading this right. It says in MRI the top tenth percentile represents 10.4 percent of the spending. Is that what that says?

MR. WINTER: Right.

MR. BUTLER: So it's hardly even -- it says that the top 10 uses 10 percent.

MR. WINTER: This is a function of the sample we were using. The sample only includes, in this case, MRI services. So every physician who was in our sample billed for at least one MRI service for a patient.

So it's not the full -- you know. We're not

looking at the full universe of physicians who bill Medicare and then just saying. We're taking the 10 percent who billed for the highest mean number of MRI services per patient. We're already looking at sort of a skewed subset, and so I want to caution you about drawing too much, inferring too much from these results.

MR. BUTLER: The way I look at that, it looks like they used a proportionate share. Everybody uses -- and I'm misinterpreting, or the data aren't --

MR. HACKBARTH: Ariel is saying it's a high-use group that they're the top 10 percent of.

MR. BUTLER: Okay.

DR. NAYLOR: Thank you for this report. If we were to look at this set of recommendations in a bundled way, 2 and 3, would you be recommending reducing payments for professional component and in addition, if these are self-referring physicians, to further reduce payments?

MR. WINTER: So actually, I anticipated this question.

DR. NAYLOR: I'm glad.

MR. WINTER: And I have a draft. I have a slide that illustrates how this would work, but keep in mind that

the percentages --

DR. MARK MILLER: [Inaudible.]

MR. WINTER: I wanted to keep it in originally. I had to take it out for time constraints

Keep in mind the percentage reductions we're showing you are illustrative, are not part of the recommendation, and what CMS would end up doing might be greater or lesser than what we've shown.

So the way we see this working is the third recommendation, which applies only to self-referring physicians, would only apply to the first service billed by a self-referring physician within a session. The overlap really only occurs for imaging. So we're focused now just on imaging studies.

So let's assume the payment for the professional component is $100, and you're just doing one imaging, just one imaging study for the session. So the non-self-referring physician gets the $100. But if you reduce that payment rate by 25 percent for a self-referring physician, to account for duplications in physician work, then the self-referring physician gets $75 for that first study within the session.

Now let's say there's a second study within the session, and let's say that payment is reduced by 50 percent for the professional component, which is consistent with the reduction for the technical component. Then the non-self-referring physician would receive $50 for that second study and then the self-referring physician would also receive $50 because we're not going to apply that self-referring specific policy to the second and subsequent services.

And that's because you're already counting for duplications in physician work through the multiple procedure reduction policy. So it doesn't make sense to apply both policies because you're really counting for the same efficiencies. For similar efficiencies, let's say, in each policy.

DR. NAYLOR: So you're encouraging multiple imaging. I'm only teasing.

And I want you on record. I didn't -- this wasn't planted. [Off microphone.] Thank you.

DR. BAICKER: Just a quick question on Recommendation 4. I don't know. I forget what slide it is.

I would imagine, not having looked at the original studies, that there are two reasons that you get a reduction

in use when you require prior authorization. One is when the physician is kind of on the fence about it and thinks maybe it's not going to pass muster, it's not really that important; they don't bother trying to do the procedure. And then the second reason is they try it and it gets turned down.

And those have different implications for the beneficiary and also different implications about how good a job the tool is doing in targeting that marginal use. I don't know what share.

So two useful pieces of information that may be in the studies that you could share is did the companies that tried this see a reduction in the number that were tried. It's so late in the day. The number people tried to do and then among those how many actual denials were there.

And from that, I might be able to infer a little bit about whether there are a lot of cases that are truly labelable as inappropriate use, or whether you're marching down a very smooth curve of appropriateness and physicians are doing an okay job at balancing that on the margin.

MR. WINTER: Both good questions. The two published studies that have looked at the impact of either

prior authorization or prior notification have not disaggregated between these two factors. They're looking at a much more aggregate level of just here's the volume before implementation, here's the volume after implementation.

The study though that looked at the impact of prior notification, so there were never denials. There's just you had to submit information, you got feedback. So all of that impact would be related to a sentinel effect or physician education. They found that growth went from about 10 percent per year before the program to basically flat afterwards, but I think it only looked at a year or so. It wasn't a long-term study, and so I wouldn't draw too much from that.

The second issue you raised is: Is there sort of a continuum of appropriateness? Absolutely. I mean based on the way the guidelines are constructed they go from 1 to 9, 1 being least appropriate and 9 being most appropriate. And the RBMs, they draw the line in different places, and some are more aggressive than others. So it's a difficult issue.

MR. GEORGE MILLER: Two quick questions. On slide 18, can you tell me what happened to the GAO recommendation

concerning the feasibility of prior authorization from 2008? Was that done?

MR. WINTER: I don't believe so.

MR. GEORGE MILLER: Okay.

MR. WINTER: CMS responded to that and said we have a lot of concerns here. And if they looked at it, it was internal. There was no public report summarizing their views.

But just to note, there was a budget proposal in the President's budget for 2010 that would use RBMs to ensure appropriate use of imaging, and it was estimated to save about $250 million over 10 years. It did not define or explain what that meant. So presumably, it was prior authorization, but we don't really know.

MR. GEORGE MILLER: And then with this, to follow up on that, with these recommendations, do we know if CMS has the bench strength to make all of these recommendations work, and should we address that issue as part of the recommendation?

MR. WINTER: That's a very important question. It's one we've raised in the challenges. You know this slide here.

And it's something that CMS has raised in their response to the GAO recommendation. They were concerned about the -- they said it would involve significant administrative resources.

MR. GEORGE MILLER: Yeah, yeah, and I wonder. In your text, you did an excellent job of talking about a decision support system. I don't know if this is possible, but maybe as an alternative. An accountable care organization or a large system, integrated system, has decision support. I don't necessarily want to use the term "exempt" them from it, but that may be a way to lessen the burden because there would be something in place by the private sector.

I don't know if we can incorporate that in our discussion, but it's something we certainly think about and look at, particularly in this budget-conscious environment that all the federal government will be dealing with.

MR. HACKBARTH: This is a really big issue, George, and thanks for underlining it.

This would be complex, and I don't know how CMS is going to come out at the end of the appropriations wars that are now underway on the Hill. But there's going to be a lot

of pressure, I would think, on their operational budget. For sure, the things that they're being asked to do are growing much more rapidly than the dollars are that they have for their operations.

MR. WINTER: And just a second point regarding exempting systems or providers that have decision support software or a decision support system from prior authorization, a couple -- there are examples in the private sector where a couple of plans have allowed this to happen. One case I talked about in the chapter, in the paper, which is Massachusetts General. Another case is Health Partners in Minnesota, and their medical director spoke to the Commission in 2007 about their approach.

DR. MARK MILLER: Just to follow up on George's question, just to parse through a few things. So we have four recommendations we're talking about. Two and three are not large administrative burdens for CMS, correct?

MR. WINTER: I think that's correct.

DR. MARK MILLER: Okay. The first one is sort of asking the Secretary to investigate packaging, putting things together in the midst of the same visit, or looking at the accumulation. So that's more of a research, kind of

identification of opportunity type of thing. It probably does have some administrative cost but perhaps not prohibitive.

Then I think it's the prior auth where we get to the real deal, and I think that's where your question applies

MR. WINTER: And really, the first two draft recommendations are building on directions that the agency has already been moving in.

DR. BORMAN: Relative to Recommendation 1, I would just say that I was on the CPT panel when the trend to component coding, which is the multiple codes sort of that in the end describe what some might consider a single service really started to accelerate, and to some degree that was payer driven by virtue of wanting to capture some parts where someone might in fact perform an image-guided service, but somebody else actually formally read out the interpretation. It really reflected combinations of things between say a surgeon sticking the liver while the radiologist is doing some guidance, or some of those kinds of things, and it was an attempt to capture the work of both physicians. Also, there were some other reasons on some

other component coding.

So I do want to be clear. I think everybody should be clear, that there were some good things about component coding, and there were some desires by CMS and other payers to have -- some of it did get out of hand probably, so just to say that.

Glenn, in terms of -- or Ariel, you've got all the answers today. You may have a prior slide. But on bullet 2, when we talk about multiple ambulatory services during an episode of care, could that potentially mean multiple office visits for the outpatient treatment of pneumonia?

MR. WINTER: Absolutely. Yeah. We tried to phrase it very broadly.

DR. BORMAN: Okay. So it's not just trying to target an imaging procedure, or whatever. Okay.

Then on slide 12, relative to Recommendation 2, this is not limited either by the nature of the imaging study. So this isn't meant to be just CT-head/neck/chest, but potentially that if somebody had a vascular ultrasound and then had an angiogram at the same time there would be ea discounting. Is that correct?

That it would cross modalities and it would cross

body sites and thereby potentially diagnoses, is that correct?

MR. WINTER: Right. The way it works now, until recently it was limited to within modality and within body site. CMS recently expanded it, as you may know, to cross modalities and body regions. So now if you do a CT of the pelvis and CT of the head, different regions, but it's in the same session, the reduction to the technical component applies.

So I would envision, and we can talk about this in the text. I would envision the same policy applying if you were to recommend a discount for the professional component, but again that's up for your discussion.

DR. BORMAN: I do think when you cross modalities there may be potentially a little bit of a concern, but that's a relevant comment.

On page 15, my last question to you is in some prior discussions, although not necessarily on this topic -- I think it was on the utilization, the equipment utilization discussion -- we sort of looked at nuclear medicine, CT and MRIs as advanced imaging because of their dollar cost, somewhat differently than we looked at standard imaging and

echography. And so, now we're sort saying that kind of was a distinction that's not useful for this conversation.

MR. WINTER: It depends on where you want to draw the line. I mean we've tried to frame this draft recommendation pretty broadly to apply to not only imaging but all other kinds of diagnostic tests that have a physician work component in the physician fee schedule. And so, that's where we have started. That's where we're starting off, but if you want to think about limiting it to advanced imaging, that's something to talk about.

DR. BORMAN: I'm not necessarily being critical. I just want to make sure I understand the nuances.

MR. WINTER: Right. This is meant to apply more broadly.

DR. BORMAN: Thanks.

MR. HACKBARTH: Okay, round two comments. Since we have draft recommendations, I would appreciate it if you would give me some sense of whether you're for or against, or could be for if X, Y and Z were changed.

DR. DEAN: I'm comfortable with the first three. I do have some hesitation about the prior authorization. Like Ron, I would wholeheartedly support prior notification,

and if in fact there's evidence that it can achieve a similar kind of result, I think that would -- it evokes certainly significantly less hostility because prior authorization evokes a substantial amount of hostility. And it's just a burden. It's just a hassle. You know. It's a hassle all the way around.

The other problem with it is that there are some conditions for which our guidelines are there's good evidence base, they're well developed, they're reliable. And in those, I think it makes sense.

There is a lot of what we do that's fairly gray, and I think the guidelines are not nearly as well developed. And there's also a concern that a guideline that applies to a particular patient who has one condition may be very different for an elderly patient that has four other diagnoses. And believe me, we see a lot of those.

So I'm a lot more hesitant about the prior authorization, both because of the resources that it requires by all the participants as well as the sort of science base we have to support it.

I would be actually more comfortable -- I suppose it makes sense that it should be applied to the high users.

On the other hand, I would be almost more comfortable to apply it to certain selected conditions where we really know we have the evidence base to support it.

MR. HACKBARTH: Let me just emphasize if there's something that you would like to see recommended that's not even touched upon here, that's fair game too.

So, Cori.

MS. UCCELLO: I think 2 and 3 are no-brainers.

With respect to the third one and whether we're talking about the physicians or the practices, I would be comfortable using practices instead of physicians to prevent gaming issues.

The first one I think makes sense.

The fourth one I'm concerned about the burdens. I would be very comfortable with notification rather than authorization, but just because -- I mean it almost seems like prior authorization for everybody would be easier than just having to identify the outliers. So either that or the notification I think might make more sense than the outlier issue.

MR. HACKBARTH: On Cori's first point about practices versus physicians, my understanding is that we

don't always know the practice. Sometimes every individual physician in the practice has their own number, and we can't relate them to one another. And other times it's the practice that has the number, and they're all using.

MR. WINTER: Right. So they should --

MR. HACKBARTH: We don't always know when people are in the same practice, in short, right?

MR. WINTER: We don't always know. However, if they share, each claim has a tax number on it, and the tax number should relate to a common practice.

One exception is sometimes physicians, if they are contracting for multiple practices, let's say, they can bill under multiple tax numbers.

MR. HACKBARTH: I see.

MR. WINTER: So I think the way to do this is to look at the tax number on the claim, and if the tax number for the referring physician is the same number for the ordering physician then you would assume the same practice.

I'll stop there. That's an important question.

MR. HACKBARTH: Okay. Scott.

MR. ARMSTRONG: So I think I am close but a slightly different place. I would support all four

recommendations. I understand the concerns expressed, but I'm much more comfortable with the idea of prior authorization, particularly limiting it to high-volume providers.

My discomfort comes, to the degree I have any, from the fact that this is so out of context of so many other things that I would want to complement prior authorization with, like discussions about utilization profiles and rates, and some kind of comparative reporting, or any number of other ways in which there are proactive, or -- other than reducing payment, there are a lot of other ways of changing practice patterns, and we really don't speak to that in these recommendations. One day I hope we would be.

MS. BEHROOZI: [Inaudible] -- because of the concerns expressed around prior authorization.

I do think that, as Cori said, you could just say it applies to everything or to everyone ordering certain types of tests. You know. There are different configurations for targeting, as talked about before.

And it does just feel like a lot of the discussion and analysis is around self-referral, and that kind of

lowers the thresholds a little bit maybe on how precise you have to be about identifying what's an outlier in certain other of those targets. So that might be a refinement that makes it more palatable.

The other issue that we aren't addressing here, maybe it's more relevant to some of the other areas besides imaging, but the whole area of things that aren't done on the same day. You know when you're talking about self-referral, right, the things that are not for the immediate diagnosis and things like that. So I wouldn't mind if we said something about that too, but maybe that's one of the prior authorization criteria then too.

DR. STUART: I support the first three recommendations with one suggested change, and that is that I don't see any reason why they should be budget neutral. So I would favor not having language about whether they're budget neutral. I would have language to the effect that you expect to have some savings going back to the trust funds

I too am a little ambivalent about prior authorization, particularly in the light of CMS's own ambivalence, or maybe opposition, to this tool. And one way

we might be able to approach this is through a recommendation for pilot tests, so that some of these questions that we've raised could actually be field-tested, or a demonstration. I guess pilots would be the best since if you find something then you can put it into play. So I would just simply add that as a possible.

MS. HANSEN: I am fine about the first three.

The fourth one is related to a comment on the previous presentation, that again it's assuming that the physicians who are ordering a lot more imaging have somehow been screened that these are beneficiaries who actually may need a lot more imaging. So in other words, is there a subgroup of looking at the appropriateness of it, or is it just the comparison of a similar practice and they still are outliers?

So it's one of the things of just distinguishing this fourth recommendation a little bit more.

DR. BERENSON: I support 2 and 3.

I'll get to 4 in a second.

I find I'm a little bit unhappy that within Recommendation 1 you've got 2 very different things that you've put together. What Karen described earlier as

component coding and putting together services that are always done at the same time into a logical comprehensive code is straightforward. That should happen. It is happening. The RUC and CPT are doing it. That is very different from an ambulatory episode of care where you're putting together a longitudinal care over time.

I am very skeptical about our ability to operationalize ambulatory episodes. And this isn't the time to do it, but I could tick off four or five design issues that I think might disable the problem. So I think it's a little too facile to just say let's go do it.

I'm all for the Secretary for studying it. I think it's much tougher even than the hospital-based episodes which at least are anchored in a hospital base. I'll just give a couple of my concerns -- is episodes will come out of the woodwork.

If we're going to pay for an episode of low back pain, what was then an incidental thing that happened as part of an office visit will now be an episode of low back pain unless we had some way to protect against that.

We have to deal with the issue of does the episode include the MRI for low back pain or does it not include the

MRI for low back pain, either penalizing or rewarding somebody who has the equipment.

I just think there's a whole bunch of issues in there. I'm happy to study it. I'm happy to develop it. I'm skeptical that it becomes a solution.

So now I'm at 4. I'm for prior authorization in this area. I would emphasize that it only -- it has to be evidence-based, and so I share the concern that Tom raised, that if we're in areas that we don't have good guidelines and there is no evidence or consensus around the right care, we've got to go light. So that's number one.

Number two is it absolutely has to include gold-carding which is the term that private insurers use, which is they should be limited to the 10 or 20 percent of practices that abuse the privilege of self-referral or of over-referring. We can't just have this as a routine intrusion into every doctor's practice, which is the way managed care did it, and I think right from the beginning that should be a principle.

And then I want to finish with the following: I am sympathetic to your view that, when done right, self-referral is a desirable thing, but I participated in a

meeting last week where an administrator of a cardiology practice with about 12 docs sort of made a presentation in which he was demonstrating how bad a partner Medicare was when Medicare had the temerity to reduce fees for nuclear scanning and things, which will reduce their income by 40 percent was the assertion. CMS finds maybe 14 percent over 4 years. It means they're doing an awful lot of these things or he was making it up.

Number two, he was talking about isn't it unfortunate that we had to buy our own CT angiography because we couldn't get together with the hospital and the other cardiology group in town. So we are all now going to do a lot too many of these because we couldn't get together. It was real clear. He just right out front said it.

And then the shocker of this discussion was he talked about CMS may have the nerve to reduce payment for PET scans that they had recently purchased.

So we have a cardiac practice with that kind of technology billing the hell out of Medicare, and so what I'm going to suggest in addition to prior auth, which presumably would catch this group, is the potential of civil monetary penalties. Tomorrow, we will be recommending some

intermediate sanctions for poor quality. I don't know why we wouldn't also tie that to the prior auth program where we find real abuse of the program -- some kind of intermediary sanctions with the ultimate threat of kicking somebody out of the program.

What we've got here is echelon practices not abusing self-referral and then people who are absolutely abusing it and actually think Medicare is the bad partner when in fact they're the bad partner. They're the ones forcing us to have to recommend these kinds of policies, which is unfortunate.

So I do -- I am sympathetic to not just banning. You know. They have invested in their PET scan. So I don't know what to do about them. But I would certainly want to hold them to a standard that they're doing it appropriately, which I think should be pretty rare, pretty rarely. And if it turns out in prior auth that they are not following the evidence-based guidance in that area, they shouldn't just walk away scot-free in my view.

MR. WINTER: Could I just clarify your comments on the prior authorization and the gold-carding?

DR. BERENSON: Yeah.

MR. WINTER: Is the notion that you would target all self-referring physicians for all high utilizing physicians.

DR. BERENSON: High utilizers. High utilizers. I assume that many of them would be self-referring physicians.

MR. WINTER: Right.

DR. BERENSON: I suppose until you develop the profiles you're probably reviewing everybody, but I would very quickly sort of give a lot of people passes.

And the final thing I forgot to say is I actually would start here. I think there are other places where prior authorization has a role in the program. There's a recent published article that didn't make our handouts, about the overuse of insertions of intracardiac defibrillators, far beyond clinical indications, far beyond what CMS has approved as the coverage. It's a $50,000 elective -- usually elective -- procedure. I think Mark has heard me say this a lot. I think it's ripe for a prior authorization program.

I think we could establish pretty strict criteria, so that we're not applying prior authorization where we don't have evidence, which is where it's not a high-cost

item, where there's no significant practice variation. But when a service meets a set of strict criteria, I think CMS should do it.

But I wouldn't start there today. I would start with something that has some evidence of success with private insurance, see how it works and then see if it can be the model for building on for other very selective uses of prior authorization.

MR. HACKBARTH: So could I ask you about Draft Recommendation 1? I think your point that the two bullets are fundamentally different is a good one, and I would also agree that the second bullet raises some really complicated issues.

So if we were -- on the other hand, I hear you saying that the first bullet is already being done. Did I interpret that?

DR. BERENSON: It's being done, but I don't have any problems with taking credit for -- I mean it could be done. I don't know if we need to.

I mean I don't know enough to know whether a further nudge would be helpful or not. I know a lot of good activity is going on this area.

MR. HACKBARTH: Okay. So the question I'm getting is if we were to drop the second bullet because it's a whole different kettle of fish, does it make sense to have a recommendation with just the first bullet?

DR. MARK MILLER: If I could just parse through, although given the passion that Bob was feeling there at the moment I wasn't sure I wanted to go in. But I just want to parse through your comments on the first thing, none of the last stuff. You're okay there.

But the first thing, when you raised on bundling, I just want to walk through a couple of levels. There is the stuff that's going on. Okay? And that tends to be procedure-oriented.

At least some of the next level would be packaging other things -- office visits and tests, that type of thing, asking CMS, the RUC to begin to think about packaging beyond what their current efforts are.

A third level of bundling is bundling like the global surgical fee where you say it's the same physician doing a series of services over a set of time.

Then the next level of bundling -- I don't know how many I have going at this point -- is the one where I

think you referred to more as the ambulatory episode where it's multiple providers, multiple time.

And I'm just trying to narrow in. My sense was it was the last one that gave you the most --

DR. BERENSON: Yeah. No, I think there are some sort of operational issues. Even on a global payment now, there's at least a suspicion that the payment for a 90-day global period for surgeons has too many post-surgical days because patients don't stay in the hospital anymore, that they may be valued at too high an office visit level. Those are technical issues, but I'm all for keeping 90-day global payments.

I am very much talking about the episode over time.

DR. MARK MILLER: So the reason I wanted to raise this is if we're re-torque this I think there's still a couple of packaging, bundling things --

DR. BERENSON: You know packaging. I think if we're going to throw the urinalysis and something else in with the office visit and get some efficiencies because there's not duplicate work there you could either do it through a package or similarly you could reduce the payment

for the second service. I think that's a reasonable area to proceed. You're not sort of changing fundamentally changing incentives for anybody. So I'm all for proceeding in that area.

It is about the ambulatory episode of care that gives me the --

DR. MARK MILLER: We'll give you something to rework there.

MR. HACKBARTH: So help me with the language here. So packaging is same provider, same visit, multiple services provided by same provider, same visit.

We can use the term "global payment" for same provider but multiple visits over time and then having a single payment as in the surgical global payment. And what I hear you saying is that there may be some opportunities for global payment in that sense -- same provider, different visits.

The area that Bob is most concerned about is bundling different providers, different visits --

DR. BERENSON: No, even the same provider over a long period of time, over an extended period of time.

And there are people who think we should go in

this direction. So I don't want to unilaterally sort of dissuade. You know.

Prometheus I guess is the group that is developing these ambulatory episodes. I think they have oversimplified the operational issues, but I'd be talking to them.

And I'm all for exploring this area, but I think there's a number of concerns, even with a single provider. What an episode of back pain is in a patient with five chronic conditions, are we going to be paying for an episode of back pain, then an episode of hypertension, then an episode of diabetes?

It's very non-holistic, and I think aimable. And so, I do raise concerns, but there are people working in this area, and I'd want to take advantage of their expertise.

MR. HACKBARTH: Okay. Herb.

MR. KUHN: Generally supportive of all four recommendations; 4, however, I'm like others. I've always felt a little more comfortable if we had an outlier policy or gold card policy or something like that where we aren't engaging all physicians but really kind of recognizing the outliers where we can be focused on.

DR. CASTELLANOS: I just have a couple questions before we go with recommendations. The multiple procedure payment thing, that applies to all settings -- a hospital, the IDF and the office. Is that correct?

MR. WINTER: Yes.

DR. CASTELLANOS: Okay. So there's no --

MR. WINTER: That's Draft Recommendation 2.

DR. CASTELLANOS: Right. Okay. Like Bob, I'm concerned about the bundled payments that include things that are episodes of care. I think we need a lot more discussion on that. So I'm for the first part but not for the second part.

The second, again, my concern here is that I want to make sure that this applies to all sites of service -- the office, the IDF and the hospital.

MR. WINTER: You're asking about the first bullet on Draft Recommendation 1?

DR. CASTELLANOS: No, Draft Recommendation 2.

MR. WINTER: Okay. Yes, that's how we drafted it.

DR. CASTELLANOS: Okay. Now Draft Recommendation 3, as it was presented, it only applies to the office. Is that correct?

MR. WINTER: Yes.

DR. CASTELLANOS: Okay. I'm against that. I would certainly like to explore the possibility of extending that, if feasible, into the hospital and to IDF.

MR. HACKBARTH: Ariel, are there issues in doing that? Why is this one cast as only the office whereas 2 is everywhere?

MR. WINTER: Right. The notion here is we're trying to account for potential duplications of physician work. And so, if the physician who is billing for the professional component is the same one who ordered the service and is presumably treating the patient, they probably have already obtained information about the patient's medical history and their symptoms and prior tests, and those sorts of things.

If it's in the hospital context, you could perhaps argue the same thing, that if the physician who ordered the service is treating the patient on an ongoing basis, or at least has enough information to make their job easier when it comes to billing for, doing the professional component, if we're still using imaging as an example. So you might want to think about expanding it to those settings as well,

but it's something we can think about.

MR. HACKBARTH: Yeah.

DR. CASTELLANOS: Only because 40 percent of the doctors are now employed, and it's going up each year. So I think we need to consider that.

MR. HACKBARTH: Yeah, I think that's a good point.

DR. CASTELLANOS: To Recommendation 4, Bob, you convinced me. When we have some of these guys that are really outliers, we need to go after them. And I have no problems with prior authorization for significant outliers.

DR. KANE: Well, after listening to all, I was inclined to be fine for all four of them, but now that I've heard all this conversation I think I certainly support 2 and 3. I agree with Ron that it should be applied to all settings.

Just on 4, I guess isn't there something in the Medicare original statute that says the government is not supposed to tell doctors how to practice medicine, and doesn't that get kind of close to that? Except, unless you're going after fraud, in which case Bob's approach is something I think is fine.

But is this getting into the government practicing

medicine? And how you avoid that, I don't that. That's just a question.

But I think the prior notification and/or prior authorization, certainly prior authorization for people who are being abusive.

And I agree. I've heard similar conversations, actually from both cardiology practices and the urology with a gamma knife. They want to use the million-dollar gamma knife. So they use it over and over and over again for things that aren't really appropriate as well. So I mean there's a lot of opportunity. It's not just in the imaging.

So anyway, maybe we need to establish a prior authorization program for physicians who order substantially more advanced imaging and possibly extend it to other services as becomes apparent because I don't think it's just limited to advanced imaging. When someone buys a million-dollar fixed cost piece of equipment, they're going to use it.

MR. HACKBARTH: Yeah. Well, I sort of like the idea that Bob mentioned, that clearly this is a tool that could be applied in a lot of different places, but maybe it makes it sense to start narrow and then see if in fact we

can make it work through all of the complex administrative issues and then talk about expanding it from there.

So as opposed to having it in the recommendation, expand it across the board. Let's just have that in the text as a possibility –

DR. KANE: Possibility.

MR. HACKBARTH: -- provided that we can --

DR. KANE: And then I'm going to let you worry about the language for whether this is practicing medicine or whether there's a fraud piece that you're preventing, and just let you worry about that because I don't know the answer.

MR. HACKBARTH: For many years, Medicare has retroactively denied payment for services, and this is more shifting the time of the decision as opposed to making a fundamentally different sort of decision.

MR. WINTER: And at one point in the 1980s, CMS or HCFA did apply -- develop prior authorization for certain surgical procedures. This was mandated by Cobra. So there's a specific statutory mandate, and it was done by the PROs which are now called the QIOs, and it was eventually dropped because the approval rate was very high.

DR. KANE: Yeah.

MR. BUTLER: Okay, on 4, I think your data in here; it said 2 percent of the ordering physicians had 20 percent of the -- it would be a little more compelling that you could say let's do prior authorization on 2 percent, and you could even outsource it to an RBM and not have CMS be even burdened with the administrative costs. I'd be very supportive of that kind of approach.

I'm really lost now on Recommendation 3, on where we're at, frankly. We started this whole exercise largely because we were worried about physicians who owned their own equipment and were over-utilizing it.

As I pointed out before, let's forget about the hospital side now. If they have a radiologist reading an image in their office, right now they're off the hook. Right?

MR. WINTER: Right. Under this draft recommendation, yes, because it's the same physician.

MR. BUTLER: Right. And frankly, if they don't have a radiologist dong it now, they will if we put in this place, and they'll just buy it on the margin, and we'll be -- right. So that defeats that one.

So I think it has to apply to the practice, but then I get lost on the hospital side. What the heck are we -- then it just kind of applies to everybody. If you do it to the whole practice in the office, now you've got to do it to the whole practice in the hospital. So basically, it applies to everyone, everywhere, and we're just reducing fees regardless of ownership, referrals or anything. Right?

We just get a rate reduction, I think. Isn't that what this in effect does?

DR. CASTELLANOS: Didn't you clarify that this is the same physician that orders it and does it, and it's not a part of a practice?

MR. BUTLER: And that's my problem. If you do it with just the physicians that are both ordering it and doing it, that will be gamed in a second, I believe.

DR. CASTELLANOS: You're probably right.

MR. BUTLER: It will be gamed. They'll say fine, I'll order it, but I won't do it. I'll have the radiologist read it.

You still get the technical component, you still get all the money, and you still make almost as much as you do now, and you don't have to do it yourself. That's what

will happen if we do this in the office.

So now if you bring in the hospital and you want to bring -- and I understand if you bring a cardiology practice. I'm not -- you know. I'm not quite sure we're on the hospital side of this and how it would work without basically saying all of this ought to be reduced in prices, period. So somebody needs to think that through.

MR. HACKBARTH: Yeah, and I think you're raising an important issue. We do need to think it through.

I'm not sure that if you're talking about an office practice that everybody is going to go out and hire a radiologist if they don't already have one in order to evade this. However, if you extend it to the hospital, clearly they'll get around it by saying oh, we'll just have the radiologist read it and then split it up.

MR. BUTLER: They can outsource the reading though and have it billed under that outsourced radiologist's name for the professional component.

MR. HACKBARTH: Yeah.

MR. BUTLER: I think. That's what happens.

MR. WINTER: I would expect in most cases in a hospital these are being billed by a radiologist

MR. HACKBARTH: I see your point.

MR. BUTLER: I'm not positive, but we just need to think that through.

MR. HACKBARTH: Okay, in the interest of time. You've made a good point. We'll think through that some more. Let's keep moving, so we can get done.

DR. NAYLOR: So I support all the recommendations. I would agree with Ron in terms of trying to think about applying this Recommendation 3 across settings, with all the caveats we just heard and Cori's recommendation with 3 about looking at it not just as a same physician but physicians within the same practice. I don't know what's possible, but I think that that's important.

Bob's recommendation about 4 being evidence-based, adding a penalty and Peter's suggesting increased clarity on it, I think all make a lot of sense.

And Ariel, I just want to say that your illustration raised a question for me which is: Is there a potential here to have multiple images at one visit that continue to add cost? I was just -- is that something that all of these recommendations cover, or any of them cover?

MR. WINTER: Right. So there's already the

potential of financial incentive --

DR. NAYLOR: Say your head, your neck, your --

MR. WINTER: -- to do multiple imaging services.

DR. NAYLOR: Right.

MR. WINTER: And the intention behind the multiple procedure reduction, which was based on our recommendation in 2005, was to reduce the financial incentive, so that it's only done when it's clinically appropriate and necessary.

DR. NAYLOR: Okay.

MR. WINTER: And so, what we're trying to do here is apply that same logic to the professional component --

DR. NAYLOR: Okay.

MR. WINTER: -- and by accounting for duplications, efficiencies, you know, reduce any additional profit incentive that might be motivating multiple imaging studies in the same session.

DR. NAYLOR: Great. Thank you.

DR. BAICKER: I support the recommendations.

I would definitely want Recommendation 4 to be targeted towards high users because I have a suspicion that it's that targeting that provides the real incentive, not the actual review, that you don't want to be the guy who

suddenly falls into the category of having to do all the prior authorization. In this instance, unlike Karen's important point about keeping hassle costs in mind, this seems like a case where hassle costs are good because you want people to avoid being in that group. So that targeting seems important.

And as for Peter's point which I think is, first order, thinking about people would respond to it, I also would want to be sure that we understood how offices were designated in that I can certainly imagine if you're just looking at the same taxpayer ID does it change your incorporation strategy, where you don't change anything real in the office but suddenly you're two independent contractors, or something. I don't know what the legal structures are, but I would imagine if they're small changes people can make to get big changes, or even small plus epsilon changes in reimbursement, they would do that.

MR. GEORGE MILLER: Yes, I'm going to give mine, and Karen asked me to take hers also although she would have benefitted from Bob's comments.

So first, Karen said on 1 she's okay, but she had concerns, and Bob covered that. And 2, she's okay maybe but

needs to think about it. On 3, she was okay. And she had concerns about 4 for all the reasons that were discussed.

And for me, it's just about the same although I like Bob's comment about the gold-carding or having, for 4, it be defined that we're dealing with those who are outliers, and either a gold card would solve that problem.

MR. HACKBARTH: Thanks, Ariel.

And now we'll have our public comment period. Let me go to the microphone, and let me quickly review the ground rules before you begin. Please begin by introducing yourself and your organization, and when this red light comes back on that means your time is up. You'll have two minutes for your comments.

And as always, let me remind people that this is not your only or even your best opportunity to provide input on the Commission's work. The other opportunities are direct contact with the staff or to use our website, where you can present longer than two minute comments.

MS. ROWE: Thank you. Can you hear me? I am Elizabeth Rowe representing the Mid-America Neuroscience Institute in Lenexa, Kansas.

Hospitals spend about 50 percent of the health

care dollar, whereas outpatient MRI imaging accounts for 0.5 percent, and as you pointed out, less than ten percent of that is self-referred. Hospitals are rapidly buying private primary care practices and thus completely capturing those physicians' referrals to their hospital-owned services and facilities, circumventing completely the prohibition on hospital payments to private physicians for their referrals. Hospital imaging centers are paid up to three times more than freestanding outpatient centers for MRIs.

Hospitals have exclusive contracts with physicians and physician groups, for example, radiology groups. Many neurologists have special training and certification in neuroimaging, but they are excluded from interpretation of hospital MRI studies on their patients. This exclusionary situation has motivated neurologists to own facilities. A similar case occurs for cardiologists, orthopods, and other specialties, as well as family practice groups. These freestanding, lower-cost facilities provide competition for the high-cost in-hospital facilities, thus lower costs and increasing quality.

Recent studies post-Stark, unlike some of the older studies, show that the so-called self-referral for MRI

by treating physicians does not lead to overutilization. I can provide references to the staff. Self-referral that is not regulated by Stark includes the self-referral of radiologists when their reports suggest further imaging and the self-referral of hospitals, as has been mentioned, requiring their own physicians to refer to their own facilities.

MedPAC is concerned about overall health care costs. The accelerating shift of physicians from private practice to hospital employment will increase overall costs for the reasons outlined above.

In conclusion, I would urge the MedPAC Commissioners to seek ways to support and even incentive these lower-cost freestanding outpatient facilities owned by physicians who take care of patients. I submit that this would contribute much more to cost savings than any of these options discussed today, which will only drive more outpatient services into the high-cost hospital environment.

Thank you very much.

MR. ADLER: Hi. I'm Dave Adler with the American Society for Radiation Oncology and I'm speaking today on behalf of a coalition called the Alliance for Integrity in

Medicare. We're a coalition of professional societies and health professional -- and groups representing other health professionals that are united about our concerns of abuse under the in-office ancillary services exception and a solution for that problem.

I think our concern in listening to the discussion today is that the solutions proposed do not get at the root of the problem, which is the loophole in the self-referral law, the exception for radiation therapy, physical therapy, pathology, and advanced diagnostic imaging.

I think we are seeing increasing data that what's happening out there, and Dr. Berenson, you're passionate in talking about it, I'm just -- from our perspective, I think it's pretty easy to say and pretty easy to see how these solutions could be gamed and, I think, will be gamed. Once you've made the investment in a linear accelerator, in an expensive CT, you're going to find a way around these things or you're going to up the volume to respond to the payment cuts, and I just -- I think we'll just keep dealing with these issues until we actually get at the root of the problem.

And as far as the very important point about the

multi-specialty practices that really are true models of health care delivery and we don't want to impact that, I think there is a way, and we've been working on it through our coalition, to make sure that those models aren't interrupted and, in fact, maybe to encourage more physicians to participate in such models. So we, of course, would love to work with MedPAC on that.

Thank you.

MR. COONEY: Good evening. My name is Patrick Cooney and I'm here representing the 77,000 members of the American Physical Therapy Association.

First of all, I just wanted to thank you for your work in this area and particularly your report from last year. I think physical therapists have felt that this area was a problem for many years, but I think your report last year really spotlighted the concern very well.

Specifically, I think our concern is that the in-office ancillary care exception does not represent -- or what it was intended to represent were those services that were integral to the patient's diagnosis on the visit to the physician's office. When you look at some of the services mentioned, including physical therapy, they're not integral

to the patient diagnosis and so their relevance to being provided in the physician office, I think, is questionable.

As we look at, for example, physical therapy, from your own report, you highlighted that only three percent of the physical therapy services were provided on the same day. And then two weeks later, still only less than 15 percent of the services were being provided for physical therapy in those offices.

We would urge you, in addition to the recommendations that you've made here that I thought were very thoughtful, we would urge you to also consider the potential that was in your original report to look at exempting out of the in-office ancillary care exception those services that are not integral to the patient diagnosis, as were mentioned by my colleague previously.

Again, we look forward to working with you on this because we want to make sure that those settings that are looking at the ACO models or that are looking at integrated care are not impacted negatively by this. But we do think that exempting out these services from the in-office ancillary care exception would be a good step forward, so thank you.

MS. McILRATH: Sharon McIlrath with the American Medical Association. Just one point. No matter what you do with the recommendations, this discussion about whether or not they should be budget neutral, the Commission and many policy makers have had a lot of discussions about the need to redistribute money within the Physician Fee Schedule. If you simply take the money that you got from these savings, and particularly if you take the money that would flow from the things that the RUC has done, and you don't redistribute it, you use it for government savings, A, I think it's somewhat hypocritical, and B, I think it will be harder to get the RUC to put in the enormous amount of effort that is involved in combining these codes and redoing surveys and actually coming up with real numbers that physicians think are fair if it's only going to be diverted from a system that has been starved for the last nine years anyway.

MR. HACKBARTH: Okay. Thank you.

We will adjourn for now and reconvene at 9:00 a.m. tomorrow.

[Whereupon, at 6:20 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Thursday, February 24, 2011.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, February 24, 2011
9:00 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
RONALD D. CASTELLANOS, MD
THOMAS M. DEAN, MD
JENNIE CHIN HANSEN, RN, MSN, FAAN
NANCY M. KANE, DBA
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
BRUCE STUART, PhD
CORI UCCELLO, FSA, MAAA, MPP

AGENDA PAGE

P R O C E E D I N G S [9:00 a.m.]

MR. HACKBARTH: Okay, good morning. We have two sessions this morning, the first on Care Coordination for Dual Eligible Beneficiaries, and then the second on QIOs or Medicare's role in supporting quality improvement, which includes QIOs, followed by our public comment period. We will finish on time today, unlike yesterday, I promise that.

So beginning with duals, Carol, are you going first?

DR. CARTER: No, Christine's going first.

MR. HACKBARTH: Christine is going first. Okay.

MS. AGUIAR: Good morning. During this presentation, we will discuss the results of an evaluation of the models of care submitted to CMS by dual eligible special needs plans, also referred to as D-SNPs. This analysis is part of our ongoing work considering how to improve care coordination for dual eligible beneficiaries.

The Commission has been focusing on the dual eligible beneficiaries because many of these individuals are frail, disabled, or have multiple chronic conditions. These beneficiaries qualify for both Medicare and Medicaid benefits, and the care is often uncoordinated and costly.

In November, we discussed the results of our site visits and interviews with stakeholders about programs that integrate the care for these beneficiaries. We learned that the programs vary considerably in their design. However, we found similarities across programs on care coordination activities and integration with Medicaid benefits.

For this analysis we are discussing today, we compared the D-SNPs care coordination activities to those of the integrated care programs that we discussed in November. We conducted this analysis because we were interested in assessing whether D-SNP care coordination and Medicaid integration activities could be evaluated through the models of care.

We also tried to assess whether there was a relationship between the model of care descriptions and D-SNP quality results. Kelly will now discuss key characteristics of SNPs and our methodological framework.

MS. KELLY MILLER: SNPs are Medicare Advantage plans that target enrollment to specific groups of beneficiaries. These SNPs target enrollment to beneficiaries who are eligible for both Medicare and Medicaid. SNPs function essentially like, and are paid the

same as, any other MA plan. Unlike other MA plans, however, they can limit their enrollment to their targeted populations. Additionally, D-SNPs can enroll all beneficiaries each month, unlike other MA plans that can enroll beneficiaries only during specific periods.

Since their creation, there have been recurring concerns about SNPs. The first, that SNPs are not accountable to provide specialized care for their target populations applies to all SNPs, including D-SNPs. The second concern, that SNPs are not coordinating Medicaid benefits applies only to D-SNPs.

To address the first of these concerns, that SNPs are not held accountable for providing specialized care, the Commission recommended that the Secretary establish performance measures tailored for the SNPs, evaluate SNPs on the performance measures, and make the information available to beneficiaries and their counselors.

In an effort to make SNPs more accountable, CMS required SNPs to report on three types of quality information listed in the top row of the table. As shown in the first column, SNPs now report 15 health care effectiveness data and information set, or HEDIS measures.

HEDIS measures are clinical process measures such as glaucoma screening, controlling high blood pressure, and persistence of beta blocker treatment after a heart attack.

Most of these 15 measures were chosen from the HEDIS measures all MA plans must report at the contract level, though NCQA has developed three measures that are SNP only. SNPs are also required to report structure and process measures developed by NCQA, shown in the second column.

These include things like complex case management, care transitions, and coordination of Medicare and Medicaid coverage. Plans are required to begin submitting these two measures in 2009. SNP performance on these measures has not been published.

Last, SNPs are also required to submit an evidence-based model of care. CMS identified 11 elements for SNPs to describe in their models of care. These include assessing patient risk, developing an individualized care plan, maintaining a centralized information system, and having an interdisciplinary care team.

Only new and expanding plans in 2010 were required to submit their models of care to CMS as part of the MA

application process. All SNPs must submit their models of care to CMS by 2012. The models of care will also be used in the SNP approval process. PPACA requires all SNPs to be approved by NCQA by 2012.

In this year's proposed rules, CMS outlined a potential approval process in which NCQA would review and score the models of care. CMS is developing a scoring methodology for NCQA to use. Plans with good scores may be allowed to submit their models of care less frequently than plans with lower scores.

The second concern is that SNPs are not coordinating Medicaid benefits. The Commission expressed this concern in 2008 when it recommended that the Congress require dual eligible SNPs to contract with states in their service areas to coordinate Medicaid benefits. D-SNPs must have contracts with states by December 31st, 2012.

We wanted to evaluate whether the SNPs were coordinating care for dual eligible beneficiaries, so CMS shared with us the models of care that new or expanding SNPs had submitted to them. We did not receive a model of care for every SNP because existing SNPs that were not expanding were not required to submit them.

Many SNPs with distinct contract numbers have the same parent company, such as a parent company having SNPs in multiple states, and the same model of care was submitted for all of their dual eligible SNPs. In addition, some of the plans submitted the same model of care for all their SNPs, chronic, dual eligible, and institutional.

We received about 140 models of care in total from CMS. After removing those models of care for chronic or institutional SNPs, as well as the duplicate models of care, there are about 40 distinct dual eligible models of care.

To analyze the models of care we developed an analytic framework based on our research on the key elements of care coordination. These key elements are SNP target population, risk assessment process, care during transitions, medication reconciliation, patient education, utilization management, and coordination with Medicaid benefits.

We reviewed the D-SNP models of care looking for elements of these key -- evidence of these key elements. After reviewing the models of care, we tried to compare the descriptions with SNP quality data. We wanted to see whether the quality of the descriptions was related to

quality measures. We looked at three data sources for quality scores, star ratings, SNP-specific HEDIS measures, and structure and process measures.

Now Christine will discuss the findings of our analysis.

MS. AGUIAR: In general, we found that important information on care coordination and Medicaid integration is missing from the D-SNP models of care. D-SNPs are not required to report about many of the key care coordination activities of integrated care programs, or about coordination with Medicaid benefits.

In addition, most of the model of care descriptions were too general to evaluate their care coordination activities. One limitation is a lack of description about the D-SNPs enrolled population. Most models of care state that SNPs enroll all duals or full duals, but they do not describe the characteristics of the beneficiaries, such as how many are disabled, have dementia, or are frail.

As a result, it was often not possible to assess whether a model of care was appropriately tailored to the enrolled population. In addition, a few plans submitted the

same model of care for multiple types of SNPs, questioning whether the models of care for those plans are, in fact, tailored to meet the distinct needs of the different SNP populations.

Of the care coordination activities conducted by integrated care programs that we have included in our analytic framework, the majority of D-SNPs only described the risk assessment process. This activity, listed on the left side of this table, is included in one of the sections on the model of care.

The majority of the models of care include very little discussion of the other key care coordination activities in our framework, which are listed in the column on the right. These activities include care coordination, medication reconciliation, patient education, and real time utilization management.

These activities are not questions on the model of care and were generally not mentioned or were only vaguely described. Only a handful of D-SNPs included clear descriptions of these care coordination activities and we will see an example of one of these descriptions on the next slide.

The table on this slide includes an example of a better D-SNP model of care description on care transitions and patient education. This model of care describes the role of the case manager during care transitions. The case manager is responsible for assuring that information is sent to the receiving institution, ensuring that members understand discharge orders, and have access to medications and services, investigating adverse events, and providing feedback to providers and institutions.

The SNP also describes how patient education varies by risk level. High risk members receive a review of the current treatment plan and calls from a nurse health coach to discuss the member's goals, while low risk members receive ongoing health education and the opportunity to contact a nurse health coach.

Another limitation of the models of care is that D-SNPs are not required to report on their coordination with Medicaid and the majority of plans do not discuss which, if any, Medicaid benefits are covered by the plan or how the SNP coordinates with Medicaid benefits.

For the few plans that did mention coordinating with Medicaid, the descriptions tended to be vague. In

addition, most of the D-SNP models of care also do not specify whether the SNP has a contract with the state, and if so, what the contract covers.

The lack of reporting on Medicaid coordination does not appear to be related to whether a D-SNP has a contract with a state or is fully integrated. For example, one D-SNP that was also a Medicaid managed care plan did not describe the coordination with Medicaid benefits, even though the plan's patient questionnaire implies that the health plan does coordinate Medicaid benefits.

Although the majority of D-SNPs do not describe coordination with Medicaid, there were a few exceptions and we will see an example of one on the next slide.

This slide is an example of a D-SNP model of care where Medicaid coordination activities such as finding providers that accept Medicaid and coordinating Medicaid services are described. This SNP maintains a registry of social services organizations, directs members to community services, tracks enrollees' Medicaid eligibility, and gives enrollees a directory of providers who accept both Medicare and Medicaid.

This information is helpful in understanding how a

SNP assists dual eligible beneficiaries access their Medicaid benefits. However, only a handful of D-SNPs included descriptions as detailed as this example.

Now I will move on to the results of our quality data analysis. Our analysis of whether dual SNPs with stronger model of care descriptions performed better on quality measures, was limited by a lack of publicly available quality data for SNPs.

For star ratings, the majority of SNPs do not have their own star ratings because this information is included in the overall reporting for the parent company, which includes data on all of a parent company's MA plans and SNPs. For HEDIS measures, we were missing measures for most of the SNPs we had models of care for because the models of care were submitted only by new or expanding plans, and these SNPs were generally not in operation in 2008 when the HEDIS measures were published.

We also found the published HEDIS subset data to be hard to use because there's not a composite measure reflecting the combined performance across all measures, and many of the HEDIS results are blank because SNP samples sizes were too small for measures to be calculated.

Finally, although CMS receives the SNP structure and process measures, they're not publicly available. Therefore, we were not able to review this data. Based on our review of the D-SNP models of care, we have concluded that the model of care descriptions cannot be used to adequately evaluate care coordination for dual eligible beneficiaries or coordination with Medicaid services.

It appears to us that D-SNPs need to be evaluated on a complete set of care coordination measures, including Medicaid coordination, in order to determine whether D-SNPs are providing appropriate and special benefits to their target population.

In addition, we feel that this information should be collected from D-SNPs in a streamlined process that reduces the reporting burden on the plans and the administrative review burden on CMS. In addition, publicly reporting SNP-specific quality data could help dual eligible beneficiaries to make informed decisions when choosing a SNP. This data could also be used to evaluate and compare the quality of care of SNPs and to identify areas for improvements.

For today's discussion, we would appreciate your

feedback on these two questions: Should D-SNPs be evaluated on the care coordination elements in our framework, including coordination with Medicaid, and are there key elements missing from our framework?

We also wanted to make you aware that we are preparing a chapter for the June report. The chapter will cover the information we presented in November on our findings from the site visits and interviews with integrated care programs. The chapter will also include the findings from our evaluation of D-SNP models of care.

This concludes the presentation and we welcome your questions.

MR. HACKBARTH: Okay, thank you. Tom, we'll begin with you, clarifying questions. Cori? Scott? Mitra? Bruce?

DR. STUART: There's a lot to be concerned about here. My question is, can you help us put this into context in terms of what this market looks like? Specifically, you talked about the fact that there were no separate reports for individual SNPs that happened to be part of a larger company. So how many entities are actually in this and then how many individual SNPs are part of these entities? Is

this all for-profit business? Is there a non-profit segment?

MS. AGUIAR: So these were as of January 2011. There were 298 dual eligible SNPs. I believe most of those are for-profit. We're not sure. We're actually not quite sure of the number of -- how many of those are unique SNPs and then not part of parent companies, but I believe that the majority is part of parent companies. So there are more SNPs that are part of a larger parent company than there are SNPs that are just SNPs.

DR. STUART: That's what I anticipated. It would useful to have that number so that we could see how many organizations are actually responsible for making these decisions, and we assume that it's the parent that's the one that's driving it.

MS. HANSEN: Thank you. You know, if this of great interest historically for me, and I think the chapter really outlines a lot. It seems like a lot of activity, actually, has occurred in the past probably a year and a half.

One of the questions -- it's interesting that one of the SNPs described from the parent company when the

application was made, the same application of conditions of participation were given regardless of what segment of SNP it was, so whether it's institutional, whether it's dual, or chronic conditions.

Do you know if that's just from the CMS side that that's something that they have changed so that they are expecting more specific criteria for these three different domains?

MS. AGUIAR: So one thing that I believe we did mention in the presentation is that now SNPs per PPACA have to be approved by NCQA, and CMS has decided that the model of care is going to be the instrument for that approval. From our conversations with CMS, they are -- that's an evolving instrument, and I believe their intention is to have some differentiation in the models of care between the D-SNPs and the chronic SNPs and the I-SNPs.

MS. HANSEN: Great. And then since I know probably the majority of the SNPs are dealing with an older population, I noticed that, of course, there is a dual eligible disabled population. Were there any particular SNPs that you uncovered that had some particular data or description on that segment?

MS. AGUIAR: I think that there was one, but one of the problems, which was basically one of our first limitations, is that the populations were not described in such detail, so they would say full duals or all duals. So they could actually really be enrolling a subset, a dual SNP subset, which could be the disabled, but we just weren't able to tell. But I believe Kelly reviewed -- is that right -- one SNP that was specific to the under-65. Carol didn't have any either.

MS. KELLY MILLER: I think there was one.

MS. HANSEN: There was one. I just think that that's going to be another interesting one just because that population will continue to grow, you know, the disabled population will age-in and so therefore, there will be a greater need.

I also noticed in the chapter that one of the descriptors on one of the plans, they had a cultural component to it, but is that anything else that you know is moving in that direction to describe that? I know in California, many of the SNPs are located in very racially non-English speaking populations.

DR. CARTER: One of the things that CMS requires

plans that are submitting their application to be an MA plan, since SNPs, all of SNPs are MA plans, so they submit an MA application. As part of that, there's an attestation, a series of questions about their --

MS. HANSEN: Right.

DR. CARTER: -- models of care and there are about 250 questions. One of the questions in there is about, do they perform a cultural assessment of a patient.

MS. HANSEN: So this is up then NCQA to consider whether or not this might be one of the things that they'll look at in the future?

DR. CARTER: Right now NCQA, for their approval process, is going to be approving the models of care and the cultural assessment is not part of that.

MS. HANSEN: Okay, thank you.

MR. HACKBARTH: Questions, Bob?

DR. BERENSON: Yeah. I want to follow-up on this issue of why the models of care were sort of so general and not specific. Carol, you just mentioned that there's 250 questions that they ask, and yet, there's a vagueness? I'm sort of confused as to --

MS. AGUIAR: Right, right.

DR. BERENSON: -- where the problem is here.

MS. AGUIAR: So there are two documents. There's the model of care descriptions, which is what we reviewed, and on this slide, we have the elements of -- there's a model of care matrix, so this slide are the elements that they have to include on the model of care and they'll just go through some measurable goals, staff structure, structure of care management, interdisciplinary care team.

Then as well as part of the application process, there's this model of care attestation, which does have these 250 questions. It's a yes, no attestation. So from our conversations with CMS, we understand that the model of care attestation will not be part of the NCQA approval process. Rather, it will be the models of care descriptions that CMS is developing a grading mechanism for, which they discussed a little bit in the proposed rule. But the final rule is not out yet, and so we don't know what the exact grading system of that will be just yet.

DR. BERENSON: So the models of care request is going to be much more precise about what is going to be required as opposed to just having some categories and tell us some information about it?

MS. AGUIAR: The model of care -- we haven't seen it yet so what we're anticipating that it will be will describe how the grading system will work. CMS has also done a number of user calls with some of the SNPs to try to give more guidance on the specificity of -- sort of what they're looking for.

As we said, we found that some of the descriptions to be rather general, so CMS is in the process of giving the feedback to the SNPs about the type of information that they want to see in the models of care. But the models of care will remain a descriptive document that then CMS is developing a grading mechanism for.

DR. BERENSON: So CMS agrees that what has come back is insufficient for their monitoring -- for program monitoring?

MS. AGUIAR: We did not outright ask them that and they have not shared their opinion on that with us.

DR. BERENSON: Okay.

DR. MARK MILLER: I think both of you are starting to zero in on at least part of the issue here. So you have this application. You have these models of care. The hope was that the models of care were going to actually describe

in some detail what was going on, and perhaps even could be used for our input to get ideas from and from the purposes of sort of looking at the program, whether programs could be evaluated on that basis.

Maybe we've just been sort of polite in our delivery here. The models of care have come back. They don't seem to be very useful, and I think the question on the table is if we want this information, is this the right instrument, or should we ask for it differently or as part of another instrument. And if we're going to continue to use this instrument for this, then I think there's probably a lot of change that has to go in place to make them useful.

DR. BERENSON: So at this point, we don't know whether the models of care are inadequate or whether the descriptions of the models of care are inadequate.

DR. MARK MILLER: Exactly.

MR. HACKBARTH: Yeah. Just to build on Bob's point, so you could have models of care that are inherently inadequate, they're not well-designed, and even if carried out they wouldn't work. You could have models that are fine, but people just are not sufficiently attentive in submitting the descriptions.

Or you could still have another disconnect. You could have great descriptions, good models, but they don't reflect what happens in the real world. And we don't know at this point which of those disconnects, if any, is the problem.

MS. AGUIAR: Right. And I would completely agree with that. Now, when we set out, we didn't know what the state of the model of care descriptions would be, and so we were really looking at this as can we evaluate them, compare their actual activities to these integrated care programs. We found we weren't able to do with that because that information wasn't in there. And then information that was in there was really general and vague, and so -- on the whole, not in every single instance.

And so, we weren't able even to conduct our original evaluation. I think when we step back to look at okay, now, why was this, we saw, well, a lot of what we were looking for were just not actual questions on the model of care elements themselves, so they weren't required to talk about coordination with Medicaid benefits.

We were sort of like, well, it's not surprising that you wouldn't see that information there because on one

hand, they're not required to report on that, and then the issue of the information that is there, you know, the usefulness of it, since it tends to be so general and vague, is something that CMS is in the process, I think, of addressing through these user calls, or is hoping to improve, again, through this grading process.

DR. CARTER: But it is why we then started to look at the quality measures, because we were thinking, well, what you have poorer descriptions, but actually all of the models of care that they're actually using on the street are fine and they are coordinating care and everything is good. Then we realize, actually, there's not the quality data to do that. So we're trying to tie that up.

DR. MARK MILLER: [Off microphone] - you want to stay on time, it's just -- so there's a lot of activity here on the part of the plan and on the part of CMS reviewing this, and then eventually it's supposed to be kicked over to NCQA, and I think one question is, is this a good use of energy or is there a more streamlined way or a better instrument to get all of this. This is not where we started off, but this is where it's starting to take us.

MR. HACKBARTH: Herb, clarifying questions? Ron?

Nancy?

DR. KANE: On Page 6, I guess I'm just wondering why -- so NCQA has not produced any HEDIS since 2008 and they haven't brought the structure and process measures -- I don't know if they've collected them, but just not shared them or sent them? I mean, I guess, are we just looking at this in a state of formative development or are we looking at this in a state of this is what it's going to be unless someone says something? Why hasn't NCQA done their piece? I can't tell if this is just because it's in a state of development or that people just don't think it's important and it's not going to ever get developed.

MS. AGUIAR: Right. I think I get what the question is asking. So NCQA does have the structure and process measures and I believe since 2009 SNPs have been reporting on them. There was a little bit of a phase-in so not all SNPs had to report on all at the same time. But now I think they actually are close to fully phased in, if not fully phased in. So that's already ongoing and CMS does get that data.

We did hear from CMS that they have reviewed that data, but it's just not publicly reported yet for reasons

which I don't think we are completely -- we don't really know why, or if they have the intention to report that data soon. But that process is already ongoing and is underway.

DR. KANE: So the concern -- the models of care data you collected you looked at and it doesn't look very good. The other two we don't quite know where the -- whether that's about to be reported or has NCQA stopped doing the HEDIS?

MS. AGUIAR: No.

DR. KANE: So the first two columns, the quality measures, what do we want to say about that? You know, hurry up or let us know when you get it? I'm a little -- I hear what you're saying as to why you look at the quality data. It was the models of care was too vague. But is there anything we need to say about the speed with which the quality matrix are being reporting or published?

MS. AGUIAR: I think we could, but I think the comments would go to CMS, not NCQA. I think NCQA has been collecting these data. They did it in phases. They've been providing that information to CMS. So I think the bottleneck is at CMS, not at NCQA.

MR. BUTLER: So it's a resource intensive group,

but I'm not sure how intense, that you've got a million members, roughly, and the dual eligible SNPs, which is what, 2 to 3 percent of membership? I'm not sure of the percentage of Medicare spending or what the per capita spending is because we don't have any dollars in the narrative that I found. Can you give me a sense of --

MS. AGUIAR: On the per capita spending?

MR. BUTLER: Either that or a percentage. If it's 2 or 3 percent of the Medicare enrollees, what percentage of the totals spent?

MS. AGUIAR: Sorry. I'm just looking over at our MA team to see if --

MR. BUTLER: Per capita would be fine, too. I'm just getting a sense of how intense the resources are.

DR. HARRISON: I think they're about 1.2 to 3, so 20 to 30 percent more on average, I think.

MR. BUTLER: I thought it would be more than that. Okay.

MR. HACKBARTH: I, too, was a little surprised at that, given -- and I'm not going to be able to recite them off the top of my head, but the numbers that we talked about early in this effort about how disproportionately high the

spending was in the dual population. The differences were way more than 20 or 30 percent. So does that suggest that the dual SNPs are selecting the healthiest of the -- I don't mean that in a pejorative way, but just happen to be enrolling, for whatever reason, the healthiest?

DR. STUART: I think one of the questions here is, because it seems to be possible for a company to have an institutional SNP which one would expect would have a preponderance of duals, as well as a dual SNP. So do we have a sense that the institutionalized population are not in these dual SNPs but are rather in institutional SNPs?

MS. AGUIAR: I mean, in short, we don't know the direct answer to that. I think you can have a company who offers both a D-SNP and then an institutional SNP, and you have a dual that's in the dual SNP that then has to go into the long-term care facility. I don't know at that point if they stay in the dual SNP or if they would be moved over to the I-SNP or not.

DR. STUART: That should be fairly easy to determine and I think would really be helpful for us to try to understand what the context is here.

MR. HACKBARTH: Probably what this conversation

does remind us of is that the dual population, on average, is very expensive, but within the dual population, there is significant variation in the nature of their problems and their costs. Some are a lot less expensive than others. The institutionalized probably would be at the higher end of the scale.

DR. MARK MILLER: Well, and again, I wasn't tracking whether you were asking specifically about the D-SNPs, but when we went through this presentation, I can't remember now whether it's been a year or whether it was in the fall or, frankly, whether it was yesterday, because I'm so hazy right at the moment, but, I mean, we went through the dual eligible population and talked about the expenditures and there were certain things. What Glenn just said is very correct. So if you hit institutionalization, it was something like a $50,000 add-on to the per capita cost. If you went into dementia, I don't remember the number, it wasn't $50,000 --

DR. CARTER: No, it was about 30 percent more. And the institutionalized, of course, is more expensive on the Medicaid side.

DR. MARK MILLER: Right.

DR. CARTER: Right.

DR. MARK MILLER: But just in terms of -- and I assume his question was about a total cost. So they're more expensive, on average, and there is a lot of variation among them depending on what their conditions and where they end up. I wasn't quite sure what you were asking. I mean, this is a very expensive population and very expensive per capita, but was that what you were even asking?

MR. BUTLER: Yes. I was trying to a sense of -- I mean, we continually say that relatively few patients or enrollees account for a large percentage of the spend, and I'm looking for both the opportunity as well as the size of the issue. And now I'm a little bit more confused because when you pull in the institutional -- I didn't realize they're not part of this dialogue here, right?

MS. AGUIAR: Well, it --

MR. HACKBARTH: They could be, but there's a separate category --

MR. BUTLER: Yes.

MR. HACKBARTH: -- for institutionalized patients. There's a special category of SNF for targeted institutionalized.

MS. AGUIAR: Right, and we did receive some models of care on the institutional SNPs, but we only reviewed the ones on the dual SNPs.

DR. MARK MILLER: [Off microphone.]

DR. BERENSON: I was also going to contribute that there's a new paper out that Gerry Anderson is a coauthor on suggesting that the risk adjustor under-predicts for the high end of spenders, and so the 1.23 may be low. I don't know the merits of that argument, but that could be in play, also.

DR. MARK MILLER: But just to be clear, that there's three kinds of -- and you guys know this better than me, but there's three kinds of SNPs, dual eligible, institutional, and chronic condition. But a dual eligible SNP is basically defined by the fact that the person is eligible for Medicare and Medicaid. They could be institutionalized. So it doesn't -- just because it says institutionalized SNP, all institutionalized people don't go there. You can have a lot of institutionalized running through the D-SNP. It's only defined by the fact that you're dual eligible. Does that help?

MR. BUTLER: [Off microphone.] Yes.

DR. NAYLOR: Thank you for this report, sobering as it is. I wanted to talk about, in the body of the report, and it aligns with the slide about what plans are required to report. So there's this -- it seems like the plans are required to report these broad categories that include complex case management and quality improvement and satisfaction, and I'm wondering, they don't align with the measures or as well as I had thought they would be. So can you comment on that?

MS. AGUIAR: I think we have some what we called hip-pocket slides at the end. So these are the NCQA structuring process measures. I think these are the ones that you're referring to.

DR. NAYLOR: Yes. So I'm trying to figure out how they -- they don't seem to align. Are they supposed to align with the 15 HEDIS measures?

MS. AGUIAR: No.

DR. NAYLOR: No? Okay.

MS. AGUIAR: No. No.

DR. NAYLOR: Okay.

MS. AGUIAR: Right. So the HEDIS measures are -- some of them are subset measures. Some others were specific

to SNPs, and those are more clinical measures.

DR. NAYLOR: I see.

MS. AGUIAR: Do we have a -- those are more like colorectal cancer screening. There is one on medication reconciliation there, but that's a separate reporting requirement, separate measures that are not related to the structural process --

DR. NAYLOR: And these are dated -- are being collected but not available, is that correct?

MS. AGUIAR: Right. Exactly.

DR. NAYLOR: Gosh, that's unbelievable. Okay.

The other thing is, is there this work on updating that goes on, because there's been such movement in quality measurement development and recognition of endorsed best practices in care coordination and transitions. So, you know, even in the last year or two. So I'm just wondering, do you know if that's work in forming adaptations in the structure and process measures?

MS. AGUIAR: When we talked to NCQA, it seemed like they update the structure and process measures, or they had added several elements this past year --

DR. NAYLOR: Okay.

MS. AGUIAR: -- so it seems like they go back --

DR. NAYLOR: Thank you.

DR. BAICKER: My question was along the lines of the hierarchy that Glenn laid out of, you know, there's something that goes on on the ground. We're not quite sure what that is. There are ways that you could report that. We're not quite sure how well those map. And then there's how well the descriptions actually fit the report that's supposed to be produced.

There's one more step in that chain that I don't know much about that I wondered if there was any evidence on. How well do those things map to the outcomes that we really care about? So all these process measures are really intended to look at health outcomes or overall efficiency of care delivery, something that we're trying to affect through the chain. I'm not even clear if we got all the way down to these measures being measured well that that would actually then take that next step to what we want to know about deeply.

MS. AGUIAR: And I think that was exactly what we were trying to do in sort of our second piece of the analysis. Again, just we're not able to, because the HEDIS

measures were from 2008 and then we had structure -- we had, I'm sorry, models of care for SNPs that weren't really part of that. And we did find some limitations, really, with the HEDIS measures themselves in the sense that they tended to have small ends. There were just a lot of blanks. And there's no composite measure.

And again, the structure and process measures are not outcome measures per se, whereas the models of care -- and I think this is a distinction we probably didn't raise before -- the models of care are really asking what is it that you intend to do, and the structure and process measures -- try to measure, are you actually doing it? And so that would have just sort of been a nice check and a nice balance if we were able to do that, but again, because that's not publicly available, and the star rating measures aren't publicly available, we weren't able to.

DR. BAICKER: So it seems clear that you can't do it from the data that's available for ten different reasons. I wonder if when they developed the model of care questions or categories, was it based on some evidence that those really mapped to the stuff that we care about, or should we just cut that whole step out of the process and just beef up

the process measures, which are already one step removed from the outcomes we care about, but at least we have a better sense that they map.

DR. CARTER: I got the sense when we talked with NCQA that their structure and process measures were evidence based, and they did a careful job of doing sort of panels of experts and going to the literature. So I'm pretty comfortable with those.

We've been thinking about sort of what kinds of outcome measures would you want about these plans, things like, you know, cost and maybe patient satisfaction and sort of -- if you wanted to compare these to MA plans, look at hospitalization rates and ER use and rehospitalizations and things like that. And right now, those aren't required as reporting measures. But we agree with you. And so you'll see in the last section of the paper, we sort of open up, aren't there other quality measures you would want to have about these plans, and I think the answer is yes.

MR. GEORGE MILLER: Yes, two quick questions. One, can you describe to me how they determine or the definition for the target populations? How does that process work, because I was concerned about the statement

saying that you may choose or select not to choose some folks to go into the target population.

MS. AGUIAR: I believe the question -- let me see if we have it -- is quite simple, just a description of the SNP-specific target population. So that's the question that's on the model of care element, and again, what we saw was most of the SNP, the models of care saying that they were enrolling all duals or full duals.

MR. GEORGE MILLER: Okay.

MS. AGUIAR: And, you know, so if they are enrolling a dual subset, that information just wasn't available. I think it's more the question on the model of care element and then the way that those questions were answered than necessarily -- we actually really weren't even able to assess what the actual target populations really were and sort of how they are selecting those, just given the information that's available.

MR. GEORGE MILLER: Okay. And to follow up on Jennie's question, particularly about the cultural assessment, is there a determination of cultural competencies for both the care managers and those providing care, particularly for those populations that communication

may be an issue, and is that part of the process, to determine cultural competencies? Is that going to be in the lexicon as we describe the model of care, as well, to determine cultural competencies?

DR. CARTER: You know, that's a good question and I'd have to get back to you. There are a couple of places that we can look. Some of the models of care descriptions require them to discuss how they train their personnel.

MR. GEORGE MILLER: Right.

DR. CARTER: And then in the attestation, there may be some questions about, you know, what kind of translation services do you have available and stuff like that. So we can get back to you on that.

MR. GEORGE MILLER: Thank you.

MR. HACKBARTH: [Off microphone.] Round two questions or comments? Tom?

DR. DEAN: Just a brief comment. Kate's question provoked an issue which doesn't really relate to this specific discussion, but it does. I mean, I think her point is terribly important because we really need to tie the measurement to outcomes. Now, sometimes you can do that and sometimes you can't, but I participate, and I don't have

much experience with this program, but just last week, I was in a quality assurance meeting for a nursing home and they had just got dinged by their inspectors and the dietary manager was having a fit because they had been written up because they weren't using a hand soap that was approved for dietary use, even though they are absolutely prohibited from ever touching the food. And so, I mean, it's things like that that get implemented when they really have no potential for any benefit to the beneficiaries or the patients or whatever.

So I think we need to continually push to make sure there is some sort of tie of the requirements to some outcomes that really mean something. Actually, that's a very general comment, but I think it's so easy for inspectors in various ways to measure things that are easy to measure and latch on to those rather than to do the really hard job of saying, does this really make a difference in the long term.

MR. ARMSTRONG: To the specific questions, can the models of care be used to evaluate these SNPs and the second question around assessing the plans, the integration of the Medicare and Medicaid plans, you know, it's hard for me to

answer that question. And I, too, I come back to, so, to what degree is the information coming forward through this reporting actually telling us -- I mean, dual eligibles is a population that we should care deeply about or a lot of obvious reasons. SNPs are an approach to organizing, managing, integrating coverage and care in a way that we would hope would achieve distinctively better outcomes, and if not, we would ask, well, why are we doing this? But if we can't measure that, then we can't determine that.

And so I would just say I think we should continue to push these questions forward. Whether this model of care approach is the right answer, it's hard for me to know, but I think this is an important topic we should continue to try to push ahead on.

MR. HACKBARTH: So let me pick up on Scott's comment. I'm trying to link this conversation to the broader discussion we've been having about dual eligibles. As Scott says, this is a very important population. It's a very vulnerable population. It's an expensive population. It's a complicated population to care for. So part of our journey has been -- and we started noting how if people were in fee-for-service Medicare and Medicaid, there are all

sorts of barriers that crop up to these patients, these complicated patients getting the care they need and various efforts to shift the cost back and forth between the Medicare and Medicaid programs. So that's not a productive, constructive approach.

So we started looking at models that try to take on the task of overcoming those barriers here in separate insurance programs and integrate the care better, and this is one of the models, but not the only one. There are PACE programs and others.

But one of the questions that's been in the background, at least, actually raised explicitly, is, oh, if there are good models and enrollment is low in those models, should we be doing something to at least nudge dual eligibles into better systems? So that's sort of the framework I've got in my head for the conversation that we're having.

So now I look at this and it seems to me that based on the information we've heard today, it would be very hard to make the case that, oh, dual eligible SNPs are a place that people ought to be nudged into.

MS. BEHROOZI: Yes, and certainly just taking as a

baseline, as a starting point, the concern for the beneficiaries and the lost opportunities to do good things for the beneficiaries is the flip side concern, that there's all this money going, you know, program money going to agencies that have exemptions from the rules about marketing and window periods and things like that. You know, this is not a statement against all dual needs, dual eligibles, rather, SNPs, because I'm very familiar with a not-for-profit dual SNP in New York that cares very deeply about care coordination and taking care of their beneficiaries. But we're making it pretty easy for people to bring in people at 1.2 level risk adjustors all year and we don't allow that for other kinds of MA plans.

I was just very unhappy when I read that plans described, when they did submit MOCs that you could actually get some information from, they described limiting their care coordination programs to specific enrollees, and I wrote in the margin, why can they do this? I mean, really, what is the point of allowing this special designation for these plans and giving them all this extra money?

DR. STUART: I think this is a really important chapter and I think what you hear around here is interest in

making sure that we are, first of all, posing the right questions, and then, secondly, getting the answers to those questions, and so I'd like to step back a bit and put a point that Peter did, or Peter asked, about what's the core eligibility population here and how does that compare to others that are not enrolled.

And this, I think you should be able to do, is first of all start with the number of dual eligibles, say, in 2008. What's the split in terms of those that are in fee-for-service as opposed to MA? And then within the MA subset, what's the split in those that are in SNPs and non-SNPs? And then on the SNP side, what's the split on the dual chronic and institutional, because they could be in the chronic side, too. There's nothing that says that they couldn't be there. So at least we have some sense of who's targeting whom.

And then it would be useful, if you can do this, would be to look at the characteristics of people who are in these different bucks and to see whether they really differ. We're not going to know exactly who is going to be helped until we have some idea about what their characteristics are, and we don't know whether the targeting is right, so at

least something. And I don't have a whole list of characteristics, but obviously total spending would be one of those that I would think you would want to look at.

And then last, and this may be even more difficult, would be to see whether there's any dynamic here. It looks like the most recent data that you have is 2008. I know these things are new, but I don't really have a sense of whether there is a dynamic. In other words, did the company just come in and then they're there, or is there an ebb and flow? Is this something -- an idea that the companies got into, thought that they could make some bucks, and now are moving out? Some sense of that. Thanks.

MS. HANSEN: I'd like to build on the request for perhaps describing the population again, I think starting with Peter and then Bruce's comment about understanding what the dual population is, because there are different groups of them. So if we could subset them, that some of them might be a multiplier of 1.2, but others might be actually a much larger multiplier because I think that's probably a bias of just the group that I'm much more familiar with. But being able to say the duals are not a universal group and to be able to do the subset even of the duals. From

previous work that we've done, I know we have that. So just putting probably the proportionality, Peter, of how large and what group is most affected by this.

I'd like to bring back up the whole Medicaid contracting and how much of an issue that was that we discussed previous, and it sounds like there's more work that again has evolved in that, and that CMS has a technical advice center now to help some of the States move this along. I just would like to kind of stay on top of what are the criteria that should be in place for any State that has this, especially if you have four large companies that have multi-sites, what should be in each? What's the best practice of the Medicaid contract to Medicare in each of these States?

Another point here that I see that I'm kind of -- probably a little surprised about, especially given the context of some of the areas of nebulousness that exist, that already there is a whole -- in the text we have that CMS is developing the scoring methodology for NCQA to use for rating these plans and that if they come out with a good score, maybe they don't have to get rated for five years. And so already we're into a kind of, almost the

accreditation process, so far ahead when there's so much kind of gray zone that's going on here.

So that's one of the questions -- not questions, it's a comment I have, that we moved ahead to begin to kind of give some passes on a model that still isn't well defined yet. So that's probably just a notation that I would have, that it's great that they want to do this, and I firmly believe that oftentimes you get over-viewed, over-regulated on the flip side, but when we don't know what we are expecting as outcomes, how do you pass that kind of judgment already to give accreditation cycles already.

And then I want to affirm what I think Mary was bringing up, is just the ability to get the rating systems and the data out there, and I do believe that if these are SNP MA plans within the larger MA, they shouldn't be just blending the two programs together to come out with one score. So somehow, even though they are small "n"s, and that is the nature of oftentimes this population. It will be a smaller "n," that they have their own star rating system at one point, even though they're owned by a centralized entity.

DR. BERENSON: To pick up some of the similar

comments, it does seem to me that the SNP program is differentiated from just Medicare Advantage generally because they think they have a model of care for a particular population. It just seems to me CMS needs to ultimately have that as a core of their program monitoring, that the program does have a care model and detail and that they are meeting what they say they are doing. I think in this area, structural criteria are real important and I would hope that NCQA's criteria are flexible enough to permit variation that will be inevitable with different SNPs doing a core set of activities, but in somewhat different ways. And I would include in that the Medicaid coordination as just an essential part of that. So that, to me, is sort of the core part of monitoring, and it sounds like they're going in the right direction after sort of not starting quite right.

I, in general, like outcome measures more than process measures. This is a tricky area because some of the clinical outcome measures may not be particularly appropriate. I'm not sure what to do with mortality rates, for example, in this population.

One area, though, I do think we can probably agree

is real important would be preventable rehospitalizations, which I think we would focus on across the entire program. That seems appropriate here.

On cost, this is a capitated program, so to some extent, almost by definition, we've got cost measures. Either the plan will live within its capitation or it will leave because it can't make it. I don't know that we -- as sort of monitoring the program, need to see if this is a good investment of public funds, but as a way of measuring performance of an individual plan, I'm not sure that helps us very much. So I would go very heavily towards patient and caregiver experience measures in this area, and recognizing, I think, there are subpopulations amongst the duals that might have some unique -- I mean, the disabled population is different from sort of the frail elderly population. I think we'd want to just be -- this is a great area to work on in those experience measures and I think that would be a core of the monitoring. We have a capitated payment system. The potential -- with care models that presumably would give higher levels of care but the same old threat of stinting somewhere. So if we ask the patients and the caregivers whether the experience is a good one, I think

that would be a package.

DR. CASTELLANOS: Just a simple question. Has there been any coordination with the MACPAC group, or coordination in working together to discuss whether they're addressing this issue?

MS. AGUIAR: We do, both at the staff level and then at Mark's level, have frequent interactions with MACPAC. I believe that they themselves are in the process of defining what their work agenda is going to be, and so I think where there are areas of overlap, of course, we're definitely open to collaborating with them. But I think -- I believe, and I'm not sure if this is finalized, that they were also interested in looking at the sort of pre-dual population on the Medicaid side, in which case would not overlap with the population that we really look at. But I think, again, we do coordinate with them fairly frequently at both our level and at Mark's level.

MR. HACKBARTH: And I guess about a month ago, Bob, Mark, and I met with Diane Rowland, the Chair of MACPAC, and David Sundwall, the Vice Chair, and Lu Zawistowich, the Executive Director, and talked about our agendas and talked about this particular issue a bit, as

well. And then I think it's next month, I am going to meet with all of the MACPAC Commissioners and talk about our common agendas. So that work is underway.

MR. BUTLER: So one of the few things I remember from graduate school is Donabedian teaching me structure process outcome, and I think Bob kind of hit on some of this. The structure process things are part of these models that we ought to get a lot clearer, so I agree completely with that, and the outcomes are going to be a little harder to kind of measure.

Now, having said that, this strikes me, as good as the paper exercise might get, it's kind of like until the Joint Commission came in and did tracers and pulled out random charts and said, let me see that you're following -- I mean, that's very effective in testing whether the model is being used or not, and this kind of strikes me as, without, again, over-accrediting and over-regulating, we may perfect the paper exercise here, and until you have somebody come in and randomly pick out Joe Jones and say, I wonder if they're adhering to this model, you probably -- I mean, that would be a better test to see if these things are working, probably, than chasing outcome measures that are going to be

difficult to -- I'm not saying you shouldn't have those, but I think you're going to have to kind of look under the covers and see how these things are working to test their effectiveness a little bit better.

DR. NAYLOR: I'm trying to think about all we have accessible to us that should accelerate us on a path here, and the continuity of care record is somewhere out there that is a really good review of things that are important to the dual eligible population. The PACE program has already spent a lot of time thinking about outcomes and processes that are important for this population.

And I really do agree -- I mean, I think that we really need to move. I mean, there are components of the analytical framework that you have that are core, key, and there are pieces like access or communication or continuity that also you might want to think about as dimensions. But until we get to kind of pairing some of these processes with what people care about or their experience, their quality of life or function or whether or not they're using a lot of health resource utilization unnecessarily, those kinds of things, I just don't think we're going to get to real improvement until we pair them.

And so I think we should think about encouraging the use of endorsed measures that are getting us a little bit closer toward these areas. There's a lot of work going on on actually how to measure care coordination itself, not just its domains. And then, you know, really promoting use or development of robust measures of things that this population really cares about, and they care about quality of life and they care about function. And many of them are cognitively impaired and they can only tell you so much, but we ought to be measuring the things that are important to them or to their family caregivers.

And I think that should be the rules across all our dual eligible populations and not -- so then you get to say, well, how does this model SNP fare relative to all the other dual eligible programs? I mean, that's the comparison group that we should be looking toward.

So anyway, I like the way this is going and I like your kind of getting to the analytical framework. I just push it, like everybody else, further to get to real expectations and accountability that things are going to change in these people's lives.

DR. BAICKER: Yes, just to marry those comments,

Peter's point is extremely well taken that it's all well and good on paper, but what's going on in reality and that we need to feel confident that those measures matter. But then I do think it's really important to get both the quality of life and satisfaction outcomes and the measurable health outcomes, like readmissions or infections or whatever outcome we think is likely to be improved by this because I'm sure there's a lot left to be learned about what good coordinated care is.

So we want measures that are real, based on what's going on on the ground, but we also want to be measuring the right thing and marrying the more rich outcomes with the process measures would help us know, you know what? These guys are doing a great job at doing process X that they said they were going to do. It just turns out process X doesn't matter or isn't effective, and here's an opportunity to advance the science in how to better provide that care.

DR. BORMAN: To try and deal with some of the practical questions that you've asked about the chapter, I would say that what struck me here is, to some degree, in addition to the big issues that have been talked about, is the disconnect between the model piece and the survey, and

basically it's sort of like having a very structured, objective question versus a rather subjective kind of essay question, right, a little bit. Both bring valuable information. At a relatively nascent stage, the more that you can capture, particularly these process and structure questions, are probably relatively well captured on this, you know, check the box yes or no, do you do this. It's essentially a true-false question, right, format and it's pretty clean, and as much in process sometimes and structure lend themselves to those kind of answers.

To the extent that we can convert things that are now sort of supposed to be covered in the essay and maybe aren't getting covered, maybe those do need to get converted, as you suggest, or at least you hint at, I think, in the chapter, that they do belong more in this survey approach.

That then allows the essay part, if you will, to be somewhat more focused on kind of what sets this SNP apart or some of these fuzzier kinds of things about what is the added value, and I think what you've pointed out to us is that the guidelines for the content of that should be crisper. That, to me, sounds like a little more of a

research project or a thought project than just moving some of the questions over to the survey.

So I would say that in terms of a recommendation, if we could move some stuff to the survey and then help to set some guidelines for moving the essay part forward, if you will, taking into account all these other big picture things we're going to find out in the meantime, that that would be the biggest service to this population.

MR. HACKBARTH: Okay. Thank you very much. I look forward to hearing more soon.

Our next session is in supporting quality improvement. Whenever you're ready, Anne.

MS. MUTTI: Okay. This presentation continues our work on ways that Medicare can encourage quality improvement and offers some draft recommendations for your consideration. By virtually all accounts, the pace of quality improvement has been slow. There has been some improvement, but there has not been the kind that many envisioned in the wake of the IOM Report 10 years ago. That is the "To Err is Human" report. The Commission has recommended payment changes to encourage improvement -- and here I'm thinking of things like pay for performance,

medical homes, preventable readmissions, a payment policy to deal with those -- but it may be that to accelerate improvement we need to pair those payment changes with a revitalized technical assistance program, updated regulatory incentives, and a public recognition program.

It may not seem like it to you with all that you have on your plate, but we've actually been talking about this issue for nearly a year and a half. In October of 2009, we held an internal panel discussion with stakeholders and experts, and actually Mary Naylor was a member of that panel before she was a Commissioner. As a Commission, we started talking about this publicly in November of 2009, talking about different opportunities for improving the programs. In the spring of 2010, we had leaders from Denver Health and Parkland Hospital come in and talk about how they have improved quality. And we included a chapter in the June 2010 report to Congress on these issues, just talking about options.

More recently, in November we had Chris Queram and Dr. Bob Wachter, two national experts on quality, present before the Commission, and we got the opportunity to hear their reactions to some of the thoughts we were discussing.

The policy options we'll discuss today reflect a multi-pronged approach to quality improvement. The approach would first focus technical assistance on low performers, and this is a strategy to complement our payment policies, address health care disparities, and minimize displacement of private sector resources.

To improve the chance that this assistance will bring about genuine improvement, it seeks to improve engagement among providers by giving them the choice of who assists them and the flexibility in how they use their resources.

It also increases the number and variety of technical assistance entities who can assist providers, improving competition and ideally the quality of the technical assistance. But with that flexibility should also come greater accountability, so this package of recommendations also includes one that increases accountability by creating intermediate sanctions for persistent low performers.

And, finally, to provide additional motivation for the full range of the spectrum of providers, it would improve public recognition of high-performing providers.

These draft recommendations would mean fundamental change to the QIO program, which funded at $1.1 billion over three years, supports currently 41 private organizations offering technical assistance to providers in all states. Some of these changes I've just outlined parallel a 2006 IOM report, the recommendations that came out of that report, as well as some recent policy proposals that were in the President's budget. But this package of recommendations would go further, particularly in directing resources to low performers and how it weaves together assistance in a revamped QIO program and accountability through the conditions of participation.

In the Ninth Scope of Work, which is the three-year contract for QIOs that ends this summer, CMS targeted some of the QIO resources to low-performing providers, but it's not clear that they are going to maintain this direction. We don't yet know the details of the 10th Scope of Work. It's due out any moment now.

Targeting technical assistance to low-performing providers, however, has several advantages and could be an appropriate way to focus the majority of Medicare's quality improvement efforts.

First, targeting to low performers can help providers respond to new payment policies that hold them accountable for 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 may face a challenging patient population. The idea here is that the goal of high performance should exist for all patients, regardless of socioeconomic status or race, but those expectations may be more likely to be met if they are combined with a policy that recognizes that time-limited resources may be needed to elevate the provider's ability to address particularly challenging environments. So instead of lowering standards, we're targeting assistance to those who need it most.

Second, by focusing on low performers, we would hope to significantly address disparities in care. Where you get your care matters, and this matters especially for minorities because they tend to receive most of their care from a limited number of physicians and hospitals, and those providers tend to have lower quality.

For example, one study found that among African

American beneficiaries in a market with high racial segregation, the risk of admission to a high-mortality hospital was 35 percent higher than for whites in the same market.

Another study, which uses volume or experience as a proxy for quality of care by looking at services where a volume-outcomes relationship has been established, found that African Americans in New York City tended to physically pass a higher-performing hospital and get their care at lower-performing hospitals.

A study on minorities and readmissions came out just last week, also showing that hospitals that tend to serve a high portion of minorities have higher readmission rates, and this echoes something that we also looked at a couple years ago or a year ago.

Third, this type of focus should minimize the likelihood that public resources would displace equally effective private sector resources. High-performing providers likely already have the resources necessary to make investments leading to high-quality care. Providing additional assistance to them effectively subsidizes their success using scarce public resources.

A key issue of course is how we measure low performance. In the paper we were envisioning a broad measure that includes a variety of outcomes, process, and patient experience measures. But I could see that might be something we want to talk further about. We also have concerns about communities rather than just isolated providers that are achieving poor outcomes and think that coordinated efforts directed at the community may be particularly appropriate in certain cases. And I'll come back to this thought in a moment.

But first I want to acknowledge a number of concerns some might have with focusing on low performers. One concern is that some providers are unlikely to improve even with assistance and that our effort will be for nothing. When certain ingredients are absent -- effective leadership, for example -- culture change and quality improvement may be elusive, even with best technical assistance. This possibility may be minimized by empowering those providers with choice and flexibility in which a technical assistance agent helps them. However, if despite these changes a provider is resistant to improving quality, this package proposes that intermediate sanctions be

available to further induce change.

Another concern with focusing on low performers may be a sense that QIO resources could be useful in developing new strategies to improve quality and communicate those improvements. And while this need is genuine, we note that other federal agencies and programs as well as private sector resources may be better oriented to this mission. AHRQ has demonstrated experience and success in this area -- funding efforts to reduce central line infections and improving the discharge process -- and it is possible that the CMS innovation center may also have a role in this area.

It could also be argued that a focus on mid-level performers would be more successful; their problems may be easier to solve and improvement more evident. The concern here, though, is that by directing public resources to the mid-level providers who may stand poised to improve, fewer resources are available to improve the care of those beneficiaries, who are disproportionately minority, who received care from the lowest performers.

That said, some flexibility may be warranted. A reasonable policy option may be to direct the clear majority of technical assistance resources to low performers, but

allow the remainder of resources to be available for community-level assistance to communities struggling with poor outcomes. These communities would have poor performers but may also have higher-performing providers. Community-level quality improvement likely involves reaching out to all of them. In addition, the Secretary may choose to use some the resources for broader community outreach activities.

So a recommendation, a draft recommendation could read: The Secretary should target a substantial majority of technical assistance funding for quality improvement to low-performing providers, and the remainder should be targeted to community-level quality improvement.

Here we're saying that spending implications are budget neutral because really what we're doing is just reorganizing and reallocating current QIO money. And for the beneficiary and provider, we're expecting improved quality of care for patients of low-performing providers, and we recognize that we're redistributing or potentially redistributing quality improvement funds among providers.

As I noted earlier, other changes could be made to the structure of the program that may increase the chance

that technical assistance is successful. Currently technical assistance funds go directly to the designated QIOs, and it is incumbent on them to reach out to providers and encourage improvement. However, if the funds went instead to the poor performers directly, who in turn could use the grant money to purchase technical assistance from a qualified technical assistance agent of their choice, we might be more likely to see the engagement and culture change that needs to occur for quality improvement to take root.

Empowerment comes from both flexibility of how to use the funds and the ability to choose the technical assistance agent. Accordingly, technical assistance agents working with their clients should have that flexibility to determine the manner in which the assistance is used. And we would expect the focus to vary by provider and community. For some, quality problems may stem from meeting the needs of a poor population or from a geographically isolated population. For others, it may be that they don't have an understanding of how to collect their data and even identify what problems they have. And for others, it may be just staff retention. They've trained their people, but they've

all left so quickly that the training was for nothing. So this technical assistance could be more tailored to the needs of the provider and the community that it serves.

To enable the market for technical assistance agents to form and work well for low performers, CMS would need to provide some structure. For example, it could create an online marketplace, where providers can see their choices of qualified assistance agents. And being able to access this information in one place might facilitate the best match between providers and assistance agents.

So a draft recommendation for your consideration is, therefore: The Congress should allow the Secretary to provide funding for time-limited technical assistance to providers. The Congress should require the Secretary to develop an accountability structure to ensure these funds are used appropriately. Again, the spending implication is budget neutral, and the expectation here is for improved quality of care for patients, and providers would having greater control over their quality improvement funds.

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

providers themselves, like Geisinger, and consulting firms. Ideally, our lowest performers should have the option to access the expertise of these organizations. Under the current QIO program, however, they do not. A variety of requirements serve as barriers to entry for other organizations. Indeed, in the last Statement of Work, CMS awarded a new QIO contract to only one new contractor, and that was another QIO.

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 that 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. First, to our point here on competition, it restricts the type of organization that will compete to be a QIO. Second, which is not directly on point but still very important, it creates a conflict of interest that can hamper

the effectiveness of technical assistance agents. It's hard to be a trusted consultant to the provider when you also may be called upon to investigate them. And it's hard to advocate for the patient when you are trying to earn the trust of the provider. And, also, we may be creating a fragmented system for capturing beneficiary complaints -- and really all patient complaints -- by having so many different organizations handle the complaints, and this can mean that we're missing patterns of problems that could help target our resources on our surveys more effectively. Currently complaints are fielded by 41 QIOs, state health agencies, state medical boards, accrediting agencies, and maybe there's even more. Creating a single entry point for complaints may be a far more effective way to use this information.

Our recommendation here, though, speaks to the competition angle here and removing barriers. So the Draft Recommendation 3 here reads: The Congress should authorize the Secretary to define technical assistance agents so that a variety 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.

Again, we envision this to be a budget-neutral recommendation and also that it would result in improved quality of care for patients. This recommendation very much echoes several of the IOM recommendations made in 2006, and also in the FY2012 President's budget are similar proposals, although they are scored as small or as savers. And to be clear, this means that the regulatory responsibilities, including beneficiary complaints, would not just disappear. They would be designated for another agency to perform.

Now I'll pivot off of QIOs to talk about conditions of participation, COPs, and these are the minimum, largely structural standards that certain providers, although not physicians, must meet to participate in Medicare, and they are a lever, just like technical assistance that Medicare can potentially better use to drive change. Surveyors and accreditors are in our nation's facilities on a regular basis enforcing the COPs, and what they are enforcing and how they do this can matter.

We don't have a specific recommendation on this today, but we want to include a discussion of possibilities

so that we're leaning forward on the need for change.

For example,, while the COPs require that facilities conduct "quality improvement activities," they do not require that hospitals, for example, adopt particular processes that are known to improve quality. They also do not require hospitals to demonstrate improvement or efforts to improve their performance on publicly reported quality measures. Yet anecdotal evidence suggests that better-performing facilities are adopting process improvements, whether it's checklists to prevent central line infections, medication reconciliation, adhering to hand-washing protocols, and these facilities are focused on measuring and improving their performance on widely accepted quality measures.

So the COPs could be updated to build in and reinforce the importance of making the process changes that improve outcomes. At the same time, the COPs could be changed to reduce the perception that being surveyed for compliance with the COPs is like "death by a thousand duck bites," as Bob Wachter put it when he was here last. And this kind of picks up on a point I think, Tom, you were just making, too, about the hand washing.

Some possible new requirements that could be included in the COPs are compliance with hand-washing protocols and transmission of discharge instructions in a timely way. And Dr Bob Wachter suggested these two requirements to you in November, noting the advantage that they really reflect the whole facility's commitment to quality improvement and aren't just isolated in a single department.

Another option is requiring compliance with the Joint Commission's national patient safety goals. These include things like checklists to avoid central line, evidence-based practice for preventing surgical site infections, and time-outs before procedures.

The COPs could also require hospitals to demonstrate physician involvement in patient safety activities. Peter Pronovost has written about this repeatedly, suggesting that hospitals provide greater support for physicians to participate.

Or perhaps facilities could be held accountable for improving their performance on widely accepted measures. The Joint Commission is exploring how it could build in consequences for failure to do so into its accreditation

process.

Again, we don't make a specific recommendation here; instead we're just proposing to talk about it in the text.

Now, we'll consider enforcement of the COPs, and here we do have a draft recommendation. One problem with enforcement under the current survey and accreditation process, especially for hospitals, is that the consequence for failing is so extreme -- exclusion from the Medicare program -- that such action is rarely taken. For this reason, the intermediate consequences or sanctions that had a real possibility of being imposed could induce providers to improve care and make the accreditation and survey process more effective. In 1990, an IOM study recommended that intermediate sanctions be adopted, as did MedPAC in 1990.

There are a range of types of intermediate measures. For example, under one approach, low-performing providers could be identified publicly. Already under Medicare's Special Focus Facility program, nursing homes designated as deficient are identified publicly. Similarly, Hospital Compare identifies poor performance on specific

measures.

Under another approach, if insufficient improvement was found after some period of time, the COPs could require that the board submit a corrective action plan. The plan would need to be approved by CMS to avert exclusion from the program, and the corrective action plans could describe the types of activities the hospital, or other provider, would pursue as well as any management changes that were necessary. There is precedent for this approach with nursing homes. If a nursing home is cited with one or more deficiencies that constitute immediate jeopardy to resident health or safety, the law allows for "federal temporary management." This allows for CMS to make staffing and management changes on a temporary basis.

More aggressive steps could also be contemplated. For example, CMS could prohibit hospitals from performing elective procedures in a given service line for some period.

So that brings us to Draft Recommendation 4, which reads: The Congress should require the Secretary to develop and impose intermediate sanctions for persistently low providers. Spending implications, again, are budget neutral, and here we're expecting it should improve quality

and recognize that some providers would be adversely affected. And what we're also wanting to make the point here, too, is that we're envisioning you might give technical assistance. If the provider still does not improve, intermediate sanctions could be appropriate.

Finally, providers meeting a relatively high standard of care could be publicly recognized by Medicare. PPACA requires that the Secretary publish hospital scores on value-based purchasing -- the VBP program -- on Hospital Compare, and this actually goes part of the way of what we're talking about to making information available to consumers. This disclosure could be the basis for recognition, but thought may be given to two particular aspects of the program design. One is whether simply posting a score, a raw score on Hospital Compare is a sufficient way to communicate with beneficiaries; it may be difficult for them still to interpret. A designation as a blue ribbon provider, as a platinum provider, may be more digestible for consumers and then more effective in helping guide their care choices.

A second consideration is whether the definition of high performance is best met by the measures included in

the VBP program. They are limited somewhat. They focus on AMI, pneumonia, and CHF initially, although over time they will pick up patient safety measures and mortality. But they don't include things like readmissions or some of the quality efforts I discussed like hand washing, discharge instructions, checklists that could be part of the conditions of participation and ascertained in the survey process. So including these other factors in the designation may provide a more comprehensive view of quality.

So the draft recommendation on this point could read: The Secretary should establish criteria for high performance to publicly recognize those providers demonstrating superior quality. Again, spending implication is budget neutral, and by definition we're expecting improved quality from providers and for beneficiaries.

So that completes the range of options we wanted to give to you for your discussion today. I'll leave this summary slide up here to help prompt you, but I'm happy, obviously, to flip back to other slides. Thanks.

MR. HACKBARTH: Thanks, Anne. Good job.

So these are draft recommendations. We want to

get your reaction to them today, and provided it's generally positive, we would have votes on final recommendations at the April meeting for inclusion in the June report.

Let me kick off the clarifying questions. I have two things that I need you to help me understand. One has to do with the conditions of participation on the one hand and the deeming process on the other. My crude understanding of this is that a provider has two tracks to choose from. They can submit to the survey and certification process, which is based on the conditions of participation. Or, alternatively, they can choose to be accredited, in the case of hospitals by the Joint Commission, against the accreditation standards established by the Joint Commission.

My crude understanding is that the Joint Commission's standards are not the same as the conditions of participation, cover the same areas but they may be different or higher, but they're not exactly the same.

So one question is: How many providers opt for the survey and cert. based strictly on conditions of participation versus the deeming process? So, in other words, how many people would be affected, what proportion of

providers would be affected by changing the conditions of participation per se.

A related question is: If we were to adopt intermediate sanctions through the survey and cert. conditions of participation track, does that mean that the Joint Commission needs to do something analogous on the deeming track?

Is that set of questions clear?

MS. MUTTI: Okay, so going back to the first one, yes, and it depends on what type of provider you are.

MR. HACKBARTH: Sure.

MS. MUTTI: So hospitals have the choice as to whether to get accredited or to be surveyed by the state. And you are right, the conditions of participation are the basis -- they have to be picked up in the accreditation standards, but in some cases they go beyond that.

As I recall, something like 85 percent of hospitals choose to get accredited, leaving only 15 percent getting state surveyed, so there's to your implication. But for nursing homes, they're all surveyed by the states, and the percentage on home health and all the other entities are lower than the hospitals. I'm not sure on each of those.

And, yes, it's envisioned here that those intermediate sanctions, if certain standards are not met, would have to be -- the sanctions for the failure to meet those things would have to be implemented by the accreditors, just as it is by the surveyors.

MR. HACKBARTH: And just to make it simple, let's just focus on hospitals for a second. So the Joint Commission accreditation process does not currently have an analog to intermediate sanctions?

MS. MUTTI: Not that I know of. Do you?

MR. KUHN: Actually, I think they do. I was making some notes here. They've had a tiered system for decades, and it goes like this: They've got accreditation of full standards compliance, conditional accreditation, provisional accreditation, and preliminary denial. So they have a tiered system already in existence.

MS. MUTTI: Yeah, I think they said that they had backed off a little bit some of those criteria because they had been concerned about the distinctions being as precise as they would like to be. When I have talked about this idea with them, bouncing it off, they were receptive.

MR. HACKBARTH: Okay. And then my other --

MS. MUTTI: We're also talking about more tools than just saying preliminary accreditation. We're talking about, when we talk about intermediate sanctions, you know, the possibility of requiring management changes or getting a little bit more involved or, you know, talking about elective procedures. So those are more aggressive.

MR. KUHN: That was going to be one of my questions as we move forward, that, you know, because they've had a tiered system experience for a decade or more, what are the learnings from that that would be helpful as we think about our possible recommendations here.

MR. HACKBARTH: Okay. And then the other sort of background question that I wanted to ask is about the IOM report on QIOs. I know in previous months' material, there's been some description of those recommendations that the IOM made. But are the recommendations here now, the draft recommendations before MedPAC, consistent with the IOM recommendations? In particular, I'm interested in are there any ways in which they might be perceived as inconsistent with the IOM recommendations.

MS. MUTTI: They also talked about low performers, didn't quite put the emphasis the sharper point that we're

putting on, but it's not inconsistent.

The second one, the idea of improving engagement of providers by giving them the choice of who assists them is a departure. They didn't speak against this. It just didn't --

MR. HACKBARTH: They did address --

MS. MUTTI: That's the major structural. They also talked about improving the variety of agents and numbers. They didn't address intermediate sanctions or a public recognition program.

MR. HACKBARTH: So no direct conflict.

MS. MUTTI: No.

MR. HACKBARTH: We're addressing some areas that they didn't address, and they addressed some things that we didn't address.

MS. MUTTI: And then there's some overlap.

MR. HACKBARTH: And there's some overlap. Okay.

Clarifying questions?

MR. GEORGE MILLER: Just very quickly, this was very well done, and I really appreciate the work and the thought process that went into it, particularly with the draft recommendations, so I'll come back to that in Round 2.

Just one technical question. I was intrigued by minority populations that would bypass -- I think you used the example of New York City -- would bypass a higher-quality hospital to go to one that I guess they were more familiar with. Do you know what the patient satisfaction ratings of the two different hospitals would be? Did you get that detail? Because I'm wondering why would they bypass a facility with higher quality. I'm trying to understand that.

MS. MUTTI: I don't think that they did a patient satisfaction analysis as part of that study. I think in our conversations with the researchers that they were speculating that these were referral patterns that were in place, that the patients were seeing these doctors, and they had admitting privileges to this hospital, so that's why they were going by it. But that was some speculation.

MR. GEORGE MILLER: It would be interesting to find out.

DR. NAYLOR: So on the first recommendation about targeting low performers, first of all, just a great balanced understanding of what these options are. I thought it was a terrific report.

I'm on an IOM study committee on a learning health system, and we're just getting started. But I was wanting to understand -- I mean, even the high-performing systems are not necessarily delivering the highest quality care all the time to all the people, et cetera. So I wanted to make sure that this recommendation -- and there's been some thinking about, you know, learning health systems, putting them all together, and really targeting the low performers, but also enabling others to kind of grow and develop. I'm wondering if this recommendation in any way is in conflict with that. I mean, the critical need to target the low performers I understand, but to have a context where everybody's getting better as we're making that investment. So I just wanted to make sure that that recommendation -- it doesn't seem like it's in conflict, especially with the second part, the community-level emphasis. But I was wondering if your thinking would put it in conflict.

MS. MUTTI: I don't know if you want to take this. I mean, there is --

DR. MARK MILLER: Go ahead.

[Laughter.]

DR. MARK MILLER: I think you've put your finger

on a philosophical question. I think it's hard to give. There are definitely people who disagree, who think that you should enter the quality spectrum broadly and try and get movement. There are some who argue that it's the intermediate performers, you know, because there's some momentum, but, you know, if you just get a push, you'll get bigger results.

I think what brings us to this -- and this is just what Anne said. There was some sense that there was this overlap between getting the bottom of the spectrum moved up and this relationship between ethnic disparities, that in a sense you could almost get some compression there as a two-fer, and I realize that that's much too cavalier. And then also the notion of displacing resources, that if there are providers actively engaged in quality improvement, then there's something there that says, well, let's go to the people who seem to have no action, if you will. And, again, that's too glib, too.

But this is truly a philosophical question. I don't know that anybody --

MR. HACKBARTH: Yeah.

DR. MARK MILLER: -- except him could give you the

right answer.

DR. NAYLOR: Yeah, I mean, PPACA seems to align -- some of the provisions seem to align with this, the 500 million to hospitals with high levels of readmission getting technical assistance. So I think that, you know, I was just wondering if it was in conflict with that.

MR. HACKBARTH: Yeah. So this is a really important question to raise, and I actually pushed further in this direction than maybe Anne and Mark would have been inclined to.

DR. MARK MILLER: Mark, not Anne.

[Laughter.]

DR. MARK MILLER: This has been a long internal conversation.

MR. HACKBARTH: Anne's with me and he's --

[Laughter.]

DR. MARK MILLER: I just want to say Anne and Glenn were right.

MR. HACKBARTH: I confess to having sort of a very simple-minded way of thinking about this, not well informed by, you know, the literature and all that. But sometimes the mental exercise that I go through is, you know, what if

this were one giant integrated delivery system that I was in charge of, and I had, you know, wide disparities in the level of quality performance, and I had a finite amount of resources to support quality improvement, what would I do? Would I spread them across the whole thing or would I target them on the parts of my system that are having the most difficulty? And to me it's sort of a no-brainer what I would do.

Now, you know, there may be other more sophisticated ways of thinking about it, and I'm open to those ideas. But that's why I pushed in this direction.

MS. MUTTI: And then we also wanted to acknowledge that there's other federal funding that can get at the broader system. There's the AHRQ money, and then there's also the Center for Innovation that may choose to get more of the middle and experiment with that, too. But maybe this QIO money could be more focused on the low performers.

MR. BUTLER: So I think Anne and Mark are -- I mean, Glenn and Anne are right, but -- that's okay, Mark -- but we'll come back to the --

DR. MARK MILLER: We don't have to get real personal.

[Laughter.]

MR. BUTLER: You brought it up.

So one clarification on the Joint Commission and conditions of participation. You can, having been in this spot myself, not meet a condition of participation but be fully accredited. So Medicare can come in and say, sorry, you're not meeting this, and it doesn't necessarily have con -- now, Joint Commission may be in the next day and piggyback on some of it, but they're not necessarily -- just because you have Joint Commission doesn't automatically mean across the board you meet the conditions of participation.

Now, what I'm having a little trouble with is that I agree with the intermediate sanctions -- well, I do think we're trying to address the bottom end and how we either support them or sanction them. But I'm having a little bit of a difficulty kind of taking the general recommendation that says you can do intermediates and what we would be recommending as the criteria that that would be based on. And the way we've presented the data is in the aggregate the field and the institutions are not moving as far as we'd like, but kind of like that last question, we don't have quantifiably kind of describe that bottom end and what it

might look like and why it needs so much attention.

So I'm not exactly clear, and maybe that's okay at this point. It's just the concept. You know, if you went and you said you had 50 percent mortality at X or Y. But I think those institutions ought to kind of get a sense of what it is that might trigger the sanction, because we're being pretty general about that. And, again, maybe that's as good as we can get at this point in time, but ultimately you're either going to have to build those criteria into the conditions of participation as a prerequisite to identify the institutions or just get a little bit more specific. Otherwise, people could challenge, well, why me, why now. And I don't know if you've thought about -- this is kind of Round 2, but have you thought about how you would then advise the -- huh?

MR. HACKBARTH: [off microphone].

DR. NAYLOR: It's Round 2.

MR. BUTLER: Well, I'll convert it to a question. Is there criteria that you've thought about that would then trigger, okay, you get intermediate sanctions?

MS. MUTTI: Right. You raise a good point. We are vague on that. We haven't done that work to specify it.

I think ultimately it would have to be. Whether it's us specifying it in this document, we can do more work to try and flesh that out. But we haven't done that detailed work. It might not be for us to do. But we could comment more.

DR. KANE: I'm interested in -- one thing that struck me as I was listening to the types of problems and the definitions of, you know, poor quality is that we are still in our silo mentality as we discuss that. It's a hospital's mortality rate or it's a skilled nursing home's. And I'm wondering have you thought about both changing the name of the type of provider from not just the siloed providers but perhaps, you know, maybe we should be focusing much more on the -- actually the community was beginning to get my attention because I think maybe that's more important. What are the levels of performance? So, I mean, I guess, you know, what -- I'm afraid we're reinforcing siloed mentality both in terms of thinking of who the provider is and the -- and so I guess I'd like to get your thoughts on both that and how we measure performance, which is related, because you can focus on surgical outcomes or you can focus on chronic disease management across the silo. I think you're going to focus very differently who's

behaving -- who's got bad performance depending on, A, what your definition of a unit of care is, and then that will automatically -- so, anyway, that's kind of my first question.

And then my second question is: Are you thinking of -- notice how I made these questions as opposed to -- are you thinking about just Medicare being the target population or all payers? For instance, in some of the communities where a lot of minorities are served, Medicare is really a minor player, and it's much more Medicaid and uninsured. So how limited and siloed do you want to make this as opposed to broader? Is this just Medicare's technical assistance? But yet if you do that, you're going to miss really, I think, some of the lowest performers who really needs help.

MS. MUTTI: On the first, we had given a little thought to the idea that -- you know, concern about being too siloed as we focus on each provider, and we picked it up a little bit in our discussion about what measures you use to measure performance. And to the extent that you use measures like readmissions or even things like emergency department use or admission rates -- because we know that providers collectively can influence how people are using

care. If we use those measures, you would be -- even if you were holding a given provider accountable for it, it required that they work with other providers. So that it would induce some community efforts, not just something within their own walls. To improve those measures, you have to go out and work with other providers. So that was one way we were sort of trying to lean to get away from the specific silo thing.

On the Medicare/Medicaid, I think it's a good question. I hadn't thought about that.

DR. MARK MILLER: Back on the first one, also doesn't the community approach allow you to kind of continue across some of the silos or two?

MS. MUTTI: Absolutely.

MR. HACKBARTH: Here, again, this is a really important question. There are some quality problems that exist pretty much within the four walls of the institution. There are some that are a problem because they go across the silos. And as we've discussed in many different contexts, many of the most important troubling problems are the ones that go across the silos.

The broad approach that we took here was that the

bulk of the resources ought to be dedicated towards the within-institution problem and focused on the low performers. But some piece ought to be reserved explicitly for the cross-silo problems, more community problems. You know, I don't think we say anything very specific about exactly what those proportions ought to be, and, you know, that's an important policy judgment in its own right, and I don't think we have the means to think about exactly how to make that split.

Just let me stop there. So it's an important problem we tried to address. Whether we addressed it sufficiently well or not I'll leave to you folks.

DR. CASTELLANOS: I think you probably answered my question already. Maybe it's getting where Nancy didn't want to go when we talk about silos. This is motivating Medicare to help all Medicare providers. I want to make sure that we're going to also perhaps help the physician community also.

MS. MUTTI: Absolutely. Thank you for that question because I did want to be sure that everybody understood that.

MR. KUHN: Two quick questions. One, as we've

talked about this Draft Recommendation 1, we've talked about the issue of ethnic disparities, but I think also a reasonable measure -- and I didn't know whether you had thought about this -- picking up on our conversation on rural areas yesterday, one of the reasons for lower quality perhaps in a rural community could be lack of a primary care physician, education, poverty levels in those communities as well. So I would want to think about that a little bit, or if you all kind of thought of that as an option as we think about this one, too.

MS. MUTTI: We definitely thought that certain rural areas would be very ripe for assistance based on this kind of targeting.

MR. KUHN: Yeah. And then the second question I had, in the materials I had, on page 14, there was this notion about the single point of intake for filing patient complaints. I think the Center for Medicare Advocacy had that; also the IOM recommended it back in '06. I was pretty intrigued by that because I thought it raised some interesting ideas about -- because there's such great variation by state survey agencies and all the other activities that go on. I'm just curious why, if this has

been a recommendation out there for several years, has it just kind of languished out there? Why has there not been more conversation about this and more take-up rate on something like this?

MS. MUTTI: You know, I think I probably would need to look into that more. I think there's been an effort to standardize the complaint process across state survey agencies, and they have made more of an effort, CMS has clearly made more of an effort to increase the awareness of beneficiaries that they are to go to QIOs with their complaints so that there is not so much confusion as to who they go to.

But the fact that there are still so many different options for who you can go to for patients and beneficiaries alike, I don't know why that hasn't been taken up more broadly as a policy direction. This is sort of an issue that we picked up incidentally as we were looking at making technical assistance more effective and just sort of stumbled on this as being perhaps an opportunity.

DR. BERENSON: I had two and I will pick up one of them as a direct follow-up on that one, which is that as I remember -- and maybe it's changed -- the QIOs not only

field complaints, but they do real-time appeals of hospital discharges. And that's not exactly the same thing, and it's a very important function, and I guess the question is: Did the IOM have a recommendation as to who should do that? The administrative contractors? Did they get to that level of specificity? Because it may be a different solution for those two different activities.

MS. MUTTI: Right. No, I don't believe they did. I think they stopped kind of where we're stopping with the idea that, you know, another entity, maybe others are better prepared to figure out who that entity is to do that. But the IOM recommended both that the beneficiary complaints go to someone else as well as these other appeals.

DR. BERENSON: Okay. The other question I wanted to follow up, Glenn asked about consistency with the IOM, but in addition to the 10th Scope of Work, which you said was due any day now, there's a Secretary's report on quality, the quality strategy, which was due January 1 and is due any day now, and I assume would be taking up some of these issues. And then I believe there's going to be a CMS patient safety report, and Don Berwick is probably the single smartest person around on strategies. It makes me a

little nervous that we'd be issuing something and then find we're outdated or irrelevant or something.

So what can you tell us about the timing of those expected products and whether you think they'll be covering some of the same territory.

MS. MUTTI: Timing, we also had heard that this was coming, and we heard maybe yesterday or something that this would be coming out. So it is supposed to be soon, I believe.

In terms of, you know, the potential for conflict here, we come out and say something, and they have a different idea. The draft that did leak focused -- suggested that they were looking at focusing efforts on reducing preventable readmissions and also hospital-acquired infections. I think that is entirely consistent with the bent that we're following here when we talk about, you know, what are the measures for low performance? Are they things like these outcomes measures? So that could be entirely consistent.

I believe the document that I saw that was leaked also made a reference to trying to marry a little bit the QIO involvement and the COPs, which sounds very consistent

with what we're talking about.

The other piece that I recall was that there was a real effort to see if they could get private sector payers to come on board and follow Medicare's lead on payment for infections and readmissions. And that obviously is separate from what we are talking about here. We haven't touched that.

Medicare's lead

DR. BERENSON: Which paper leaked, the quality strategy or the patient safety?

MS. MUTTI: Patient safety.

DR. BERENSON: The safety one, okay.

MS. MUTTI: I don't know anything about the quality strategy.

MR. HACKBARTH: So I asked the same question, Bob, about how this might square with work underway in CMS, because like you, I think Don is -- this is exactly the area that he knows best, as well as anybody. And so what I will commit to do is connect with Don and talk to him about draft recommendations that we're considering, is this in any way inconsistent with what you're trying to accomplish, and bring that back to the rest of the Commission.

DR. MARK MILLER: And I guess this does go without saying, but we've had several conversations with CMS about this and different elements of CMS, and part of why, you know, Anne can't answer everything specifically is because on some of these things, they haven't -- you know, they've listened politely, but also haven't given us a lot of information. But Anne has made every effort to make them aware of what's going on. So what's happening here today is not a surprise to them.

MR. HACKBARTH: So my assumption is that because things are in process, Don isn't going to reveal to me what the patient safety strategy or the 10th Scope of Work is going to say. But I think he would say, Oh, you guys are just headed in the wrong direction, don't do this, this doesn't make any sense.

DR. STUART: Bob raised the point that I was going to raise -- oh, I'm sorry.

MS. HANSEN: Sorry. I was just going to wait for Round 2, but just as a point of information on the patient safety strategy, one of the things I do know is that the business community has already gotten the leak as well, too. So this is going to be kind of a 360 effort from all

different sectors.

DR. STUART: I won't repeat what Bob said. Those were my issues as well. But do we have any sense in terms of whether the 10th Scope of Work will make any of the kind of structural changes that you've suggested here in terms of, you know, whether other competitors would be involved specifically?

MS. MUTTI: Actually, law prevents them from doing those changes. The only one of these recommendations that affect QIOs that they could do administratively is the first, focusing resources on low performers. But the competition they cannot -- but that goes right to the point that in the President's budget there is a request for legislation that would change that to increase competition.

MS. UCCELLO: A quick question. In thinking about how to direct the money, do we have any information on whether the gap in quality between low performers and high performers has been widening or narrowing over time?

MS. MUTTI: I don't think we're aware that it is one way or the other, but we can definitely double-check ourselves on that.

DR. DEAN: On the issue of recognizing high

performers, is there any real evidence about what impact that has? As I think about it, it could be either on the public's decision about where they seek care, which is probably the most obvious thing, or it might have an impact on the performers themselves, just a motivation to keep doing it. I guess I'm thinking about our own local situation. Our hospital has been recognized several times by Press Ganey, the big national survey firm, for patient satisfaction in our emergency room. And this got lots of publicity in our local paper and all that sort of stuff. I think the average person on the street, if you ask them today, would have no idea about that.

I don't think that -- we would assume that it makes a difference in terms of people's decision about where they seek care. My impression is that it's not nearly as effective as we might assume it is. On the other hand, I think that it may have an effect in motivating the professionals, the providers themselves to make -- I don't know. Is there any data about that?

MS. MUTTI: In general, I think the findings are very consistent with what you're thinking, that the public disclosure of performance tends to really be digested by

providers themselves, and their professional pride kicks in, and they want to demonstrate and get better, and that the consumers are not using it.

The one part that I don't know so much about is, you know, these kind of marketing campaigns where it's on every billboard or draped across a banner in front of the hospital. That kind of promotion, I'm not sure if I know of the data on whether that's effective or not.

MR. HACKBARTH: Okay, Round 2 questions or comments?

MR. GEORGE MILLER: You want us to comment now on the draft recommendations.

MR. HACKBARTH: Yes, thanks for the reminder. Since we have draft recommendations, it would be helpful for me to hear from people whether you support them or what reservations you have. And not everybody needs to speak. If you're just comfortable, I'll assume silence means assent. Karen, is that a valid assumption in your case? Okay.

DR. BORMAN: [Nodding head.]

MR. HACKBARTH: Okay.

MR. GEORGE MILLER: Just in general, I do support

all of the recommendations. I really like the direction that they're going in, but I think Peter brought up an important question, and I just wanted to echo particularly about Draft Recommendation 1. One of the things we just have to be careful of is to make sure we hit the right targeted population and do it correctly, part of the philosophical discussion that you mentioned, just with that caution. Otherwise, I do support the draft recommendations. I'm particularly pleased that we're also trying to deal with disparities, and this does take a step in that direction.

DR. BAICKER: I really like the tenor of the recommendations, and I also thought Nancy's point was important, to be thinking across silos as much as we can flavor that in with the recommendations.

MR. GEORGE MILLER: Right.

DR. NAYLOR: I also really support them, but would recommend considering bundling them because I think focusing technical assistance -- if we end up with focusing technical assistance on low-performing providers without increasing competition and positioning those agents with technical assistance, you know, whatever, I think we won't have accomplished as much. And so I don't know if this is even

possible, but I have some wording that would suggest combining 1, 2, and 3. And then number 5 I really like, but I also wonder is public recognition going to be enough. You know, is there a way to think about kind of these stretch performance expectations for which they get stretch -- not just kudos but real recognition and reward? And so that was just a consideration.

MR. BUTLER: So I think we're being pretty bold in support. I think it's because we're not moving any money around.

[Laughter.]

MR. BUTLER: Or not as much as we usually would. I'll make up for my Round 1 behavior and say I support the recommendations. I like them, with one exception. I think 5 I'd say two things about. One is that I think consumer-driven social media kinds of activities are going to trump all of these recognition things in terms of driving consumer behavior.

Having said that, I would support the public recognition using the Hospital Compare. I think adding another set of metrics with one more scorecard for providers to chase at this point would not be a good thing. We've got

enough set of things to run after, and I think that the value-based purchasing, which really starts this July, in effect -- because how we start performing against the measures on HCAHPS and the -- really starts the nine-month cycle or something. It's this July. You'd get far more bang out of your buck expanding that more quickly and putting more dollars at risk in terms of focus than simply adding an additional set of measures that would be publicly reported. So I don't support the addition of additional measures as part of the recognition system.

MR. HACKBARTH: So let me just ask a question, Anne, about what you envision would happen. I guess I was assuming, maybe too quickly, that we wouldn't be talking about a whole different set of metrics, that we would be applying existing metrics to develop this designation. So, you know, the metrics in hospital value-based purchasing as opposed to giving you another set of targets to shoot at, I'd say let's take those and use them to create the recognition program. Is that what you envision?

MS. MUTTI: I understand what Peter's responding to because I was allowing for the possibility that you might want to have a recognition program that builds on Hospital

Compare, but also picks up some of the things that we're going to get caught in in the survey, which might include the hand washing or the discharge planning.

MR. HACKBARTH: Right, right.

MS. MUTTI: You know, that kind of thing.

MR. HACKBARTH: Got it. Yes.

MS. MUTTI: But that was thrown open for discussion.

MR. BUTLER: So I would rather have those kinds of things put right into the payment system when they're ready as opposed to being flagged. And then you might even change your mind whether those are important and when they're eventually put in the payment system. Meanwhile, we're -- but if you want to put big huge stars next to the Hospital Compare stuff so you highlight them in different ways above and beyond just making -- that's fine.

MS. MUTTI: Yeah, a raw number or something.

MR. BUTLER: That's good. Can't hurt.

DR. KANE: I'm very supportive of the notion that, you know, we should more efficiently target these technical support resources. I think in defining performance, however, I would like to have at least Medicaid and Medicare

metrics involved, not just Medicare alone, particularly so that you can pick up some of the communities I think that do serve lower-income and minority beneficiaries and have less Medicare but a lot of Medicaid and people who are more vulnerable. You know, if you're thinking these are really public resources, they should help public patients, both types.

I think on Recommendation 4 about sanctions, I'm all for sanctions, but I think we should -- the one that said, you know, suspend or prohibit elective procedures, that makes me very nervous. That could really have a long-term negative financial impact. So maybe if you're going to do something like that, you should try to have some modifier that whatever intermediate sanctions are there, are there to primarily address directly the poor performance but not generally damage the place financially just for the purpose of being, you know -- it shouldn't financially damage them because that could really damage an institution that's struggling. But certainly replacing the management and/or the board or not allowing performers who have very bad outcomes to continue to operate or whatever, that's okay. But I think generally you don't put things in there that are

going to really damage the long-term survivability of the institution. So, otherwise, I'm very supportive of all the recommendations.

MR. HACKBARTH: A question about the Medicaid/Medicare issue. Are you suggesting that in evaluating performance we ought not just use Medicare data? Or are you suggesting that a different set of measures be used to reflect the issues in caring for the Medicaid as opposed to Medicare population?

DR. KANE: Well, I think things like readmissions or hospital ER use, inappropriate hospital ER use, or ambulatory care center conditions, those kind -- I think you want to look at the low-income population in particular. That's where a lot of the poor performers might be located. And Medicare patients don't often use those providers. You know, if you look across the spectrum of where are the real safety net hospitals, Medicare is less than 10 percent sometimes. But there's a serious problem going on. Medicare patients do use them, but the much bigger groups are these other populations. And I think if you are going to define low performers just on Medicare definitions, you're going to miss a lot of the really lower performers, I

think.

So I'm just saying if you could get -- and there are all-payer data sets and just pull out the Medicare and Medicaid --

MR. HACKBARTH: In some places, yeah.

DR. KANE: In some places. And certainly this is another example where we should be sharing with Medicaid, you know, their claims or whatever data they use to -- and put them together and say, okay, well, this particular neighborhood has terrible providers, and a lot of it it's going to be picked up because of the Medicaid data, not the Medicare data.

MR. HACKBARTH: Okay.

DR. MARK MILLER: The only thing I would say is in the extreme, if somebody took your thought to the extreme, you know, are we saying that this money would go to -- let's just pretend the hospital has no Medicare? Because then, you know, we've really just taken trust fund dollars and sent it off to a very different function. And the way I would try and square the reasonable question that you've raised is that there is this portion that is devoted to community, and certainly thinking about the community

broadly in that context I think makes sense. But in the extreme, if you're saying that this is driven off of, you know, uninsured, Medicaid, or those populations, you could be shipping dollars to a hospital that doesn't serve any Medicare. And then I think you've really taken this function and this money and the trust fund dollars and headed in a very different direction.

DR. KANE: I'm not suggesting no Medicare patients, but they are often not the 30 percent they usually are. They're much smaller. And they may be -- I mean, it may show up in the Medicare data, but I think it's more likely you're going to see poor performers when you look at the broader payer mix. It's the provider that's --

MR. HACKBARTH: Implicit is the premise that you might get different results for the small Medicare population in these safety net hospitals than you get in the Medicaid. And they could look fine on Medicare, but be --

DR. KANE: [off microphone] Okay. They might be okay, but if you really look at the broader provider performance, they're really low-performing. And it could only help -- also, Medicare performance, you still always know -- you know, you're looking at three conditions. And I

think you might pick up more variability if you try to expand them a little bit through some of these other metrics. But I don't have the technical answer.

MR. HACKBARTH: Yes.

DR. CASTELLANOS: In the context of Medicare's role of motivating and supporting quality care, I'd like to go in a little different direction, and I recognize there's a tremendous threat to me to get tarred and feathered by the medical profession. But I'm going to take Bob Berenson's approach. I'm going to call a spade a spade.

[Laughter.]

DR. CASTELLANOS: I'm going to call a spade a spade, and sometimes I'm going to call it a shovel.

The question here is, if you remember, in the November panel discussion with Chris and Bob Wachter, they had a great quality and outcome thing, and the question I asked them was -- there was no discussion on appropriateness, and Bob Wachter's answer was, "You're right." And we've talked about clinically appropriate guidelines, and I've kicked this can down the road for so long, I would really like to try to see if we continue to kick it and do something.

What do I mean by clinical appropriate guidelines? Well, Nancy brought up a subject yesterday. She said the cyberknife for prostate cancer. It's a very appropriate treatment. There's good quality. There's not a lot of data on it. But is it appropriate to treat everybody that way? No. Sometimes we treat it just by observation, and sometimes, as you and I talked yesterday, IMRT, but there's a lot -- and what the societies need is help in developing appropriateness criteria.

I can tell you, I've had discussions with my society on it, and it was very interesting. I had a very pretty negative approach by the physician community on the Health Policy Council, but the staff of the Health Policy Council came back to me and said, you know, you're right. We can use some help. We can use help getting the data. We can use help developing some of these criteria.

Now, I recognize it's going to cause a lot of uncomfortableness in the medical community, but we really need to start looking at appropriateness. What's appropriate?

You know, here we're starting to talk about comparative effectiveness and stuff like that, and I would

like to see where perhaps not with the QIOs but perhaps with AHRQ or PCPI where there's money set aside for societies who are willing and able to go ahead and recognize maybe we do have a problem with appropriateness criteria.

Now, how vulnerable is that? Well, our society said that. I had a very brief talk with Karen about this two months ago, and as she was walking out the door, she said, well, you know, that's something that maybe general surgery would be interested in, and I talked to the AMA, and they've had other societies come to them asking for help in doing this.

So instead of continuing to kick this can down the road, I would like to try to see if we can somehow establish a role in motivating and supporting development of appropriateness criteria.

MR. HACKBARTH: I think Ron is making a good point that maybe our title is too broad for this. There are a lot of things beyond QIOs that Medicare can do to motivate and support quality improvement, and I'm with you, Ron. I would consider issues of appropriateness quality issues as well as cost issues. And so we may need to think about how we title this, but also some of the text that leads into the QIO-

specific discussion to make the point that the quality issue really is broader than what we're talking about here. It covers issues in payment policy. It covers issues -- you know, I think an important thing that the government is starting to do to support the development of guidelines is the investment in comparative effectiveness research, a huge investment that will provide raw material, hopefully, to inform evidence-based guidelines.

So I think to get into the guidelines issue, appropriateness issue in this particular chapter would take it in a whole new direction, and so I'd like to see us, you know, narrow the title, do some appropriate lead-in to suggest that there are many other issues in quality than just this. But this chapter is focusing on QIOs. And, you know, let's talk about the appropriateness issue in a different place, and let's you and I talk about how to take that up.

MR. KUHN: A couple quick things here. One, to kind of revisit the issue of COPs, and I think we're missing an opportunity by not putting forward a recommendation in this area. And I've shared before with the Commission that a number of the COPs right now continue to reinforce the

silos that we have in health care out there. I've talked about ones dealing with discharge planning, for example, right now where you need to report it within 30 days, and how is that going to fully support a 30-day readmission policy as we go forward.

I've heard of ones recently dealing with drug dispensing in hospitals, where you need to dispense the drug within 30 minutes, and so hospitals, in order to deal with adverse drug events, issues like that, have started to buy new technology, these carts that help in the dispensing to try to get it down to zero defects. The interesting thing about those carts is that they time and date stamp when the drug is dispensed, and if it's 31 minutes, hospitals across the country are now being written up as violating the COPs as a result of that. So what nurses are doing, they're doing the work-arounds. They're opening the carts, they're taking the drugs out, which could lead to safety issues as we go forward.

So I think the COPs are in bad shape, and I'd like to see us think about a recommendation where we would perhaps ask the Secretary to evaluate -- you know, do a pretty thoughtful evaluation of the COPs and think about an

ongoing effort to update those to meet the new standards of care plus to really support the new payment delivery models that are coming forward. I think that's a troubling area that I'd like to see us go back and look at.

On the other recommendations, I think the first three make a lot of sense. I think the fact that we will strengthen -- I think we'll strengthen the process through those, and I think those work very well.

On the issue of enforcement, I'm kind of torn on this one, and when Anne kind of described it in terms of kind of the intermediate sanction opportunities -- because as everybody in health care knows, that's kind of a death penalty. You know, there's no chance for intermediate sanctions, and I think even CMS and surveyors struggle with that because they see a violation but it doesn't warrant kicking someone out of the program. But that's the only option they have.

So when you kind of described it that way, it made sense to me. But when I see the recommendation, it doesn't translate that way in terms of what I thought we were trying to achieve there. And the reason I'm a little troubled by this and I want to think about it more, Glenn, is the fact

that if you look at what's in PPACA now, there are some new payment issues, whether it's readmissions, hospital-acquires conditions, things like that, where there are going to be payment penalties now as a result of that. And the way those payment penalties work, it just kind of hits the lower quartile of certain providers out there. And some people are very concerned that that might be a self-fulfilling prophecy here that these providers are going to continue to get dinged in terms of their payments and are they going to be able to catch up. And then if you layer a sanction on top of that, are we just driving them to the bottom on a regular basis? So I'd like to kind of think that one through a little bit more. And the fact that the Joint Commission has had a tiered process for so long, I kind of want to understand how these sanctions will interact with the new payment policies, which will be putting penalties on there as well. And will that help support that effort or will that continue to drive people to the bottom? I don't know. I want to think that through.

Then, finally on the -- I'm sorry.

MR. HACKBARTH: On that issue, Herb, what I hear you saying is that in some ways with the new payment

policies and financial consequences to poor performance on certain measures, there is, in fact, a type of intermediate sanction already.

MR. KUHN: Already as a result of that. I think the payment policies do drive that, and so that's why I'm wondering if this is more towards low performers, or is it something to give CMS a more robust tool kit in order to do gradations that are out there.

MR. HACKBARTH: Yeah. Now, one issue is that although, as you say, PPACA started down this path, they're very focused on particular problems, like surgical infection rates and readmissions as opposed to broader quality problems.

MR. KUHN: Right.

DR. MARK MILLER: You know, I think the way these things come together -- and I do see -- just divorce the thought for a second of do the payment policies effectively capture the intermediate sanction thought. Just let me hold that aside for a second.

I think the thinking here works like this: There is a recognition in PPACA that there were certain penalties for certain kinds of, you know, readmissions, hospital

acquired, and a concern that if a provider is driven into the basement and stuck in the basement with those penalties. And that's in a sense what I think motivated a lot of this, this notion of focus the resources on those providers, give them a renewed flexibility to go after their specific problems in some measured way, you know, time-limited way. And then if they can't turn the operation around, then maybe that is an indication of a problem, and I think that's where the intermediate sanction thought comes in. But you're not bouncing the person entirely from the program, but the notion of trying to graduate them through it.

But I think some of the motivation was specifically to keep a provider or give at least a provider who might end up in the basement and not ever able to get out of the basement the chance to come up. And I think that's why it's focused on the low performers and trying to put the money right in their lap and saying find the problems that are driving you into the basement, work with an array of providers. At least that was some of the thinking.

But, nonetheless, you've made the point that there is an overlap here between some of the payment policy and

intermediate sanction, and we can at least think that through.

MR. KUHN: That's helpful, Mark, both what you and Glenn shared helped.

DR. MARK MILLER: Sorry it went long.

MR. KUHN: Finally, on the high performers, I'm just curious. It makes sense to me. I think we all know it will probably, you know, help the outdoor advertising industry in terms of more billboards and things like that. But I'm curious right now. Within the Medicare program, you've got a star rating system for skilled nursing facilities, a five-star rating system. You have a five-star rating system for MA plans. In fact, as part of PPACA, that star rating system now is triggering a bonus payment to MA plans. So it has been in effect already within the Medicare program. Has it been an effective tool? You know, how does this differentiate from what Medicare is already doing now is kind of my thought on that one.

DR. BERENSON: First, let me just address Ron's issue, and I will protect you with the medical profession. I think, as I said yesterday, that the lack of -- the inability to address appropriateness is to me the Achilles'

heel of episode-based payments, and we need to work on it. I think it belongs on a different timeline and a different context, but it's very important and I think it's something we should take up. And so we may need some title issues here.

I wanted to pick up just where Herb had left off on the last recommendation. I had a different notion, especially in the slide when you talked about superior quality, that it would be something more like an award given to one, maybe even one but maybe a couple of organizations a year, as prestigious award. Part of my thinking is that I actually don't think that performance measures that are currently in use and, in my view likely to be in use for the foreseeable future capture more than a relatively small part of an institution's commitment to quality. And we do, as Herb said, have -- it's part of the sort of momentum is that we are going to have ratings and we'll see how that affects public behavior. I mean, that's part of the system anyway. So my idea -- and this is just off the top -- was that -- what's the name of that award that people strive for?

DR. KANE: Baldrige.

DR. BERENSON: Baldrige, yes. The Baldrige Award.

It would be some kind of equivalent of that which actually, I think, organizations would probably apply for and tell a review panel what they are doing. They clearly have to meet the high levels on the performance metrics, but in addition, they present their sort of institutional commitment that captures culture and leadership and management, and the two are not mutually exclusive by any means. But I wonder whether we should give some thought to that kind of an approach as well.

So, you know, obviously it's in the interest of organizations to win that award. They have media around them. That's something that's not awarded to a hundred or a few hundred organizations. And you can one year pick the one that's about care coordination across silos and say -- and, again, I don't know if it should be one or it should be ten, but something really superior that goes beyond just using performance metrics. And I agree with Peter. We don't just want to create a whole new set of performance metrics because I don't think that gets us where we want to go.

MR. HACKBARTH: That's helpful. It's a way of distinguishing.

MS. HANSEN: I just want to say first off thanks to Anne for the chapter. I think you wove in a lot of the previous work, and some of the issues of safety with our presenters this last fall.

I am very supportive of the direction of the proposals, and I appreciate the focus on kind of the high-risk performers who don't want to necessarily, of course, be in that category, but oftentimes are in that circumstance with comments made by other folks on the other side of the table.

My one concern from another dimension of the fourth recommendation relative to the punitive side is that oftentimes people who are already at the bottom, the ability to get up, so to speak, takes not just a small amount of time. It's a huge change because there are many variables that aren't easily just controlled by having a board look at, you know, their performance and all.

So I just wanted to be cautious about the unintended kind of potential consequence -- I think maybe Herb said, you know, it almost becomes a way to get reinforced at the bottom, even though the intent was really, frankly, the opposite, because there's enough work that's

gone ahead. The National Academy of Social Insurance just spoke about how health disparities persist despite the fact that people have coverage under Medicare. So, you know, it's not so straightforward as a performance improvement program. So I just wanted to make sure that that group getting assistance will actually get a risk-adjusted consideration of how it gets to move along the line of improvement. So it's certain considerations of that crowd, because oftentimes the absolute safety net of a given community would some degree of Medicare population, but they tend to always get a rough piece of this.

The other point of information that I know the American Hospital Association has had some work in this whole area of disparities moving along, and they have renamed its committee Equity of Care Committee. That's going to be focused specifically on closing the gap of disparities. So there is some work, I think, by the AHA to deal with this. But, again, good intention, support this, especially with the more high risk population, and getting it from providers who will understand the nature of the issues of improvement that are not mainstream issues.

DR. STUART: I strongly support the

recommendations, and I think this chapter deserves a five-star rating.

[Laughter.]

DR. STUART: And there are a couple of things that I'd add. I think that this is touched upon every Commissioner's interest. I think we're all interested in this, and so there's a sense of kind of piling on to make sure that our particular interests are covered here. And one way that we might be able to address that is maybe the title is something, but I think it would also be useful to have a schematic that says, okay, well, here are the things in this large domain that we're going to focus upon here that we think are important, and we want you to keep those things in mind as we go through this and not be distracted, but not to suggest that we are, in fact, ignoring the others. It's just that we are going to be signaling that those are going to be picked up at another point in time.

The other thing that I think is a bit awkward about this chapter is the fact that we've got these three major reports that are going to be coming from CMS, and on the one hand, obviously we're not a toady for CMS. We're an independent agency and, you know, we say what we think. On

the other hand, there's a real opportunity here if there are things that we agree with to support those and to double -- you know, to give a strong appreciation for what CMS is doing. And so I'm thinking that over the next -- well, we've got about six weeks between now and the next meeting. And to the extent that any of these reports are released, if you could make those available to the Commissioners, I think that would be really helpful. And if it turns out that maybe there's something that we would even want to postpone a formal vote on or at least to consider after the April meeting but before -- and I recognize the timelines are tough here on publication, but at least to do whatever we can in our power to make sure that we are building upon the strengths that we perceive when they come out in these reports.

MR. HACKBARTH: Our time is short, not just because the April meeting isn't all that far away, but also because of production issues that we have.

Having said that, you know, I will talk to Don and make sure that we're not at cross, or if we are at cross purposes that you folks know that when we talk about what the areas of agreement and disagreement might be, and then

we can act accordingly in April.

The patient safety initiative, do we know if that's going to be something that comes out and is subject to some sort of a public comment period? Because that is another avenue for us to say, you know, go, CMS, you're doing great things. I just don't know what kind of a format that's going to come out in. It doesn't --

MS. MUTTI: Yeah, I don't know either. It may be like a broad rubric pulling together a bunch of different its, like the 10th Scope of Work, like some COP reform that I think they're planning on anyway, and sort of pulling it together and announcing the cooperation with the private sector. In that case, maybe there's not a specific comment on that, different pieces.

MR. HACKBARTH: But even if there isn't a formal public comment opportunity, we could do, as we did on ACOs where we plan to just write a letter, you know, this is an area of interest to the Commission and, you know, we want to applaud these particular aspects of the initiative.

So we've got two objectives here. One is that we don't, you know, run at real cross purposes with them, and I'll try to track that down with Don. And then second is we

have various avenues that we can use to support CMS if we're so inclined.

MS. BEHROOZI: We hate silos and we love integration, so I just want to comment that this is a great integration of previously siloed areas of analysis, and particularly, obviously, the disparities research and quality. So I think the recommendations are great, and I support them, and I just have a couple of comments.

With respect to Recommendations 1 and 2 -- and 3, I guess -- or 3 in particular, eliminating the unrealistic barriers to participation in the QIO program sounds great, but, you know, going from a highly regulated sort of static kind of situation to a market situation carries it's own perils. And, you know, I'm just sort of envisioning a post-transition landscape with every consultant in the world, many of whom we know and many new ones who will pop up on the scene, you know, flooding providers with, Oh, oh, we can help you. And we're talking about providers who are low performing, and as you identify in the paper, that might be because of ineffective leadership. So I think we need to be very cognizant of the fact that those leaders who need help might need help figuring out who the right consultants are.

And so I think that we need to -- we probably should reinforce in Recommendation 3 that while we're removing the barriers, there really still should be high standards and some kind of limitations around those entities that are eligible to participate in the program. And in the paper and on Slide 7, you talk about CMS could create an online marketplace to provide some structure and protections, and I think we should kind of beef that up, talk about that being a really robust tool, also with guidance about how to select among, you know -- well, qualified entities but still probably a much broader range of entities.

And then also on Recommendation 1, if we're going to say the remainder should be targeted to community-level quality improvement, I think we should be more explicit about what we mean by that. I think what I saw in the paper that referred to that was one paragraph that talked about certain geographic regions are persistently low performing, but we also know that within geographic regions you have high and low performers. So what does that mean? Does it mean we would distribute the rest of the money to all the providers in a region, or that we would encourage using the money for coordination efforts among providers? All of the

above? I think we should flesh it out a little bit if it's going to be in the recommendation.

MR. ARMSTRONG: So briefly I just want to affirm I support the direction we're heading with these recommendations. Bruce did a great job of making the points I wanted to make. In fact, he made them better than I could have, so I thought that was a five-star comment.

[Laughter.]

MR. ARMSTRONG: I just do think, though, that with this context, you know, what are all the different ways in which quality is being advanced. It would really help us then to be more specific about how far we want to push some of the specific components within this one piece. And so to the degree we could map that out in some way, I certainly would learn a lot, but I think it would help us deal with many of the issues or concerns that were raised in this conversation.

DR. DEAN: I, too, support the direction of the recommendations and basically support the individual recommendations. I have some caution about the difficulties of identifying low performers in very small volume facilities because of the whole small numbers problem and

the challenges that that presents. In my particular state, we've got about 50 hospitals and 40-some are critical access.

That doesn't mean that they shouldn't be scrutinized. They absolutely should. And it's just tough to make that decision, and I just put out that caution.

I really think that it is important to broaden the perspective on the causes of low performance because there are many, many different causes, and some of them are relatively simple technical things and some of them are deep cultural things. And some of them you can bring in a consultant and they can show a few techniques to do some measurement or whatever, and you can solve the problem.

Unfortunately, that's probably the exception, and the more common thing is traditions and cultures and things that have developed over time. And those certainly need to be addressed.

I was bothered a little bit in Recommendation 2 by the phrase "time-limited technical assistance," although I certainly understand why that's in there, and there is obviously a limit to what can be done. On the other hand, some of the changes that I know need to take place in some

of the facilities I'm familiar with are just simply not going to change very fast. They can change and they need attention and they need to be pushed and they need help. On the other hand, it just is not something that's going to change very fast. So I would -- I don't know exactly how to rephrase that, but just with the caution we need to be a bit flexible in how we look at that.

I guess that's the biggest part of it. I mean, clearly this is a direction that we need to move and we need to support and emphasize. As in so many other aspects of health care -- and it's particularly true in -- the smaller the community, it is so incredibly dependent on local leadership. And where local leadership is there these problems tend not to exist. And where local leadership is weaker they are very difficult to change.

And so I guess I'd just say we need to recognize that and be sure that we take that into account in terms of any kind of sanctions and so forth. That doesn't mean that -- you know, sanctions may well be appropriate in some cases.

I guess just the other approach, I think we need to do everything we can to try to keep it in a positive vein

because so much of what we on the front lines encounter in terms of regulatory enforcement is much more of a punitive kind of approach, and that engenders pushback and then things don't move forward.

So it's hard, and a lot of times it starts out at the upper levels with a very positive approach. But when it sort of filters down to the actual implementation at the individual facility level, it sometimes deteriorates into much more of a punitive approach. So I don't know. I'm not sure how to solve that, but I think we need to keep it in mind.

MS. MUTTI: I think one thing we were trying to allow for in our outline of intermediate sanctions is that it doesn't necessarily have to be a monetary penalty here. We could be talking about helping to change the management so that if the problem is leadership, you know, we don't have to financially penalize the facility. We can work with the board to get management changes so that we can get the quality that would otherwise be very hard to reach.

DR. DEAN: [off microphone].

MR. HACKBARTH: So I just wanted to underline what Anne was saying, and whether intermediate sanctions are the

best tool, the right tool, I'm not sure. But there is this dilemma that both Mitra and Tom have touched on. What if the problem begins at the top? And, you know, how do you create the impetus to change there. If the problems at the top, they may not effectively use technical assistance, they may not be moved by penalties on their hospital value-based purchasing metrics, what can the program do to resolve problems at the top? And part of the concept, as Anne says, is maybe that's a role for intermediate sanctions.

If people have other ideas as to how to deal with problems that begin at the top at the executive board level, you know my e-mail address.

[Laughter.]

MR. HACKBARTH: Thank you, Anne. Well done -- oh, Peter.

MR. BUTLER: Just one more comment, because I was going to do what Herb did, and that is, suggest the conditions of participation be a recommendation. I think whether it's intermediate sanctions or whatever it is, if we have outdated, out-of-sync conditions of participation, you can't kind of go in and say here's what you got to do, and you don't even have good -- you know, so I do think that

would be a nice addition to the recommendations.

MS. MUTTI: We debate that internally and weren't sure that we had a specific enough one to come forward with, but if you feel that way, we can --

MR. HACKBARTH: Okay. All right--

DR. MARK MILLER: I guess the only thing I would say is that what I have my doubts about is whether we would have enough precision to delineate at this point. So I think the recommendation would have to be fairly directional in general to ask for the Secretary to do something rather than us coming up and saying, okay, here they are. I mean, unless Anne's going to do -

MS. MUTTI: That's why we were hesitant because we could not be more specific, oh, should it be on hand washing or discharge planning or, you know, national patient safety goals. You know, what specifically do we want to tell them to update? We didn't feel like we were quite there yet, but there could be something --

MR. BUTLER: And I'm not sure we're the best to do it, but this would be a good Berwick question. If he says that little nudge is all I need and we would have a good idea of how to draft these, then we've done our job.

DR. MARK MILLER: [off microphone] -- aware of, you know, that we could say here's the list. That's what gave us pause.

MR. HACKBARTH: Good. Anne, thank you.

We'll now have our public comment period, albeit a very limited one because of our time constraints, and I apologize for this, but Commissioners have plane reservations.

So we have one person at the microphone. Anybody else? We'll have two people. I'm really going to have to limit you to two minutes each. So when this light comes back on, you're finished.

Please begin by identifying yourself and your organization. Thanks.

MR. KETCH: Good morning. I'm Todd Ketch, the Executive Director with the American Health Quality Association. I represent the Medicare quality improvement organizations.

Just a quick note on some of the discussion here around competition. In this contract, what we know so far is that there are actually six contracts that are going to be fully competed in this round of competition out of 53.

Sometimes there are more than that. It just depends on how the organizations perform under the criteria that they have to meet for their evaluation. But, in fact, those criteria are very, very strict, and when the government sees that there's an opportunity to continue a relationship with an organization, they have an opportunity under the statute to renew that contract with that particular organization. When they're performing well, I have a hard time seeing that necessarily as a bad thing, and so I'd just point that out to you.

There are other organizations that could compete for these contracts if they can qualify to be a QIO. There are requirements in place to be a QIO that were put in place to provide a connection with the community. A lot of that was physician driven at first, but there have been changes in the contracts and in the way the regulations require the boards to be set up for these organizations that have spread out the representation across provider types, including as well having consumers on the boards of directors of these organizations. So they're much more diverse in the representation and the participation of the community in the organization by requirement. And so organizations that can

meet those requirements can compete, and that's certainly welcome.

I would say that looking at focusing on low performers only is not necessarily an inexpensive proposition. The QIOs are doing that now in the 9th Scope of Work. With the amount of funding they have available, the numbers they can work with are very small. So what you lose when you do this is efficiencies that you can gain from having an organization, one organization that is spreading out costs across the providers that they're working with. So, you know, you have to be careful with how you're going to approach this. If you're going to have lots of different providers, you're not going to have the ability to spread out that overhead.

I agree with Mary Naylor about the performance measures not necessarily always correlating with financial status. Maybe I'm misreading whether you said that, but I think there's certainly evidence that that's not always a strong correlation, so I think we have to be careful there.

I just would say we need to walk cautiously into this, and I would urge just continuing to think about some of these recommendations and how they're ultimately going to

impact not only the organizations but the people they're trying to serve, which is the beneficiaries.

MR. HACKBARTH: And I'd urge you to, if you haven't already, be in contact with our staff and also take advantage of the opportunity on the website to register your comments.

MR. BRINGEWATT: My name is Rich Bringewatt, Chair of the SNP Alliance and president of the National Health Policy Group. I'll be very brief and follow up with staff subsequent to this with some more detail. But I just want to make a few comments, one in relation to the lack of data.

The SNP Alliance kind of shares a lot of the frustrations and concerns that were expressed here today -- in fact, are fully supportive of the kind of recommendations that were made. We are in our third year of a data collection of all of our members that looks at specific data in terms of member characteristics, utilization in terms of hospital utilization, et cetera. We'll be happy to share that information. It relates to about 650,000 beneficiaries, so it's about half of the SNP enrollment that cuts across the SNP types. So I'd be happy to share some of that.

We support kind of caution and concern about use of some of the specific measures that are in existence as it relates to HEDIS and star measures, particularly as it relates to high-risk populations, have some recommendations in terms of how those might be saved. We're particularly interested in moving rapidly towards an outcome measurement approach, looking specifically at five outcome measures -- hospital utilization, long-term nursing home stay, emergency room visit, adverse drug events, and consumer satisfaction -- as a place to begin in terms of looking at outcome measurement.

Don't underestimate the importance of aligning Medicare and Medicaid payment and policy and oversight structures. Medicare and Medicaid use different definitions for care management. States and CMS have different expectations in terms of models of care. You kind of scratch below the surface and in virtually every piece there's something different. Moving forward with encounter data collection on the Medicare side, there's no connection of the Medicare encounter data with the Medicaid encounter data, so that there's concerns there in relation to how we deal with dual SNPs.

A few quick things as it relates to points of clarification. Dual SNPs don't get paid more money than other MA plans, and they also aren't exempt from marketing regulations.

Secondly, there's a fairly significant number of people under 65 particularly that are part of the SNP Alliance plan. The survey has 40 percent of dual SNPs under 65, a way to begin to look at some of those. Institutional SNPs and chronic SNPs, virtually all institutional SNPs are focused on duals. Some C SNPs are also exclusively focused on duals. So look more broadly.

Then finally--

MR. HACKBARTH: Okay.

MR. BRINGEWATT: One last quick -- dual SNPs aren't all for-profits. We have Kaiser and Health Partners and UCare and a number of other nonprofit organizations that are actively engaged. So thank you.

MR. HACKBARTH: Okay, and please do take advantage of talking to the staff and using the website. Sorry to have to cut you off.

MR. BRINGEWATT: That's all right.

MR. HACKBARTH: Okay. Thank you all and see you

in April.

[Whereupon, at 11:51 a.m., the meeting was adjourned.]