MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
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10:06 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
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P R O C E E D I N G S

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

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

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

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

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

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

of GDP in 2015.

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

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

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

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

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

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

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

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

Let's briefly review the findings of the Medicare

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

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

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

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

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

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

increases would be needed or even larger spending cuts.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

panel for the Medicare trustees reports.

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

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

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

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

So what do we have to consider? We have to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Thanks.

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

DR. MOON: Absolutely.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

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

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

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

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

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

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

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

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

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

The three questions that Rachel posed for us to

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

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

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

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

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

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

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

Second, I think we can all agree that the proper

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

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

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

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

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

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

a bigger hammer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

places. How can we move there?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The problem is, we come up with these great

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

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

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

Thank you very much.

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

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

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

My question would be, how do you go about defining

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

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

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

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

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

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

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

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

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

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

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

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

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

I think we need to suffer. We need to have

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

But we clearly are on a policy track in this

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So I agree about alignment of incentives. I agree

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

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

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

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

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

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

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

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

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

But the other side of this coin that I worry about

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

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

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

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

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

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

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

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

whomever.

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

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

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

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

more than some of the plans have over time.

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

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

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

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

policy panel might do in Baltimore versus Minnetonka. That's just too great a distance right now.

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

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

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

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

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

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

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

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

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

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

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

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

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

[Laughter.].

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

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

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

situation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. ANTOS: Easily spoken, hard to do.

DR. MOON: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

part they trust their physician.

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

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

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

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

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

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

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

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

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

DR. KANE: What did the Democrats ask?

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

[Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AFTERNOON SESSION [1:21 p.m.]

MR. HACKBARTH: We begin this afternoon with another outside panel, this one on reengineering health care. Anne, you'll introduce it for us?

MS. MUTTI: We have organized this panel in response to commissioner interest on the topic and find that it flows really nicely from our agenda on improving efficiency of providers and improving value in the Medicare program. It also, I think, flows nicely from this morning's conversation. I think we'll get into some specifics that might be helpful building on that conversation.

Specifically today we are hoping that the panel will give you the opportunity to assess the potential for improving efficiency in the health care system, and as part of that give you a sense of what the tools are that people are using out there and how effective they are, and perhaps also a little bit on the potential for others who aren't using those tools right now to adopt them.

And also I think that their collective research and experience in the field will help give us some insight into the adequacy of Medicare's payment policy and rewarding these kind of innovations.

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

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

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

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

So with that, me turn it over to Steve.

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

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

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

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

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

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

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

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

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

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

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

cervical cancer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Characteristics of great, highly performing

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

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

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

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

Quality and Patient Safety.

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

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

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

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

more line days and lower rates of infection and mortality. To take

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

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

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

And so over the course of several weeks they

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

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

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

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

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

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

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

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

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

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

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

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

I'll end there and welcome your questions later.

Thank you again.

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

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

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

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

industry. That's what's driving us.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

serious about our vision of becoming the quality leader.

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

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

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

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

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

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

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

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

added variation.

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

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

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

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

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

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

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

The next two slides are very important slides, and

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

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

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

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

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

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

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

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

We have what's called our patient safety alert

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

It's a pleasure to share that with you.

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

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

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

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

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

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

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

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

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

And so we're talking about tools not to replace

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

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

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

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

It can be shown quite conclusively that optimizing

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

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

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

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

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

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

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

queuing theory.

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

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

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

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

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

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

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

constraints that each work within.

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

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

Thank you.

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

Arnie, do you want to go first?

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

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

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

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

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

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

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

DR. KAPLAN: Yes.

I'll just make a comment.

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

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

DR. KAPLAN: Yes.

But even to get to there requires the kind of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

That's for anybody and everybody.

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

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

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

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

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

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

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

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

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

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

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

Those are just some random thoughts.

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

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

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

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

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

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

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

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

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

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

And he started running through primary education,

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

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

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

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

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

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

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

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

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

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

the customer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We just have to figure out and make our choices as

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

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

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

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

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

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

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

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

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

Any thoughts you have would be helpful.

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

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

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

have an easy answer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

just a centralized finance department.

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

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

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

Sol it's fascinating. I think your point is well

taken, it's way beyond the physicians.

MS. DePARLE: I'll be brief.

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

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

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

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

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

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

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

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

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

what that should be.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. Compton, thank you.

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

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

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

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

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

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

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

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

I'll turn it over to Dr. Kramer.

DR. KRAMER: Good afternoon.

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

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

million Medicare beneficiaries per year.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We found that the rehospitalization measures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

can get there.

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

Another issue is staffing and the extent to which nursing home staffing is getting worse over this period. Some of our other work shows a very strong relationship between rehospitalization rate and staffing levels of all types of staff and staffing skill levels, not just how many CNAs do you have and total levels but RNs and experienced RNs that aren't turning over frequently. And so if that situation is getting worse, again you're going to drive up re-hospitalizations.

So it's a multifaceted problem but it's a serious problem. And certainly one way to address it is the way they're trying to address it in pay-for-performance, where they have this array of quality measures that are going to be used for paying facilities. And the one that's going to be weighted most heavily, actually, is hospitalization because that's where the pool of money is going to come from

to pay the incentives. So it's going to be a critical measure for pay for performance.

That's certainly one way to do it, put an incentive in place and see what providers do. But public reporting is another way.

So at this point I guess I'd be curious on people's thoughts and take questions on the issues.

DR. MILLER: Let me just do one thing before we go to the questions, and this is for the public and for any of the new commissioners.

There's obviously the sort of what's going on here aspect to all of this. But the other way that this work fits into what we've been doing is a year and half ago we made a set of recommendations on pay for performance for various areas, hospitals, physicians, and other areas. One of the areas that we didn't feel prepared to move forward on was skilled nursing facilities because the measures were so general to nursing homes we weren't sure that we were really capturing the experience of the skilled nursing facility patient.

That surfaced the issue of well, if they're not serving tremendous amounts of patients can you, in fact, put

together measures and stable enough measures to use it in a pay for performance system? And that's what brings us to this presentation.

So the other ball to keep your eye on here is moving forward are we going to be looking at these measures and feeling that they're robust enough and stable enough to then move forward and start making recommendations on pay for performance in skilled nursing facilities?

MS. BEHROOZI: I guess I want to start with where Andy ended. When I was reading your paper, I put little stars next to the places where you identify the issue that you just mentioned, which is that increased hospitalization rate, rehospitalization rates, may be associated with growing staffing shortages and increases in staff turnover. You say that same thing at least three different times in here.

And while it's not quantified, it seems like -- referring back to the more, I guess, developed pay for performance and quality measure scheme that's been developed on the hospital side, there are both process and outcomes based measurements. And so the staffing ratio and the training of staff seems like the perfect kind of process

measure that you could put in next to these outcome measures. You'd capture that additional 10 percent of facilities that you couldn't otherwise capture. You would control for some of that distortion that you were talking about in a purely outcomes based system where the incentives would be to hide the fact that they are dumping the patients that aren't going to make them look good and things like that if they also have to meet this other standard.

And I wonder if seeing it quantified, seeing increases in staffing produces this much of a reduction in the rehospitalizations factor, if that would be helpful to seeing whether this would be a useful process measure.

DR. KRAMER: I'm glad you opened that door because there are several issues related to that. The first is that in the report we did we actually looked at incremental benefits of staffing and the reductions in potentially avoidable hospitalizations. There are these striking incremental benefits as you go up the staffing levels that are associated with reductions in rehospitalization rate. In this study we'll actually explore it further by doing some other comparison of high staffed and low staffed facilities.

Your point is extremely well taken about using that in pay for performance, along with other measures. CMS has recognized in part because the technical expert panels have been pushing it, and we've been pushing it for years because frankly I also think for public reporting, if you could give people a really robust and well risk-adjusted staffing measure it, but simplify it into a way that they could understand it, it would mean more to a potential nursing home resident than anything else you can give them.

I mean a delirium rate or a prevalence of UTIs is pretty hard to interpret. But how many people are there working for me, working in the facility relative to what the needs are? How fast do these people turn over? Do I get to see the same people every day? Those are the things that people want to know. Those are the things I want to know.

The problems we've encountered, one is a data issue. The current staffing information is reported through this self-report, facility self-report system, OSCAR, online survey and cert. And that's what goes up on the nursing home compare website. It has really been shown to be not very accurate, particularly at low end staffing, which is where you're concerned. So that's one of the big problems.

We've actually done some studies recently where we've been studying how to use payroll data directly downloaded from facilities and standardized reporting. You can get many more measures from payroll data because you get shift measures, you can get staff mix measures, you can get turnover measures, you can get longevity measures. You can really get nice measures from payroll data.

And so that's really what we've been pushing. And that's going to require some standardized specification requirement for what payroll companies will have to submit, and some incentives to make sure they do submit that. But ultimately, that's the way to go. You don't have to audit it because they use it for payroll purposes.

And then you also need to handle the risk adjustment thing because, as you know, there's such a variability in nursing homes that staffing levels in one facility really aren't accurate for staffing levels in another.

But I think you're right. I think we need to go there and I think we need to go there really aggressively. And I think we need to make very strong recommendations. If it forces the payroll industry to comply, and nursing homes

to comply because of various incentives, you do that rather than have everybody filling out these forms.

DR. MILLER: I think there's also just a couple of other things to think about here, and we had something of this conversation when we were going through the prep for this.

I think there are some parts of your work that suggest it's not just staff counts. You did touch on this but I want to make sure that this gets drawn out. It's how much turnover, how much experience, what level of training. So you'd want to be real careful in moving to these kinds of measures. If you say I can meet the body count, that doesn't necessarily mean that you're actually getting the "staffing ratios" -- to put quotes around it -- that you're really looking for.

The other little problem here, or maybe it's a bigger problem, is once again the Medicare skilled nursing facility beneficiary sits inside the nursing home. And so the question becomes if the staffing is for that patient -- will the staffing actually be meeting the needs of that patient? Or is this more of a general measure for the nursing home?

Now I would argue there's probably some relationship there. But again, we're also trying to drive on getting measures that are fairly specific to this population. Which is not to rule out the staffing, but I think there's a couple of issues here beyond the data that also need to be thought through.

DR. SCANLON: I have comments in two areas. First of all, I thought this was an incredibly piece of work. I really enjoyed it. Particularly I think in terms of -- and this is the first area -- setting out, in some ways, elements of a framework for thinking about coming up with measures for either pay for performance or quality measurement. And I guess you touched on it, Andy, this issue of something where we don't have to worry as much about the reported data. These are two measures that are very hard to game because the people actually left the institution, as opposed to sending in something off of the record that no one has looked at to see whether or not it's accurate.

We may not have many circumstances like this where we have these kinds of measures available, but when we do we should think about can we exploit them.

The second thing, which you didn't talk about in your presentation but which is in the paper, is the issue of multiple measures and what do we get for multiple measures? This is in terms of the rehospitalizations by condition and the fact that you did statistical analysis and you looked to see is there independent variation or can we go to with a composite?

I think that's something that we need to pursue more, is the idea of statistical analysis to decide how much independent variation there is among all of these different variables and can we create composites?

You did a relatively simple composite. There is the issue that statistics sometimes can create very arcane composites, which are powerful from a statistical perspective but not necessarily from the understandable perspective.

Tomorrow there's going to be a discussion of composites and the idea of some of what goes on in the consumer world. If you think about it, the number of smiley faces or the number of stars, those, in some respects, are not very understandable either. It's not the number of stars for some very specific thing. It's somebody's

judgment about a whole array of factors. And this becomes the rating.

There is that issue of whether that actually is more valuable to a consumer, to have some kind of bottom-line judgment, even though it's much harder to get to the "details", aspirin after heart attacks.... that kind of thing.

We need to know whether we can mature, in terms of our confidence in data, our confidence in statistics and the ability to summarize things to get to that level because it may actually be more powerful in distinguishing the differences in terms of provider performance.

The last thing, I think, was the issue of the risk adjustment and the careful effort in that regard and how critical that is.

Having said that, and this is the second area, which is is this ready for prime time in terms of pay-for-performance? And even there I guess my concern is that as careful as you are, this is an area where risk adjustment is fraught with difficulty. I would raise the issue that the geographic variations in the patterns of post-acute care and in the availability of nursing home care and the

availability of assisted living complicates this story.

One of the things, if we're talking about pay for performance on a national level, is we need to be thinking about what kind of equity issues we're raising, given these underlying variations.

MR. BERTKO: I just wanted to again add something only on the technical topic of risk adjustment and comorbidities. In the larger Medicare world comorbidities, other studies have shown, have gone up dramatically in the last four or five years. And in the Medicare risk adjustment for payment purposes: the comorbidity studies, when updated, have had bigger effects and larger interaction terms.

So I was just nothing here, on one of your sites you talk about it. But comorbidities could depend on the baseline. When you set the coefficients, particularly in the time of rapid movement. Any comment that you had about how comfortable you are with the comorbidity adjustment might be useful, too.

DR. KRAMER: We were extremely concerned about this same issue of the comorbidities, in part because although the functional measures and other things drive

community discharge and some of these other things, clearly the major predictors in a lot of these hospitalization areas were the comorbidities.

We actually examined three different comorbidity indices quite extensively for this, the DAO, the Elixhauser I, and then the Dartmouth/Manitoba I. We actually worked with all three of them.

Whenever we do comorbidity analysis like those scales, we actually go back retrospectively six months for picking up ICD-9 codes and comorbid diagnosis. Because, as you know, the prior hospitalization may only have the ones people have thought of. They don't necessarily have the one from the hospitalization six months ago. And yet the person had diabetes six months ago. It's just nobody thought about writing it down this time around because it wasn't on the radar screen on this hospitalization, which lasted a day and a half. It's understandable. So we use that to go back.

We actually had rather -- I know Kathryn was concerned whether we were ever going to come up with our models and agree on what they were because we kept changing and relooking at our comorbidity scale. So we would lay them out in different ways, see how they interacted.

That's why, in addition to having comorbidity indices, we actually use selected diagnoses for each of the models, as well, because even though the comorbidity index would read one way, there were clearly selected conditions that would be associated with some of the individual conditions. And then we pooled them for the combined model.

That being said, I think that's an example of how much respect we have for the issues that you two have raised about risk adjustment and comorbidities. Whether that makes me ready to say we've sort of overcome any problem with it, I'm not sure I am ready to say that. But on the other hand, I look at the risk adjustment modeling that's being used and I think we're well ahead of a lot of what those models look like.

This pay-for-performance thing, it's discomforting when you figure you're going to tie these payments, these incentive payments, to these risk-adjusted rates. Because you really don't want to put facilities that are taking sicker patients at risk.

But I actually think, again, these measures are more robust and it's easier to risk adjust them than I think they've had with almost any of these other measures.

MS. HANSEN: Actually, a couple of the areas have been covered but I just wanted to underscore the element of the personnel factor, of the continuity of the personnel is such a major factor in terms of the care and the handoff, per se.

The other one has to do with I'm really pleased to see this whole aspect of the time frame because it relates to our whole sense of episode, of what happens to the individual rather than the discreteness of the three quality variables, per se. I would like to see how that potentially relates to some earlier work that we also have on the hospital side because the point of dumping back-and-forth that occurs.

Let's just take the decubitus issue that was raised before in acute episodes, because quality is measured there as well, too.

Is there a way to follow the person, other than the physical facility, say the skilled facility in the nursing home? Because it's oftentimes the one and the same patient. But if a system like this supports dumping it back and forth, the quality of care issue as well as the system issue really isn't addressed relative -- whether it's the

risk adjuster payment or whether it's the whole sense of appropriateness of just location for that care.

So that's one of the areas that I just wonder about, having it more person-focused and follow the claims on the individual, and then sorting out the facility issue because it's the same individual.

DR. KRAMER: I think that's very important. Let me comment briefly on both the points. The first one, on the retention or turnover. One of the biggest problems with the publicly reported quality measures from OSCAR, the staffing measures from OSCAR, is they don't have any information on turn over retention. One of the reasons they don't is, again, people estimate that in all different ways. The payroll data has allowed us to come up with various standardized and accurate measures of that.

I think you're right, the limited work we've been able to do in that field suggests that it's key.

The second issue, about linking the episodes, I think is absolutely key. A lot of these patients are your classic frequent fliers. They are in and out and they are in and out and to call the episode ending when they go to the hospital misses the full picture. We are doing some

other work where we're putting together patient histories and linking multiple episodes and not basing it purely on a single say.

Of course, you run into all of these issues about which provider now are you talking about and so on and so forth. But nevertheless, I think that needs to be done.

MS. HANSEN: I just want to emphasize the staffing part of it is hospitals are already feeling the shorting of getting qualified nurses. And nursing home facilities are kind of a lesser desired place to go. So you have even a volume and quality component of that.

Just as a point of information for many people who don't deal with nursing homes, the turnover rates for supportive staff are oftentimes 100 percent over the course of a year. So it really is an issue that has an impact on quality.

DR. KRAMER: And incidentally, the most recent work we've done on turnover suggests that it's not just CNAs that everybody publicizes where there's supposed to be high turnover. We found RN turnover rates equally as high as CNA turnover rates. This is highly skilled staff that are turning over nowadays. It's not just the CNAs that had 75

hours of training or something.

DR. MILSTEIN: First of all, relative to the last batch of measures we looked at, these do score a lot better on conventional measures of are measures good enough, clinically important, scientific validity and feasibility/usability. They score well across all of those.

But for measures to be good for pay-for-performance, it's relatively important that there be some significant differences, facility to facility, on these measures.

As I look at our 2004 numbers and look at the 100 day rates, if I interpret these correctly, I know I want the community discharge rate to be high and I want the rehospitalization rate to be low. So I'm looking at the 100 rate and I'm saying it looks like normative currently in the United States is about a two-to-one ratio, if I divide community discharge divided by rehospitalization rate because I want the high numerator, low denominator.

If that's my composite index, if the two-to-one ratio is average, order of magnitude, you've had a chance to look at these numbers, what do you think top decile or top

quintile performance would be? Would it would be 2.2 to one, four to one? In other words, how much better than average are the best of the facilities on these two measures?

DR. KRAMER: The community discharge, and we actually have another paper looking at some of that, it is actually extremely variable. I was actually pretty stunned. It's easily two-to-one on the upward side. You can go down very. very low. What's interesting is not only do you get -- there's a couple of other things about that that are interesting.

One thing is that there's an MDS item that says, that is about -- where you rate the patient on whether they're going to go home at the end of the stay. One of the things you find is in the facilities that have a very low community discharge rate, many of the people that they rated as likely to go home don't go home. And in the places that have a very high rate, many of the people they rated as maybe not being likely to go home actually go home. All of that stuff follows it.

The other thing you find is facilities that have a very high volume of rehab services have higher rates of

return to the community. Places that have very low volumes of rehab patients can actually have low rates.

We also did a validation study of community discharge with processes and there were certain key process variables related to therapy and discharge planning and care planning that were associated with likelihood to go home.

So I think there's a lot of things here. The rehospitalization one, again you can go up pretty high. One of the issues, we haven't look so much, is the composite. On the individual ones you get down into zeros pretty fast on some of them. Like the sepsis one, probably the 50th percentile is zero.

But again, we found they're pretty discriminating. You get pretty good variability on them.

DR. MILSTEIN: Am I interpreting these measures correctly, that we would aspire to facilities that were outstanding on both measures?

DR. KRAMER: Yes.

DR. MILSTEIN: So that the ratio would be, our ultimate -- if we needed to base a smiley face on a small number of things, you'd want the ratio and maybe some of the other structural measures that Mitra raised.

Also, can you remind me where we stand on patient experience measures? It seems to me on all levels of care on which we might think patient experience might be a very important variable, I would think nursing home would be one I would put right near the top. It's a prolonged stay and the humanity with which people feel treated is something that intuitively, it seems to me, would be very important because of that.

DR. KRAMER: I think that's a very important phrase. Let may point out a couple of things. There is this sort of nursing home CAHPS that's being discussed. I'm not that engaged in it.

There has been a long-standing tendency to avoid talking to residents and family in nursing homes when you're assessing quality. There's a large proportion of them that are cognitively impaired. So you have to take that with a grain of salt. But nevertheless. that hasn't been the focus of it.

We actually have been -- in a CMS initiative, we've been developing an alternative survey process. One of the things that goes on in that survey process is an extensive resident and family interviews. It's called the

quality indicator surveys and they're very structured interviews.

In fact, there's a cognitive assessment that you conduct first to test people's insight and try to capture those kinds of things and determine whether people are interviewable or not interviewable. And CMS, that was part of the nursing home initiative, as well. The General Accounting Office has been pushing that. It's a demonstration now in five states. It's a major undertaking to change the survey process.

I'm very hopeful, anyway, that that will see the light of day because it does require you to talk to residents and family.

DR. REISCHAUER: The discharge rates are adjusted; right?

DR. KRAMER: These are risk-adjusted rates; right. The unadjusted ones show up on that sixth slide, 28.8 for 30 days and 38.2 for 100 days. But those aren't facility means. Those are just if you took all SNF residents, what proportion of them go home in 100 days? The ones in this final slide --

DR. REISCHAUER: But I mean, for Arnie's measure,

you would want risk adjustment enumerator --

DR. KRAMER: Those are in the final slide where we actually have risk-adjusted facility mean rates, because that's really what you're looking at.

DR. SCANLON: Since it was the discharge to the community which was the one with the greater variance, that was actually where my concern was more because it includes discharge to assisted living which I think of as potentially the nursing home of the 21st century or the ICF of the 21st century.

So if it's possible, it would be nice to look at discharge to home instead of to the community, because I think that potentially is a more valid measure of the kind of rehabilitation that might go on.

DR. REISCHAUER: With or without home health.

DR. SCANLON: That's an issue. But I guess I'm concerned about this geographic equity. I think that the prevalence of assisted living as a substitute is different in different areas. You've got places like Minnesota, where they've had a moratorium on construction of nursing homes for 20-some years. So they've probably got a relatively healthy assisted living industry instead.

So people are going to be going there, as opposed to staying in a nursing home that would've been built over the last 20-year period.

DR. KRAMER: Since that distinction is not in the data, as to where they're discharged to, would you be comfortable -- or at least reassured to some degree -- if you adjusted for assisted-living beds, nursing home beds using a hierarchical model for some of those kinds of things?

DR. SCANLON: Right, or exploring some of the geographical differences, I think would be helpful in terms of reassuring.

MR. HACKBARTH: Andy, in talking about the increase in rehospitalization in the 2000 to 2004 period I think it was, you said one hypothesis was declining length of stay for inpatient hospital means tougher patients. But you said you didn't find that all that persuasive, given that during that time period the declines in acute patient stays were not that great.

You said another hypothesis was that this was when the SNF prospective payment system was really taking hold and, given its features shall we say, it may be creating a

strong incentive to send back to the hospital patients that require a lot of care, at least certain types of care. I want to just pursue that for a second.

I've had concerns about the very idea of laying side-by-side prospective payment systems for inpatient hospital and post-acute care because of the potential scene it creates and the incentives each way to sort of throw things over the wall to people on the other side. We often talk about silos. This seems to be a particularly egregious risky case for having payment silos.

I often wonder whether we're just barking up the wrong tree entirely in trying to have a SNF prospective payment system and really the only sensible way to think about this is bundling the acute with the post-acute SNF care.

Any thoughts on that?

DR. KRAMER: You know, I agree with your first point. I don't know how you win this battle you now have. Even that 1 percent decline in hospital stay, given that hospital stays are so short now, that 1 percent overall, I don't know what it means in terms of an individual hospital SNF relationship and whether somebody is really getting

there that much more unstable and with that much less information and so on.

So I am very curious about -- and that's one of the things we're going to look at here is places where there are longer lengths of stay relative to shorter legs of stay. Do those places have different rehospitalization rates? Some of that issue. So that side makes me very nervous.

You're very right, the PPS for SNFs, I think it's a set up for patient dumping back and forth.

You know, probably better than I, the sort of struggles over bundling. But I do think that ultimately some kind of a bundled system is going to be necessary to deal with this.

Part of the reason I say that is not just because of this work but some of the other work we're doing, for example, stroke rehabilitation. You know very well the SNF PPS was implemented when the rehab hospital PPS was implemented and the home health PPS was implemented.

One of the things we saw in our SNF study, which is post-PPS, it's an ASPE funded study -- is that the rate of multiple provider episodes has just gone off the charts. I mean, 90 percent of people that go to inpatient rehab

facilities have at least one or more providers, and many of them have two. They go to SNFs and then they go to home care and then they go to outpatient care. It's like this across the board. Of the SNF patients, two-thirds of them are going somewhere else subsequent.

The home health, the direct admits to home health, they're least likely go somewhere else. But they're the healthier bunch of patients.

So you're right, we have a system now where people are stepping down. Lengths of stays, we showed between 2003 and 2004, a two day drop in length of stay in inpatient rehabilitation hospitals in one year after implementation of the PPS for stroke patients.

I mean, we're cutting the stays smaller and smaller, taking full payments. I know you'll adjust those payments at some point because you'll say well it's less cost. But you're right, we're going to wrong direction on the post-acute care side. We really are fragmenting these.

Our offices, we have a couple of people doing a lot of work on care transitions. You not only introduce these extra costs, but you really introduce quality problems because medication lists get fouled up as you move people

very rapidly across these settings.

MR. HACKBARTH: Obviously people have talked about this at a conceptual level for a long time, and that is bundling these things together. One of the problems is political, is that you've got institutions with vested interests and their concerns about the one losing autonomy and power and money to others, who are given the money to manage, so to speak. All of that is very real and very difficult to deal with and I understand and sympathize.

On the other hand, when we talk about our big health care issues, we talk about how care is fragmented and we've got this atomistic approach to health care delivery in the U.S. and if we allow to drive payment policy as traditional institutional arrangements, we'll never get out of that. And so at some point payment policy needs to start driving institutional realignment and organizational change, as opposed to that becoming a barrier to sound payment policy.

The key, obviously, is to make the payment policy aligned with what is good care for patients. That needs to be the guiding principle, and not historical institutional frameworks. I think there are many examples of that in

Medicare. I don't think there's maybe a better one than post-acute care.

So that's my speech for today.

DR. MILLER: Can I say something right here? That was a really great set up for the fact that the next conversation that we're going to have, and I don't mean to move this along, but the next conversation is going to start with the hospitalization as the focal point for the episode and begin to examine resource use across multiple providers, including post-acute care. Quality obviously has to become part of it, too, but at least we're beginning to try and look at it from an analytical point of view. The policy problem that you've identified still exists.

DR. KRAMER: If I might add these, performance measures that we're talking about here, one of the nice things about them is even though the data systems have to evolve and so on and so forth in some of these other areas, these kind of performance measures can cut across post-acute settings. They're not depending on an MDS or an OASIS. These are the big things that you have to do after you discharge somebody. If they're acutely ill or post-acutely ill, you've got to keep them from going back into the

hospital. If you're trying to get them better, they're going to have to recovering and get home. It doesn't matter how many different settings you go through to do it.

And that's why they're compelling and that's why they're useful in those kinds of frameworks.

MR. HACKBARTH: This is an excellent terrific piece of work, Andy. Thank you very much.

Now we must move ahead to the next topic which, as Mark said, is episodes associated with inpatient admissions.

MS. MUTTI: This presentation describes our approach to and initial findings when creating relatively short episodes that are triggered by an inpatient hospital stay.

We have explored this possibility in the context of our work on measuring the relative efficiency of providers. And again the thought here is that if we can validly measure the relative efficiency of providers, we can design policies that will encourage that efficiency, align incentives. Examples of such policies might be public disclosure of performance, P4P, bonus payments, bundling of services. Many of these things have been touched on today.

We have sought to measure resource use in

particular here around episodes of care so that we can measure the longitudinal efficiency and identify the widely documented variation in service use by providers.

This work is intended to complement our other work that has looked at ETGs and MEGs, the two commercial episode groupers. Those groupers identify both short episodes and longer episodes. They capture chronic care episodes as well as acute care episodes. And they don't necessarily require an inpatient stay to trigger the episode. So those are all differences to the approach that we're going to talk about today.

Our hope here, though, is that by exploring multiple ways of defining episodes, each which has its advantages and disadvantages, that we'll help policymakers move closer toward thinking about measuring resource use, pairing it with quality measures and eventually enabling us to purchase much more efficiently and value-based.

As I mentioned, in this analysis the episodes are triggered by acute inpatient stays and they are limited in duration. These types of shorter episodes -- and in this analysis we've experimented with 15, 30, 60 day long episodes -- have certain advantages. They recognize that

many fee-for-service providers have little experience managing care over multiple sites and over time.

Combined with the fact that beneficiaries are free to go to any other providers in fee-for-service Medicare that they'd like, some providers may be uncomfortable being held accountable or being measured for their care over a long duration.

Another reason to focus on shorter episodes triggered by inpatient stays is that they capture the most costly Medicare covered services and many of the most costly Medicare beneficiaries. So if you're looking for an initial step, this one may be particularly cost-effective.

Additionally, because the hospital is central to these episodes, there is the potential for the hospital to pay the role of convener. Some researchers have identified this convener role as really integral to getting the behavior change that you're looking for.

As a convener, hospitals can help inform physicians about their variations in practice styles, enable discussions about evidence-based medicine and best practices across sites, and where they have a role in changes in the process of care, like some of the ones that we heard about

earlier today, investing in staff, and investing in IT, or other examples.

One of the key disadvantages of measuring care over these shorter episodes is that providers are only measured on their management of acute and post-acute care. Except in the case of readmissions, they are not measured or potentially rewarded for their ability to provide the good chronic care and preventive care that would have prevented the inpatient stay in the first place.

The longer the time frame, the more providers have the time and incentive to invest in the preventive care and realize the gains associated with the avoided admissions.

A related concern is that multiple episodes per beneficiary may dilute per episode spending, making certain providers look more resource conserving than they truly are. So to prevent this possibility, that is of rewarding physicians with the lot of episodes, we may need to pair measures of resource use during these shorter episodes with a measure of the number of episodes. This is consistent with those dimensions that we had talked about in the past where a third dimension is to look at the volume of episodes in addition to the spending per episode.

To begin to assess some of the implications of this approach, we created episodes using three years of data, 2001 to 2003 from a random sample of 5 percent of beneficiaries. We calculated standardized Medicare payments for each service. That is, we used national payment rates that neither reflect geographic adjustment for input prices or wages and they also don't include teaching or outlier payments. We included all services except hospice and durable medical equipment. This is the same data that we used for the physician resource use exercise.

We experimented with four types of episodes that vary in duration. The first type is the inpatient stay only. This includes Medicare spending for the inpatient stay, the DRG payment, as well as all physician services delivered during that stay. This also includes the multitude of short episodes as well as the less frequent very long episodes, the 50 or 60 day long stays.

The second type that we looked at was inpatient stay plus 15 days. Again, the duration of the episode varies depending on the length of the stay and then 15 days are added to it.

The third type was 30 days from the date of

admission. This window eliminates the variation in time and the episode length, which may be useful in examining how services may be substituted for one another and their implication on total episode costs.

Our last type that we looked at was 60 days after the date of admission. Here we hoped to capture more readmissions and post-acute care.

We looked at the data to understand the magnitude of spending measured by these episodes and the dynamics of varying their duration. For this stage of our examination we have not risk adjusted the data.

As expected, average spending increases as the episode grows longer. For our first type of episode, the inpatient stay only, the mean episode duration is 5.4 days. That mean spending for that episode is $6,776. The median spending is $4,807. We see the number of episodes for the year 2002 for that episode type is 515,209.

As you can see, looking down that column, the number of episodes shrinks as we get to the longer episodes types. And this makes sense because the longer the episode duration, the more care -- and particularly admissions and time -- are captured in a given episode, which in turn

permits fewer episodes.

Not surprisingly, the distribution of per episode spending is skewed. A minority of extremely high-cost episodes raises the mean of per episode spending above the median for each episode type.

DR. MILSTEIN: [Inaudible.]

MS. MUTTI: Right. Because the episode length is longer, it just permits fewer episodes in a defined period of time. Did that help?

DR. MILSTEIN: At the end of whatever arbitrary period there's still some episodes that are unfolding.

MS. MUTTI: Right, and we will also see that we will not count those if they have not completed. So in 2003 we'll have more episodes that we did not include because they were not complete.

DR. KANE: The inpatient stay is completed discharge plus 15 days -- [inaudible.]

MS. MUTTI: Right but that's only a factor for 2003 here. I think that that's kind of a sideline consideration. I don't know if you want a give it a try.

DR. MILLER: Go ahead.

MS. MUTTI: If you had the whole thing and you

were going to allow yourself to divide it into very small pieces, you could have the potential for many more small pieces, many more small episodes.

If we say an episode is 60 days long and it will only be triggered by an inpatient stay, there's just the opportunity for fewer episodes. Maybe this will help. Because more of those admissions will be considered readmissions.

DR. MILLER: Let me say it just a little bit differently. Your point about starting and ending episodes at the end of the year is well taken, but just to deal with that, I think, relatively quickly. These guys have put together three years of data. As we've tried out work through this, I think your results mostly focus on 2002. So we're sort of picking a year in the middle where we have the least problem with sort of end of the year problems or episodes being cut off or truncated.

Le's put that aside for one second.

I think this is the way to think about it. We had to talk about this a while internally too, but think about it this way: let's say you said I'm going to have an episode that is 15 days long, and then you get admitted on the 17th

day. That starts a second episode so you'll have two episodes.

Now somebody says let's make the episode 20 days long. That second episode disappears from the data because it's now counted in your -- exactly. That's really the key thing to keep in mind here. And that's why the number drives down as you expand the number of days.

DR. REISCHAUER: Why don't we want to add the second readmission to the first episode?

DR. MILLER: That is precisely what you're doing as you move up to 30 and 60 days.

DR. KANE: [Inaudible.]

DR. MILLER: You could do arithmetic like that. But if there's a readmissions that occurs, then that is counted in the episode.

MR. LISK: Just to clarify, the readmissions do not start a new episode, do not start an episode themselves. They are only counted as part of an episode that may have occurred if it happened in the window.

MR. BERTKO: But here's a problem when you contrast that with the way the commercial ones to it. You are blending together here readmissions for the same

diagnosis as opposed to a new admission because there was a hip fracture following an illness.

DR. MILLER: That is precisely right in and Anne was trying to lay out at the beginning. Now you have the episode groupers that we've been talking about prior to all of this that are conditioned based and they have certain characteristics and all the rest of it.

I think the underlying logic here -- and I'm using that word to say we're exploring here -- is the episode is a significant event. To the extent that you capture the services very close to that, a little further out, a lot further out, you're starting to get things that are probably related to the admission when they're close.

And then the $64,000 question is at 60 days, am I still catching stuff related to that admission? Or are we talking about something else?

So this is more of a data-driven episode where we have the clinical driven episodes kind of working in that separate project that you've seen those results, as well. So we're trying to run both of these tracks is what we're doing.

MS. MUTTI: I meant to mention that earlier.

DR. MILLER: You did.

MS. MUTTI: Another important consideration is the magnitude of Medicare spending that has captured by measuring these types of episodes. We found that it was fairly a large percentage. Our shortest episode type captured 39 percent of Medicare spending, and our longest episode type, the 60 day long episode, captured or measured 53 percent of Medicare spending.

We also looked at how episodes in which a beneficiary died compared to episodes in which the beneficiary survived. And while far less common than survivor episodes, the decedent episodes are quite a bit more costly.

As you can see for the inpatient stay only episode, average spending for decedent episodes was $10,793, which is about 64 percent higher than the $6,572 for survivor episodes. Accordingly, they account for 4.8 percent of episodes but a higher percentage of episode spending, 7.7 percent.

A key question for policymakers is what portion of providers are involved in a sufficient number of episodes to allow valid measurement? We have only preliminary data on

this question at the moment, but our one indicator is our examination of the percent of hospitals with at least 25, 50 or 75 episodes in our sample. Looking at all acute care hospitals -- and this includes the smallest of the small, as well as the very largest -- we found that the majority had more than 75 episodes across a three-year period. And perhaps another helpful statistic is one example is 86 percent of hospitals have more than 25 inpatient stay plus 15 day episodes and 66 percent have more than 75.

Obviously a larger sample will increase these percentages, and we'll be coming back to you in the future with a more refined analysis so you'll have a better sense of what to conclude on this.

Commissioners have expressed interest in focusing on the most common or the most costly conditions as a place to start in measuring resource use. So we have illustrated the implications of selecting the 20 most frequent DRGs. We found that just these DRGs accounted for a substantial portion of Medicare spending, ranging from 15 percent for our shortest episode length to 22.3 percent for the 60 day episodes.

So by limiting the focus to these, we account for

just less than half the spending that we captured when looking at all DRGs. So just to make sure we're all clear on this, under the 60 day window we capture here 22.3 percent of spending, looking at the top 20 DRGs. In contrast, if we looked at all DRGs, we would've captured 53 percent of spending.

We also found that a majority of acute care hospitals had at least 25 episodes over our three-year window in each of our episode types. On the last slide I highlighted the implications for our inpatient stay plus 15 day episode in my example. There I said in looking at all DRGs, 86 percent of hospitals had 25 stays. Here it is somewhat lower at 76 percent.

This slide gives you a sense of what services are captured in the episodes and the amount of their spending compared to the rest of the episode. As you would expect, the initial stay is the largest part of episode spending. For episodes defined by the inpatient stay only, the portion of spending for the initial stay is 88.5 percent. The remainder is comprised of physician spending. That's in the yellow there.

As the episode length extends, a greater

proportion of spending in the episode is for readmissions and for other types of services, including post-acute care. Readmissions grow from 7.1 percent of episode spending in episodes that include the stay plus 15 days, to 14.3 percent for the 60 day episodes.

And lastly, we have taken a look at what percentage of Medicare spending for each service is captured in these episodes. So on this slide we show you the 30 day episode, as an example.

By definition, the vast majority of Medicare inpatient spending is measured. We defined this as episodes triggered by an inpatient stay. A large portion of spending for SNF inpatient rehabilitation facilities and long-term care hospitals is also captured in these episodes. A substantial portion for physician and home health spending is also picked up. It's just less than a fifth for each. Outpatient hospital services, which include ASCs, are the least likely service to be captured in this approach.

Of course, these percentages increase when we look at the 60 day stay and they decrease when we look at the shorter episode lengths.

The dotted vertical line there shows that across

all services this type of episode accounts for 47 percent of all Medicare spending and that it is consistent with an earlier slide.

Our immediate next steps in this analysis are to risk adjust the episodes and calculate per hospital average spending for each of these episode types, examine the degree of variation is spending for hospital and MSA, and examine spending patterns by episode type, medical versus surgical care, and by hospital characteristics.

But for the moment we are looking for your input on this research design and we're certainly not asking you to pick one of the options we've outlined here. In fact, we would like you to comment on whether these are the ones that most interest you.

I should also note that the collectively we that I've used through this presentation also includes Craig, Jack Ashby, and Sharon Cheng also.

MR. BERTKO: I want to be helpfully critical, perhaps, because I know the amount of work that goes into this.

My first question is one which would be what's the unit of observation? On the surface of it, it would seem to

be that you're looking at hospitals that had an admission. I can think of another one almost immediately, which would be hospital and its affiliated, even if inferred, physician systems, so a PHO, physician hospital system.

In that case, then I worry a lot about risk adjustment, which I just see you're getting to, because in some ways I could see some of the most efficient physicians might be successfully treating people and keeping them out of hospital, but when they get a hospital stay it's a very sick person. So the resource use for that very sick person would be quite high.

By missing the front end of that, which if I'm interpreting you right, the beginning of every episode is a hospital admission. So you may be missing a bunch of stuff out here and thus piling folks up differently.

So I guess I would look to you to maybe think about that unit of observation in terms of trying to rate it, and the whole thing again about implying physicians to a hospital, particularly in a lot of multi--- let's see, MSAs or cities with multiple hospital systems with multiple admitting privileges, could be actually quite difficult.

I'll throw that out as a conundrum and then maybe

Arnie, if you have any comments, if you've thought about that.

I caught him off guard for once. Arnie's speechless.

DR. MILLER: Yes, but you didn't catch me off guard. I'll cover for you, Arnie. Get your thoughts together.

You raise a very good point. And another place that you should keep in mind that this issue will be brought on point is as part of the mandated SGR report. Cristina is kind of riding shotgun on this. We're going to be bringing work in front of you that looks at the hospital and the related physicians as the unit and begins to start thinking about that. So there'll be a process there to discuss that.

But we can also think about how to tool this project in that direction and address those questions.

DR. BORMAN: Just related to what was just brought out, how difficult would it be if this is the trigger to then go back 30 days forward from the inpatient trigger? And then there's a lot better statisticians and analysts here than me, including you. But in looking at your chart about the percent capture spending with the different

models, there's something of an implication that the inpatient plus 15 and the 30 day total come pretty close to measuring the same numbers. And whether or not there's utility to continuing to pursue both those models, as opposed to taking your time and effort and you maybe adding the 30 days in advance, or whatever.

Because my guess is the reason for that is that the inpatient plus 15, that if the inpatient stay is 15 or less it's going to come pretty close to meeting your 30 days post-admission. Those two groups seem to be measuring a lot of the same thing. And whether or not those are worthwhile keeping as separate models, I don't know.

Maybe that's just a naive question based on how the numbers present.

Another question would be as you're looking at other data, is there the opportunity, for example, to take some of these same -- you've look at this in a Medicare 5 percent sample. Could you look at this in the VA system for similar conditions?

And the reason I ask that is number one they have more likelihood to have an integrated system. That is, that they're inpatient, outpatient, SNF, whatever care, is more

likely to be captured within a single system.

Number two, it's a highly geriatric base population, perhaps not quite the same. And it's one in which, at least in theory, there are fewer incentives to initiate separate episodes or to increase resource use, other than potentially say that my hospital works harder and gets a bigger share from the VISN. But on an individual level there's less incentive.

There might be value in being able to look at some of those things from a database that presumably should be one that could be gotten to.

DR. SCANLON: I would say it would be valuable if we could identify that the person got all of their care from the VA because these people very often are going to be Medicare eligible, as well. So there's that pattern of people using some Medicare services of some VA services.

DR. BORMAN: They would most likely stay in one system as opposed to --

DR. SCANLON: VA has a constraint, a supply constraint. So there's the issue of waiting and closeness to home, et cetera. And so, depending upon those circumstances in the particular VISN that they're in, there

could be very different patterns.

MS. MUTTI: We can think about adding the 15 days beforehand or a time period before hand. That is something we can give some thought to. It should be possible.

I just want to clarify, and maybe I'm misunderstanding your point a little bit on the difference between the two types of episodes. The first one is just the inpatient stay only. So this chart is showing for that episode, what's the portion of services that are comprising it? It makes sense that the inpatient stay, and then it would only be the physician services that were delivered in that stay. The 15 day one then allows us to look -- all right, that episode includes the post-acute care also delivered, and physician visits outside the hospital. What is that distribution?

DR. BORMAN: I'm not asking between those two. I'm asking between the inpatient plus 15 versus the 30 total.

MS. MUTTI: I'm sorry.

DR. BORMAN: Those two seem to be relatively measuring a lot of the same things. They're not 100 percent overlap, but they measure a lot of the same things. And

maybe you don't need one of the two of those, freeing you up time to look in other ones.

DR. MILSTEIN: I don't have a good answer to John's question. And it really is more of an intuitive suggestion, and I can't really pull it together in a way that is as coherent as I wish it were.

But it seems to me that one of the considerations in selecting the ideal length of episode around which to create measures and incentives is -- it would be helpful to consider, for our beneficiaries, what is the average patient recovery trajectory? So that we could begin to, as one of the things that we might consider, identify the average length of time post-hospital admission where the average functional recovery curve begins to flatten.

I'm trying to think of what are the different variables we might want to take into consideration in deciding. And that, it seems to me, would be one of them. If we knew that the vast majority of beneficiaries, by day 50 under average care, are really at the flat of the curve in terms of level of functional recovery, that to me would be a factor I might want to -- one of the factors, not the only factor -- I would want to consider in selecting an

optimal post-admission duration.

DR. REISCHAUER: But it would differ for each DRG and for each severity category too, probably.

DR. MILSTEIN: Yes.

DR. CROSSON: Just a small comment, but then there's a question related to it. As Mark said, we're now going to be looking at two different kinds of episodes and they're conceptually different. It struck me as I was reading this before that using the term triggered in this sense has different meanings to people. In the sense it's used here, as I understand it, means triggered analytically; right?

DR. REISCHAUER: Not associated with the 8.4 percent that died.

DR. CROSSON: But in health care we often use triggered to mean causality. So just for clarity, as we starting putting together documents, it might be better to use a different term, like defined by an initial hospitalization, or something like that.

But that then was also related to the question, and you alluded to it, but are we going to have a sense after time across at least the three or if we go to two on

the right there, what actually is the percentage of the care that is in some way rationally related to one medical condition versus a collection of very different things? Because that will then sort of play very differently, I think, in the end with issues around attribution and things like that.

MS. MUTTI: I'm trying to follow you.

DR. CROSSON: If you take the 60 days one after admission, I assume we're going to get, at some point, some information to suggest that on average this way of categorizing episodes, 75 percent of the time is characterizing an episode that in some sense of clinical logic would be consistently related to one medical condition or associated medical conditions, as opposed to only a third of the time because it actually collects a whole lot of different things, automobile accidents and heart attacks and things like that.

I would imagine that the number would be maybe 85 percent or something, but it would be interesting to know what that was.

MS. MUTTI: If you did basically apply a clinical logic to this, so that we could be sure that all the care in

that window related to that underlying condition.

DR. CROSSON: It won't be but just to know what the level of confidence or validity is.

MS. MUTTI: Right. We can look into that, too.

DR. MILLER: I would suspect that our ability to do it, particularly in this dataset which is different than the other work that we're doing, is somewhat more patchy. So for example if, in the 30 day episode there's two hospital admissions, you can probably go in and check the diagnosis codes for the two hospitalizations and start to see whether they are at least in the same neighborhood.

But for the other types of care you can, in some instances, go and look at the kinds of codes that are put on the claims that come with it. But it may get much more variable in terms of being able to say -- to draw up rules and say I think this is related, this is not related. Because you really won't have a medical record type of detail that you would want.

So it will be, I think, somewhat approximate. That's a nice word.

DR. KANE: I'm still trying to understand what we're going to do with it. And I think it's not just

condition but it's also somehow linking together providers who may be totally unrelated to each other. People get moved around from one facility to the next by discharge planners who make that transfer and have nothing more to do with the patient. So you may have two or three different managements in charge or physicians in charge.

I guess I'm just having trouble getting a sense of how you create a locus of responsibility when you start moving outside of the institution.

And then I guess I promised myself I would always bring up the fact that you need the pharmaceutical information in here, as well. I just didn't want to forget that. But I think where's the responsibility here for these kind of artificially created episodes?

MS. MUTTI: I'll start and I see that John has something to say, too. We have focused here on this idea of how to define the episode, because that's because we felt this is a really critical underlying question.

But assuming that we can define this right, the idea here was -- and we've talked about this a little bit before -- that if you can actually make people more cognizant of their partners and the continuum of care that

beneficiaries have and it is their responsibility, that they have a substantial role in caring for that patient. If we can encourage them to take greater responsibility for the continuum of care, then we can get some of the results that we're striving for.

I'm not sure what kind of policies you might design around this, but you could either hold the hospital accountable for that episode of care, and that would encourage the hospital to think about who it partners with and how it trains its discharge planners, please consider home health if that is appropriate, think about your lower cost alternatives. It may make them look toward working a little bit more with their SNFs and encouraging their physicians to try and limit the readmissions that you might see to the hospitals.

The hospital scores will look better and they may have a role in that.

Alternatively, you could hold more than just the hospitals responsible for this episode. You could have multiple players held accountable for this episode, and I think we've touched on this in the past. It could be the hospitals as well as the medical staff. It could be the

SNF, also, so that they collectively have the incentives to work together to make the overall performance across the whole episode more efficient.

They would have to think about their partners. They would probably need more information about who their partners were and how effective and what kind of quality they were delivering and what kind of resources they were using so that they could make some better decisions. I think this is kind of consistent with some of the change that we've been talking about today.

MR. BERTKO: Just to continue what Anne was saying, in a commercial universe where Arnie and I are going with some of ours is to say what should we pay hospitals that are more efficient? I should be willing to pay a higher unit cost per day or per admission to those hospitals that do a better job widely spoken.

In our context here, we've got DRGs which are focusing strictly on inpatient stuff with a little bit of outpatient. Here's where I could see the P4P, along the lines of the presentation from the guy from Virginia Mason, and saying if we're going to spend some extra money here, where should we do it? And in fact, it's for that topic I

brought up.

Again, with all respect to what Jay's and group practices are trying to do, I'd like to get something done in Texas and Wisconsin and a variety of other places where the docs work by the twos.

DR. CROSSON: Not Wisconsin.

MR. BERTKO: There's only a couple parts of Wisconsin.

DR. CROSSON: Every single county in Wisconsin has a large group practice presence in it.

MR. BERTKO: And then there's a bunch of docs who don't belong to it.

DR. REISCHAUER: I'm actually with Nancy on this. I think we've transferred the use of the term episode inappropriately. Because episode in the groupers had a relationship to a condition. And episode now means a length of time, no matter what's going on during that time. Efficiency relates to how well the accountable parties deal with something.

And what Nancy was pointing out is there could be several somethings going on. I have a heart attack, go into the hospital and my episode starts. But I had a broken

ankle before, or something like that, and I'm still going to somebody for that. So those costs are suddenly lumped in with this episode and we're mistakenly saying this isn't a very efficient provider.

We're making an assumption that these expenditures relate to this condition. Most of the time it will, but some of the times won't. And that might be what distinguishes two hospitals.

MS. MUTTI: Absolutely. I guess I failed to mention one of the caveats here is that we knew we took some shortcuts in this analysis. We didn't have the clinical logic underneath. But it is something that we thought that would be necessary to add on before you would ever implement such a thing.

But for us to do this in-house, to look to the data and start exploring the idea of -- it's a baby step in the episode world. We thought that it was -- for expediency, we decided okay we're going to fudge this a little bit. We're not sure that every readmission is related, every service is related to the initial condition. But we wanted to start at least bringing to you this idea that it would be possible. I think that there are vendors

out there that have products that could be overlaid, that the logic could be overlaid on this.

But we wanted to start getting a sense of okay, if you took a baby step like this in episode creation, what kind of impact could you hope to have in terms of capturing Medicare spending? If people were more comfortable starting with a shorter episode, a very defined episode, it's a little bit similar to the Centers of Excellence kind of approach. If people wanted to start somewhere along those lines, let us give you a little sense of the scope of what it could cover.

But by all means, we knew that we didn't have the clinical logic and that it wouldn't be appropriate to do it without it probably.

DR. REISCHAUER: By definition you're capturing all of the Medicare spending for those individuals who go into the hospital. And what you've told me here is most medical expenditures are by those people who go into the hospital. You know, I knew that already, from long study.

DR. MILLER: I don't think I would back off as far as you just did, Anne. I think a couple of things here.

We just had this conversation. Glenn just made a

whole set of comments about post-acute care and related to the hospital and we have this fragmented system. A different way to take your comment is you're right, 60 day episodes we're probably getting out there. But 15 days around the episode? Or maybe you come back off of that.

In your example, Nancy, you said the discharge planner just hands this person off and they don't think about them anymore. That's the point. I think we're trying to begin to bring the data together. We know that when that discharge planner hands off the patient to the hospital, at least that's related to the hospitalization. And I guess some of the conversation we could have here is about well maybe we need to keep these episodes relatively short.

Because I think the closer you are to the episode the stronger the argument is that the care is related to that episode.

I agree that when you get further out you really start to implicate this issue. And I think that's part of the way I would respond to this.

DR. REISCHAUER: Can you marry this or compare this with the commercial groupers? For these DRGs -- I mean, this is a very fast and easy way to do something. If

you found out that there was a correlation of 0.98 between the two, then you could drive them all out of business.

DR. KANE: Can you just take the physician project and say let's take a subset of them, anybody who had an inpatient admission. That makes sense.

MR. BERTKO: You could resort those. It's technically possible. I don't know how difficult it would be based on what you're doing, to do just that and then maybe do that correlation.

MS. MUTTI: We thought about doing this. It was just a resource constraint. We were still coming up to speed on using the groupers, and to ask it to do two projects at one time seemed like a lot so we thought we'd get started with this.

But we could look at that, certainly.

MS. CHENG: [off microphone.] There's one more issue with the groupers that the team did spend a little bit of time thinking about. For some of these services, especially for the SNF and the long-term care hospitals, Medicare is the primary user of the settings. The groupers that we have that we're been working with extensively are generally for a commercial population.

So we do have a little bit of an advantage here in that at least when we do it this way we're going to capture what Medicare actually uses. We might see some [inaudible] in our population that the grouper wouldn't see as well because it's not set up particularly well to capture the kind of services that we're very interested in doing. So there's always going to be a little bit of tension.

MR. HACKBARTH: If possible, I'd like to steal a few minutes here and move ahead to our next topic since we're well behind schedule. Good job, Anne and Craig

Next up is IME and DSH payments.

Jack and Craig, before you start, let me just set the stage on this. And if I'm stepping on your lines and taking things from your presentation, I apologize. I just wanted to talk about the history here because this is an issue that we've taken up in the past with some controversy.

We last discussed Medicare payment for indirect medical education two or three years ago. At that point we considered a draft recommendation offered by me to cut payments for indirect medical education, specifically to cut the amount above the so-called empirical amount, that is the amount that is analytically tied to the actual expenses

associated with medical education.

That draft recommendation was defeated, rejected, on a nine to eight vote.

We spent a lot of time on the issue, and what the time did uncover was a consensus among commissioners, the commissioners at that time, that although people weren't prepared to cut the payment, not all was well in the world of payment for medical education.

And although we didn't take a vote on it, per se, I know from both the public discussion and individual discussions with each of the commissioners, that there was a very broad consensus that there was a problem in how we were paying for medical education, a problem specifically with the IME adjustment.

The problem was, and we articulated this in our report, we were paying a lot of money without any assurance that we were achieving specific Medicare policy goals with that investment. And that, especially in these times of growing fiscal challenges in general and for Medicare in particular, that was something that we ought to look at correcting.

So we talked conceptually about a number of ways

that might be done. And one, as an illustration, hardly something that we were prepared to embrace, but as an illustration, one might say well, we ought to take this increment above the empirically justified amount and tie it to a specific policy goal like uncompensated care. And we talked about that in the abstract and identified both some positive potential there, but also some potential problems with doing that, and said that well, we would come back to this issue once we had information on uncompensated care so that we could talk not in the abstract about that potential policy but actually have some data.

Consistent with that, the Congress mandated the collection of data on uncompensated care from hospitals.

Now fast forward to the present. An effort was made to collect those data, but the data really are rife with problems and pretty much unusable from a policy perspective.

So here we are several years later, and we've not got the data that we would like to have to advance the issue the way we discussed it several years ago.

So the question becomes well, if we don't have the data, why talk about it? And that's the thing I wanted to

address at the front end. Believe me, given how difficult this was last time, this isn't something I really was running up excited and eager to do. But there are two reasons I think it is important to take it up.

One is interest from our principal customer, the Congress. I wouldn't characterize it as a clamoring, but we've had specific inquiries about this issue and requests for us to look at it again from both the House and the Senate.

The second reason for my thinking that it's time to take a look at it again will be evident as we go through the presentation. I won't go into detail, but it seems to me that there is a reason to be concerned that there's a growing equity problem here, namely a growing disparity in financial performance under Medicare between teaching hospitals and non-teaching hospitals. And that disparity is getting bigger over time.

So for those two reasons we are back again, two or three years later, talking about indirect medical education.

DSH has a little bit separate history but many of the same issues arise there.

So with that preface, Jack, do you want to take it

from there?

MR. ASHBY: Glenn has covered some of our presentation and we'll shorten up in spots, as a result.

This session does launch a project to consider whether changes are needed in the IME and DSH adjustments. These adjustments, both of which are structured as percentage add-ons to base rates, have played a major role in distributing payments in the acute PPS over the last two decades, as we're going to show in a moment.

Unlike any of Medicare's other PPS also, the acute inpatient PPS has separate base rates for operating and capital costs. We're going to address capital costs in this project, as well, because the DSH and IME adjustments are both applied to capital, and also because capital has yet a third adjustment and that is a payment add-on for hospitals in large urban areas.

And then finally, we're going to address outlier payments. The central question here is a little different. It's whether changes in outlier payment policy would be needed under MedPAC's proposals to refine Medicare's DRGs and DRG relative weights.

So we'll begin by providing some descriptive

information on the IME, DSH and capital payments, how each has evolved and how they work today and so forth, starting with IME.

MR. LISK: To make clear from the start, Medicare does provide two payments to teaching hospitals. We want to make sure that's understood. There's the indirect medical education adjustment, which Glenn went over, which covers higher patient care costs associated with teaching activities in the hospital but not the cost of the residents themselves. That's reimbursed under the direct graduate medical education payment system. That's not going to be our focus. Direct GME is not going to be the focus of our discussion here. That's separate and that's a separate payment provided by Medicare.

To give you a little history, first of all, IME payments totaled about $5.5 billion in 2004. The IME adjustment was established in 1983 at the beginning of the inpatient prospective payment system. The IME adjustment was put in place because analysis showed teaching hospitals to have higher costs than other hospitals, higher patient costs than other hospitals. That's after removing direct GME expenses.

However, when the financial impacts of the original system were being studied and what was the "empirical level" at that point in time, they found that teaching hospitals weren't going to perform very well under the new payment system. So Congress doubled the adjustment. And that doubling was a quick and easy way for Congress to deal with this problem in terms of the system. So that's what was happening.

It's also important note though that, in doubling the adjustment, the doubling was done through reducing the base rates. It was funded from the rest of the payment system. So it wasn't added money to the system, it was money taken out of other hospitals.

Another important point about the current IME adjustment is when the BBA went into place, the resident numbers and the resident-to-bed ratio that's used was capped, although there are some exceptions to that. But at the same time, the IME payments started to be made for Medicare Advantage patients.

This next showing slide shows the history of the IME adjustment over time. When the system first went into place the adjustment was very high, at 11.6 percent. It

then dropped down to 8.1 percent when the DSH adjustment was put into place. When some further expansions of DSH were put into place again in 1989, I think, the adjustment dropped again down to 7.7 percent, where it stayed for a long time. And then with BBA some reductions took place.

Today, in 2006, the adjustment is about 5.5 percent for every 10 percent increment in resident-to-bed ratio.

If you're interested in what the exact formulas are for IME for inpatient operating, in the very back of your paper the formulas are actually there. They're different for operating and capital payments.

In 1988 Medicare paid about $1.8 billion in IME payments to hospitals and, as we already said, in 2004 they totaled $5.5 billion. This is more than $60,000 per resident that Medicare supports.

The Commission has also conducted empirical analysis of the IME adjustment. Our most recent estimate, based on 1999 data, which was part of our 2003 March report, showed that teaching hospitals costs increased about 2.7 percent for 0.1 increase in the resident-to-bed ratio. Thus, the current adjustment is about double what the

empirical level is, based on this earlier analysis.

Our estimates of the empirical analysis as we've done at ProPAC and at MedPAC before, our estimates of the empirical level have come down over time. And we will be coming back to you at the next meeting with some new estimates based on 2004 data on the empirical level.

This next graph just shows you for information purposes how the adjustment changes with increases in the resident-to-bed ratio. The top line is a current adjustment and the bottom-line is what the adjustment would be if set at the empirical level using 1999 data.

For example, just to give you an example, a hospital with an IRB of 0.1 gets an add-on of a little more than 5 percent. A hospital with an IRB of 0.5 would get an add-on of a little more than 24 percent.

This next slide goes over the conclusions that the Commission made in 2003. I'm not going to review them because Glenn did a very good job of going over that. And so we'll going to go on to DSH and then we'll come back to with some other data after that.

MR. ASHBY: Turning to the DSH adjustment, the adjustment was implemented in 1986, two years after PPS

began, and payments now total $7.7 million as of 2004. The add-ons are determined by formula, and each hospital's low-income patient share. That low-income patient share is the sum of two ratios: Medicaid patient days as a percentage of total patient days and patient days for low-income Medicare patients, those eligible for the SSI program, as a percent of Medicare days.

You'll notice that these two ratios have different denominators. One of the implications of that is that a hospital can actually have a low-income share that exceeds 100 percent.

The original justification for the DSH adjustment was to compensate for the cost increasing effect of treating low income patients. The initial regression, done when it was first implemented, showed that that effect on cost was small and it was concentrated among large hospitals located in urban areas.

So the original adjustment was predicated on those results and in aggregate provided only a 1.9 percent add-on to base payments, as we see in this next slide.

But over the last decade many observers have argued that the adjustment subsidizes indigent care provided

to the uninsured and underinsured. And largely on that kind of rationale, Congress has expanded eligibility for the program and the adjustment rates several times.

In addition, the courts have expanded the count of Medicaid days that go into calculating low income shares. Just one example is that days paid for under 1115 waivers are now counted. They once were not.

As a result of these two phenomenon, DSH payments as a percentage of base payments have grown fivefold, from 1.9 percent in 1987 to 9.9 percent in 2004. There have been two legislative increases just since 2000 and both of these were geared towards improving DSH payments for rural hospitals.

This next chart shows the distribution formula for the operating DSH adjustment, which is actually three formulas. We have one for urban hospitals with more than 100 beds, that's represented by the solid line; one for smaller urban and most rural hospitals, that's represented by the dotted line. The key feature here is a cap of 12 percent on the maximum add-on that can be obtained. And then we have a special adjustment of 35 percent, which only goes to a handful of hospitals, shown by the green dots

here. That adjustment is targeted to public hospitals that receive substantial subsidies from a state or local government, which is viewed as a proxy for providing substantial amounts of uncompensated care.

One other thing to note about the distribution approach here, and that is that there is a 15 percent threshold. In both of the primary formulas, only hospitals with low-income shares above 15 percent receive any adjustment at all.

Again, if you're interested in more detail, the complete formulas are in the back of your handout.

The formulas for the capital DSH adjustment are quite different. Just to summarize quite briefly, the add-ons are a lot smaller. They are restricted only to urban hospitals with more than 100 beds. Rural hospitals don't get anything on the capital side. The 15 percent threshold does not apply, which is kind of a curious aspect of it, in some sense, because that leaves several hundred hospitals getting only a DSH adjustment on the capital payments, which is really tiny, in the neighborhood of 0.1 or 0.2 percent of their inpatient payments.

Now we're going to turn to capital payments. A

little background on this. Capital was initially paid as a pass through up until the capital PPS was implemented in 1992, with a 10 year transition. But payments were almost immediately thought to be too high, in part because of a curious practice at the time of basing the update to capital payments on the growth in capital costs rather than the growth in a market basket, representing prices. So Congress made two cuts, the second one in the BBA, totaling 22 percent.

One other unique thing about capital payments is that CMS, rather than Congress, sets the update each year. CMS now does have a special capital market basket to guide those decisions.

Once capital payments became fully perspective in 2002 there was no longer any need for separate operating and capital base rates. The only reason we still have the two separate base rates is because the distribution formulas for IME and DSH are different on the capital side, and then also because there is this third adjustment. And that is that on the capital side hospitals in large urban areas get a 3 percent add-on to their payments. That policy was suggested by a regression back in 1991 that showed a cost difference

associated with large urban locations.

One other thing to note about capital payments, for sort of perspective, and that is that because it's a fully prospective system now hospitals' capital payments are not affected in any way by how much they spend on construction and equipment. And conversely, hospitals are not required to use their capital payments to purchase capital items.

MR. LISK: So how much do we spend on IME, DSH and GME, as we show these in this overhead here for operating capital and Medicare Advantage program. But we see combined, IME and DSH combine to totaled about $13 billion in fiscal year 2004 or about 14 percent of Medicare PPS payments were distributed through these two adjustments, a substantial portion of those payments.

Teaching hospitals also received an additional $2.6 billion in Medicare direct GME payments.

And also just to note on this aspect, nursing allied health programs is an additional $2 billion distributed hospitals for this.

This next slide shows the proportion of hospitals receiving IME and DSH payments. As you can see, many more

hospitals receive DSH payments than IME payments, 75 percent receive some DSH payments whereas 30 percent receive some IME payments. Almost a quarter of hospitals receive both.

Now both urban and rural hospitals, a substantial proportion of both urban and rural hospitals receive DSH payments. But IME is, of course, concentrated where residency training takes place and that's an urban hospitals. So only 7 percent of the payments are to rural hospitals for IME.

What you also can see here though is that over 90 percent of major teaching hospitals also received DSH payments. Major teaching hospitals are those with 25 or more beds. I think -- 7 percent of rural hospitals receive IME payments. I said -- never mind.

In this next chart we show the destination of IME and DSH payments and add-ons as a share of base payments. What we see is that hospitals can have some fairly large payment add-ons for these adjustments. 10 percent of hospitals receiving just IME payments haven't an add-on of 13 percent or more. That's the 90th percentile there. 10 percent of hospitals receiving just DSH adjustment receive a payment add-on of 18 percent or more.

But add-ons go to that quarter of hospitals that receive both IME and DSH payments. Over half of this group receiving adjustments add-on of 19 percent or more and 10 percent receive an adjustment of 52 percent or more added to their base rates. That's about 2.5 percent of all PPS hospitals. This can result in substantial difference in payments between hospitals in the same market, one that has no DSH and IME payments. For instance for a stroke patient, if they are in a wage index area of one, would receive about 6,400 for that patient whereas a hospital at that 90th percentile in that group receiving both of those payments would receive about $3,300 more for the same case.

Another point we'd like to make is that these payments are highly concentrated. 200 teaching hospitals out of 3,500 hospitals total account for 68 percent of the IME payments. They receive 68 percent of the IME payments. Similarly, the top 200 DSH hospitals out of 3,500 hospitals receive 38 percent of DSH payments. Finally, of the $13 billion in total DSH and IME payments made in 2004, 45 percent of these payments go to just 200 hospitals, an average of almost $30 million per hospital.

MR. ASHBY: Turning to our inpatient margin data,

we can readily see the substantial role that IME and DSH payments play in determining hospitals financial performance under Medicare. Major teaching hospitals have by far the best performance. But you'll notice that the high margins, over 12 percent, are limited to those that are getting both IME and DSH. Those getting IME only have a margin about 2.3 percent. Many of those are getting quite small adjustments.

The other teaching hospital group is below average as a group. But again, those getting both IME and DSH are faring considerably better than those that get IME only.

Among non-teaching hospitals we see that just under one-fifth of all hospitals that get neither IME or DSH have margins that are averaging below minus 14 percent. So there's quite a range that can be linked to these payment adjustments.

The next chart shows the distribution of inpatient margins. You'll notice here that the group receiving both IME and DSH has substantially higher margins than the group receiving neither at every point along the distribution. And then, at the top of the distribution, we have some strikingly high margins here, 30 percent and above in the group receiving both adjustments as well as the group

receiving DSH only.

Next we turn to the policy questions for the Commission to consider as this project progresses this fall. For IME and DSH, in light of the large and growing gap in financial performance between those that do and do not receive the adjustments, the question is are the current levels of the IME and DSH adjustments justified? If not, we might think in terms of returning any savings from reducing the adjustments to the base rates so that the overall effect of the change will be an improvement in the equity of payments among all hospitals.

Our first step in addressing this question, as Craig mentioned, will be to establish the relationship between Medicare costs and both the teaching activity and treating low-income patients.

Then I was next going to cover that uncompensated care issue. Again, I think Glenn covered that pretty well. The data collection is underway but there has been pretty much substantial agreement by a number of people that have looked at the data that there are substantial problems with them and the data, at the moment, are essentially unusable.

Staff have worked with CMS on revising the data

collection forms and instructions but we are at least two years away from having usable data there.

The second major question is whether changes are needed in the formulas that govern the distribution of payments, somewhat apart from the overall level of the payments?

For capital the first question is whether the DSH and IME adjustments really need a separate distribution formula for capital payments? The second question is whether the 3 percent capital add-on for location in a large urban area is justified? And in an analogous way, we will begin looking at that question by establishing the relationship between costs per case and large urban location at our next meeting.

Then, depending on how the deliberation of these first two questions comes out, the Commission can consider whether the program even needs to have separate operating and capital payments? They were once essential because of the transition. We might revisit that today.

MR. LISK: Finally, we wanted to turn briefly to discuss outlier payments. Outlier payments are for extraordinarily costly cases. Outlier cases are identified

by comparing their costs to a DRG-specific threshold. It acts as an insurance policy for extremely costly cases.

Outliers are funded through an offset to the base rates, 5.1 percent for operating and 4.8 percent for capital. This is like a premium that the providers pay to fund this insurance.

Outlier payments are made once the cost of the case exceeds its payments plus a fixed loss threshold, which in 2006 is set at $23,600. We can also think of this amount as the deductible for each to receiving outlier case.

This fixed loss threshold is adjusted for input prices so that hospitals in low wage markets have slightly lower fixed loss thresholds and those in high wage markets have slightly higher fixed loss threshold. CMS attempts to set the fixed loss threshold so that it will pay out the full 5.1 payment onset, though CMS often misses the mark.

Once the fixed loss threshold is reached, CMS pays 80 percent of costs for the case over the amount. You can think of this as the coinsurance amount. And costs are determined by multiplying a hospital-wide cost-to-charge ratio by the total allowable Medicare charges for the case.

So with severity adjustment potentially on the

horizon, is it time to rethink our current outlier payment policy? One of the issues is whether the current 5.1 percent payment offset remains appropriate. CMS, by law, is required to set it between 5.1 and 6.1 percent. Severity adjustment may reduce the risk associated with high-cost patients that the outlier policy is set to cover. Thus, a lower offset might be appropriate given refinements to the system. A reduction in the offset would result in higher base rates and a smaller share of PBS payments going to cover outlier cases.

Another issue to consider is whether the 80 percent marginal cost factor is appropriate. The 80 percent marginal cost factor likely pays more to hospitals than the direct costs they incur after the fixed loss threshold is reached. Although it may allow hospitals to recoup some of the losses they incur in reaching this amount, it may also reduce the incentive hospitals have to discharge these patients or to treat these patients efficiently once they start receiving outlier payments.

Any change in the marginal cost factor would result in a redistribution of outlier payments. It would not affect total program spending.

We are going to be looking at IME, DSH, capital and outliers over the next three meetings, and actually there is some relationship with outlier payments and IME in terms of the empirical level. If we pay out less in outlier payments it may affect our empirical level for the IME, and that's one of the reasons we're bringing this issue up for you today.

We would be interested in any issues you have or concerns you have with IME, DSH, capital, and outlier policies as we discussed today, and where you might like us to focus our analysis.

MR. HACKBARTH: Thank you.

Let me just start this. At the beginning I talked about the recommendation we considered several years ago to cut the payment. The way that recommendation was formulated, any reduction in the payment would have resulted in savings to the Medicare program, which would have gone to the Treasury.

That is not the way I think we ought to even approach the issue, regardless of whether we choose to move forward or not. I think the context is quite different now.

Several years ago, when we looked at this,

hospital Medicare margins were substantially higher than they are now. As you'll recall from our discussion last year around the update, the average overall Medicare margin is negative -- I think it was what, minus 2 percent or thereabouts?

MR. ASHBY: Minus 2.2 for '06.

MR. HACKBARTH: Given that overall picture, my thinking about this discussion is that we're talking about not taking the money out of the system if we change IME but rather putting it back in the base and redistributing it. So I just wanted to make that clarification at the front end.

There are two commissioners who are not here who have a lot of knowledge and experience about this that they wanted to make sure got into the discussion. One is Ralph Muller and the other is Sheila Burke. I'm Ralph, and this is Sheila. I'm going to do Ralph's part.

[Laughter.]

MR. HACKBARTH: Incidentally, Ralph has had a perfect attendance record at MedPAC. This is the first meeting he's missed and this is his sixth year on the Commission. But he just had a conflict with a board

commitment that he simply could not miss. And it only came up very recently or we would have rescheduled the whole discussion to have it when Ralph was here.

But because of that I told him that we would make sure that his observations were on the table and he'll have plenty of opportunity later on to talk about this personally.

The first thing he wanted us to raise on his behalf is that we had said we would come back to this when we had uncompensated care data. We don't. That's not the fault of hospitals, from his perspective. And so he really would prefer that we not take it up at this time, consistent with our earlier discussion.

The second point that Ralph wanted to make is that right from the outset Congress knew that they were setting the payment at higher than the empirical level. Indeed, it was a quite conscious decision to double it, and Dave Durenberger can speak quite directly to that.

From Ralph's perspective, that was a conscious congressional decision to shift resources to teaching hospitals because of the important mission that they serve beyond simply caring for Medicare patients. And he thought

that that piece of history, at least his vantage point on the history, ought to be on the table.

He would also note that there are other examples within the Medicare system of Congress making somewhat similar judgments that we have to use Medicare dollars to support broader public policy missions. For example, some of the rural hospital adjustments, critical access hospitals, a conscious decision is made to pay more under Medicare to assure access, not just for Medicare patients but for all patients in rural areas meeting certain standards.

Finally, Ralph wanted to note that the data that Jack and Craig just went through on margins is inpatient margin information, whereas we usually look at overall Medicare margin information. And for the uninitiated, the difference is that the overall Medicare margin combines Medicare payments for both the inpatient care and hospital-based, SNF care, hospital outpatient departments, and combines all of those revenues and all of those costs.

The overall margins for teaching hospitals is substantially lower than the figure that Jack presented. For major teaching hospitals the overall Medicare margin is

6 percent, as opposed to 12.5 percent for inpatient alone. For other teaching hospitals, just to continue the series so we've got comparable figures, other teaching hospitals have an overall Medicare margin of -- is that a minus 2 or a 3? Minus 3.5 percent. The Medicare inpatient margin for other teaching is minus 1.5 percent.

For the non-teaching hospitals, the Medicare inpatient margin is minus 6.5 percent. That's the number that Jack showed. Whereas the overall Medicare margin for non-teaching hospitals is minus 7.5 percent.

So those were points that Ralph wanted to make right at the beginning of the discussion. Sheila?

DR. MILLER: And Sheila wanted to make the following points. First of all, she said that she thinks that it's healthy that we revisit this issue but, much like Ralph, she said that hospitals have missions that go beyond just serving Medicare patients, they have community missions. This concept that Medicare payments may be for more -- you can make Medicare payments all about efficiency and accuracy, but also Medicare payments can also reflect social policy.

So she said that it's important that when we consider this we consider it in the broader context that there are other parts of Medicare where payments have social policy. And she, too, cited the critical access hospitals, swing beds that type of thing.

She then went on and said that, and I think this gets to the -- the next two points are sort of the nut of some of her concerns -- is that on the one hand one could argue, and it's not an unreasonable argument, that Medicare maybe shouldn't be involved in this. This is a social benefit for society in general. And that maybe it should be something that's more of a general revenue, an appropriated type of function. Here I'm talking about IME specifically. That was the example I think she had most in her mind.

She said one could make those arguments. But she has at least a couple of concerns. One is will Congress, in fact, step forward and fund this if Medicare does not? And two, she also was making the point more eloquently than I am right at the moment that there's also some assumption that maybe the private sector should pay its part. She also is skeptical that the private sector would step up to that responsibility.

Then she said one other concern that I think I should make is we have -- and Glenn did this just a second ago -- we have cast this as if we pursue this, the notion of taking the adjustment down and redistributing the dollars to other hospitals --and she pointed out that of course Congress does not have to do that, they could choose to take the money out of the system.

And so she had that concern, as well.

MS. DePARLE: I'm glad we're having this discussion again, too. And I want to replay the tape a little bit. We've talked already some about the history of this issue. And it's reminding me how unsettled I was at the end of our last discussion of it and the vote that we too -- I can't remember, Glenn, whether it was two or three years ago, I think two. I'm worried that we're about to get drawn into the same kind of discussion in this way.

What was unsettling to me was that at the end of it, and Bob and I and at that point Jack Rowe, a fellow commissioner, had spent 18 months on an IOM panel examining some of these issues, the future of academic health centers. And in both processes I felt at the end that we concluded we don't really know whether we are getting what we're paying

for here. What is it that we want to get out of these payments? And are we getting them?

I worry, it's a natural thing to get drawn into these numbers. But I want to make sure that in re-examining this, which I support, that we look at, for each one of these items, what was the policy objective? Is that still appropriate? And then get into is it the right amount for it?

Because I do think there needs to be more discussion of that. I actually think we could probably reach consensus in this group on that. We haven't really had the time to do that. It will take time.

But I would just urge that we try to do that.

I actually think both Sheila and Ralph's comments kind of go to that issue, as well. Let's figure out what this is for.

I don't think it's in here but just looking at the numbers, we're talking almost $20 billion a year now that we're spending on all the items together; right, if you add it all up?

MR. ASHBY: $13 billion for IME and DSH.

MR. LISK: $13 billion for IME and DSH. If you

add indirect GME, it's another $3 billion.

MS. DePARLE: But you've got capital and outliers up here, as well. Are we talking about all of them?

MR. ASHBY: Capital, remember, is part of the base rate so we're not considering that.

MS. DePARLE: You're not looking at that separately.

MR. ASHBY: We're looking at capital because the IME and DSH adjustments are made to capital as well using totally different formulas.

MS. DePARLE: What about outliers? Is it in there again just as a context?

MR. LISK: Outliers is one way we distribute payments for exceptionally high costly cases and it's really, under DRG refinement, rethinking whether 5.1 percent as the right amount and whether how we distribute it out in terms of paying 80 percent of marginal costs after they reach that point.

DR. MILLER: To her point, if you threw that in the pot, that's another $5 billion?

MR. LISK: Yes.

DR. MILLER: So she's about right.

MS. DePARLE: There is some commonality among -- there's some overlap in the policy objectives here. So it starts to be a rather large amount of money. So what are we getting for it? After all this time I'm still not sure.

DR. SCANLON: I definitely agree that this is an important area for us to be looking at. It's in the broad context of what's the basis for Medicare payment. I think one of the things that, in some respects, started with ProPAC when we first introduced the PPS and it has continued, is the idea that we're going to measure as well as we can the cost of delivering a service and then try to make payment as close as possible to the cost of that service.

I think we have to recognize that in the case of hospitals -- and since I'm agreeing with some of what Ralph and Sheila have said in the respect -- is that hospitals potentially provide social benefits that go beyond the service. We need to think about how is it as a society we're going to fund those social benefits.

And while, in an ideal world I would like to know what all those social benefits are and hold all hospitals accountable for how much they got for them and did they

deliver them, I also recognize the difficulty of measuring all of the social benefits.

The idea of having data on uncompensated care would have meant a movement in the direction of measuring a social benefit. But it would have been one social benefit out of many. And one that has concerned me a lot, starting with some work that I did or was done while I was at GAO, is the whole issue of emergency capacity. We had to look at the capacity of hospitals to respond to outbreaks of infectious disease. We found that hospitals didn't have much in the way of that kind of capacity. The response of executives was that they had taken the signals that all of the payment changes had given them, in terms of rightsizing, and they had right-sized out all of the slack that you might want to have in the case of an emergency.

How do you define how much slack you want to have? How do you define whether it's there? It's a really big challenge.

And then I think if we sat down and thought hard enough we could come up with a set of even more intangible social benefits that we might want to have and we might threaten, depending upon how good we get at getting payments

down to the level of the costs of an individual service.

So I think this is a big issue. It extends well beyond teaching hospitals. It really extends to the hospital sector because hospitals, in some respects, are unique among the provider community. They are the provider of last resort. Not just by practice. We've made them provider of last resort by law. We've said that if you're going to participate in Medicare, you better treat people that show up at your door. And that's unique among all the providers that we've got.

So I think we're right in doing this. We've got a lot of challenges in terms of how we end up trying to resolve it.

MR. DURENBERGER: One question first about outliers. I just spent part of my vacation with Jack Wennberg and his wife in the Tetons. You can't get 10 minutes into any conversation without him telling you about the outliers and the excessive volume and running you through every hospital, every community in America and the disparities.

So just watching that at work and looking at the data, it impressed me that thought might not otherwise get

mentioned here, to compliment you both on the inclusion of that in this analysis and the work that we'll all benefit from that Dartmouth and others have done on that subject. It goes way beyond the fraud and abuse stuff. It goes to the heart of how is it best with limited dollars to compensate people.

The second thing that I would love to see in looking at this, and I agree with everyone that this is the right thing to do. It's going to take a long time to do it. I don't think we should set deadlines for ourselves. Maybe our discussion will stimulate others who should be interested in the topic to get more interested in it.

But one thing that's sort of like a distributional question that I have, which is in what states will we find what amounts of GME, IME, DSH money? I think I know the answers to the first two, at least in bulk, but I think it would be important because it is important to talk a little bit not about distribution but to talk about the quality of education and the quality of the educational system in health professions and the role that Medicare should pay in that. And I'm going to bring that up in a second.

Since I was around when we did all of this, I'd

like to first mention the basic policy goal. The basic policy goal was to restrain costs in the health care system. That's what we were up to. That's what drove the whole prospective payment system approach.

Having made that distinction, having adopted in the early '80s to the DRG as a way to do that with regard to hospitals, we went on a very fast learning curve. And again, by we, we're not a bunch of researchers. We're not the talent around this table. We're a bunch of politicians, basically.

But the nice thing about it was it was never partisan. It was always people deeply concerned about how do you broaden access by reducing cost, if that's even possible?

So the learning curve involved a variety of things. One, if you start literally averaging everybody in the country and giving them one of whatever it is DRG categories and so forth, you're going to bring a lot of things to a halt that are currently being subsidized inside America's hospital systems. And a lot of that was uncompensated care. We knew about that. We didn't know how to deal with that at the time. Eventually the DSH comes out

of it.

But the one we did know about was teaching and was education. The feeling at the time was -- and I hope I do this passionately enough for Sheila, too. But the feeling at the time was what good is talking about high quality medicine, access to high quality medicine, if you're going to use the cost reduction system to kill off the education system?

So it was a conscious decision for us to adopt GME and IME and a lot of these support systems.

There was a conscious decision taken early on to put more money into that reimbursement than we necessarily felt might be necessary. But it was important, as we did in some other areas, to protect the beneficiaries and to protect the people who were involved in the infrastructure for education.

So as I recall, particularly that six or seven or eight year period of time, there were a lot of learning curves. We began to learn about some of the claims that were made by academic medicine that all of their cases that they treated were much more severe than other hospitals was not necessarily true. And also the claim that was made that

all academic medicine and all teaching hospitals had more of a burden of uncompensated care than other people. That wasn't true. Not that they're being dishonest, but simply that's what the research was showing, as we still see here today.

So a lot of the evolution of the policies since then was not in the direction of not necessarily having any role at all in what we've come to call social benefits or social policy like the uninsured, but say are we doing it realistically?

With regard to medical education and the teaching adjustment, the notion in the beginning was that everyone ought to contribute towards the cost of caring or for providing health professions education. We hoped that by the example that Medicare was going to play with regard to GME and IME that we would provide a precedent for private insurance to take on the burden for the non-Medicare population. It really hasn't worked out that way. But the idea never really went away.

As I recall in the early 1990s on the Finance Committee we voted on a very specific 3 percent tax. We said there should be a 3 percent tax on all health insurance

in this country to provide for medical education.

I remember voting against that, not because I thought that was anything wrong with education or funding education but because I had a deep concern about what we were going to get for our money if we just levy a 3 percent tax and create a whole new fund. There was no distribution formula. There was no qualitative or evaluation or anything like that.

And I also had my own personal feelings, which is if you're going to fund education, you ought to fund the students, you ought not to fund the institutions. But I don't bring that up here today.

The challenges that we're spoken to by both Ralph and Sheila, who's had even more experience or longer experience than I have, you talk about the politics of this. The politics of this over the last umpteen years have been driven by the distribution formula, which you will see when you see where all the money is going. You can look on the Senate Finance Committee or the Ways and Means Committee. And if you think you're talking policy, you're not really necessarily talking good national policy. You're talking good national politics being practiced by a few people who

are well positioned.

And since I'm talking about people I admire more than anybody else, Daniel Patrick Moynihan and others, I don't diminish their contribution to national policy in any way. Simply that we can't just say it's always been congressional policy that we ought to do what we've been doing for 20-some years. You can reconsider it.

I would say the same thing about critical access hospitals. It's pretty easy to point to the chair and the ranking member of the Senate Finance Committee and say but for the fact that they were there, would we be spending that much money?

So mainly I'd like to get on the table the issue that what may have been the right thing to do in those days, as Len Nichols said this morning, many of us were too busy being successful to be very good at what we do. But what may have been the right thing to do in the '80s may not be, with a whole new policy goal which is pay for performance, pay for value, it may not be the best policy today. But we can't leave either the poor or the uninsured or the education issue behind. It may not be -- I don't happen to think it's the right thing to use beneficiary money to pay

for the uncompensated in this country. I think we all have a responsibility for that.

But I do think that we have some responsibility to think about what is the specific role that we would expect from health professions education, as far as beneficiaries are concerned.

If I were voting today I would vote to end a lot of these programs as being paid out of the trust fund and have them hopefully be appropriated, recommended them be appropriated, authorized and appropriated, from other sources.

But having said that, I think it's probably an important contribution we could make as a commission if we did talk at least about the important connection between high quality high performing health professions education and the quality of care that we expect for all the beneficiaries in this country, regardless of what we may say about how that should be financed.

DR. KANE: I'm trying to remain passionate at 5:30 and it may be a little hard, so I'll try to be short.

But I think one lesson that I learned, and not just in the teaching hospital IME adjustment, but that being

vague about the social benefit you expect and yet allowing large sums of money to go out on their behalf does not result in the social benefit being provided. But it often gives amazing competitive advantage to those who can latch on to the gravy train.

So what we have, even though the overall Medicare margin is only 6 percent for teaching hospitals, if they're competing against hospitals with a minus 3.5 percent overall Medicare margin, they have competitive advantage. As I've said before, we have seen some of the implications of that in markets where there is a concentration of academic health centers. Certainly Massachusetts is one of them, where I'm from.

So I would argue that I certainly don't want to not pay for indirect medical education, but doubling the adjustment seems totally unfair to those who have to compete against those hospitals.

Now perhaps critical access has that same problem, or all the other adjustments, and we do really need to think about what are we getting from them? Are we getting it? And is the right way to do that?

I guess I always thought that the doubling was

there to get the political situation such that the teaching hospitals bought in on the DRG system, and that once you're bought in you sort of stop those things. So maybe I just have a misunderstanding of why the Congress doubled the --

MR. DURENBERGER: I think that sustained it.

DR. KANE: I guess if we want to rationalize the IME, the only other thing that seems nonsensical to me or of concern, is that right now the IME is distributed on the basis of an inpatient adjustment. Well, there's a lot of teaching that's not inpatient. There's a lot of outpatient out there. Is the inpatient only adjustment giving incentives to maintain an inpatient treatment when it should be outpatient? Is it keeping more of our care inpatient that should perhaps go outpatient? I mean, why is it just inpatient care? Is that just so we can attach it to the trust fund instead of Part B? Why is IME only based on an inpatient formula?

DR. REISCHAUER: They can use the money for anything.

DR. KANE: I understand, but there's an incentive -- I know how they can use it. They can finance competitive strategy with it. But if you really -- you have a formula

right now that you can -- that gives you an incentive to increase your interns and residents per bed and then make sure you have -- it's only coming through your inpatient payment, not through your outpatient payment; is that correct? So you're only going to get it through the DRG system. You're not going to get it through the APC system.

So I'm just wondering, have we thought about why it's all loaded into the inpatient side? That's just the piece that might be legitimately for IME right now gives incentives to treat people on the inpatient side rather than outpatient that maybe no one's thought about. But somehow I think the teaching hospitals have figured it out.

MR. LISK: When the outpatient prospective payment system was developed CMS did an analysis and didn't find an indirect effect. We do, though, see lower outpatient margins for major teaching hospitals compared to other teaching hospitals. So you're right, on a theoretical standpoint you do have that incentive type of thing potentially there. It's something that we could consider. We were going to be focusing on, and our analysis has been on the inpatient side. It hasn't been on the outpatient side. We're going to focus on the inpatient. But it's a

good point.

MR. HACKBARTH: Because it is linked as a percentage add-on to the inpatient payments, it also means that the amount that an institution gets is proportionate to its Medicare volume and case mix. It really isn't linked to how much teaching it's doing. It's linked to its Medicare volume. Those two may not track perfectly with one another.

DR. MILLER: The only thing I was going to do is take Nancy's point and make it sort of even broader than your incentive inpatient/outpatient. It's even broader than that. If someone woke you up in the middle of the night and said let's pay for the teaching function in a country, you would pick one payer and tie it to their inpatient formula.

It's a good question, is what I'm getting at.

MS. BEHROOZI: I think in light of Sheila's caution, and I think some people have echoed it and it's implicit in a lot of what Dave says, the inability to control the response of those who have control over the payment system to MedPAC's identification of a problem and suggestions that we might make about how to cure the problem, it becomes that much more important how we define the problem, define and measure the problem. I think that's

also underlies what Ralph pointed out about the measurement that was initially presented was based on the inpatient margin rather than the overall margin. The problem doesn't look quite as big. You're right, there's still a gap but it's not quite as big.

So I think that we should bear in mind that there are judgments embedded in the comparisons that we make, the denominators that we use, saying that the current system pays double the empirically justified amount. Right now you're raising questions about whether that empirically justified amount is too high, is too low. Does it really reflect the actual inefficiencies in indirect costs?

So as we proceed, I think we should proceed very carefully and not just go on the face of what looks right now like a really out of whack system. Maybe it's slightly less out of whack. Or maybe it's in whack with other things. Maybe there are other societal goods to be measuring it to, some of the things that Bill has brought up about the necessity of maintaining hospital capacity. Or simply the fact that Medicare beneficiaries disproportionately utilize doctor services, physician services, and that's not strictly measured when you're just

talking about the inpatient payment system. But the necessity to maintain a core of physicians ready to treat those patients outside of this context is another one of those goods to measure this against, I think.

DR. BORMAN: I have a couple of numeric questions first, and then just a couple of philosophic points. The first thing is is the resident-to-bed ratio the right thing in today's world? I can tell you in what I do fully 50 percent of the patients are either AM admits or true ambulatory surgery. And I think that the resident-to-bed ratio may be a number whose time has passed.

Exactly what the best substitute of the number is, I'm not sure we know but I think there certainly is a question about that.

I would ask, you've showed us the increases over 16 and 17 year periods in the IME and the DSH. Are those adjusted for inflation? And if not, what has medical inflation been over that time? Because there are huge increases, billions of dollars, serious money. But they are over a fairly long prolonged period.

MR. ASHBY: On the disproportionate share chart, we were showing the payments as a percentage of base

payments. So that's implicitly controlling for medical inflation. And with that controlling, we still had a quintupling of the payments.

DR. BORMAN: How about on IME though?

MR. ASHBY: IME, we didn't put it quite in that form. The payments were 7.9 percent of base as of 1997, which is actually the last data we have, and are down to 6.2 percent as of 2004.

But we have to remember that even some of that is offset by the fact that there was new IME money coming in during that period for MA patients. So it's part of the overall IME picture.

DR. BORMAN: Do we know what percentage of MA patient, though, seek care in teaching hospitals? I frankly don't know the answer to that, but I'm not sure if they are outside of that because frankly, a lot of capitated plans or predefined payment, or whatever we want to call them, are less often associated with those hospitals.

MR. ASHBY: I can't answer the number of patients, perhaps Craig can. But let me just qualify what I just said a moment ago.

The reduction in IME payments as a percentage of

base was from 7.9 to 6.2. They said if you input the MA patients into that, it's reduced from 7.9 to 7.0. So it's not a huge reduction. really.

MR. LISK: In many ways the MA payments offset some of the reductions that were made in the IME adjustment because before BBA we were not paying for MA patients in terms of this additional amount. Currently, we now pay the teaching hospitals an IME adjustment specifically for those patients. That's $600 million dollars in 2004. And in addition, the MA plans also have additional money from the IME adjustment that they're getting when they did -- was that the BBA? I'm sorry, the MMA plan they put that money back into the plan.

DR. BORMAN: So as best we can tell, we believe that we're comparing apples to apples over time?

Another question would be what is in table 4 in the handouts a couple of slides back where you do the 25th, 50th, 75th, 90th, whatever percentile. Just on an eyeballing basis, this looks like a hugely skewed to the top end curve, and that does suggest that some of this is driven by outliers.

And again, in your information about concentrated

among certain hospitals, I think that's a pretty important point here because we're getting pretty wrapped up in that there are some things -- as Nancy points out -- some groups that are being enabled to do some things that we think would not be good by this. But I think we have to be a little bit careful about what might be an outlier phenomenon versus the validity of an entire principle or process or system or whatever we want to call it, a deployment of money or whatever. It just looks to me when you look at this, that when you go from the 50th percentile on IME is at 3.3 percent. Yet when you go, it's like it almost exponentially goes up. It doubles at the next level and comes close to doubling again.

There's a high-end askew here. And I think that's pretty important and it's not intrinsically obvious just looking at the numbers.

And then a couple of things. There was a mention of the $60,000 per resident, and I know that that sounds like a pretty substantial chunk of change, and I don't mean to say that it's not. But I would point out to you that, as we've learned recently in substituting for residents with mid-level providers relative to the work hours, which was

not incentivized by this at all, it costs way more than $60,000 a year to make up for one of those individuals.

MR. LISK: I do need to clarify, from a Medicare standpoint that was just for IME. It's actually more than $60,000. When you talk about direct GME, you're talking another $30,000 and total Medicare's paying about $90,000 on average per resident, Medicare itself.

DR. BORMAN: I understand. I just want to try and put it in a perspective when you try and equate, is that a good number? What does that buy you outside of the resident market? I would tell you that we budget probably that $90,000 easily for someone that takes the place of one of those individuals. Again, it was necessitated by a totally different context than trying to constrain costs. So just in terms of what are you buying, that's just a comparison number.

I think philosophically just a couple of things. Number one, remember that teaching hospitals are not only teaching physicians, they are probably the place that's more often associated with nursing students, lab tech students, EKG students, whatever they may be. And so that when you adjust this, you may in fact be affecting the spectrum of

care, of people that participate in care, not just physicians. So you want to be just a little bit careful about what is the impact here on allied health? And is that something that you want to think about as well?

The idea of it being nice and clean in an appropriations setting absolutely has clarity of thought appeal. That you unwind this from Medicare and you say we're consciously funding this. It introduces, however, a level of volatility that, considering the pipeline of medical education, a minimum of four years in medical school, a minimum of three years of residency, that that makes it pretty hard to sustain an educational program if the volatility in your funding from year to year might be like we see for certain other specific appropriation items. Or that we can mandate it but not fund it. That does create some special issues on a long educational pipeline.

The issues of what social good are you getting have already been well addressed.

I would point out that as a very gross measure of are we getting benefit from this, that we still have a huge number of people from other countries who seek medical education, and in fact even retraining, here for some

reason. So there must be something positive about our medical education system. And it may not be as crisp as we would like to see it elucidated. But there's some background, gestalt, smiley faces, whatever, that would suggest we are sought by others who go to a lot of lengths to get to it. Presumably there is value to what we're producing.

I support the notion that we should have some criteria to know what are we buying. And I despise the fact that there are not better data. I will push in every form I can that we get better data to be available because this does need to be a data-driven decision.

One last comment would be a background issue here that is a little bit certainly beyond the purview of the Medicare program entirely, but is the issue of physician workforce. As every medical school almost in this country is increasing its enrollment, there will clearly come the question of funding the training of those individuals and anticipating is this the work force that is going to be needed to care for an aging population?

So that is a background issue here. And while we can't solve the issue of workforce, I think maybe some

projections about where that's going will figure into this discussion. And it's obviously a fairly lengthy complex project.

Than's for listening.

DR. CROSSON: I'll be brief.

I'm speaking to IME again. And I support us taking a thoughtful look at that, for a number of reasons but I'll just talk about one of them.

Without getting into the question of whether Medicare should be providing subsidies for a social benefit which is different from what it's actually paying for, it would seem to me that if it is and if we're going to talk about this, we ought to talk about what that social benefit is or what we think it is.

So I tried to write one sentence thinking about what I think it is. And it might sound something like well, it's to produce a well-trained physician workforce with skills to match the nation's need for health care services. That would be something like it.

The second question then would be how effective is that? How effective is the subsidy at meeting that goal today, as opposed to where it was when it was originally

designed? As Dave said, things have changed.

And I think at least in one area, and we've talked about it before, it appears to be failing in that regard. And that has to do with the issue we've brought up before about the growing maldistribution in the production of primary care physicians versus specialists.

That's not to say at all that that's the fault of the teaching hospitals. I think it's not, actually. It has more to do with payment policy.

But I think it would be a legitimate question to talk about whether or not the teaching hospitals might have a role in helping craft the solution to that problem. Because if the, again, the social benefit is to, in fact, produce a well-trained physician work force with skills to match the nation's need for health care services, and that's failing, then we would expect, I hope, that the teaching hospitals would have a role in helping craft the solution.

DR. CASTELLANOS: I'd like to address both of the issues. Under DSH, you're right, EMTALA requires the hospital to provide this care. In my community, we have 20 percent of the people that are uninsured and 20 percent on top of that that are underinsured.

I just want to make a comment that the DSH money just goes to the hospital. The physician who's taking care of those patients don't enjoy any benefit from DSH.

Under IME, first of all, I find it's deplorable that there's no good accountability and I think this needs to be corrected and directed for the IME money.

Karen, I don't really agree with you on the workforce problem. I think we have a significant problem today with the work force. I think you can look at the data and it's not just with primary care but it's with specialties. I think this may impact on the access to care to the Medicare beneficiary.

So before, I would like some information on where do we stand today with the workforce problem, and the potential problem we may have by cutting back on IME funding for medical education.

We have two potential new medical schools in Florida today, that's where I love. Both of these are having startup problems. One is funding. Another one is they can't find a hospital where they can work at and have that post-graduate medical education paid for.

Thank you.

DR. MILSTEIN: I just wanted to endorse Nancy-Ann's three-part approach. I think that's a nice way of organizing the task. It would be helpful to me the next time we discuss this to actually have in front of us what are available in terms of measures for ascertaining a hospital's either level of or performance in delivering uncompensated care services to lower SES patients, teaching content specifically in the areas -- it would be helpful to Medicare. And I would think Jenny's point about geriatrics. And I think the point made in the prior panel about training in cross-silo process engineering. That would be near the top of my list.

And last but not least, measures of -- ways of ascertaining hospital levels of and performance in, taking care of outlier patients but in categories generally considered to be not preventable.

There's where I think, if I had to be critical of outlier policy in terms of our overall policy objectives, it's an outlier policy that treats categories of outliers that are generally considered either totally preventable or highly preventable, the same as being struck by lightning, if you'll excuse the inappropriate metaphor.

MR. HACKBARTH: Okay, more on this later. We are at six o'clock and well behind schedule.

I do want to have a very brief public comment period, and I mean very brief. The usual ground rules. For those you didn't hear me this morning, no more than two minutes. And if someone before you has said what you were going to say, say ditto and we'll move ahead.

And could you identify yourself and your affiliation before you go?

MS. HELLER: I'm Karen Heller from the Greater New York Hospital Association. And I just want to make a couple of recommendations for the ongoing analysis.

First of all, I think it's vitally important to look at total hospital margins as well as the Medicare inpatient and the overall Medicare. The Commission has pointed out over and over and over again, year after year, that the major teaching hospitals have the worst overall margins in the country.

Just as Dr. Compton this morning was talking about silos affecting the whole system, Medicare does affect the whole system. So we have to do that.

Number two, with respect to uncompensated care,

even though the data collected from the cost reports weren't very good, one idea -- I don't know if CMS could do this -- would be to collect the DSH CAHPS of all the hospitals. Because for the Medicaid DSH program, every hospital has to compute uncompensated care that meets the federal definition for that.

So I don't know if the states actually give that to CMS or not, but it's something that could be explored potentially.

Thank you.

MR. SCHONGALLA: Tom Schongalla. I'm an independent economist. Three minor points.

Any discussion of DSH has to include the $15 billion each year put out in the state Medicaid programs. Completely different program but covered by statute. It's 18 USC something. I don't know how we can segment one without the other.

Second, I'd like to direct this comment to Dr. Reischauer. I've looked at both the actuarial type of projection for the payments by people before they draw Social Security and Medicare. I think somebody ought to get a CRS or CBO report that gives us some numbers that we can

hang our hats on. Right now nobody knows what those numbers really are.

I did some numbers yesterday for a talk I'm giving in the not too distant future that said that a person retiring this year is going to have a lump sum of something in the neighborhood of $450,000 that he's accrued, including imputed interest.

I would like to see what a reasonable calculation is because you're ultimately going to have to ask people how much have you put in? How much are you drawing down from what you've put in? And how much is left? Perhaps the Social Security actuaries have done that.

DR. REISCHAUER: The second part of that is really easy. It's a negative number.

MR. SCHONGALLA: Yes, but not for the guy retiring this year.

The last one that I would use, which is the same type of question, is what's the total malpractice outlay each year? If you take $30,000 per physician or $40,000 per physician and you multiply it by times 532,000 practicing physicians, you come up with something between $17 billion and $20 billion a year. That's less than 1 percent of the

health outlay.

But we keep -- you know, you guys have been around longer than I've been. Three times in the last 25 years we've trooped out this medical malpractice crisis. And somebody needs to come up with some numbers again that you can hang your hats on so we can decide how serious it really is.

MR. MAY: Don May with the American Hospital Association, and I really appreciate the conversation we've had today. A lot of good things have come out.

All of the questions and issues that you've raised I think we really need to dig into those and move very cautiously as we talk about IME and disproportionate share payments to hospitals.

Unlike a lot of the topics that you all talk about every month, this goes way beyond just the Medicare program. And the system as a whole really needs to be thought about as we start to think about tinkering with this one piece of the inpatient payment system.

So I just would urge you to move slowly and cautiously and think about all the different issues that you're raising and really try to get behind some of the

analysis on that.

Thank you.

MS. LUKENS: Hi, I'm Ellen Lukens with the National Association of Public Hospitals and Health Systems. We represent over 100 safety net providers and I just want to make two quick points.

One is that in the March 2000 report I think, which was reiterated here, we would agree that there is a social benefit to supporting safety net hospitals and ensuring access for Medicare beneficiaries at those hospitals.

The second point I'd like to make is that we also really support MedPAC's efforts to better target DSH funds and to include all low-income patient care costs in that formula, including uncompensated care costs.

And I believe that -- we are happy to work with MedPAC. We've put a lot of thought into this. And I think there are ways that we can get around some of the data limitations. And we are happy to work with you further on this.

Thank you.

MR. HACKBARTH: Okay, thank you very much. We

reconvene at 8:30 tomorrow.

[Whereupon, at 6:03 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, September 8, 2006.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, September 8, 2006
8:23 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
MITRA BEHROOZI
JOHN M. BERTKO
KAREN R. BORMAN, M.D.
RONALD D. CASTELLANOS, M.D.
FRANCIS J. CROSSON, M.D.
NANCY-ANN DePARLE
DAVID F. DURENBERGER
JENNIE CHIN HANSEN
DOUGLAS HOLTZ-EAKIN, Ph.D.
NANCY KANE, D.B.A.
ARNOLD MILSTEIN, M.D.
WILLIAM J. SCANLON, Ph.D.

P R O C E E D I N G S

MR. HACKBARTH: Good morning everybody.

First up on this morning's agenda is our report on SGR. Kevin?

MS. PODULKA: Actually, I'll be starting off. Kevin and Scott will be joining me.

Good morning. We're here to talk about our mandated report on alternatives to the SGR. As you know, after a period of low growth, the past several years have seen spending on physician and other SGR-related services growing quickly. From 2000 to 2005 expenditures grew by more than 60 percent and about three-quarters of this growth is due to increases in the volume and intensity of services provided. These increases contribute to the SGR calling for multiple years of physician fee cuts, which most call unsustainable.

As a result the Deficit Reduction Act of 2005 requires that we report on mechanisms that could be used in place of the current SGR system for updating physician fees. That report must do several things: identify and examine alternative methods for assessing volume growth and the

extent to which these alternative methods should be specified in law; review options to control the volume of physician services while maintaining beneficiary access; and examine the administrative feasibility of implementing these options, including the availability of data and time lags; examine the existing application of volume controls under the physician fee schedule, as well as a potential for volume controls using five alternative types of target tools: group practice, hospital medical staff, type of service, geographic area and physician outliers; and finally, identify the appropriate level of discussion for the Secretary of HHS to change payment rates or take other steps to affect physician behavior.

The report is due March 1 of 2007. We will be presenting information about each of the five specified alternatives from September through January at the commission meetings. This month we'll be beginning with preliminary data about the geographic area and type of service alternatives.

All of these alternatives raise many questions about design and implementation. None is likely to solve

all of the flaws of the current system. MedPAC is not required to recommend any of the five alternatives but we will explore the advantages and disadvantages of each to provide information for the Congress.

While the report must explore these modifications, we realize that the commission feels that other reforms should also be contemplated. Therefore, the report will also examine a number of other mechanisms. You see the examples on the slide. These potential reforms range from large systemic mechanisms that recognize that Medicare exists within a broader health care delivery system which contain signals that affect the program. And these signals may need to change in order to affect real reform.

The reforms also range from broad Medicare changes that are designed to improve the value of the program to narrower more technical Medicare changes also designed to improve value. We will be presenting more information about these other reforms in subsequent commission meetings.

Coming back to the mandated five alternatives, as we've begun to examine each of them we've identified a number of crosscutting issues that we ask you to keep in

mind as we present our preliminary data today. We would appreciate your feedback on how you would like to see these crosscutting issues addressed.

First, in a target system how should targets be set? For example, under the SGR targets are cumulative but that leads to problems when large amounts of past excess spending needs to be recouped.

On the issues of levels versus growth, should the target address initial levels of volume, rates of growth over time or a combination of the two?

On the next bullet for trade-offs among administrative feasibility versus volatility and accountability, for all of the alternatives, a number of pools and the criteria we use will affect the volatility of updates and the degree to which an individual physicians are held accountable.

For example, if we were to use a very small geographic area such as a county or ZIP code, we would come much closer to the individual physician but actual spending would tend to be more volatile due to year-to-year changes outside of physicians' control.

In addition, moving to these smaller unit pools would increase the administrative complexity of a system that is already faced with data availability time lags.

Starting on the next column, any of the alternatives carry the risk of unintended consequences. For example, given the way beneficiary cost sharing is currently structured, paying physicians differentially could perversely affect co-pays. If high quality efficient physicians were rewarded with better payment updates, then beneficiaries would have to pay more to see these physicians.

In the coming months, as we continue to work through these alternatives, we will also be discussing crosscutting issues associated with attributing spending and volume to physicians, risk-adjusting and data availability questions.

Now Kevin and Scott will present preliminary data analysis about the type of service alternative.

DR. HAYES: Just as an alternative to the existing policy, the single national target, a system of multiple expenditure targets could have separate adjustments for fees

based on targets for various types of services, visits, imaging, procedures and so on.

There is precedent for this. Under the volume performance standard policy that preceded the SGR, targets were set for three types of services: surgery, primary care and other nonsurgical services.

A rationale for doing this would be mainly that it would focus payment adjustments on services experiencing rapid volume growth. This option would also be a way to make adjustments to payments for health services priorities such as higher payments for primary care or other services.

Third, there is the issue of mispricing. It's possible, under a mechanism like this, to use targets to serve as a set of signals that payments are no longer accurate.

As you know the commission, in recent reports, has addressed problems with the five-year review of RVUs in the physician fee schedule as well as other issues.

The first design issue to address with an alternative like this would be setting the targets? As Jennifer said, setting targets requires consideration of

whether the targets apply to the level of spending or growth in that spending. In addition, targets could be based on an objective standard. GDP growth is one such standard. Others, of course, could be considered.

Historical trends for each type of service are another possible basis for the targets.

And finally, spending could be allowed to fall within a corridor around the target before updates affect it, or not.

In your mailing materials, we addressed all of these issues in the context of a type of service SGR.

For the next few slides, though, I want to focus on the middle bullet shown here and that is the objective standard versus basing the target on trends.

In the examples that I will show, we have chosen to compare various options for type of service targets with growth in the volume of services and not growth in spending. In doing so, we assume that the factors other than volume which determine spending, prices and enrollment, would be addressed in the type of service SGR just as they are in the current SGR. Taking these other factors out of the

comparison allows us to compare volume growth with various targets such as GDP growth and see clearly how fee updates would change depending upon the type of service target considered.

So let's look first at a GDP growth as a type of objective standard that could be used in a type of service SGR. This would be relevant if the choice was to simply modify the current SGR and establish a target for each type of service with objective standard being GDP growth.

The measure of GDP, by the way, is a measure of goods and services produced in the United States and is used as an allowance for how much growth in volume society can afford.

In a type of service SGR what are the likely impacts of using such a standard equal to GDP growth? Considering broad categories of services, evaluation and management, imaging, major procedures, other procedures and tests, we see on this slide that recent trends in volume growth for each of these types of services would have all exceeded a standard of GDP growth. E&M and major procedures would have been closest to the standard. Imaging, other

procedures and tests would have exceeded the standard by wider margins.

Comparing volume growth and a target, the differences in percentage point terms would determine the payment adjustments under a type of service SGR. In this example, E&M and major procedures would be subject to payment cuts of just over 1 percentage point. Imagings growth differs from the target the most. That type of service would experience a cut of 8.8 percent in this example.

Of course, objective standards could be higher than just GDP. If we were to just raise the target here and move to something like GDP plus one, for example, CMS's Office of the Actuary uses GDP plus one in its projections for the report of the Trustees and Medicare trust funds. If we were to consider this standard and compared it to trends and recent experience with volume growth, we see that E&M and major procedures nearly met the standards.

Rapid growth in volume of imaging, other procedures and tests, by contrast, in recent years have exceeded the standard. So those services would still be

subject to negative payment adjustments.

Moving now to other bases for the targets, we could consider trends. The rationale for basing the target on trends is that volume growth -- those trends represent technological advances, changes in beneficiary needs for care and other factors that could be considered in setting targets.

As shown on the slide, we did something very simple to illustrate how this approach to setting targets might work. We took the trend in volume growth for the years 1999 to 2004, split off the last year of growth, which is growth from 2003 to 2004, and compared that last year to the trend of 1999 to 2003. We then had a year of volume growth to compare to a trend. Very simple illustration is all we're after here.

Looking more closely at this example, we can take E&M services and see how payment adjustments would be calculated. For E&M we see that volume growth fro 2003 to 2004 was 3.3 percent. By contrast, the trend in previous years was slightly higher, 3.6 percent. Basing the payment adjustment on volume growth in that most recent year, we

could calculate a payment adjustment for E&M as the difference between the most recent growth and in the trend, or 0.3 percentage points.

In this kind of an illustration, similar calculations would show an increase for major procedures but cuts for imaging, other procedures, and tests.

In addition to these specific examples that we've shown here, objective standards versus trends, we could also consider some combination of the two approaches to setting targets. In the interest of time we are not showing the example, but there is one in your mailing materials.

The rationale for this approach would be a desire to recognize trends in volume growth for selected services but at the same time to apply an objective standard that would, say, bear on volume growth overall. Thus, payment cuts would be calculated and targeted -- payment cuts would be targeted at selected services.

Let's now consider another issue related to the type of service alternative, and that has to do with how services are defined and grouped. Within all of the type of service options that we have discussed policymakers could

choose among alternative ways of doing this. Services could be grouped into five categories we considered in the examples: E&M, imaging, major procedures, other procedures and tests. Alternatively, a more detailed breakdown is possible, such as the one shown on this slide.

And then within these different types of categories you can consider more finer detail still. Within the other procedures category, for example, we could get down to the level of detail that would include things like minor procedures, ambulatory, skin procedures, cataract removal and so on.

Just to summarize here on this type of service alternative, we can think about some advantages and disadvantages that go with this. The advantages are the ones that I mentioned earlier about payment adjustments focusing on rapidly growing services. It's a way to address health services priorities. And it's a way to address concerns about mispricing.

Disadvantages are listed here, also. We can see that one problem with the targets and adjusting payments by type of service is that the volume of specific kinds of

services depends only in part on the physicians who provide them. For example, the volume of imaging services depends in large part on referral patterns of physicians ordering diagnostic services for their patients and not just the physicians who furnish the services directly.

Another problem concerns the one that was encountered with the previous VPS policy. If such targets were readopted, over time they could undermine the purpose of the fee schedule. We would have payment adjustment that would override other parts of the payment system that account for differences among services and resource requirements.

A third issue with this option concerns perverse incentives whereby physicians might substitute among services to avoid payment cuts.

And lastly, while using targets by type of service would account for technological advances and other factors unique to those services, the price for doing so is that the trends could include some high volume growth that you might not want to reward.

We're now ready to move on to another variant on

this, and Scott will talk about that.

DR. HARRISON: I'm going to present a type of service option that is motivated by rationalizing volume growth with the growth in physician work time and increases in physician productivity, as well as the desire to address the mispricing Kevin has mentioned.

Let's briefly explore the relationship between volume growth, work time and productivity. How can physicians increase Medicare volume? Well, they could increase the time they devote to treating Medicare patients by either working longer hours, increasing the number of physicians who treat Medicare beneficiaries, or by shifting some of their time away from other types of patients and devoting a larger share of their time to Medicare.

Alternatively, physicians could increase their productivity by either performing services more quickly or by substituting capital or non-physician labor for physician labor.

The physician time available stays the same, and this is something we would want to research, but if it were true, then physicians must be performing services more

quickly, meaning they would be increasing their productivity.

How do we account for increased physician productivity? Under the current SGR, all volume growth is treated the same regardless of where the growth comes from. This option we will discuss here attempts to account for the increased productivity and focuses on the volume of work RVUs performed. Work RVUs were intended to reflect the physician time and intensity required to perform a service. The more time required, the higher the work RVU value assigned to the service.

Kevin has already discussed that we have doubts about the accuracy of the RVUs and we are especially concerned that productivity gains are not reflected in updated RVU values.

We will now go through an example of a type of service option that uses a productivity model. The payment effects of the option could be accomplished either by adjusting the actual work RVU values or by allocating the updates to reflect volume for increased productivity for different types of service.

You have a table in your meeting materials that gives a hypothetical example of three specialties producing a mix of three types of service in two time periods. The point of all of the math in that example is to measure the contribution of each type of service to the overall productivity gain. Once we do that we can allocate total payment changes to different types of service based on the type of productivity gains physicians have made in delivering those services.

Let's look at the example in your materials in a simplified way. In this hypothetical example, we have three services X, Y and Z. As shown in the first column, Service X volume was the same in the two periods. Service Y's volume grew by 6.7 percent and Service Z's by 15 percent. Overall volume growth here is 6.3 percent.

In this example we assume that the total work performed for Medicare patients stayed the same over the two periods, and thus the physicians were able to perform these services more quickly. We calculated an adjustment factor for the work RVU portion of the fee schedule through the model to account for productivity gains for individual types

of service. Those adjustment are found in the second column of this table.

Those values are dependent on assumptions of specialty and service mix that we are not showing here but are in the materials. Again, those assumptions are purely hypothetical. The calculations behind this adjustment process are complex and conceptually they're similar to the method used to calculate the practice expense values for the physician fee schedule.

Note here that even though volume did not change for Service X, it would receive a downward adjustment in order to help account for overall volume growth. It does receive a smaller negative adjustment than average under this option, however, whereas under some of the others everybody would get an average reduction.

Presumably we would still have a target update under this assumption. For this example we chose a target of 3.2 percent for all services, and that's displayed in column three.

The conversion factor update, shown in column four, for a type of service combines the work RVU adjustment

factor and the target update. So Service X would have a very small conversion factor update in this example, while those services with volume increases would have negative updates in this example.

DR. MILLER: If I could just say something here to draw your attention to it. The example is assuming some kind of standard like GDP, if you look at the first column, volume growth has exceeded that standard by three-some-odd points. So what this process does is says based on the volume growth of this particular service you're allocating the impact differently. And that's what the last column is trying to get at.

So if people are wondering why is there a reduction here, it starts with the assumption that if your target is 3.2 in the third column at the bottom, and volume growth was 6.3 at the bottom of the first column, you're saying you exceeded the target. And then the rest of the example is how it ends up getting worked through the type of services.

DR. HARRISON: This approach would have the ability to address mispricing but it is not clear how the

pricing decisions would interact with the RUC process that also has been set up to address mispricing.

The example we just went through would result in different conversion factors by type of service. It could be done instead by keeping a single conversion factor and changing the RVU values by the RVU adjustment factors that you saw in the second column of the table. Neither method, however, would account for the substitution of practice expense costs for physician labor. For example, if physicians were more productive because they hired more nurses or bought labor saving machines, the model would recognize productivity savings but not the additional practice expense.

The practice expenses are just one of a number of new data needs this approach would require. Ideally, we would also like to see the timely collection of work force data, physician work hour data, and data on the share of total time devoted to Medicare patients. Administration of such a system is likely to be complex.

Now I would like to turn it over to Jennifer who will discuss geographic options.

MS. PODULKA: The geographic area alternative mechanism for controlling expenditures is motivated by regional variation in physician practice patterns. The target formula would still be used to determine how much total spending growth society could afford but the overall target would be allocated to each geographic area. Each year each geographic area's target could be based on how the rate of increase for Medicare physician services in one area compared with the national average. The target could be based on the level of volume, volume growth, or some combination of the two.

Because reducing volume growth would be more difficult to achieve in areas where the volume of services was already low, the formula may have to take into account initial volume levels. Regional per capita spending would be adjusted for risk and updates would be higher in areas with lower volume growth and/or lower volume levels.

To illustrate the potential impact of using this geographic area alternative pool we chose to use the 50 largest metropolitan statistical areas. These are largest in terms of the number of fee-for-service Medicare

beneficiaries.

For this first example, we're looking at volume levels. Our analysis of physician claims for 2004 revealed that volume level measured by RVUs per beneficiary adjusted for risk varied nearly twofold across the 50 largest MSAs, from 44 to 81 RVUs per beneficiary with an average volume of 58.

If we look at the other option, so this example is volume growth over time, the rate of growth of volume of services per beneficiary from 2000 to 2004 also varied widely, from 9 percent at the low end to 37 percent, with an average growth of 25 percent. Of course, this indicates that rapid volume growth is widespread. Only one area, the lowest there, fell within the SGR's allowance for growth of less than 10 percent during this time.

These two sets of findings suggest the following question: do areas with high levels of volume also experience high growth and vice versa? We found the following: areas initial volume level in 2000 had a weak inverse correlation with volume growth from 2000 to 2004. That correlation coefficient there of negative 2.7, to put

it in perspective, zero would mean absolutely no correlation. Negative one would be a perfect flip-flop inverse match. In other words, areas that started at a high-volume level in 2000 were somewhat likely to have low volume growth from 2000 to 2004.

Despite this, we found that areas ranked by volume level in 2000 had a very strong tendency to remain in the similar volume level rank in 2004. You see that that correlation coefficient is nearly one. This means that high-level areas had a very strong tendency to remain high and low level areas tended to remain low.

So if one were to pursue a geographic area target alternative, ideally areas that have both low volume growth, low level would be rewarded with better physician fee updates. Conversely, areas with both high volume growth and high volume level would be penalized with lower or even negative fee updates.

However, a key remaining implementation question is what to do about the other two combinations: high growth/low level and low growth/high level. How should these areas be treated?

To summarize the advantages and disadvantages for this option, under advantages you can see that payment updates are a function of variation in practice patterns and volume and this may help to address variation over time.

Under disadvantages, selecting the appropriate geographic unit size involves some trade-offs, which I mentioned earlier, among accountability, volatility and administrative feasibility. We've selected the 50 largest MSAs as an example here. This, of course, does not incorporate the entire area of the country.

Also, updates based on levels lock in existing variation while updates based on growth, given the incredibly high rates of growth in some areas, could result in deep cuts which could harm beneficiary access to physician services.

And finally, attributing spending and volume of services to physicians requires assumptions about those physicians responsibility for those services. And of course, we face the key problem in fee-for-service Medicare that beneficiaries are free to see multiple physicians.

This concludes our presentation and we look

forward to your comments.

DR. CROSSON: Thank you.

DR. REISCHAUER: Can I just ask a point of clarification?

When we're talking about high growth or levels, we're talking about just physician fee schedule payments or total payments for Medicare?

MS. PODULKA: That's just the SGR-related.

DR. REISCHAUER: Do we have correlations between the two? Between that total and --

DR. MILLER: To the extent that research has been done on this in the past, these tend to be correlated. So in other words --

DR. REISCHAUER: Positive.

DR. MILLER: Positive, yes. So your point is if I do more physician, do I do less hospital?

In the past that has not been the case, that if you do more physician you see more hospital, you see more test. It's pretty much correlated across the board. I think you see that it the Wennberg work and some other work done a few years back, maybe a lot of years back, as I'm

vaguely remembering.

DR. CROSSON: Thanks a lot. I continue to think that this is a fruitful area for analysis. Every time we look at it we see not only the complexity and the disadvantages but we open up a new set of ideas.

I have the sense, not to gainsay our discussions later in the fall, that we may find something in the end that is a combination of these five approaches and in so doing minimize some of the disadvantages that are obvious in any one individual approach.

I had two questions for clarification in the type of service growth option. I guess one comment and one question. The first one is I think that you present two options for setting the target. One is the objective target, the growth in GDP, which is currently used. And then trend target.

But I wonder, and it plays out in the geographic option, if in fact there's not another choice. And that would be to use the growing body of evidence about regional variation, or perhaps other types of variation by, for example, delivery system type, to essentially set a running

benchmark. For example, the 25th percentile of regional variation or the 10th percentile or something that would be consonant with our philosophical approach which says something about the efficient provider.

So I think that would be something to explore.

With respect to the productivity approach, I may be wrong here but I was trying of understand if, in fact, what was being said was that if more services are provided per unit of time, that represents an increase in productivity. And not being an economist, I would think that generally it does, provided that the output is standardized.

So yesterday we heard, for example, from Dr. Kaplan that in the management of low back pain there was a prior pattern which involved, as I remember, 50-some percent of people receiving an MRI and x-rays of the back and multiple consultations. And then the end product was management by physical therapy.

And then after reengineering, they changed the process. There, in fact, were less services developed but the output arguably was the same.

So if you measured productivity by the number of Medicare services provided over a unit of time and, in fact, decided that that was better productivity but the output was the same, is that actually better productivity? Or is it not?

MR. HACKBARTH: Any comment on that?

If you think in terms of bundles, like caring for low back pain and you're not talking about a discreet service, you can imagine how the mix of services might change to get the same or better outcome with fewer inputs. And therefore you're increasing productivity for that particular type of care.

DR. REISCHAUER: Resources used per unit of output, and the question is what is the unit of output and what are the resources? And resources in the example they're using this time of physician only.

MR. HACKBARTH: And the output is a very narrow discreet service, a billing code for whatever.

DR. MILLER: I just want to say this because I think your question implicates this. It wasn't just a random choice to say if you assume that a time unit, the

RVUs, that's what they are intended to reflect: time and intensity. And so starting with that assumption, and time doesn't change in the units go up, then the assumption is that maybe that work RVU wasn't set properly.

If during the RUC process you sit around and say okay, the complexity of the service, given the time and intensity it takes to do it, results in a RVU of this much, and with no about to change in the amount of time that a physician spends in the office and the amount of Medicare patients they see, volume grows 11 percent in one year for that service, maybe time and intensity you were assuming about the RVU was not correct.

And so that RVU, in theory, should come down. This is all predicated on the assumption that the RVU is a time and intensity unit, which it is. And in a sense you're bringing in the notion of what about quality and the outcome. But that's not what the RVU --

MR. HACKBARTH: I think Jay is on to a really important point, though, that causes me real reservations about the type of service. We know that our current mix of services is not optimal, certainly in the aggregate. If you

look at Part B, a lot of what we talk about is how do we change the mix of services so that we get as good or better outcome with a lower cost set of inputs? I think that's our general goal as a society. So why would we want to, in Part B, start saying we want this current mix, we want to somehow make it more static?

It may be that we want more imaging to reduce major procedures. That's a good thing. Now we all have -- at least I have my suspicions about whether all of the imaging we're getting is good. But we certainly don't want to say this is the right volume of imaging and we want to stop it. We want to have a fluid system that allows the mix of services to advance with medical knowledge. So why do we want to start regulating the individual silos?

It's sort of the old world that we're trying to get away from, not the new world where we want to go.

DR. KANE: I'm sharing Jay's discomfort on the notion that higher volume is higher productivity and therefore -- and that the output is the same. But I'm also concerned about things like what if we want a medical home and primary care docs to managed care and to take

responsibility for coordination, and we actually give fees for that, and that starts to increase the E&M visits beyond their historic trend levels or beyond their historic growth -- how do you get into this formula policy goals that are below this overall SGR target? And I think we're setting arbitrary targets.

I guess my other question is why is it that the physicians are the only ones being held to the GDP standard, that this is how much we can afford when it actually -- they're about what, 12 or 15 percent of total expenditure?

I guess I just find the whole construct very hard to make logical sense of. I can see why it makes policy sense because these are targets and they're kind of measurable and you just go after what you can measure. But I don't understand why A, physicians are the ones that have to live within our means and nobody else does; and B, how do we then encourage appropriate care when we've got these arbitrary targets?

DR. MILLER: Those are

all fair questions and gigantic questions. A couple of just things for everybody to keep in mind.

One is the system, as it stands, is arbitrary and there is a target and there is no variation. So it hits everybody the same. So remember that's the starting point.

Remember also, at least in a mandated report context, we were asked specifically to consider these specific ideas, type of service, that kind of thing, so we're trying to explore them to the best of -- and I know you know this.

As I think the next point I would make is some of the statements that you're making and the notion of should there be policy objectives here, should quality be part of this calculation, are also things that we need to say -- whether we're talking about type of service, geography, whatever.

But just try and keep, as much as possible, two tracks in your mind, responding to the mandate and then the things you want to say beyond that.

MR. HACKBARTH: Part of our original critique of SGR was just that, that it applies to part of the system and we're not sure that that makes a lot of sense.

Arnie and others have said at various points maybe

in world we want to get to, the share of total spending going to physicians increases rather than -- even relative to the current level -- rather than decreases if it represents an efficient substitution of services.

The way I envision this unfolding, and I'm essentially repeating just in different words what Mark said, is that when we comment on these different options we are not bound to endorse any one of them. We are bound to analyze each of them.

I see the preface to all of this being our laying out some of our often stated principles about where the system ought to be going to help establish a benchmark then against which we assess the individual alternatives.

And so you're raising very fundamental points, as Jay did. And I see those as coming first and then we delve into option A, B and C, and so on, and assess them against those.

At the end of the analysis -- I won't prejudge where we end up -- but a lot of these are problematic in terms of basic long-term objectives for system change and reform.

That's not to say there without advantages and potential benefits but there are some real fundamental problems in looking at this as a Part B only issue, among other things.

DR. SCANLON: Let me first respond a little bit to the issue that Nancy raised, why are physicians different? I think part of it is that they are different. They are unique in our system in that they are the ones that we have given the power to control the use of other resources, as well as they're pretty much in charge of the resources that they are going to provide themselves, in part because we're not ever going to be in a position to review what they decide to do in a very detailed way. We've roughly got a billion claims coming in from physicians every year. And the idea that we're going to review them and be able to say yes/no is ludicrous.

At this point, there's huge outcries that you get from the physician community about the amount of review that goes on. It's less than 1 percent of claims. Most physicians have one claim that they're asked to turn medical records in on.

So we're not going to get to a point where we're going to be able to say that we're very confident these services are appropriate.

For other types of services we haven't had the same problems of volume and intensity that we've had in the physician area. And so there are reasons why physicians are unique. The Wennberg supply related service patterns continue to support that perspective.

I think we're opening up, and Jay started it, I have unease about this because I worry about the overall economic framework that we should be thinking about in terms of evaluating these things. The thing that triggers it is when we talk about this issue of mispricing because the mispricing, in some respects, and it goes back to when the volume performance standards started to create some divergence in the conversion factors.

The relative value units are reflective of resources. But they're not necessarily reflective of what the prices that might be paid in a market where there was good competition, people were well informed and the market was determining the prices. Because in those kinds of

markets prices are partly determined by the demand for different services. And if you've got to attract more resources to one type of service, you may end up having to pay higher prices.

In some respects in the physician fee schedule we did do something similar but we did it on a national level. We measured the relative resources. We decided that the overall amount that we were spending on physician was adequate and we used that to create the conversion factor.

We didn't go and measure, as we did for other services, costs because we can't. The biggest cost of a physician service is the physician's time, which we have no measure of what that "real cost" is. They may tell us what they would like to be paid but we don't necessarily have to believe that.

My concern is that we need to think about this a rigorous economic -- what's the rigorous economic framework? What's the prospective that a purchaser should have in this exercise? And what should a purchaser be willing to do in terms of payment for different kinds of services?

That may lead us to something very different than

the national fees that we have today. We've had all kinds of discussions over the time I've been here about the issue of the value of primary care and concerns about the future of people going into primary care. Well, that's a classic example. If it's going to take more to attract people to primary care for one reason or another how do you get there? Do you get there through the fees for the current configuration of services? Do you create new types of services so that the primary care physicians are rewarded in different ways and people will be attracted to that field? Those are the kinds of questions that we should be asking.

I think it also applies to all of our discussions about pay for performance. Pay for performance is going to start to distort fees as well in terms of their fees relative to costs, fees relative to the RVUs. The question is are we doing that in the right way.

So I hope we can think about how a broader, more rigorous economic framework can be constructed to be able to assess what these various options imply.

A couple of other different points. One is I think we shouldn't use the GDP plus one as a potential

target on the basis of the actuary using it as that. The actuary is kind of giving into reality that the increase has exceeded the GDP in health spending historically but it is by no means necessarily desirable.

So I think in doing this we should be thinking about what are the desirable targets that we would like to have.

The last thing which is something we've talked about, and I think this is area where it applies, is the issue of the administrative ability to implement options that we create. This comes to the resources that CMS is going to have to do this.

One thing of a historical note to remember is part of the SGR problem that we have is because of data errors that existed in 2000 and 2001 when the physician fee increases were actually larger than they should have been and then that had to be recouped. The ability to create or to assemble appropriate data on a timely basis is always a challenge in a program this large.

As we start to think about how we're going to cut it in various ways and ask for actually a lot more precision

than we've had to date it becomes even more challenging. We shouldn't raise the white flag and say okay, we can't do anything. We should be thinking about the strategy in terms of how do you complement a proposal for having a more detailed SGR like our physician fee schedule updates with an increase in the resources and the capacity of a CMS to be able to implement it.

MR. HACKBARTH: I'd like to invite some comments on the first part of what Bill said. What I hear you saying Bill, and correct me if I'm missing it, is that this discussion is organized as a result of a mandate around adding or altering a piece of the physician payment superstructure, the volume related piece. What are alternatives for changing SGR?

But you see problems in the foundation. The RBRVS, the underlying system, is based on some assumptions about how you want to price services, attach prices to the resources that go into producing them.

What I hear you saying well, that's one model but it may not get you where you want to be in terms of important policy goals. You may want a greater supply of

primary care and RBRVS won't produce it. So you need to break out of the resource-based way of thinking to achieve some of your policy goals.

DR. SCANLON: If what you interpret as the resource base is equal to the RVU times the conversion factor, that that's the price and that's the only way we're going to get to the price, then the answer is yes.

I think of the RVUs as information that is useful in terms of determining the prices that we want to play. But that single conversion factor may not be appropriate in all circumstances. And I think we're moving away from it in on a lot of our discussions.

MR. HACKBARTH: Any reactions to that particular point, John?

MR. BERTKO: Yes, I'm going to give you a completely pragmatic reaction to it. I like RVUs for a simple factor that they are a solid framework in contracting, both on the Medicare side an on the commercial side, which I think is an important consideration. The power is held by small single specialty groups and there are a number of them.

Having the RVU in place, let's just say no, it's going to be a flat 105 percent of Medicare. That's what our contract is. It actually is beneficial in that aspect to paying PCPs, as opposed to having to pay 150 percent to certain very demanding relatively exclusive groups in areas. To move away from that at this stage, I think, would a distraction at best and hurtful in most case.

MS. DePARLE: I think I followed you but I don't understand why does it keep them from saying 150? If they have the leverage, they have they leverage.

MR. BERTKO: If they have all of the leverage but it allows us to have a target point, again using that phrase, and we said no, that's it. We always contract at blank percent and take it or leave it.

It gives the payer side of it a little bit of assistance in some ways by saying we're doing this -- I'll use the fair here -- equitably across-the-board.

DR. SCANLON: Can't you still use Medicare as a standard? If Medicare uses a different method for setting its fees and you go into a market and you say to them here are the Medicare fees, we do 105 percent?

And the other thing I guess I would say is John, I'm sorry, but we can't have Medicare policy be done for the convenience of insurers. Medicare policy has got to be targeted on Medicare's needs.

DR. CROSSON: But I think if you were to follow Bill all the way through and assume that there was a rational and better way that came out of this, then I would assume you could still reference that better way.

MR. BERTKO: Yes.

DR. CASTELLANOS: Just to answer your question of pricing, you're concerned about the overpricing where the physician is asking for that. I can tell you in competitive markets in South Florida they're not paying Medicare rates. They're paying something discounted, 80 percent, 70 percent. I've seen them down at 60 percent. I'm telling you, managed care says take it or leave it. That's what we pay.

MR. BERTKO: And you prefaced it with the correct adjective, competitive markets. For every competitive market you cite for me, I can give you 10 noncompetitive markets. Smaller areas but it's a very difficult contracting issue.

DR. CASTELLANOS: My point is contracting is on both sides. It's not always in your pocket and it's not always in my pocket.

MR. HACKBARTH: Let's continue through our previous list.

MR. BERTKO: So let me give a couple of parts to that intro you talked about first, so I can feel better about having said them, and then directly address the questions.

Number one, any fix we make to the SGR is going to be very expensive in budget terms and I support the list of additional features to get more value out of whatever we're paying for.

Number two, I think keeping a target of some kind, in spite of all of our discussion, is important. Taking a target off would send a bad message or the wrong message at this point in time.

So now, getting down to specific comments, and Scott, I compliment you for showing an absolutely Byzantine method here, which I think is important to know. Jay and I, in different ways, have designed and help run systems of

things which are SGR-like, capitation funds, service funds, whatever you call them. I was associated with the Minneapolis mechanism here which changed essentially the RVUs on a quarterly basis, and to some degree helped make it collapse of its own weight on that.

And so I would say, first of all, simpler is always better.

Secondly, I agree with Jay's comment which I think he said quickly, some combination of these things is probably the best. But simple and broader targets divided by geography are very important.

In the world that I see the capitation funds for physician groups are still reasonably popular. As we heard Dr. Kaplan say yesterday, he would take capitation today, even though he got rid of it six or seven years ago.

In some of our markets, in some of our Florida markets, we have extremely efficient physician groups who love capitation. But the trend has been and pretty much now locked on, to capitation within the services they deliver. So in spite of the comment that we ought to include other things like inpatient, or you could put drugs in that mix,

the answer on a practical basis seems to be no. Let's just keep it within either primary care or, more likely, the one that is a general physician services type of thing, which is administrable.

Bill mentioned this a moment ago, the concept of administering anything very complex is just amazing. The amount of time and effort we put into administering a fund for 100,000 employees and dependents in Minneapolis on a quarterly basis, changing RVU schedules, it was almost beyond us at the organization I was in at the time.

To think of CMS having to do this, or with contractors, in 250 areas if it was geographically designed, would be just mind boggling. So simpler is much better.

And then lastly, I think maybe to address the correction of protections, I think it has to be cumulative. There's a bunch of ways to think about doing this. Medicare Advantage plans are subject to cumulative corrections in the way that the updates come out. I think that's for the best on both sides of the fence. If there are over projections they get corrected the next year. If there are under projections they get corrected the following year.

One other assumption here I've kind of made in my mind is that this involves a fresh start, that is forgiveness of the current cumulative overhang. I don't know if that needs to be a separate topic that needs to be addressed.

MS. DePARLE: I agree on that fresh start. We've had that discussion in here before.

I'm glad that Nancy took the pin out of the grenade because I was sitting here thinking, as I always do every time this comes up, that I might as well just say it. I have never understood why the volume of physician services is tied to GDP growth. Every time -- I was I guess at OMB when this thing first was implemented or right after it, and then at HCFA. Every time it came around to doing the rule I really had to go back to first principles and say why is it this way?

I suppose one could argue it's an elegant way to constrain health care growth. Some of you may recall during the Clinton Administration's health care reform, the discussions that we started on health care reform. There was discussion about global budgets. And there are ways of

doing that. But that isn't what we've chosen to do in any other area.

I question it frankly as our policy goal. I was amused when Bill said that the GDP plus one target that was discussed in this presentation was based on the actuaries, that they were grounded in reality. I think the actuaries would be thrilled to hear that someone thinks that they're grounded in reality.

It's not just historical. It's like the last 50 or more years, 75 years, that health care has grown at not just one point above GDP but several points. And with other areas of health care, perhaps not as effectively as we'd like to be, but we use other policy levers. We use the update with hospitals. We use the transfer policy or whatever as ways of trying to constrain what we think is inappropriate growth or volume and intensity.

So I understand, Mark. You and I have had this argument too and discussion before. I understand that on this report we've been asked to look at these various ways. But if I were writing the preface I would start with I don't think this formula makes sense.

If we are going to look at the type of service, that's an interesting way of looking at it, I suppose. But I'd be very troubled if we didn't try to look at -- if we get drawn again into this kind of formulaic thing without looking at why is volume growing in particular areas? It may be, and others have said this, that there are things that we want to increase. It may be that Congress has enacted policies to have colorectal cancer screenings or whatever. And things are growing for that reason.

DR. REISCHAUER: Those are all taken out though, remember. There's an adjustment made.

MS. DePARLE: Is it really?. I'm not so sure that that's really -- that we've really gotten to the bottom of that.

MR. HACKBARTH: The statutory and regulatory changes are, in theory, adjusted for in the target. But there are other changes in health care delivery that would not be captured by those that are desirable.

MS. DePARLE: I'm not even sure of the other.

MR. HACKBARTH: For example, pay-for-performance. There are a lot of areas where there is known under service

and quality care requires an increase in the provision of certain sort of services. The formula doesn't adjust for those.

DR. REISCHAUER: But there are equally areas in which undesirable things are going on. And while we criticize the RUC because it only looks in one direction, and we can't in fact look in both directions. This is down in the level of the weeds here anyway. And what we're try to do is say as a society what can we afford? And what we can afford, we think, is something around the growth of real GDP. That could be too low. As a society we could say no, we want health care to be more robust. We could set it at two GDP. That would be fine, too.

MS. DePARLE: That's an elegant way to run the world but that isn't the way the world is run. And that certainly isn't the way other areas of Medicare are run. That's my concern.

DR. REISCHAUER: Put me in charge.

MS. DePARLE: I agree, if Chairman Mao/Bob were in charge, that's what we'd be doing.

I can go there. That's a very interesting way of

running health care. But that isn't what we're doing. And I think if we want to look at other policy levers, that would be open, self referral. There lots of things that need to be looked at here. I'm not saying that those things should be off the table. I just think we're shrouding all of this in some veneer of this is the way we should do it and it really isn't the way we're doing anything else. I'm not even sure it's consistent with our policy calls for the Medicare program.

Again, it's tilting at windmills I know because all of this would cost billions to fix. And if we start over again, it would be very difficult. But if we're going to get drawn into all these formulaic discussions again, I just felt I have to say it. And I don't think it makes sense.

MR. HACKBARTH: This is a very important point, I think, for the preface. Some things we get too much of. Some things we get too few of, both within the Part B realm and in the prior package of health care services. I think everybody around the table agrees with that. Everybody who pays any attention to health policy agrees with that.

What we need are mechanisms that give clinicians and other providers the incentives to work with their patients to get a better mix, a more efficient mix and not use efficiency to mean quality and cost in patient satisfaction.

The fundamental issue that I have with these Part B only approaches is they are not giving an appropriate reward, incentive, set of penalties to clinicians and providers to make better decisions. In fact, most of them, many of them, actually may lead you in the wrong direction. And looking at just the Part B part of the problem is, I think, very dangerous in that respect.

DR. MILLER: Can I just do one quick thing? Can you give me the third slide?. I just want to respond a little bit to Nancy-Ann because I also want the public to understand what's going on here.

Maybe it's the second slide. I'm sorry, maybe it's the fourth. See what the problem is?

I want to be very clear here. We went through and we used GDP in our examples because that's the current system. One of the issues that we can consider is what the

target is. And that's why, for example, we started talking about an objective versus a trend. So I just don't want you to think they we're going down the GDP road because we're saying we must do it. I also don't even think the mandate is saying you must do it. We're just doing it because it's the easiest reference point where people will go oh right, that's the current objective standard, just to illustrate some impacts here.

So you should know that that is on the table and a question that can be addressed of how to set the target, if at all, I suppose.

DR. REISCHAUER: That's a question that's well above our pay grade. That's what we elect Congress for.

DR. MILLER: These are all above my pay grade, let me be clear that point.

DR. REISCHAUER: If we want to talk about what we're paid to do...

DR. MILLER: Can we talk about my pay?

[Laughter.]

MS. DePARLE: You're talking to Chairman Mao there, remember. He's not the right guy to talk to.

DR. MILLER: Will you guys stop saying Chairman Mao. This is a public meeting.

[Laughter.]

MS. DePARLE: Just to respond to Bob. It is what we elect Congress to do. But Congress asked us to give them the best advice about this. And if we can't say -- I don't know that everyone agrees. I've been on this for a while. But if we can't say that we don't think it makes sense, I don't know who can.

DR. CASTELLANOS: I don't know where to begin.

I guess I have several issues that I'd like to bring up. One is I know we're mandated by DRA to look at these five multiple spending targets. And we need to do it and that's what we're doing. And I think we're doing a good job at it. I think these need to be discuss openly and frankly and the good points discussed and the bad points discussed.

But DRA also required this commission to report on other alternatives or alternatives to the SGR. I think it's important that we look also at other alternatives.

Nancy, I couldn't agree with you more. I don't

think GDP has any relationship to medical care. And why are the physicians held to that while no other provider really is? I don't know. I didn't write those rules.

I think a fairer index may be MEI. And I know MedPAC has looked at that before. Unfortunately, I'm new on the commission and I don't have the history that you have. But I do know that Congress has gone on record, CMS has gone on record, every medical society has gone on record that what we're doing now isn't working.

And I suggested that we just not look at these five alternatives but look at other alternatives, also.

MR. HACKBARTH: Can I just pick up on that point, Ron? There are two separate issues. MEI is an index used in helping to set the price of individual services. And the basic notion is that these prices ought to have some relationship to the increase in input cost that physician's experience in producing them.

GDP, in this context, is used as an aggregate target that combines both price and volume.

In fact, the GDP increases more rapidly than the MEI because it does increase national wealth. The GDP is

total -- there's real GDP growth above inflation.

And so physicians don't want to substitute the MEI, a lower number, for GDP, a higher number. But I think your point about MEI is for the unit prices and have a unit prices system linked to MEI; correct?

DR. CASTELLANOS: That's correct.

MR. BERTKO: Glenn, may I just add that part of our charge here is not only keeping providers equitable under this, but consumers. And broader measures tend to address the part of what should be the increase in Part B premiums here and cost sharing? And so I think broader rather than more targeted ones are important for us to consider, as well.

DR. SCANLON: To clarify what you're saying is to apply MEI to the unit price and ignore the volume changes. Because right now the way we do the updates is we take into account MEI and then we look at volume. And if volume were to equal GDP growth, then it will be the MEI. If it's less, it will be greater than MEI. And if it's more, it's less than.

DR. CASTELLANOS: I'd like to continue on the

issue and I'd like to continue a what is specifically volume.

What we're trying to do here is control costs. And the way we're trying to control costs at present is by controlling the volume of what the physician orders. You may not like it, but it's a price-fixing in my opinion. It's a way of controlling costs.

I've had several discussions with Mark concerning volume and, not to pat him on the back, but on his report to Congress in July he probably gave the most astute answer to volume. I think we look need to look at, as Mark said to the Congress at that time, was to look at the root causes of volume. And I don't think we've adequately done that.

I've looked over some of the work that MedPAC has done but I think there's a lot of other answers perhaps to volume control than what we've looked at. And there's been several newer articles concerning obesity, comorbidities, lifestyle, smoking, et cetera, that add to this.

So I think when we talk about volume, I think we need to look at why we have the increased volume.

Increase in volume isn't that bad, in some

respects. In some respects, it's bad. I'm not saying that doctors don't abuse it at times. I think you can show me examples of that.

But I think we need to really look at volume a little bit more carefully.

DR. REISCHAUER: Can I make a comment on the origins of all of this which really goes back to what Bill said? Let's assume there was no waste and all increased medical care was good, meaning it had some positive value to society. We wouldn't just have an infinite amount of medical care. We have limits. The limit is the size of our economy and how we want to allocate it between pet food and medicine and transportation and compact discs.

And in a government program, we don't have a market that will do that. We have a political system that is based on the collective judgments of society that the resources, public resources we devote to this activity should be about this much and growing at about that pace.

And that's what this is all about, really.

MR. HACKBARTH: I'm not sure that that was the origin of the SGR. If that's, in fact, what they wanted to

accomplish, they would have looked at total Medicare spending. I think the origin of the SGR was that they -- I think the origin of the SGR was that there was seen to be a specific problem with growth in physician spending, an increase in volume and intensity, and we needed some mechanism to change the dynamic. It wasn't well, let's think rationally about how much want to spend on Medicare.

DR. SCANLON: But you could be thinking in the back of your mind rationally what do we want to spend on total Medicare? And you say to yourself hospitals are under control, nursing homes are under control, home health is under control. Remember, this is back in the '80s before we had our home health and SNF explosion.

And you say yourself wait a minute, there's one surface that's going up volume and intensity, not price, volume and intensity, two to three times to GDP every year. What are we going to do about it? And we're not going to review claims because we can't.

And so therefore we're going to send this signal to say we want some control. And we had pretty good control under the volume performance standard. We had pretty good

control through 2001. And we did.

No, if you look at the data, we did.

MR. HACKBARTH: But it's an illusion that you had control. There were other things going on in health care that meant that that was a period of relatively low increases. You had no control.

DR. SCANLON: We achieved our objective even when we didn't have control. The best of both worlds.

[Laughter.]

MR. HACKBARTH: It's delusion.

DR. SCANLON: We cut the rate of volume and intensity growth in half.

MR. HACKBARTH: To the extent that anybody cut, it was John Bertko and people in private plans who were changing how the market worked temporarily, temporarily. It wasn't anything related to VPS or SGR.

MR. DURENBERGER: Can I add just one other point?

I'm only doing this because I saw George Greenberg walk in the room. George from CMS was sitting in my office the weekend we actually did this. We had Waxman and Stark and Rockefeller and myself and we're banging heads and

things like that.

I'm not going to speak to the origin. I agree with you that that was a problem. But one other important point which makes me a pin-puller on the grenade, whether we're confined to the first paragraph or the introductory chapter of all of this.

The other thing that a lot of us knew at the time, we're struggling with the impact of DRGs on hospitals on physician spending, we're trying to get physician spending under control. We also knew that the TEFRA risk experiment that was going on in the mid-80s told us if you've got the docs, the hospitals and the health plans together in certain areas of the country at least, you could drive down the growth of cost substantially. So we knew that at the time.

One vivid memory I have, besides George missing his kid's soccer game or baseball game or something, was the realities of sitting there with the then-CMS administrator and getting a promise that right off the bat she was going to find some way to deal with this problem, which of course she was never able to do from 1989 -- this was the administrator in 1989, not you.

So I add that because of the nature of the discussion.

MR. HACKBARTH: Karen has been waiting patiently.

DR. BORMAN: Uncharacteristic for a surgeon, too; right?

I'd like to just ask a technical question first. Remind me that in the differentiation of major procedure versus minor or other, is that based on global periods?

DR. HAYES: The distinction is based on a type of service classification scheme that CMS has developed -- this Berenson Eggers type of service classification scheme. The clinical input that CMS received prompted this distinction between major procedures and others.

I think it's fair to say that, for the most part, the major procedures include a global surgical period that would include the procedure itself as well as pre-and postop visits. But I can't guarantee that that's the clinical input that CMS received, but the result is that in the general that's the way it works.

DR. BORMAN: Because certainly at the CMS level major and minor procedure distinguishing does relate to the

episode, the length of the episode, which certainly kind of starts to move into some of the other things we've talked about in terms of looking at episodes and how you define them and so forth.

And so I think it's important not to collect apples and oranges to the best that we can control it unless we're going to say up front we've collected a fruit basket as opposed to saying we're making a valid comparison.

So that was helpful.

My observation would be, and I agree to some degree with what Bill Scanlon has said, whether you agree or believe how it was done, why it was done or whatever, there was some effect of VPS in the context and the time at which it occurred. Now you can argue up and down about what you attribute to each piece of it but I'm not sure that any of us, myself included, can wave the magic wand and say there was no impact of that or it did match up with reaching a portion of a goal. And maybe the challenge is to find out what in there helped to get to the portion of the goal and extract that out.

And let's be careful about throwing out the baby

with the bathwater here a little bit and sort of maligning VPS a little bit.

I'm a little puzzled, and I'm sure this is my naivete and perhaps statistical ignorance or whatever, which may be blissful, but we're talking in some significant degree about a method of controlling cost. Yes, over here we're also saying we want that to subserve advancing quality. But that out here the big gorilla is the cost.

If we say that's a pretty overarching target, then we send a pretty mixed message to people who did indeed control their growth, the increase in the conversion factor did, in fact, reward those people to some degree. Now you can argue whether that translated down to the individual physician level, objective or whatever. But it was controlled growth and you get something for it. If we're talking about incentivizing people, that's incentive, in my simpleminded approach to the world.

What we're, in part, doing is saying even if you don't control growth we're going to reward you.

As we broke it out into finer and finer things we then said okay oops, we're going to combine it all into one

conversion factor. Intentionally perhaps there was a message sent that to the subset where volume was controlled that well yes, we told you that we were going to reward you, but now we're not.

I think we have to be a little bit careful about mixed messages that we're sending here. Physicians don't spend huge parts of time sitting back and thinking about the wonderful policy considerations going on here. You're sort of dealing with a message from the bottom line. And you have to be a little bit careful about the message.

MR. HACKBARTH: The reservation that I have about that, Karen, is the rate of growth for major surgical procedures is lower now. VPS doesn't exist. There's no differential conversion factor. People aren't responding to incentives. There's something different in the dynamics of growth in major surgical procedures than there is in imaging.

So I absolutely do not believe for a second that the reason that surgical procedures grew less under VPS was because surgeons were responding to incentives. The incentive of the individual physician is never to control

volume in a fee-for-service system, even if there's an aggregate national target. The incentive is to do more. It's a classic free rider problem.

If you want to create real incentives for individual clinicians to change behavior, the incentives have to be way closer to home than national targets.

DR. BORMAN: If I could just respond to one piece of that, and to say a very academic phrase, I don't disagree with all of what you've said there, and I hate saying that, that don't disagree part.

But I have to also tell you that one thing that's a bit different about some chunks of major procedures, whether they're accomplished through open operation by classic surgeons or whether they are major procedures that are accomplished through other means that are not typically thought of as surgery. I would challenge anybody that angioplasty is not a major procedure. It is.

So I think that one thing you've got to remember is there are some pretty big chunks here of surgery that are unable to be repeated. I can only take out your appendix once. I can only take out your gall bladder once. My

ability to grow that pie relates to population growth. It does not relate to my ability to do more of the services that I do.

I would say that imputing that I will do more questionable things in order to up my growth, I would resist -- and I know you didn't mean to imply that. But I do think that we do have to be a little bit careful and think about the whole pie.

MR. HACKBARTH: Absolutely. Just for the record, I want to be clear that I wasn't saying that you or any other surgeon was going to try to take out the appendix twice because of fee-for-service payment.

My point is that there are different dynamics in the growth rates for different types of services. Under fee-for-service the economic incentive is always to do more. Obviously there are other factors, including professionalism, that affect clinical judgment. And thank God for that or we'd be in even worse shape.

DR. MILSTEIN: I'd like to, first of all, just very strongly endorse Glenn's original framing that what I think the nature of this opportunity is and the fundamental

lack of fit between this tool and any objectives that we share.

My view is that we want physicians to lead a transformation in quality and affordability of the Medicare program, and in doing so, the whole U.S. health care system, since Medicare is by far and away our strongest lever.

That said, it's important to recognize that any attempt to facilitate that goal that's limited to physicians service growth only is, I think, likely impossible to achieve. There's too much of a mismatch between the subject or the lever which is changing in physician service volume only and the quality and total affordability goal that we're after.

I think the only exception to the incontrovertibility of this tool to our objectives is that the current SGR results in extremely severe physician fee cutbacks across the board. This is going to sound a little counterintuitive, but that actually could be, in that way, makes it quite useful.

What I have in mind is for us to consider, as one option, the unaltered continuation of it as a valuable tool

for motivating physicians to opt out of it and into a system that rewards them robustly and overwhelmingly for the transformation we're after.

MR. HACKBARTH: Let me pick up on that with a piece of personal history. When I was at HCFA in the mid-80s we actually looked at proposing an SGR-type system with that specific strategic objective. The idea, to put it frankly, was to make fee-for-service Medicare untenable and then give physicians an escape route that would result in better organization and delivery of care where it was total expenditures, the whole package.

Obviously, we got cold feet and never did propose it. One of the reasons we got cold feet was that we had doubts that, in fact, Congress would ever stick to it and ruthlessly apply the stick to get the system to change. And evidence has shown that that reservation was basically correct.

I think the elephant in the room in the policy debate is the fee-for-service system does not work. Originally, when the program was first devised, you could

say well, this was an approach that would maximize clinician autonomy, maximize patient choice, and at least what we would get out of it is access to high-quality care.

Well, we've run the experiment for 40 years and it doesn't even give us that. At the end of the day we're not getting consistently high quality care. We're getting lots of access. We're getting lots of technological sophistication and advancement. Those are very good things. But at the end of the day, we are not even getting consistently high quality care, let alone efficient care for our beneficiaries.

All of this is a dance around how we patch a system that is fundamentally mistaken in terms of its assumptions and its operation

Except I'm a practical enough person to know that you can't overnight legislate that there won't be any more fee-for-service. But I think the strategy needs to be to move the system strategically towards arrangements where physicians are given the incentive, the opportunity to better organize care for patients.

These Part B only systems just, I don't think, get

you there except in the very limited sense that Arnie described.

MS. HANSEN: I just would like to pick up on the fact that the system, this Part B, is not effective as is. And I'd like to, again, highlight the unintended consequences that have been brought up a couple of times already from the beneficiaries' perspective.

I'd like the story to still be visibly told of the double digit premium increase that beneficiaries are facing and have been facing, coupled by when you increase volume, regardless of what it is, there are more copays. And then looking at beneficiaries as a whole, many of the beneficiaries are older women. That's really your older geriatric population. And about two-thirds of older women rely only on about $950 for their basic Social Security check for 90 percent of their income.

So when you start looking at the economic model for creating the so-called access and choice and what not, doing a practical math problem, it also potentially cuts off access without addressing some fundamental issues.

So I just wanted to make sure that face is really

portrayed in the course of the data that we present.

MS. BEHROOZI: Everyone else has expressed so eloquently the problem with accepting the definition of the problem as it's been presented to us. But since a lot of us spend our days working within systems that we didn't create and trying to make the best of it, I'll try to do my assignment and address what we've been given just a little bit, just a couple of points.

One of the questions that you ask is whether we should be looking at existing levels of volume or growth in volume. I think that that really gets back to the question of what is it that's within the physicians' control. It seems to me that something like geographic area, the factors that influence volume, are less within the physicians' control. It's got to do with the historic patterns of utilization and beneficiary demand and access and marketing and all kinds of things that may be less within the physicians' control. I could be wrong about that but that's the way it strikes me.

Type of service is more within their control and is also something more related to the policy judgments that

we might want to be supporting or suppressing or whatever, in terms of what are the types of services where we think growth is appropriate or less appropriate.

But I think part of our problem with our discussion today is that we've been asked to talk about only two of the five potential areas and we all know that they're all out there. I think confining ourselves to two at a time makes us all a little crazier about the exercise.

I would just suggest that when you look at the last one on the list, physician outliers, that's the one that says this is what's in the control of the physicians, and maybe gets a little closer to what it is that physicians can control and controlling inappropriate volume growth, something that we talked about when we had the discussion in the summer, as opposed to controlling volume growth which might be appropriate in some cases, in some overall fashion.

So I'm not going to say that physician outliers is the one and only place we should look, but I do think that in general thinking about this problem we should be looking more to what we can incent, what physicians can control.

And then, by the way, if it turns out, I just want

to say one thing about the physician outliers point. There's a lot of talk about the Medicare system, about state Medicaid systems, about how much waste and fraud there is. And if you just controlled the waste and fraud the problem go away and everything would be affordable. And then there are other people who say physician outliers, you're talking about outliers. It's not that big a group. There aren't that many podiatrists who bill for six toes worth of treatment or whatever. So let's look at that.

And if you do that, if you respond to the people who are saying oh, it's all about waste and you show that you're only going to save 0.02 percent of your total spending, then we're done with that.

But we have saved that 0.02 percent or whatever it is that we shouldn't be spending. Or maybe we'll find out that that's a way to provide incentives for appropriate care and appropriate volume growth and be able to look at in a little bit more refined way.

DR. KANE: I agree that outliers may be actually a fruitful way to go only because I think when the fraud and abuse statutes were passed, weren't they estimating that 10

percent of expenditures were fraudulent and if you really had good edits in the claims system -- electronic edits, that you would catch more of this. So I think that's probably a good way to look.

But why don't we use the technology of managed care to set limits rather than GDP? We have all of these private insurers and Medicare themselves who do estimate per capita costs in a geographic region. And they obviously have some sense of how that per capita cost breaks down by type of service, like physician, hospital, post-acute care.

And can't you do by region some kind of capitation guide that is the limit, rather than affordability, so it reflects the Medicare beneficiaries' health and demographics and burden of illness in any geographic area, so you have sort of an indicative capitation budget for a geographic area that's broken down. Maybe 15 percent of that is physician services and that would be the target.

I guess I'm trying to say why doesn't the target reflect the way HMOs set targets, which is expected per capita costs rather than affordability?

DR. MILLER: This is a point that Bob Reischauer

brought up in another discussion. We are aware of it and we're trying to troll through the thought, both conceptually and what kind of data could be used to support it. So it's something that we are trying to think through.

DR. KANE: But don't we already do this?

DR. MILLER: For Medicare managed care, yes. But some of those targets are based on fee-for-service.

DR. KANE: They are now, I understand. But fee-for-service hasn't gone away.

DR. MILLER: Let me put it this way. I think the thing that we would like to drive at is since the administrative benchmarks are, in part, driven by fee-for-service, what we'd like to look is are the bids, so that you could then go in and say am I coming in underneath that? That's the point that we're sort of thinking about.

DR. KANE: But there are also managed systems -- I mean, there are already managed systems of care that had people over 65 in them for decades that aren't driven by the fee-for-service. And there's also the VA has managed -- there's different ways you can get these.

MR. HACKBARTH: So if you're running a delivery

system in a managed care organization, there was an era a long time ago where you build up from your costs and said this is what we're going to charge. But that changed pretty dramatically.

And so you're taking a market price, what the buyers are willing to pay, and then divvying that up among the delivery system. So what you would need here is a market price to serve as your guide. One place you might look for that is the bids under MA.

DR. KANE: Also, the actuarial science for the build up from costs didn't go away. We stopped using it. I'm not sure we have to -- why can't you go to Kaiser or Humana's -- somebody's managed care business and say here's what we think the efficient per capita amount is, maybe inflated by some amount because it's not in the managed care system, and say that's the cap.

In other words, base it on the demographics and health burden of the geographic area rather than on GDP.

MR. BERTKO: Let me only confirm what Mark and then Glenn said, that the bids which are bid on the standard Medicare package, as part of it, as one step, do incorporate

all of that. The difference is what Jay and I offer all the time. It's a very distinct well-defined delivery system, as opposed to the fee-for-service system. Those are apples and oranges.

MR. DURENBERGER: I would just mention, Mr. Chairman, what I did yesterday, that two members of this commission are involved in an application for a 646 demonstration doing exactly what she has proposed. It isn't just the plan. It's the physician, the doctors, what we've been talking about all morning.

MR. HACKBARTH: Let me just try to make a couple of other connections here. The outlier idea that Mitra was talking about, immediately a question you ask is what are you looking at in your definition of outliers? And one approach to that is you'd need to look at it in episodes of care, as opposed to just service counts. And that has a host of complications.

But I'd link that back to the work that we have been doing in trying to look at tools that can actually look at efficiency in the delivery of particular clinical episodes as a way that you might start to think about

outliers.

And Mark says that may include A and B, and not just the Part B portion.

Geography. Set aside the SGR alternatives piece of this. We keep coming back, the health policy debate keeps coming back to these huge geographic variations. If we recommend anything in this area that makes me inclined to want to think about we might combine geography perhaps with other models to start moving the policy debate to doing something about geographic variation, as opposed to observing it. Just a reaction on my part.

Last, going back to the productivity model that Scott described, one potential use of that is as part of an SGR formula. But I wonder whether some elements of the thinking could not be relevant even in the unit price increase with MEI adjustment model that MedPAC has worked from in the past because we had this productivity assumption that we assumed that productivity was going to improve last year by 0.9 percent based on the 10-year moving average for the economy as a whole. And we have repeatedly said that's not an empirical estimate, that's a policy objective.

The sort of a productivity thinking that Scott was describing is a way of starting to introduce into that some empirical elements of what we're observing in the production of services. I'm not sure exactly how you combine it with our policy, but it gives you a benchmark.

We often hear from physicians well, I can't increase my productivity by that amount. Yet we see perhaps some evidence that at least some of them are. It sort of gives us some framework, empirical framework, for thinking about productivity, even if it's not linked to an SGR-type formula.

DR. KANE: As a way to discuss this whole topic of how we should redo the SGR, I would find it helpful if we started off by saying what should the right target be? And then say okay, therefore what is the best way to group however we went to group them. I think it's really hard to talk about these things, the groups themselves, without saying what are we trying to achieve.

If we all agree on a target we want to achieve, let's play along with this whole notion that physicians should be under a target and nobody else. But let's agree

on what's the most reasonable target and then go backwards and figure out which of these different methods gets you there best with the least amount of administrative complexity and the least amount of political resistance.

DR. MILLER: Just a couple of things. Can I get slide three up there? I'm pretty sure that's the one I want.

There are a lot of good comments here on a policy and technical. But just in the interest of clarity, and because I believe in some respects, in repetition. I really appreciated Mitra's comment about we're considering these things and it's driving us crazy. There are a number of things that are driving us crazy and I just want to lay some things out.

I think as a matter of procedure we're going to put this slide up and it's going to stay up in all of our conversations. Because I don't want you guys to forget this report will have a place where it will talk about the many things in all of the work that you're doing that you need to change in the system and the way things need to change. You could have this conversation entirely separate, and we have

come, from SGR, that we're going to include in this report. This is things like pay-for-performance, encouraging groups, cost-effectiveness.

And so, as you consider the difficult task of dealing with the five things that they've asked you to look at, don't forget, we have not forgotten, that there are other things that you want to say. And Dana right now is working in this part of the chapter.

Which brings us to Mitra's point, which is it is crazy. We have to work every month and bring to the table what we can get done from month to month. And we'll be constantly considering these things in bits and pieces. And it's very frustrating, because many of the things that you're raising might not be problems in an outlier policy or a group policy, which we're all going to consider as we come along.

There are things -- and if I could go to the next slide -- we were asked to deal with other ideas all together if we have them. Targets can be in play. There are other things that we need to comment on here.

So if we're throwing GDP around, for example, on

the target, it doesn't mean that we have to stick with GDP. There are other ways to think about the target. We've been thinking about the bidding but you're right, there may be other ways to think about it.

And again, it's frustrating for you because you don't necessarily know that we're trying to bring something to the table on that.

I think maybe I'll stop there. There are couple of other things, but I think they can wait.

MR. HACKBARTH: We are exactly on time, so thank you very much. Much more on this later.

Now we turn to another mandated report, this one on rural hospitals and payment provisions directed at rural hospitals.

DR. STENSLAND: Good morning. Today we're going to present some supplementary data on our mandated study of how certain rural provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003, the MMA, affected payments to rural and urban hospitals.

Our mandate states that MedPAC shall analyze the effect on total payments, total growth in cost, capital

spending, and other such payment effects of certain rural positions of the MMA. It should be noted that these sections of MMA called rural provisions often also affect hospitals in urban areas.

An interim report on how the MMA affected critical access hospitals was presented in our June 2005 report to Congress. Our final report on all the rural provisions of the MMA is due this December.

Today we'll discuss the effect of certain MMA provisions on inpatient payments, outpatient payments and capital expenditures and overall cost. First Tim will touch on inpatient payments, then Dan will discuss how the MMA affects outpatient payments and we'll present a policy option that could assist low-volume hospitals when they lose their outpatient hold harmless payments at the end of 2008. Finally, I will discuss how the MMA provisions and expansion of the CAH program may affect capital expenditures and overall hospital costs.

I think it's important first to put the impact of the MMA inpatient payment changes in context. It is important to note that most rural hospitals are not paid

traditional PPS payment rates. CAHs are paid 101 percent of their current costs. SCHs have the option of receiving an inpatient rate based on their historical cost of care. MDHs have the option of receiving an inpatient rate based on 75 percent of their historical cost and 25 percent of PPS current rates.

Therefore, when the MMA adjusted traditional PPS inpatient rates, most rural hospitals were not significantly affected because their rates are primarily based on current or historical cost.

And now Tim will talk about the specific inpatient changes.

MR. GREENE: Historically hospitals in large urban areas received a base operating payment amount that was 1.6 percent higher than rural and other urban hospitals received. The first row shows the effect of the MMA provision bringing rural and other urban base payments up to our large urban levels.

Before the MMA, rural and smaller urban hospitals had their DSH payments capped at 5.25 percent of total payments. The MMA moved the cap up to 12 percent. The

second row shows the effect of this change.

CMS increases operating payments in high wage areas and reduces payments in low-wage areas to reflect local input prices. The MMA modified this adjustment to increase payments in low-wage areas. This benefits hospitals both in urban and rural low wage areas. The third row shows the effect of this provision.

The MMA also increased the wage index of hospitals if they were in a county of residents of workers who commute to higher wage areas. Relatively few hospitals take advantage of this provision and it's a very modest effect on payments. The fourth row shows the effect.

These MMA provisions overall have a greater dollar impact on urban hospitals but a larger percent impact on rural hospitals. In total, the provisions increase overall payments by 2.5 percent and urban payments by 0.8 percent.

DR. ZABINSKI: The MMA also has two provisions affecting the outpatient PPS that the law requires us to examine. The first of these provisions required CMS to do an analysis that resulted in rural sole community hospitals, SCHs, receiving a 7.1 percent add-on to their standard

outpatient PPS payments. This policy pays the rural SCHs about $90 million. But the policy is also budget neutral, with most of the $90 million being transferred from urban hospitals to the rural SCHs.

The MMA also extended hold harmless payments for rural hospitals. The idea of the hold harmless policy is that the qualifying hospitals receive the greater of their outpatient PPS payments or the payments they received under the previous cost-based system.

The hold harmless payments had sunset at the end of 2005 under the MMA but the DRA, the Deficit Reduction Act, further extended them to small rural hospitals that are not SCHs through the end of 2008. This policy pays these hospitals about $70 million per year.

You might recall that last year we discussed options for replacing the hold harmless payments. But when the DRA extended them through 2008 we halted those discussions. But because the hold harmless payments are again scheduled to expire in the near future, we are again looking at alternatives for replacing them as well as replacing the add-on to the rural SCHs.

Our motivation for considering alternatives to the hold harmless payments and add-on to the rural SCHs is that both policies do not efficiently target hospitals that are in need or that are vital to beneficiaries access to outpatient care.

However, we also recognize that without any supplements such as the hold harmless payments rural hospitals would have worst financial performance under the outpatient PPS than their urban counterparts.

So with this backdrop, we set out to accomplish two goals. The first of these goals is to identify the factors that are beyond hospitals' control that cause the rural providers to have relatively poor performance under the outpatient PPS.

The second goal is, based on our findings, we want to develop a payment policy that directly addresses those factors.

Our work in accomplishing these two goals resulted in two key findings. Our first finding is that hospitals do exhibit economies of scale in their outpatient departments, meaning that outpatient costs per service tend to decline as

outpatient service volume increases.

The second finding is that rural hospitals tend to have lower service volumes than urban hospitals. We believe that this low volume strongly contributes to the poor financial performance of the rural hospitals in the outpatient PPS.

And because of these findings, when the hold harmless payments sunset in 2008 you might consider replacing the add-on for the rural SCHs and the hold harmless payments with a policy that gives low-volume hospitals the percentage increase over their standard outpatient PPS payments. A low-volume adjustment would be more efficient than the hold harmless payments and the SCH add-on, first of all, because if it is designed properly it can more efficiently target hospitals that are vital to beneficiaries access to outpatient services. Also, it would directly target a factor that affects hospital financial performance, that being whether a hospital is low volume or high volume.

Now an effective low-volume adjustment would have the following three features: first, hospitals would be a

minimum distance from other hospitals in order to receive low-volume assistance. This would help avoid making additional payments to hospitals that are low volume not because of isolation but because of poor performance in relation to their competitors. Also, it would help target hospitals that are vital to beneficiaries access to care.

Another feature of an effect of low-volume adjustment is that the adjustment rates would decline as hospital volume increases. That would assure that the lowest volume hospitals are receiving the highest adjustment rates.

And finally, critical access hospitals would not be affected and would maintain their cost based payments.

On the next two sides we show the effects of moving from the current policies to our proposed low-volume adjustment. First, under our current policies, first the SCH add-on is a budget neutral policy that transfers about $90 million, mostly from urban hospitals, to rural hospitals. But it does not increase total spending in the outpatient PPS because it is budget neutral.

Second, the hold harmless payments add $70 million

to the outpatient PPS payment for small rural hospitals but those payments go down to zero when this policy expires at the end of 2008.

Our proposal would replace the current policies with a low-volume adjustment starting in January 2009 after the expiration of the hold harmless payments. In your briefing materials we included an illustrative example of a low-volume adjustment that has a 15 mile distance requirement and empirically-based adjustment rates that result in about $40 million going to about 500 rural hospitals. We understand that some may be concerned about the magnitude of the assistance provided by this low-volume adjustment, so I really want to emphasize that spending under a low-volume adjustment can be increased by changing the parameters such as the distance requirement.

So to close this part of the discussion, I want to just present a draft recommendation where beginning in January 2009, the Congress should enact a graduated low-volume adjustment to the rates used in the outpatient PPS. This adjustment should apply only to hospitals that are more than 15 miles from another hospital offering outpatient

services.

The spending implications are pretty modest and that would add less than $50 million to budgetary spending. The implication for beneficiaries is that it would help assure their access to hospital outpatient care.

Jeff is going to conclude our discussion.

DR. STENSLAND: While it's fairly easy to estimate the changes in Medicare payments, Congress also required that we look at the effect of MMA on capital expenditures and overall hospital cost. In the past, we've shown that hospitals tend to spend less when they're under more financial pressure and tend to spend more when they have more money to spend. So we would expect some increase in capital expenditures following the MMA.

However, the MMA only increases rural PPS hospital Medicare revenues by roughly 2.5 percent on average, which is roughly equivalent to a 1 percent increase in total revenues. This is probably not enough to cause a measurable increase in the average rural hospitals' cost. There's too much noise in the data to detect the impact of a 1 percent shift in revenues.

To test the impact of changes in IPPS payment rates, we would have to focus on hospitals that received the largest increase in payments and look at capital expenditures and hospital costs at least through 2006. That data is currently not available.

However, the MMA also changed the CAH program and conversion to CAH status does lead to increased expenditures as CAHs modernize their facilities. Some may be concerned with this spending growth while others may see this as a positive sign that old rural hospitals are being updated.

Our preliminary analysis of 2003 and 2004 data indicate that aggregate CAH capital cost, such as depreciation and interest, grew by roughly 8 percent at CAHs compared to a 5 percent growth rate at small rural hospitals that have not converted to CAH status. The difference in growth rates is statistically significant. We will be examining cost data further and plan to present more analysis during our October meeting.

In our June 2005 chapter on CAHs, we projected that the number of CAHs would grow to roughly 1,300 by 2006 and the average CAH would receive roughly $5 million in

Medicare payments, which would be approximately $1 million above PPS rates.

There are currently over 1,280 CAHs and given what we see in terms of growth in payments from 2003 to 2004, and what we see in terms of increases in the size of CAH converters, our original estimates regarding CAHs appear to be on target.

In this slide, we examine the rate at which Medicare expenditures continue to grow after conversion. The sample is limited to CAHs that had converted before 2002. In general, the trends are as you would expect given the financial incentives. We see expenditure growth focused on swing beds and outpatient payments. These are areas where cost-based rates tend to be significantly higher than PPS rates at small rural hospitals. Some observers may view expenditure growth as a positive sign, indicating that rural individuals may be receiving more health care services. Others may be concerned about the rate of payment growth given past experience with cost-based reimbursement in hospitals, SNFs, and other providers.

We should caution that a significant increase in

outpatient payments may in part reflect CAHs starting to bill jointly for physician services. CAHs are able to receive 115 percent of the physician amount if they bill for the service rather than the physician billing for the service.

The most important provision of the MMA was that it requires new CAHs to be 15 miles by secondary road or 35 miles by primary road from the nearest alternative hospital. States can no longer waive this distance requirement for new CAHs. Most existing CAHs do not meet these criteria but were grandfathered into the program.

Since our preliminary report was published, CMS has published regulations governing the degree to which CAHs can be allowed to build replacement facilities in a new location. CAHs can relocate as long as they continue to serve the same patient base and have the same employee base. Some CAHs may be reluctant to significantly change their location or to merge with other facilities for fear of losing their CAH status and the cost-based reimbursement that goes along with it.

The current system, in essence, encourages the

status quo of maintaining all the current CAHs in all the current locations. In essence, the structure of rural health care delivery is, to some extent, encouraged to stay the way it witness.

However, rural communities continue to face some difficulty recruiting physicians to practice in towns with only one or two colleagues, and if economies of scale become important as we move towards pay for performance and electric medical records, there may be a few rural communities that consider consolidating with a neighboring hospital that is five or 10 or 15 miles away. To provide these communities with more flexibility, the Commission may want to consider the following draft recommendation.

The recommendation states the Secretary should allow CAHs to merge and retain their CAH status if one or both of the two CAHs closes and the new CAH serves both communities. The new CAH should be allowed to staff enough beds to meet the combined 2006 peak census of the two closed hospitals.

Not to be clear, this would not expand the bed limit to other hospitals that aren't merging where one or

both of the two hospitals closed. And I don't want to oversell the importance of this recommendation. Many rural communities feel very strongly about keeping their hospital in their town and they would be very reluctant to see a hospital closed. This recommendation would only come into play if you can find a rural hospital board that's going to agree to saying we should close the hospital that's in our town and that's going to be a rare occurrence.

But in some agricultural areas, farms continue to consolidate and population continue to decline and we may want to give those communities that are changing the option of changing the structure of their local health care delivery system, especially if a new health care delivery system is seen as a more efficient way to serve their communities.

To give you a concrete example, in my mind I think that maybe there are two hospitals, they're 14 miles apart. They each have a medical staff of three. The physicians are on call covering the ER every third night. Maybe they're getting tired of that. And they're thinking about remodeling, the hospital 14 miles down the road is thinking

about remodeling. And they say maybe we should just get together and have one hospital rather than two.

Then they talk to their CFO and he says if we move the hospital in between the two towns, Medicare is going to cut our payments by 20 percent. The concern is that maybe we don't want that to be the end of the discussion.

Now we'll open it up for your comments on the work so far and to hear your suggestions on the recommendations.

MR. HACKBARTH: Can I just pursue that last idea of allowing mergers. I understand the logic and it makes sense, at first blush at least.

As I said when we've talked about CAHs in the past, one of the concerns that I have is their impact on nearby PPS hospitals. We tend to look at them in isolation and not in a broader competitive context.

I've been worried that when we start to allow CAHs that are not really geographically removed that we start to then affect the nearby PPS hospitals. To the extent that we allow CAH hospitals to merge and become bigger, I wonder whether that would be an even greater risk, that we would start to have been adverse effects on nearby PPS hospitals.

DR. STENSLAND: The regulations that CMS put out, I think, were influenced by some PPS hospitals complaining that some CAHs were planning to move and move very close to their facility. So there would need to be new regulations on the part of CMS that would govern what would happen if two CAHs merged. I could foresee they could, for instance, say the new merged entity cannot be significantly closer to any PPS hospital than the current entities are, or something of that nature.

MR. HACKBARTH: Comments, questions?

MR. DURENBERGER: Number one, as usual, the work is excellent and it's also responsive, if I understand from the executive summary, what you were asked to do. So this is merely by way of suggestion to be more responsive perhaps then they asked you to be.

My first question is whether or not you've consulted a former commissioner at all, just in terms of the tone of the response and some of the information. But I just think it would be a great idea because Mary Wakefield puts her whole life not into to this kind of an issue, but into the service and the beneficiary-related issues. And I

think it would be helpful to talk to her, for other reasons too, because she has a good political sense and making sure that the way in which it's presented is helpful, particularly to the people who have sponsored a lot of this legislation, as well as those who might be a little critical of it.

MR. HACKBARTH: I think that's a good idea, Dave.

MR. DURENBERGER: The second one goes back to the discussion we had previously. In this presentation and in the paper I was reminded of the previous discussion, which mainly reflects that we're sort of on the wrong track if we only look at critical access hospitals and we look at distance and we look at things like that. That's not the way people are looking at it. The definition of medical home is a little town nobody's ever heard of in rural South Dakota where a bunch of docs have gotten together to create a medical home for people -- and Nick can do this better than I can because this is the area that he works.

But all of the things that we discussed when we were pulling the pin on the grenade last time is what's going on in rural America today in a white variety of ways.

It's probably helpful in some ways. I'm not asking you to analyze that. I'm simply saying it's helpful to reflect that it isn't just hospitals that are going to change the access, the quality and the cost. It's going to be physicians, and that's where the creativity comes.

My the third point is simply a question, and that is do we have information on ownership of critical access hospitals? You talked, I think, Jeff, about the consolidation and all the rest of that sort of thing. And I don't know how helpful this is. Most of us have this image of, just like the little schoolhouse on the prairie or something like that, there's this little hospital out on the prairie.

One of the biggest health systems in America, the Mayo Clinic, probably owns about 50 of these things in rural -- maybe not 50, maybe it's only 40 -- in rural Minnesota, Iowa and Wisconsin. I'm sure that they appreciate the financing that comes from this. But at the same token, they probably know better than we or payment system or their members of Congress how to enhance the value to the communities that are served by changes in the way certain

hospitals are structured and certain hospitals are served.

I don't know what knowing that would add to policymakers' understanding of is that a good policy or not.

MR. HACKBARTH: I think that's an interesting point. It makes me wonder about the ownership as well, not just the Mayo Clinics of the world. But has this become sufficiently attractive that for-profit companies are starting to enter the business? It might be interesting to know that. Or are they still largely not-for-profit governmental institutions?

DR. STENSLAND: I think the vast majority, almost all of them, are going to be not-for-profit or government institutions. They can be for-profit, but I've never heard of a for-profit CAH. Though some of them are owned by -- in a few cases, they are owned by a system and the system may view it more kind of as an outpost and a feeder kind of hospital to the larger system and there is a lot of system ownership of CAHs.

DR. KANE: And some of them are managed by for-profits and the for-profit takes a chunk off the top as their fee.

MR. HACKBARTH: Other questions and comments?

DR. BORMAN: Just one quick question. In looking at the capital add-on piece, do we have any sense of how much that can really be accounted for by true pricing cost differences to the CAH hospitals because they are in a more remote location? And we can all envision the increased costs of trucking in certain things and whatever.

Because as more purchasing gets done in consortiums and so forth, you kind of wonder whether or not that's a valid thing. And one of my concerns is that it then goes to capital funding of equipment that's used to initiate diagnostic events or testing or things upon which those individuals can't act and aren't going to act. And then when they move to another piece of the system, and this gets to the grouping issue about where people have been, a bunch of money has been expended on stuff that provided no benefit to the beneficiary when they next entered the next piece of the system. That wasn't done in a way that's useful, it wasn't the right, whatever.

And I just wonder if this capital piece fuels that at all?

DR. STENSLAND: There shouldn't be much of a difference in terms of the trucking distance because we compared the CAHs to other small rural hospitals that have 1,000 or 900 or fewer beds. So the comparison groups are fairly similar.

We also were looking at growth rates as opposed to levels. So it's a growth rate issue and so it shouldn't be affected by the distance.

If anything, the differential might be a little bigger than what we state, and that's because at some point CAHs change the way they do their accounting a little bit when they become a CAH. For example, maybe they're buying a bed for $4,000. Maybe they used to capitalize that and depreciate it. Now maybe they expense it rather than capitalize it and depreciate it.

So actually the increase in their capital costs might be even a little more than what we show there.

DR. KANE: We're sharing this question. But Mitra pointed out that when we looked at DSH and IME and all these other add-ons, we looked at the distribution of the Medicare profit margin, maybe even we'd like to look at the total

margin for each of these little benes and to see how they distribute across the population of hospitals that get them.

And just to be consistent, it would be nice to have the same kind of information about these hospitals and the rural hospitals. Because what we do see with, for instance, IME is that we've created a little monster of 200 hospitals -- I shouldn't say that way.

DR. REISCHAUER: Are you planning to return to Cambridge?

DR. KANE: I guess my grenade thrower personality is starting to pop up again.

But it would be nice to be sure that these are reasonably distributed and not creating competitive advantage/disadvantage inappropriately and out of sync with what we're intending.

So I would just ask that we can see the same kind of distributions for how these monies would flow and the profit margin distributions that go with that for the rural hospitals just as we did when we looked at the teaching distributions.

DR. STENSLAND: We can do that. We could either

look at the dissipation of margins, which we're going to show the 1 percent margin for Medicare across the board, and then some variance in the total margins. We could also look at some variability in the cost.

Because in a way, at least CAHs all have 1 percent Medicare margins but they may get that very different ways, depending on what their cost structure is.

MR. HACKBARTH: Okay, thank you.

Next we turn to physician payment again, this time practice expense payments and CMS's proposed change in practice expense.

MS. RAY: This summer CMS proposed a major revision of the methods it uses to calculate practice expense payments. Ariel and I will take you through the impact of CMS's proposal.

As you will see these changes, if implemented, will result in some large changes. Some of these changes are unexpected. Ariel will also summarize three analyses we are conducting that address some of the proposed changes.

Just a little bit of background very quickly. This work on practice expense fits into our broad agenda to

examine physician payment issues, in particular the accuracy of payments. Recall that in our March 2006 report we made a series of recommendations to improve CMS's process for reviewing work RVUs. These recommendations address the concern about the mispricing of services in the physician fee schedule.

The Commission and others have argued that inaccurate price may be leading to increased volume for certain types of services. Inaccurate pricing is also an issue on the PE side. In our June 2006 report, we raised concerns about the age of the data CMS uses to calculate practice expense payments and some of the assumptions CMS uses to estimate the practice costs of imaging services.

So what are practice expense payments? Practice expense payments pay cover the costs of operating a practice. Direct practice expense payments cover the cost of non-physician clinical labor, medical equipment and medical supplies. Indirect practice expense payments cover administrative labor, rent, utilities and other expenses. Practice expense payments are important. They account for a little under half of the payments to physicians.

Like I said, in June CMS proposed a major overhaul of its practice expense methods. The four main changes are listed here. CMS is proposing to calculate direct practice expense RVUs using a bottom-up method instead of a top-down method. CMS is proposing to use supplemental data. That is more recent data on the total cost of operating a practice from eight specialties. There is a proposal to modify how to allocate indirect costs to specific services and CMS is proposing to eliminate the nonphysician work pool.

As expected, moving to a resource-based method for all services and modifying how direct and indirect practice expense RVUs are calculated results in changes. The impact of these changes varies by type of service. On average, practice expense RVUs would increase by about 5 percent for E&M services, decrease by 5 percent for imaging services and 10 percent for major procedures, and increase by 4 percent for other procedures, I'm sorry, and 1.5 percent for tests.

Within these categories, there are a lot of large changes and some of these changes are unexpected. For example, although as a group PE RVUs for imaging services goes down, they increase by about 27 percent for certain

types of agography and 13 percent for certain types of CT services.

Please keep in mind that the practice expense accounts for different shares of total payments across these five categories.

So what are the factors that contribute to these changes? First is the move to a bottom-up method to calculate direct practice expense RVUs. CMS will calculate direct practice expense payments by summing the cause of nonphysician clinical labor, medical equipment and medical supplies. Moving to a bottom-up method would, not unexpectedly, move direct RVUs towards non-facility services that use costly labor, equipment and supplies such as certain tests and certain procedures performed in physician offices.

Under CMS's proposal, direct inputs play a greater role in determining both the direct and indirect PE RVUs. A better understanding of the process used to refine the direct inputs may help us consider ways to ensure their accuracy in the future. We contracted with the Urban Institute to interview stakeholders about the process for

refining the original estimates of the direct inputs and examine changes in practice expense RVUs between 1998 and 2002 when CMS phased in resource-based payments and 2002 and 2004 when most of the refinements were made. The appendix in your mailing summarizes the findings of this report.

I'm not going to go into the results right now but I'm happy to take questions from you. The take-home message is that the refinements to the direct inputs and other changes between 2002 and 2004 affected practice expense RVUs differently across the five categories of services.

Back to the proposed rule. Using supplemental data, that is more current date on the total cost of operating a practice, is another factor that contributes to the change in practice expense RVUs among services and specialties. Under CMS's proposal, total indirect costs are needed to calculate indirect practice expense RVUs. Keep in mind that indirect RVUs are important. They account for, on average about 67 percent of the practice expense payment.

As we noted in our June 2006 report, supplemental data could cause distortions in the relative practice expense payments across services. For example, practice

expense RVUs for coronary angioplasty increased by 38 percent. By contrast, among all major procedures, practice expense RVUs declined by 10 percent. Cardiology submitted supplemental data.

Indeed, four of the eight specialties with supplemental data experienced some of the largest gains in practice expense.

In addition, supplemental data may offset some of the effect of eliminating the nonphysician work pool for these specialties.

Now Ariel will take you through the other factors contributing to the change in practice expense RVUs.

MR. WINTER: As Nancy said, indirect expenses, which include rent, utilities, and administrative staff, account for more than 60 percent of most specialties' practice costs. These costs cannot be directly associated with specific services, so CMS has to develop a way to allocate them. Under its current method CMS allocates aggregate indirect costs for each specialty to the services they perform based on the sum of the direct cost and the physician work RVU for each service.

The proposed method makes two changes. It adjusts the direct practice expense part of the formula based on the ratio of indirect costs to direct costs for the specialties that perform the service. This change increases the indirect cost allocation for services that are, on average, performed by specialties with higher indirect costs. It decreases the indirect cost allocation for services that are performed by specialties with lower indirect costs.

Second, instead of using the physician work RVU in the formula, it uses the higher of the work RVU or the clinical labor RVU, for example the cost of a nurse's time. The clinical labor RVU is also part of the direct practice expense, so it could be double counted, depending on whether it's higher or lower than the work RVU.

This change is designed to protect services with little or no work RVUs that might be disadvantaged by the current allocation method.

Nonphysician work services include services like imaging and radiation therapy that are performed by nonphysician staff. Currently, the practice expense RVUs for these services are not resource based as they are for

other services. Rather, they are based primarily on historical charges. CMS has now proposed to set resource-based RVUs for these services using the same method it uses for all other codes. This change will increased RVUs for some nonphysician work services and decreased RVUs for others depending on the relationship between charges and resource estimates.

The effect of this change is unclear for specialties that have many services in the nonphysician work pool and that have submitted supplemental data, namely radiology, cardiology and radiation oncology. Use of supplemental data for these specialties may offset sense of the reductions to their services caused by the move to a resource-based method.

Now I'll briefly review our proposed work plan for the coming year. First, as Nancy described, using more current practice cost data for some, but not all, specialties could cause significant distortions in relative practice expense payments. We plan to examine the impact of using supplemental data on practice expense RVUs.

Second, CMS's method for allocating indirect

expenses among services may raise equity issues. For example, CMS currently uses the cost of medical supplies to allocate indirect costs. It's part of the direct practice expense part of the formula that I showed you earlier. This approach rewards services with high cost supplies, although it is questionable whether high cost supplies are associated with higher indirect costs. So we plan to model alternative approaches for allocating indirect expenses.

The third issue relates to how CMS adjusts practice expense payments for geographic differences in input prices. The geographic adjuster is called the Geographic Practice Cost Index or the GPCI. When CMS constructs the GPCI, they calculate the proportion of practice expenses across all services that are related to staff wages, office space and equipment and supplies. They assume that prices for office space and staff vary geographically and that prices for equipment and supplies do not because they're purchased in a national market.

The problem is that CMS uses the average share of equipment women and supplies in the GPCI but, in fact, this share varies widely among services, as we'll see on the next

slide.

This chart shows the distribution of direct practice expenses by clinical staff and equipment and supplies for different categories of services. Services such as E&M, which is the bar at the far left, use a lot of clinical staff resources, shown by the yellow portion of the bar, while imaging services use primarily equipment and supplies, shown by the blue portion of the bar. The average share of equipment and supplies across all services is shown by the dotted horizontal line.

Now remember that CMS assumes that staff wages vary geographically but that equipment and supplies do not. So using a geographic adjuster that's based on an average share of equipment and supplies means that Medicare is over-adjusting payments for imaging and under-adjusting for E&M. In other words, equipment and supply intensive services like imaging are overpaid in areas with a high cost index and underpaid in low cost areas. Conversely, E&M services are underpaid in high-cost areas and underpaid in low cost areas.

We plan to have our contractor model the impact of

applying the geographic adjuster to the portion of each service for which prices vary geographically. In other words, the labor portion of the direct expense and the entire indirect expense.

So to summarize, CMS has proposed a major change in the method it uses to calculate practice expense RVUs. The effects of this change are large and unexpected for some services. We're concerned that the use of supplemental data from some specialties could cause distortions in RVUs. Changing the indirect cost allocator would redistribute payments to services performed by specialties with higher indirect costs. Eliminating the nonphysician work pool means that RVUs for all services would be resource based. And finally, we described our proposal work plan for the coming year.

We look forward to your questions and comments.

DR. BORMAN: Just a couple of technical questions, because we've had some conversation off-line about some of this.

Number one, could you help me to understand how the in-facility/out of facility approach plays into this or

where it may impact this? Where does it potentially change these numbers?

MR. WINTER: In terms of the geographic adjuster?

DR. BORMAN: Currently we believe that many things that are done out of facility, that is in outpatient settings, get a much larger practice expense, sometimes very legitimately but sometimes in a seemingly artificial way.

Is there anything in this that will look at particularly changes that come to the out-of-facility and whether those are differential versus in-facility and whether it further widens that gap or not?

MR. WINTER: I was going to go back to our work plan if I can get back there.

The one thing is that looking at how they allocate indirect costs could play into that because under the change -- I'll go back to the formula, which I put up before.

So the current way it works is it's based on direct practice expense plus the work RVU. Now they propose to adjust the direct practice expense by the ratio of indirect to direct costs by the specialty. Most specialties have higher indirect costs than direct costs. So that's

going to increase in direct practice expense part of the formula and relatively decrease the work RVU part of the formula. And services that are done outside the office, they're more dependent on work RVUs for allocating those indirect expenses.

And so it could have an effect that way. And that's something we might be able to look at through our model.

DR. BORMAN: Because I think, particularly in the minor procedures, other procedures kinds of categories, the number of things that are done on an outpatient basis may be substantially higher and it may drive some funny things in there. I'm not sure that it does, but it might.

MS. RAY: Just to be clear, we presented the changes by these five broad categories of service. What you're talking about is looking at the changes facility versus non-facility.

DR. BORMAN: Within that is it facility verses out-of-facility? And I don't know that there is an impact there but I think if we're looking at that we ought to know. Are we enabling something that we want -- getting back to

the philosophic issue -- or are we disabling something that we want? That would one thing.

MR. WINTER: Right now our contractor is in the process of modeling the bottom-up methodology and they're going to present to us results by facility and non-facility.

DR. BORMAN: Great. I think that's fabulous.

MR. WINTER: And by type of service as well as by specialty.

DR. BORMAN: This is great work and I also think CMS did a much better job this time of making it to where mere mortals could understand the process a little bit and follow the calculation. So I think that's great. That was very helpful. Of course, this is wonderful staff work.

Another piece of it that I would bring up and it sort of relates to Nancy's comment about set a target and then figure out where it is. At least my understanding is in the rule that it's talked about that what's really being covered here is roughly one-third to two-thirds of physicians' practice expense costs. That sets an implicit target, if you will, on this little piece of the puzzle.

Certainly, that's influenced by the Medicare mix

of an individual physicians' practice or a group's practice or whatever. But you need to know you are sort of setting a target there that even though the way we measure your cost it's 100 percent, that we have decided that what we can pay you for is 35 percent, 65 percent of your directs or indirects. And that implicitly sets a target, whether you want to think about it that way or not, it does seem like it does sort of imply a target for physicians. So I think we should look to see are those the things we want to encourage.

The other piece, just very philosophically, is that as you get into more of the technical arcanery here, that it does bed the issue of whether or not a system that was developed in a very well-intentioned way, in terms of trying to break out what are the inputs into these costs, now it seems to be progressing way past its value by virtue of the way we've learned to slice and dice this. Being a slicer and dicer, I understand that part.

MR. HACKBARTH: I'm glad you're on our side.

DR. KANE: First of all, although it might be clear to you, I frankly don't understand the new indirect

allocation.

But before I go back there, I actually worked on this years ago as a research project, maybe in the early '90s. My main focus was what drives indirect costs and which ones are fixed and which ones are variables. And it turns out indirect costs are largely fixed, but we're paying them on a 100 percent variable basis.

And I'm going back down to our volume problem and I'm thinking maybe this is one way to think about the volume problem is that -- and I don't know if -- it's probably administratively impossible.

MR. HACKBARTH: That's never stopped us before.

DR. KANE: That's never stopped us before. But my recollection, because I ran around the country talking to physicians and collecting their costs and doing an analysis of what drove their overhead costs. First of all, most of them are fixed. But we're paying them on a variable basis. And I wonder if we should have some cut-off point at which you're only getting to work part instead of -- if you really want to get at volume.

I guess the other thing is whether -- and I know

this is probably too complicated. I don't understand the allocation formula but I do know it doesn't relate at all to the cost drivers for indirect costs. So I guess in traditional industrial cost accounting we try to create an allocation method that really reflects what's driving those costs. Is it more the size of the staff which is what's creating overhead or the size of the -- but this doesn't have any of that in there.

So I guess I'm concerned -- first of all we should throw the whole thing out, I know. I'm just wondering if we want to at least do a fixed variable consideration and in terms of indirect costs whether there should be some point at which you're getting work and you're not getting -- because your volume -- and whether we can even track that at the practice level. I don't know.

But this is really just a totally arbitrary way of allocating indirect costs that bears no relationship to the science of cost accounting. And on top of that, I don't understand it yet.

MR. WINTER: I can take a stab at trying to explain how it really works. So for a given code you have a

direct practice expense, and that used to be derived on a top-down method and now we're doing a bottom up. So that's summing up the direct inputs, supply, staff and equipment.

And you add that to the work RVU for that code. And then there's a whole process where they apply a scaling factor to it, at which they relate the total indirect cost for the specialty, as derived from a survey, the SMS survey or the supplemental surveys. They relate that to the total allocation across all the specialties' codes. That is what you derive from that formula, direct PE plus the work RVU. So you try to make the two equivalent on an aggregate basis.

DR. KANE: If the indirect to direct relationship in surgery was two-to-one, but then you've made the one, the direct both direct cost plus physician work, do they maintain -- do they keep it two-to-one, so you're adding an indirect on to something that wasn't in the original relationship? Am I wrong?

MR. WINTER: That's a good point. I'd have to think about whether -- you're asking whether the relationship between direct and indirect is maintained at the specialty level.

DR. KANE: No, I'm saying you're allocating -- I should probably take this off-line, but just one more shot.

If a specialist, let's say the surgical specialty, is two-to-one indirect to direct. But you're going to allocate it two-to-one to the direct plus physician work. But that's not the original relationship.

DR. BORMAN: It's the effect of the scaling factor that's carried on for multiple pieces of the equation.

DR. KANE: I think I'll ask this separately because I don't understand it. But I will say that cost accounting is one thing I'm pretty good at, so I'm concerned.

MS. RAY: I'm not going to try to explain it, but it is clear and this is a point that we did make in the comment letter, that it is still not a transparent method and it is still hard to understand for us mere mortals. I think your point is well taken.

DR. MILLER: I also thought in your work plan there was a discussion to look at this and to look at the scaling factor.

MS. RAY: Right, and to look at different ways of

allocating indirect costs; that's correct.

DR. MILLER: So beyond just getting you to understand it, and we'll have this conversation by phone, we can get to that point. But we've recognized that there are some issues here and that by doing it the way they are doing it, they may be having effects that one wouldn't necessarily have anticipated. So we do understand that there's an issue there.

DR. BORMAN: Relative to this process I think, as Mitra brought up before, there's an assignment here. And part of the assignment is to look at what is the impact of this.

Just to reiterate some of the things that you pointed out, the issue of the supplemental data kind of, as everybody very quickly saw, relates to some of the earlier silo and movement discussions that have been had here. And some of you might fairly quickly think well -- because it occurred to me at first, well I can go out and get supplemental data. But in actuality, to collect this kind of information is pretty expensive and it does disadvantage smaller groups from doing it in the same kind of way to

present comparable data. So the supplemental data piece is an issue, I think.

And the SMS data that is your default data, those are now 1999 data at best. I think we would all agree that probably some things have changed in the economics since then.

The piece about the zero work pool I would say, as you mentioned, the issue has been raised about you're double paying. And I think it's a little hard to figure it out in any other way other than it is double paying. And if that's again a good policy goal or something we want to reward, great. But it is double payment. I would wonder what other rationale there could possibly be to do that other than this notion of trying to give back something to a group that you perceive that you've hurt. And we keep doing this patchwork stuff and it takes us further down a road that presumably we don't want to go.

DR. CASTELLANOS: Just to clarify the supplemental data, every specialty had the option to do this. It wasn't mandated. There were eight that did. One of them happened to be a urologists, which I am. We did it because we wanted

to correct some supply question problems we had. As far as the cost, it cost urology about $60,000 to do that.

DR. CROSSON: I just want to talk to one item on the work plan, and that's the issue of the basis for the geographic adjuster. A few meetings ago we discussed another issue related to the GPCI and that had to do with -- oh, goody. That had to do with, I think, a sense of inequity in California as at least one of the multi-locality states. That's still an active issue.

I think we talked about that for a while and recognized, I think, the validity of the concern and also the complexity of potentially addressing it.

So my question is is it likely that remodeling the factors that go into the geographic adjustment factor, as laid out here, might mitigate that problem in multi-locality states? And B, could we model, as we're doing this, the impact of this different way of doing it on that problem?

MR. WINTER: We had not been thinking of interacting variations, changing the way the GPCI is applied along with changing the locality areas. That was part of your question. The other part was the effect on multistate

areas? I'm sorry, the single state areas?

DR. CROSSON: I think that the sense I have here is maybe the degree of difference between the localities in multi-locality states might be made smaller if you change the calculation for the geographic adjustment factor. So that the differences that have created so much concern might not disappear but might be smaller.

So the question is -- you haven't done it yet. But is that likely to be the case? And if so, could we model that as an additional piece of work?

DR. MILLER: My sense is, I'm talking to guys here, Nancy and Ariel, my sense is there's no reason that any of these changes that you would anticipate that as you stepped across locality boundaries it would necessarily minimize. Because there would have to be -- I think there would have to be significant differences in the distributions of specialties and services across the localities in order to get that effect.

What you'd really be reflecting there is not so much that the methodology did anything as did the mixes in the two localities.

So my instinct, without doing the arithmetic, is that no, there's no reason to anticipate in advance that it would have any effect of minimizing it, that we're still stuck with the problem that we discussed a couple of meetings back about the definition of the locality and the GPCI differences between it.

That's my initial reaction but you guys obviously know this better than me.

MR. WINTER: You're on the right track and it depends on the mix of services, because with imaging if you adjusted only the portion of the practice expense where the prices varied, so you held the equipment and supplies constant -- and for imaging that's a very big portion -- then you're essentially compressing the price differences across geographic areas.

But for E&M, you're expanding the price difference about geographic areas because they have a larger than average share of clinical staff and you'd be adjusting for -- therefore you'd be adjusting for a larger share of their direct expenses geographically.

So it does depend on the mix of services. If

you're doing a lot more E&M, then it could increase the variation. If you're doing more imaging and maybe tests where the variations are going to be compressed, then it would be compressing the variation.

DR. MILLER: And in the California situation, my sense -- and you're being from California, you probably have a stronger sense. But my sense of this is we're talking about localities that are next door to each other, where the differences on the GPCIs are relatively high in some instances. And I'm just speculating that rolling across that border it's not so much that you're going to get big differences in the services and the mix of specialties that you would see this compressing effect. Plus the fact that it could go in either direction. That's my sense.

DR. CROSSON: I've been somewhat at a loss, actually, figuring out how we can address this concern although I could certainly raise it at future meetings. Because I think I'd like to explore that.

So I guess I'd only ask in the modeling process if the intuition we have for it now turns out not to be the case that we could take a look at that.

MR. HACKBARTH: Other questions or comments?

Okay, thank you very much.

And last, Sharon is going to talk to us about building quality composites. I should say last but certainly not least.

MS. CHENG: I'm going to spend a little bit of time with you this morning. Really this is probably an introduction to this topic. We will talk about this again. The topic is a building quality composites.

What I'm going to do with the time that I have is describe what we're working on here, what is a quality composite, look at some other groups that have built these and are using them. We're going to look at a quick list of actions that we could take relating to this topic. Why are we talking about this this morning? And finally, we're going to discuss some potential criteria for how we could describe and perhaps assess different quality composites, their strengths and their weaknesses. What are the criteria of a good quality composite?

The first one I thought we would look at is a pretty high level quality composite. This is available on

the web from the Agency for Health Care Research and Quality. A lot of people call this kind of measurement a dashboard. I think this ones kind of slick, it actually looks like a speedometer or something.

And what this does is it is a composite of quality information, in this case for the state of Virginia. And what AHRQ has done is taken about 100 different indicators of the quality of health care in the state of Virginia and given it to you in a fairly simple graphic.

There are two needles up here. So the solid needle tells you where the state is in the most recent year and they dashed needle tells you where it was last year. So you get a sense of current level and also a little bit of the sense of change.

There's a lot of stuff going on then behind this needle. Preventive care, what's the rate of immunization in this state? How are they doing at testing for diabetes? It's got acute care. Are they dispensing aspirin in hospitals to people who present with an acute MI? It's got admissions for asthma. It's got chronic care. So there are a lot of things that have been rolled up into a single

score, in this case, for a state.

Here's another one. This is a consumer website. This is available to people who are looking for a hospital. It's a hospital level composite of quality. Actually, you're looking at several different composites here.

Let's look at the stars, for example. This hypothetical hospital is a five-star cardiac hospital. That is a composite of the quality of care for surgical procedures in the cardiac field. So we've got CABG in here, we've got treatment of heart failure patients. The five stars tell you this is one of the best hospitals that was graded.

Another composite that's also available here is up at the very top of the screen there's a little silver medal, a critical care excellence award. That gives you a somewhat different piece of information about that same hospital. It tells you it was in the top tier, and that's a composite of mortality that results from things like the complication of diabetes, sepsis, pulmonary embolism and respiratory failure. It also includes a structural component. So part of the award that this hospital has gotten is meeting

Leapfrog's requirements for staffing and intensive care unit with intensivists. So those are several different hospital level quality composites.

Let's look at just one more. This is from the state of California. This is also a public website. I just picked the area of Fresno County in California.

This is a rating of medical groups that are operating in Fresno. And here you've got two different composites. Again, they've used stars to compare them to their peers.

The first one is getting the right medical care. So that's a composite of whether the physicians in that medical group tested for blood sugar. Did they test their patients for cholesterol and composite process measures?

The other composite is a patient rating of care. This is sort of a collection of different pieces of information based on patient surveys. It indicates whether the docs in this group coordinated care well for their patients. Did they communicate in a clear fashion? And was the patient able to access their care in a timely way? So it's got several different pieces of information wrapped up

in a star rating.

So what each of these systems have in common is that these groups have a large number of quality indicators and they are trying to give the consumers of information a way to summarize it and a way to use that summary to compare, in one case states, in another case hospitals, and in this case medical groups, to each other on a summary score.

The reason that we're looking at these kinds of activities is that we have, and CMS has, similar kinds of information. We have a number of different ways to measure the quality. In our case, we've got several different ways to measure the quality of physicians, of inpatient hospital care and of home health agencies. And so we have the possibility then of also creating these summary level scores. So we can start comparing groups of physicians to each other, hospitals to one another, et cetera.

So this is a list of things that we could do with the quality information that we have. We could build a set of quality composites that would allow us to make these kinds of comparisons. We could describe then the strengths

and limitations of different approaches that we could take to building those composites. There's certainly more than one way to put this information together.

We could use composites in our work. This is directly relevant to the congressionally mandated report that we have on designing options for pay for performance for home health agency. It's also relevant to our own efforts to start to describe efficient providers. If we'd like to compare hospital A to hospital B, a summary of its quality, in addition to its resource use, would helps us make comparisons about their relative efficiency.

Also, we could discuss an entity that could administer quality measurement and build a quality composite. A lot of the work that goes into a quality composite is to set priorities among things that we all probably agree are very important. But what's the relative importance? And how would we put that information together? And an entity that we could describe would also help to set these kinds of priorities and goals for a national program like Medicare for private and public payers perhaps. And we could think about with that entity would look like

So let's switch now and get a little bit down to brass tacks then. How would we describe what a good composite might look like? What MedPAC staff has spent the summer doing is looking at different government agencies that have put quality information together like AHRQ. We've looked at the work of various researchers that have started working in this area, notable Wennberg and the folks at Rand that have described the quality of U.S. health care.

We've also looked at sites and systems that were designed and are being used right now by consumers in the marketplace such as the HealthGrades we just looked at. We looked at America's Best Hospitals from U.S. News & World Report, a system that was designed by RTI and the University of Chicago. We looked at the state of California and the work at Integrated Health Care Association that's put together a lot of this information into quality composites, as well.

These are the criteria that emerge from looking at a body of work and we're going to run these past you to start thinking about whether or not these describe a good quality composite.

They are all up on the screen and what I'm going to do now, with the next couple of minutes, is go through them one by one.

So our first one: a good quality composite applies to most patients, most providers and most quality traits. What this really hits is what you try to do a quality composite in the first place because, first of all, any time you use a single square, the kind of scores that we have, you're going to exclude certain types of patients. If you're looking at a score for AMI, you exclude patients that don't have AMI. And so by bringing different scores together for AMI, for pneumonia and for heart failure, you get a better picture of the all the nations that a hospital or a physician group might be caring for.

Sample size is another thing that you get to address when you start bringing different measures of quality together. Some small hospitals do quite a bit more medical procedures than they do surgical procedures. So if we can account for both surgical quality and the quality of their medical care, we're going to be able to include some hospitals that would be excluded if we just tried to use a

single surgical score.

And finally, bringing more than one piece of quality information together in a composite lets us get at a lot of traits that we think we're going to have to measure separately but they're all pretty important. So from the Institute of Medicine we've got three key traits that we think are important. Was the quality of the care, was it safe? Was it effective? And was it patient centered? Measuring those three traits probably are going to involve different measures and we might want to bring them together to say in summary, one provider compares to another provider in this fashion.

A good quality composite trait is that it accounts for differences among patients. This gets really at the heart of whether or not we're making a fair comparison between hospital A and hospital B. Especially also if we thought about moving this into public reporting or attaching a financial incentive to it, you want to make sure you're not creating an access problem for patients that might be a little less easy to care for that might bring a providers score down. So you want to account for differences among

patients that might have an impact on your quality score. And it begins then with the adequacy of risk adjustment for each measure. If you are including an AMI mortality, you want to make sure that your risk adjustment on AMI mortality is pretty robust.

You want to compensate then when you bring things together for differences in patient characteristics like their age, their cognitive status and comorbidities so that you can describe the patient population adequately.

What it might suggest is that it might be very difficult to compare all the patients that a medical group sees to all of the patients at another medical group. What you might want to start thinking about then is stratification. Maybe you'd like to compare groups of patients to each other. And stratification can have a lot of different levels.

Going back to U.S. News & World Report, I am proud to say that my undergraduate alma mater was the best small, single-sex, masters level university in the Southern region of the United States in the most recent ranking of colleges and universities. I just bring that up to suggest you can

think of a lot of different ways you stratify. And what you want to do is compare apples to apples, but you don't want to end up with only one or two apples in your basket. So there's some balancing going on.

Another characteristic that we want, all that said, is that at the end of the day you'd kind of like to have a score that's easy to describe and understand. As important as it is to get these things right, the have to be useful to the people that are going to have to digest this information and use it for comparison. So something that you can at least describe is going to be more useful to the consumers of the information.

And also, there has to be some level of transparency. If you're going to tell a medical group that they're better or worse than the group up the street, they have to be able to understand how they were ranked and why those differences occurred in the information that you're collecting from them.

This is a complicated endeavor. And one of the things that is going to increase how good your composite is is the extent to which you can acknowledge and identify

where the areas of uncertainty are. For example, a composite could make note of the variability in individual scores. Maybe something is very sensitive to having a small sample. Maybe risk adjustment has a big impact on making a certain comparison. You might want to note that that's what's going on underneath that score.

You could choose, and in the couple of grades that we looked at, HealthGrades for example only includes significantly significant differences. It makes it a little bit easier for the consumer, rather than giving them two different numbers and telling them these really are the same, only include the things that you can test and you can validate as being statistically significant.

And finally, you could contemplate reporting a confidence interval around your score rather than just coming out with a single score and saying this score is definitely 35. You could say this is 35 plus or minus 3 percent or whatever your range would be around that. There are several different ways you could imagine of building that confidence interval around a single score.

You want to look at the composite that you've come

up with and determine whether or not it reflects the relative importance of the traits that it integrates. One way you can do this is you can say these traits are all equally important to us and we're going to weight all of the things that go into this composite equally.

Alternatively, you could group measures within -- when we looked at the California report card, for example, there were two composites that we were looking at side-by-side. So they've grouped things under those and then put them side by side. So you could have unequally numbered groups or you could assign different weights to different groups within the composite.

The point in the middle here, there are different ways you could use to calculate the average among similar scores. That has an effect also of reflecting what you think is important to measure about the characteristics of your provider. I'm going to hit that on the next slide.

Two ways that are widely used in the research to create an average of similar scores are the appropriateness model and the opportunity model. The appropriateness model is patient level and it doesn't assign partial credit. The

opportunity model is provider level and it does award partial credit. So let's think about this for just a second and I hope this helps.

Imagine a system in which you have four measures for diabetes care. You want to check the health of their eyes, the health of their feet, you want to measure their blood sugar and you want to measure their cholesterol. If two groups of doctors both did all four of those things to all of their diabetic patients, then these two models would give them the same score.

However, if one group, for example, was very good at giving all four measures to most of his patients but not to others, then you would start to see a difference.

So in the first case, if a diabetic patient got three out of the four measures, that physician group would get a score of zero for that patient. In the second one, they would get a score of 75 percent because they did three out of four things that were indicated for that patient.

The appropriateness model could provide a kind of a checklist for patients. It gives you an idea as a patient of all four things that probably should happen to you over a

year or at an encounter. It emphasizes that the care should be patient centered and that's the center of the measurement. This was a system that was used by McGlynn at Rand when she was looking at similar types of quality indicators.

The opportunity model would have the advantage of being able to acknowledge a very high level of performance at doing something. If there were a medical group that always checked their patients eyes and feet but didn't routinely do the blood work for sugar and cholesterol, they would get some credit under the opportunity model. And the opportunity model would then acknowledge the difference between those two groups.

That was kind of tough. And probably no easier then is assigning explicit weights to traits that are even less similar that are four processes of care. There are many different ways to assign weights. Several that we have to think about: Leapfrog, as a group, put a quality composite together. They used a consumer utility function. So they put greater weight on processes that had a greater impact on reducing mortality.

Another group of researchers proposed using excess mortality. So you might assign more weight to the adverse event of acquiring a serious blood infection than a hip fracture, because the blood infection is going to lead to more excess mortality than the other adverse event.

You could have consensus weights. Blue Cross-Blue Shield values its consensus system and they get all of the people that are grading and being graded together and they set the traits and they set their relative importance together. This is also flexible and it changes over time as the community feels they've hit certain goals or they want to emphasize different aspects of quality.

One of the things we could do to elaborate on this point a bit, if this would be of interest, would be to do a somewhat more systematic look at scorecards that are available, describe who's using them and how they set the weights on those scorecards and maybe put a matrix together for you.

So where to from here? Well, I'd like to bring you some real numbers and we can start looking at how these composites would go together with the kinds of quality

information that we've got on hand. We could apply the standards for sample size to the home health agency measures. That kind of hits our first criteria. Are we able to measure most of our providers with what we've got on hand? And if not, where are our weaker spots?

We're going to continue to assess risk adjustment, and especially we're going to do that with the home health outcome measures to see how that risk adjustment is working. We're going to bring you different kinds of composites, probably several different ones for home health agencies and several different ones for inpatient acute hospitals, and then we can use that criteria to compare how well they meet the different criteria and compare the alternatives to each other.

We'd also like to convene some stakeholder panels and get their input on the way we've put these things together and the traits that are important.

So what that, I'd like to turn it over to you guys to describe the actions that are relevant for this and what do you need from staff to be prepared to take some of those actions in upcoming meetings?

DR. REISCHAUER: I think this is terrific, Sharon.

I apologize that I'm going to have to step out and go to memorial service for a close friend.

But I think we would serve a tremendous value to the debate and understanding if we just laid out how this is done and all of the different ramifications and variations that you have laid out here.

I think the value added from us trying to build additional composite indexes is quite limited and could prove to be confusing. And there's already a proliferation of these things. It's not really our area of expertise, I think.

So if we are considering how far to go down this path, I think our comparative advantage is really analyzing what others have done and showing the strengths and weaknesses and limitations of all of these approaches in a comparative way.

MR. HACKBARTH: Bob, before we lose you, what about the issue of discussing an entity that might, in fact, have the ongoing responsibility for maintaining such a system? Would you include that as something that we ought

to address?

DR. REISCHAUER: I think we should. As you all know, the Institute of Medicine issued a report on this committee that several of us are on, on this issue. I think it would be great if MedPAC expounded on the wisdom of that report and similar recommendations. There are a number of these recommendations by other groups for how this should get done.

I think just sort of saying composites have advantages and complexities and somebody go do it isn't really enough, because if we want to bring some kind of organization and effectiveness to this area you can't have everybody out there doing their own thing. And there has to be some kind of entity or entities that play defined roles in this.

That's my opinion, and if this group felt the same way, I think we'd be making a real contribution.

MR. HACKBARTH: I, too, would like to see that as an issue we discuss, without prejudging the outcome. My personal feelings are much like Bob's. But I think, especially given the IOM report, we ought to address whether

there ought to be an entity to do it and what the characteristics of that entity might be.

DR. MILLER: I agree with all of that, and internally we've had discussions of this kind as well in putting this together.

There is one complication here, and I suspect this is on Sharon's mind too. So we have a mandated report where we have to demonstrate how someone might do this. Even if it's just illustrative, we're going to have to put a couple of these things together just to show how these things work.

And of course, being in the position that we're in, we also to try to distance ourselves and just say this is just illustrative and everybody will forget that. So it's going to be kind of this funny walk we're going to have to walk.

DR. CROSSON: On that basis, that we're going to be talking about how one would model this, I'd like to talk about the criteria. Because I think I heard in the discussion of the criteria something that sounds implicit. But I wonder whether it ought to be explicit in thinking about the criteria.

And that has to do with -- I don't know what the right term would be, something about the subjective importance of discreteness. And it's like where on the lumper-splitter continuum do you want to be? In the text they used the automobile model, so I'll talk about the automobile model.

You go out to buy a car and arguably you're interested in how much it costs, something about the power, the acceleration, the fuel economy. You might or might not want to know the difference between highway and city. Comfort, safety, crash survivability, quiet, and then maybe some fancy stuff like a satellite radio or whatever.

I think most people who are going to buy a car are kind of interested in those things, as opposed to whether the car is rated 75 or 84.

I think when you get into health care, it gets a little bit more complex because some of the things that are important are not as intuitive or well known as those car characteristics.

MR. HACKBARTH: Jay, do you think it's also dependent on who the measures are being developed for? You

might have different criteria if it's being used for a P4P system versus consumer information versus provider feedback. It's just three possible purposes for the information.

DR. CROSSON: So as I was defining it, I said subjective -- and that would mean to the observer -- importance of discreteness. So the thought is if we're going to describe the criteria that one should use to create a composite, I wonder whether or not that might be one, which is -- in your context. For the customer, the observer, the target audience, there ought to be an explicit understanding of where on that lump-split continuum it should be.

MS. DePARLE: Actually, I realized my question was what Bob was asking, sort of where are we going with this? So I don't need to probe that more.

MR. DURENBERGER: That's probably all of our questions to one degree or another.

I didn't want to raise it, after we learned about where her undergraduate degree came from. We probably shouldn't even be questioning Sharon.

[Laughter.]

MR. DURENBERGER: But since we're all in this together, I guess it's all right; right?

I think I too -- and I don't have an answer for this. I'm searching for our comparative advantage and I'm not yet clear exactly where our comparative advantage comes in.

I remember doing a press conference in like 1990 with Sheila Leatherman, who was then at UnitedHealth Group and standing up and describing a scorecard. She was predicting the future of all of these composites, as they're now called, but she's talking to us about a scorecard for doctors and hospitals, and one of these days we'll all be buying quality. I think that was 16 years ago. So we sort of like, as a community of folks, we've been at this for a long time.

The community that I'm most used to though has been doing this in one way or another almost internally rather than involving the public. So you think of the Institute for Clinical Systems Improvement and the work that they've been doing, funded by health plans but principally aimed at doctors in Minnesota and the larger community.

They've always debated whether or not they ought to take that to consumers and things like that. As of today they haven't done it. They haven't exactly -- they felt more comfortable internalizing change than they have trying to take it to the level that I know it's important to take it.

The folks next door in Wisconsin, this is just a way of recommendation and maybe you're already talking to them, but I think it's probably unique in this country. Over the last four or five years now, starting with six medical groups and now it's like 70 percent of the docs in the state. Even -- well, I won't go into that.

It's about 70 percent of the docs in the state have been providing the leadership in Wisconsin to develop the kinds of measures that will first -- and this is the distinction I'm trying to make -- first change physician behavior and then change public behavior.

And I don't know where they are on that, except I know they have now involved the business community. They hired Chris Querum to come over from their employer group to run this effort.

I suspect if we're trying to think about what works for various -- starting with the providers -- and then going to the public, I think we might have something to learn from this because it's a collective, as opposed to going to the Society of Thoracic Surgeons who are also leading in this area or the orthopedic surgeons who believe that they're coming up with unique things and things like that.

It might be really interesting to go to a community that is addressing all of the service concerns that are raised in the work that we are doing.

I guess the last thing on the entity, I know my initial reaction to the IOM suggestion that there be a commission or a government body was oh my God, nobody will buy that. In other words, there's a yearning to have somebody set the rules for everybody. But when you think about the people whose behavior you have to change, I'm not sure how quickly it changes because some entity somewhere nationally described the way in which change ought to take place and so forth. So that only may mean what you ask that entity to do rather than whether there should be one.

And I'm only describing a gut instinct. One of the cochairs called me immediately and said what do you think about it. And I said this is my gut instinct. It's sort of like the cart and the horse maybe, that if we know what we're doing and for whom we're doing it and then we think about what entity does what, it might work better.

MR. HACKBARTH: I think a lot of people have that instinctive reaction. The other side of the coin is to what extent are we going to get clinicians or institutional providers to move if they're repeatedly inundated with different sets of measures that pull them in multiple directions and burden them with data collection. So there are trade-offs definitely to be made.

MR. DURENBERGER: Can I just respond to that very quickly? I thought, and maybe you all know better -- and I'm sorry I didn't raise it in the executive session so we wouldn't be taking up everyone's time.

But Mike Leavitt has been to Minnesota twice in the last couple of weeks and I know he's been to Wisconsin. I know they've selected these six or seven places, the AQUA [ph] places that they're going to. And they're going to

expand them and so forth. So it seems to me the administration is on a track right now in the implementation of MMA and some of their pay for performance. They're going to look at local committees and see what's going on. And also to try to start dealing with the issue of measures and see what you can learn at a local level about who's doing what kind of measures, as opposed to relying only on an NQF, although that is a -- anyway, I was curious as to what they are up to, other than the obvious.

MS. BEHROOZI: I guess whether this is to inform the work that an entity with responsibility for doing this creates from scratch or whether it's used as a threshold for judging whether other things that are being done out there meet the test of validity that Medicare beneficiaries could rely on or the Medicare program could eventually rely on.

It's interesting to talk about all the issues that you've identified, Sharon. It's really great that you pulled it together in one lucid paper here. So I'm just going to focus on one small thing.

In terms of accounting for differences among patients, whether it's risk adjustment or patient

characteristics or taking into account and stratification of it, I would suggest that looking at the socio-economic status of the group that the entity serves should be added to the list. It might be more important in a home care setting than in a hospital -- actually, Arnie, I should turn this over to you to talk about differences in socioeconomic status and things that don't show up as comorbidities.

You will find socio-economic status reflected in comorbidities and some of those other characteristics. But there are other things that are hidden that you won't find, such as family and social network connections, language, as Jenny has pointed out, things that will interfere with the ability to provide care or achieve the same outcomes.

So that's just a suggestion.

MR. HACKBARTH: Dave's mention of Sheila Leatherman reminded me of the same point. Sheila has, for a lot of years now, been toiling in the quality measurement fields and I've had the occasion to sit on a couple of groups with her recently. And she's quite concerned about this issue and whether -- I'm trying to remember the exact terminology that she applies to it.

But you need an adjuster that's not just morbidity and risk but social circumstances, particularly when you have measures where patient compliance is a big part of the outcome.

DR. HOLTZ-EAKIN: Let me just repeat some things that probably have been said at this point.

First of all, I am looking forward to this but I am worried about the scope just exploding on us. So to the extent that it would be possible to, within that scope, address some of the things that have come up. I'm very worried about distinguishing the purpose for which these different things are used. You could imagine all you want to do is get things in the right order and then just getting an ordinal measure is fine. Sometimes you want to know how far apart they are, and then you need to put more structure on it. And then you want to pay based on the differences.

So I think laying out those issues very clearly in a single set of examples might be very helpful for people.

And having done that, what's the purpose? You could then ask who's going to get it? Is it going to be the consumer? Is it going to the provider? Is it going to be

the payer?

And when you do that, look at the incentives it will provide for the other parties. If we're doing this for providers, it's not going to be secret. The payers are going to know about it. The consumers will eventually get their hands on it. Does it lead to bad incentives overall?

I'd worry about that when you do this.

The other thing I'd like to see us think a little bit about is the data. If you restrict yourselves to the data you've got, you will dictate the incentives for data provision. And so a good thing to think about is what data do you want to elicit from people in the construction, even if it's not currently available? I'd like to have that be part of this discussion.

I'll hold my fire on building the large monopoly government agency that's going to tell us how good every doctor in the country is.

I think we ought to, all kidding aside, be careful about that and think harder about whether you want to have something that's the standard setter. You don't want to be the accountant, you want to be the accounting standards

board and tell people how to do this well. I think that's a focus we might want to bring to this.

DR. MILSTEIN: One dimension that would be helpful to bring to bear in the next iteration of this, because it's directly relevant to what might -- at least I think down the chess board more moves, what kind of an aggregate would be most useful A, to a consumer and B, to a provider, and C, to other interested stakeholders is the issue of the user specificity of the aggregate. I think, as I imagine Medicare beneficiaries in my family, what they'd be interested in is an aggregate measure of quality for a doctor or hospital or a home health agency that was specific to their particular health conditions rather than weighted across-the-board or even weighted by category, patient experience versus effectiveness versus safety.

And similarly for a physician, I think if I were a physician -- if I were practicing today, I would like to see an aggregate that was weighted for the particular clinical activity that I primarily engaged in, rather than, for example if one out of a thousand of my patients is a diabetic but my diabetic measure counts as one out of 10 --

gets weighted 10 percent of my score.

So I think ultimately what you'd like is almost any stakeholder would like, if they're in the market for aggregates as a general goal, is going to be interested in an aggregate that is specific to them and especially Medicare beneficiaries.

If we could, maybe in the next iteration, take that as a general objective, and maybe you could share with us your thoughts on how that might be achievable or what we might put in place as a first step toward achieving that ultimate goal.

MR. HACKBARTH: Okay. Thank you, Sharon.

We'll now have a brief public comment period with the usual ground rules. No more than two minutes, no repeats. Sharon knows those ground rules very well.

MS. McILRATH: Except it's going to be harder this time.

Let me start with practice expense. I just wanted to stay on that one that, in terms of when the RUC was doing the refinement on the practice expense, actually most of it occurred before 2002. So if you're looking at that as one

of the factors, you need to change the way you're thinking on the timing.

I think you also should keep in mind when you're looking at those things that it's a four-year transition. So you're not going to see that all immediately. And when you're thinking of the supplemental surveys, just keep in mind that you would have probably two years of the transition before there was another survey that was a cross-specialty survey that would be available. The AMA is working with specialties and we're going to pilot one we hope this fall, and then it would be done in 2008 and be ready by 2009.

On the GDP, the volume targets, to start out with I don't think that some of us would think that GDP was an objective standard. There's a lot of subjectivity to that.

On productivity, the relationship to the MEI, I don't know, are you talking about not doing a productivity adjustment on the MEI if you do it on work values? Are you going to be penalizing some services twice if you do it? And also, keep in mind that BLS just changed the way that they figured the multi-factor productivity and that actually

has led to a lower MEI this year than was originally anticipated.

It's also very much at odds with the other providers in terms of how their productivity is treated.

On the question of overall versus physician only expenditures, in terms of looking at targets, there are other areas of the program that are growing even more rapidly than physicians. If you look at the last two years for hospital outpatient department, I think you would find that to be true.

On the question of regional, I do know that, for example, in Iowa, even though they have overall low expenditures, the physicians -- I think it's about the sixth highest in the country. So there does seem to be perhaps some trade-off of where you have higher physician expenditures you may the some lower other expenditures.

And I think that ought to be part of the discussion in terms of impact on beneficiaries, as well, because though they may have a higher premium they may avoid a hospital deductible or a hospital outpatient copayment.

Risk adjustment, there was some discussion about

that. I wonder if you wouldn't want to have some discussion of the different risk adjusters that are out there and what exactly they do include. We're hearing all this stuff recently about obesity. That does vary by area. I believe Kaiser even does a map of obesity. And you might look to see how well that lines up with some of the Wennberg maps.

In terms of using other tools, as Dr. Castellanos said, I think that the attitude of the profession is generally that the best way to get at volume is to try to figure out which volume is appropriate, which isn't, and address it that way. The episode groupers, of course, is one way to do that.

In terms of what happened in the early '90s, a lot of people think it was as much or more going to the RBRVS. And in fact, the lower volume didn't start until you began the RBRVS. There were global surgical codes. They were new CCI edits, those were coding edits. So before you assumed that it was the target that had that impact, look at some of those other things that were going on.

And finally, in terms of improving payment to primary care or other specialties where there are beginning

to also be shortage problems, there are other ways that you could go about it. For instance, there's talk about the medical home. But there are even already, in the CPT book, codes for coordinated care. Those have been valued by the RUC but they are not paid for by Medicare. So you could see some kind of way that you could use some of the existing codes to begin to get at the problem.

And finally just to note, as I think Dr. Borman did, that the rule that came out recently on practice expense did, for the first time, quantify that the Medicare is paying for only two-thirds of the physician's direct costs.

MR. HACKBARTH: Okay. We are adjourned. See you next month.

[Whereupon, at 12:01 p.m., the meeting was adjourned.]